

A Guide for Using the Cultural and Linguistic Competence Policy Assessment Instrument



DEVELOPED BY

**National Center for
Cultural Competence**

Georgetown University Center for Child and Human Development

Acknowledgments

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Introduction

Assessing attitudes, practices, structures, and policies of programs and their personnel is a necessary, effective, and systematic way to plan for and incorporate cultural and linguistic competency within organizations. The National Center for Cultural Competence (NCCC) supports the concept that cultural competence is a developmental process and evolves over an extended period. Both organizations and individuals are at various levels of awareness, knowledge, and skill acquisition along the cultural competence continuum. The capacity to engage in self-assessment helps organizations to:

- gauge the degree to which they are effectively addressing the preferences and needs of culturally and linguistically diverse groups;
- establish partnerships that will meaningfully involve consumers and key community stakeholders;
- improve consumer access to and utilization of health and mental health services;
- increase consumer satisfaction with services received;
- plan for the systematic incorporation of culturally and linguistically competent policies, structures, and practices;
- allocate personnel and fiscal resources to improve the quality of services that are culturally and linguistically competent; and
- determine individual and collective strengths and areas for growth.

There are numerous benefits of cultural and linguistic competence organizational self-assessment. Such processes can lead to the development of a strategic organizational plan with clearly defined short-term and long-term goals, measurable objectives, identified fiscal and personnel resources, and enhanced consumer and community partnerships. Self-assessment can also provide a vehicle to measure outcomes for personnel, organizations, population groups, and the community at large.

Values & Principles for Self-Assessment

The NCCC uses a set of values and principles to guide all self-assessment processes.

- **Self-assessment is a strengths-based model.**
The purpose of self-assessment is to identify and promote growth among individuals and within organizations that enhances their ability to deliver culturally and linguistically competent services and supports. Self-assessment emphasizes the identification of strengths, as well as areas of growth, at all levels of an organization. The process also allows organizations to identify and acknowledge the internal strengths and assets of personnel who in many instances are inadvertently overlooked.
- **A safe and non-judgmental environment is essential to the self-assessment process.**
Self-assessment is most productive when conducted in an environment that (1) offers participants a forum to give honest statements of their level of awareness, knowledge, and skills related to cultural and linguistic competence; (2) provides an opportunity for participants to share their individual perspectives in a candid manner; and (3) ensures that information provided will be used to effect meaningful change within the organization. The NCCC embraces the concept that cultural competence is developmental and occurs along a continuum (Cross et al., 1989). It matters not where an individual or organization starts, as long as there is continued progression toward the positive end of the continuum.

- **A fundamental aspect of self-assessment ensures the meaningful involvement of consumers, community stakeholders, and key constituency groups.**

Principles of self-determination and cultural competence ensure that consumers are integrally involved in processes to plan, deliver, and evaluate services they receive. These principles extend beyond the individual to the community as a whole. Self-assessment must solicit and value the experiences and perspectives of consumers. Similarly, opinions should be sought from key stakeholders and constituency groups within the broad integrated service delivery system. An inclusive self-assessment process can forge alliances and partnerships that have long-lasting benefit for the organization and for the larger community.

- **The results of self-assessment are used to enhance and build capacity.**

The intent of the self-assessment process is neither to render a score or rating nor to label an individual or an organization. Rather, it is intended to provide a snapshot of where an individual or organization is at a particular point in time. Results should be used for strategic planning to improve the organization's capacity to deliver culturally and linguistically competent services at all levels, including policy makers, administrators, providers, subcontractors, communities, and consumers. The NCCC's experiences with self-assessment have demonstrated that comparisons between professionals and among organizations are of little benefit. Greater benefit is derived from individual and organizational self-comparison over extended periods of time to ascertain the extent to which growth has occurred.

- **Diverse dissemination strategies are essential to the self-assessment process.**

Self-assessment results should be shared with participants and key stakeholders in a manner that meets their unique needs. The NCCC has employed an array of dissemination strategies that are tailored to the specific interests of the participating organization. This information sharing involves identification of the audiences and presentation of the data in formats that are most useful and accessible. This approach recognizes that the need for information may vary for policy makers, administrators, service providers, consumers and other stakeholders.

From 1999 to 2006, the NCCC provided training and technical assistance to health centers and other programs funded by the Bureau of Primary Health Care (BPHC), Health Resources and Services Administration (HRSA), U.S. Department of Health and Human Services (DHHS), with a primary focus on planning and conducting processes for cultural and linguistic competence organizational self-assessment. The NCCC created a tool, the Cultural and Linguistic Competence Policy Assessment (CLCPA), designed to support the BPHC, and its funded programs, in (1) improving health care access and utilization, (2) enhancing the quality of services within culturally diverse and underserved communities, and (3) promoting cultural and linguistic competence as essential approaches in the elimination of health disparities.

Instrument Description

The CLCPA is designed to examine cultural and linguistic competence in four dimensions: values, policy, structure, and practice. Within these four dimensions, the CLCPA assesses Knowledge of Diverse Communities, Organizational Philosophy, Personal Involvement in Diverse Communities, Resources and Linkages, Human Resources, Clinical Practice, and Engagement of Diverse Communities.

The **Knowledge of Diverse Communities** subscale consists of 11 questions. It concerns knowledge of the identified cultural groups, how they differ internally, and how they differ from the dominant culture. The central focus is organizational policy that takes into consideration cultural beliefs, strengths, vulnerabilities, community demographics, and contextual realities.

The **Organizational Philosophy** subscale consists of 10 items. It involves organizational commitment to the provision of culturally and linguistically competent services and the extent to which it is legitimized in policy. This subscale probes the incorporation of cultural competence into the organization's mission statement, structures, practice models, collaboration with consumers and community members, and advocacy.

The **Personal Involvement in Diverse Communities** subscale consists of 7 items. It concerns the degree to which organizations and their staff demonstrate reciprocity within diverse and ethnic communities. The subscale addresses the extent to which an organization and its staff participate in social and recreational events and purchase goods and services within the communities they serve.

The **Resources and Linkages** subscale consists of 4 items. It concerns the ability of an organization and its staff to effectively use both formalized and natural networks of support within culturally diverse communities to develop an integrated primary care, community-based health system. The focus is organizational policy that promotes and maintains such linkages through structures and resources.

The **Human Resources** subscale consists of 8 items. It involves an organization's ability to sustain a diverse workforce that is culturally and linguistically competent. This subscale probes policy that supports workforce demographics, inservice training/professional development, and related resource allocation.

The **Clinical Practice** subscale consists of 8 items. It concerns the ability of the organization and its staff to adapt approaches to health care delivery based on cultural and linguistic differences. The focus is on assessment/diagnosis, the provision of interpretation/translation services, use of community-based resources, and adaptation based on literacy and health literacy levels.

The **Engagement of Diverse Communities** subscale consists of 3 items. It involves the nature and scope of activities conducted by an agency and its staff to engage diverse communities in health and mental health promotion and disease prevention.

The CLCPA is designed as a self-assessment instrument and requires approximately 30 minutes to complete. Most items use a four-point Likert scale (e.g., from Never to Often). The instrument can be administered to all agency personnel.

The CLCPA has a demographic form that elicits information such as job title, educational level, previous training in cultural and linguistic competence, and racial and ethnic affiliation. The form can be modified to include information pertinent to an individual health center.

Checklist for Conducting Cultural and Linguistic Competence Organizational Self-Assessment

General steps for the self-assessment are delineated below; however, considerable flexibility must be built into the proposed process.

Phase 1. Establish a structure to guide the work

- Identify an external organization or consultant to coordinate the self-assessment process.
- Convene a committee or work group, endorsed by the governing body, and discuss the self-assessment process (i.e., review the CLCPA and discuss data collection and analysis strategies, issues of staff confidentiality, timelines, and logistics).
- Identify past and current agency efforts and resources.
- Review the geographic service area and determine what demographic data are available.
- Establish parameters of the assessment process (i.e., timelines, sample population, logistics, and roles and responsibilities of the committee/work group).

Phase 2. Create a shared vision

- Convene a forum to explore and define the concepts of cultural and linguistic competence and their value and relevance for the agency and community members served.
- Convene agency leadership (governance body and executives) to develop consensus and ensure “buy in” for the process.

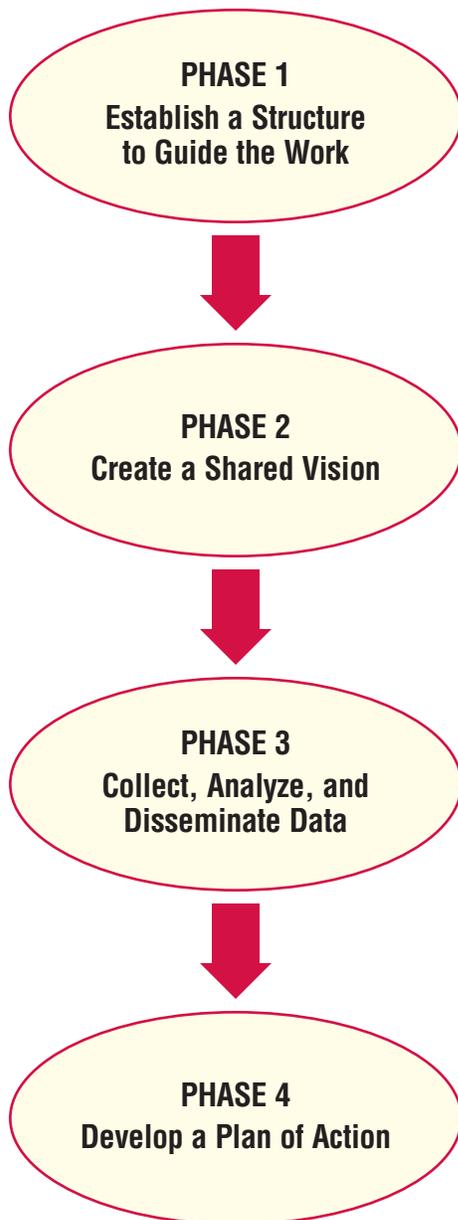
Phase 3. Collect, analyze, and disseminate data

- Conduct interviews with key staff and cultural key informants.*
- Pre-test the CLCPA among committee/work group members.
- Conduct consumer focus groups.
- Distribute the CLCPA to staff, governing board, and other participants.
- Forward CLCPA data to the organization or consultant conducting data analysis.
- Organization or consultant prepares a preliminary data summary and narrative report for review by the committee/work group.
- Disseminate the report to agency leadership and governing body, solicit feedback, and revise the report as needed.
- Develop the final report.
- Disseminate report findings in a variety of formats accessible to the diverse stakeholders including, but not limited to, consumers, community-based organizations, health and mental health providers, and state and local government agencies.

**Cultural key informants are those individuals who are knowledgeable about the beliefs and practices of a racial, ethnic, or cultural group and able to articulate these beliefs and practices to another group or individual for the purpose of promoting understanding of diversity.*

Phase 4. Develop and implement a plan of action

- Use a facilitator to guide a consensus planning process to develop a plan of action.
- Develop a draft plan for review by key stakeholders and incorporate their recommendations accordingly.
- Finalize the plan of action.



Phases to Conduct an Organizational Self-Assessment

- **Establish a structure to guide the work**
Convene a work group, committee, or task force with the responsibility of coordinating the organizational self-assessment. This group can serve as the primary entity to plan, implement, and provide oversight to this process. The group should include representation from all levels of the organization, consumers, the governing board, and community partners.
- **Create a shared vision**
Convene a forum to explore and define the concepts of cultural and linguistic competence and their value and relevance for the health center, consumers and their families, and communities served. Forum participants should be composed of key stakeholders including, but not limited to, staff, consumers, community organizations in the service area, clinics and hospitals, and other invested constituency groups.
- **Collect, analyze, and disseminate data**
Data for analysis are collected from the administration of the CLCPA, consumer focus groups, interviews with key health center staff, a review of demographic data, and organizational records. Results are interpreted and compiled within a comprehensive report that can be adapted for dissemination to diverse audiences.
- **Develop and implement a plan of action**
Create a plan of action based on the results of the organizational assessment that identified priorities. Determine the specific strategies/activities, partners, resources, timetables, and responsible parties and establish benchmarks to monitor and assess progress.

PHASE 1 Establish a Structure to Guide the Work

It is important to take the time to carefully plan the process of conducting a cultural and linguistic competence organizational self-assessment. The process of self-assessment is as important as the outcome. Phase 1 of this guide is devoted to establishing a structure to guide the work.

■ **Identify an organization or consultant to coordinate the self-assessment**

Ideally, a health center should partner with an organization or consultant to coordinate the assessment process. This partnership will ensure objectivity. Suggestions include local universities; regional clinic consortia; the state primary care association; member organizations of local, state, or regional health coalitions; or individual consultants. The organization or consultant should adhere to a conceptual framework of cultural competence organizational self-assessment that is strengths based and developmental.

There are other factors that need to be considered in the selection of the organization or consultant. These factors may include, but are not limited to, the extent to which they have experience with underserved or underrepresented groups, and the dynamics of difference that may occur based on race, ethnicity, gender, age, sexual orientation, or other cultural factors. Careful attention must be given to the particular cultural context of both the organization and the community served.

The organization or consultant should have expertise in the analysis and evaluation of data trends related to cultural and linguistic competence. The health center may choose to have the self-assessment conducted by one organization or consultant or may contract major aspects of the self-assessment process separately (i.e., data analysis, focus groups, report, and dissemination). If the latter approach is chosen, it is vital that the health center identify an individual whose primary responsibility is to coordinate all aspects of the assessment process.

■ **Structure support for the process**

Some organizations use the resources of an existing committee structure, and others find it beneficial to create an ad hoc committee, task force, or work group devoted to this function. The group should have representation from all levels of the health center including policy making, administration, practice/service delivery, support staff, consumers and their families, and other community stakeholders. It should also reflect the racial, ethnic, cultural, and linguistic diversity of the health center and the community at large. This group is the primary entity for planning and implementing the self-assessment process, and should have ready access to decision makers or have the authority to make decisions.

Committees or work groups will go through a process of “group norming.” Let the group “be” before it “does.” Consider the need for cross-cultural team building that explores issues such as race, ethnicity, nationality, gender, sexual orientation and identity, class, language, power, and job functions. Initially, the exploration may require a facilitator to ensure a safe forum for the exchange of ideas and feelings.

The diversity of the committee or work group results in a collection of people who have not previously worked together, and may have very different experiences and preferences for how work is to be accomplished. For example, some group members will want to progress quickly through an agenda because saving time is an important value. For others who value relationships or may need additional time to process complex information, longer meetings may be more desirable. These diverse perspectives and group dynamics will require an excellent chair or leader. Agreements need

to be reached related to how the work is to be accomplished early in the process. The committee or work group should consider establishing ground rules that include, at a minimum, communication styles, conflict resolution, and decision making and should review them periodically.

Another helpful strategy is to use “parking lots of ideas.” Use large sheets of paper, visible to all members, to capture important ideas or questions. The ideas are important, but they may be off the current topic of discussion or require additional meeting time to fully address. By writing them, the contributors see that their ideas are respected, and this strategy assists the chair or leader so that no ideas are lost. There may be times when the chair or leader will need to ask a member to stop and move on. Meeting discussions should avoid a debate of ideas. It is important that all participants understand that the variability of ideas is important to both the process and the outcome.

A final strategy to consider is preparing all members to participate fully and effectively. Provide meeting summary notes, agendas, and reading/recorded materials in advance. Some members may benefit from being paired with another who has more experience in group processes.

■ **Allocate personnel and fiscal resources**

Personnel resources

Conducting a self-assessment process is resource intensive. It requires a dedicated budget and a level of effort for agency personnel. These requirements may also extend to community partners and key stakeholders involved in the process. Consideration should be given to the necessary level of effort for personnel who have responsibility for this process. This work will entail delineating responsibilities and determining the duration and intensity of time required for personnel. It may require deferment or reassignment of current workload and duties. The success of a self-assessment process depends on a well-crafted allocation of personnel and fiscal resources.

The ability to coordinate numerous logistical tasks effectively is vital to the self-assessment process. The committee or work group needs to establish the parameters of assessment, including timelines, the number of people to be sampled, and individual staff responsibilities. A plan must be established to ensure the timely dissemination of information to all work group members and the development of a calendar and schedule of activities (e.g., sites and times for regular meetings, teleconferences, focus groups, administration of the self-assessment instrument, data collection and analysis, and dissemination of results).

Fiscal resources

The budget amounts will depend on the resources of the agency. Some resources may be accrued as in-kind or donated from community partners and key stakeholders. Although the amounts and sources of funding may vary, the following categories are essential:

- Organization or consultant to coordinate and/or conduct the self-assessment process
- Organization or consultant to complete the data analysis and develop the final report
- Supports for focus group participation (see Appendix 1, “Self-Assessment Protocol”)
- Stipends and honoraria to support consumer and family participation in committee or work group meetings and activities
- Translation and adaptation of English language materials
- Accommodations for people with disabilities
- Interpretation services for focus groups and/or committee and work group meetings as required

- Refreshments need to be appropriate for the time of day the focus group or meeting is scheduled. (Snacks are sufficient for early afternoon or late evening, but if the focus group occurs during lunch or dinner, more substantial food needs to be provided. Food choices should reflect community preferences.)
- Meeting space rental
- Local and/or domestic travel reimbursement
- Copying, mailing, and other dissemination activities

■ **Identify collaborating partners and engage community members**

A self-assessment process that is inclusive of a variety of community partners provides an opportunity to obtain rich information and lays the foundation for developing innovative strategies to promote cultural and linguistic competence. A major principle of cultural competence involves working in conjunction with natural, informal, support and helping networks within diverse communities (Cross et al., 1989). Oftentimes, health centers are reticent about involving other organizations in this process for fear of exposing their inadequacies. Including a variety of partners initially takes extra time and resources. However, when partnerships are developed early in the process, and when community members see themselves as part of the visioning and decision making, all will see a stake for themselves in the collaborative effort. These partners may inform other community members about the self-assessment and its role in quality improvement efforts for diverse populations served, thus providing positive public relations for the health center.

Examples of meaningful involvement include developing a shared vision, identifying leadership roles and responsibilities, distributing tasks equitably based on capacity, and allocating resources in compensation for contributing time and talents. It is important to recognize that individuals and groups will choose different levels of involvement and ways to participate that may be culturally based. Their choices may vary from serving on committees or work groups, participating in focus groups, making in-kind or other fiscal contributions, and subcontracting for specific services to providing meeting facilities and other accommodations. It is essential to demonstrate that the contributions of each community partner are valued and respected (Goode, Jones, & Mason, 2002).

■ **Review demographic data for the service area and select designated cultural groups for the CLCPA**

The committee or task force can access demographic data from varied sources such as the U.S. Census Bureau; U.S. Departments of Agriculture, Housing and Urban Development, and Labor; state offices of minority health; local health and mental health departments; tribal councils or governments; territorial governments; school districts; and health policy centers. This information can be used to identify emerging issues impacting culturally and linguistically diverse groups receiving services from the health center (e.g., changes in local or regional demographics such as new immigrant or refugee populations, relocation of low-income housing, increase in the number and composition of the homeless and migrant/seasonal farm worker populations, incidence of racial and ethnic health and mental health disparities, changes in state health policy for Medicaid or State Children's Health Insurance Program [SCHIP], new federal statutes, and literacy and health literacy data).

The committee or task force should use these data in several ways. They provide an overview of populations in the service area, raise critical issues impacting these population groups, describe consumer populations currently served by the health center, and identify new groups that need to be engaged. These data should be used as a basis to choose the designated cultural groups that will be listed on the CLCPA. Centers may choose racial or ethnic groups (i.e., Asian Pacific Islander,

Latino, Native American, and African American), and/or other non-ethnic cultural groups such as homeless, HIV/AIDS, gay, lesbian, transgender and bisexual, and rural populations. These data will be thoroughly analyzed along with other data collected in Phase 3.

PHASE 2 Create a Shared Vision

Convene a forum to explore and define the concepts of cultural and linguistic competence and their value and relevance for the health center, consumers and their families, and communities served. Forum participants should be composed of key stakeholders including, but not limited to, staff, consumers, community-based organizations in the service area, clinics and hospitals, and other invested constituency groups. The issues discussed during the forum should be reviewed by the health center governing board and leadership to offer formal acknowledgment of the process and to provide guidance about how to approach significant issues. It is incumbent upon leadership to convey a clear message that the process of cultural and linguistic competence assessment is important to the future of the health center and is essential to the provision of quality care.

PHASE 3 Collect, Analyze, and Disseminate Data

The data set that will be analyzed and developed into a report will come from five primary sources: (1) the CLCPA instrument completed by policy makers, administrators, and practice, service delivery, and support staff; (2) consumer focus groups; (3) interviews with the agency executive directors, administrators, staff, and the health center governing board; (4) demographic information about the geographic area of service delivery; and (5) organizational records. The organization or consultant that is responsible for data analysis and interpretation must be skilled in integrating cultural and linguistic competence into self-assessment processes or must be able to collaborate with someone who possesses those skills.

■ Determine analytic strategy and choose appropriate software

1. Completion of the CLCPA instrument

The NCCC has always sought the widest level of participation of all stakeholders in using the CLCPA and other cultural competence organizational self-assessment instruments. This approach has several benefits; the primary benefit is that employees see that this process seeks and respects their input no matter what their role within the organization. If the agency is viewed as having a “top-down style of management,” more time will be needed to elicit staff participation. The request may need to be made through a union representative or shop steward.

The best results have been achieved when an opportunity is given for staff to be informed of the process and when staff are given some incentive for participation. For example, the progress of the committee or work group should be reported at regular staff meetings or published in newsletters or e-alerts. Whichever method is chosen, it is important for staff to know why the information is collected, understand the philosophy of self-assessment, and know that the information provided is confidential. Some health centers been successful in soliciting participation when a meal is provided in conjunction with the time to complete the CLCPA. Larger health centers may need to assign team captains or managers to be responsible for the collection of the completed CLCPA.

The NCCC currently has a Web-based methodology for the collection of CLCPA data. Rather than using a paper-and-pencil format, participants can log onto a site and complete the CLCPA. The

method has several benefits by assuring participant confidentiality, eliminating consultant or staff time for data entry, and allowing staff to complete the CLCPA at time convenient to their schedule (NCCC, 2006).

2. Consumer focus groups

The collection of data from consumer focus groups adds to the reliability of the information collected from staff and board members. These data serve as a reflection to ascertain whether consumers view services in the same way that staff do.

<p>Recruitment</p>	<ul style="list-style-type: none"> • Assign health center staff to recruit participants. • Participants should reflect the demographics of the populations served by the health center. • Include representatives of demographic groups new to the geographic area served, or groups that the health center has not been effective in engaging. • Collaborate with community-based organizations including churches, synagogues, and mosques; faith-based and spiritual organizations; ethnic-specific advocacy groups; schools; or legal advocacy groups. • Develop a simple flyer describing the purpose of the focus groups, logistical information, and a personal contact. • Provide information in other formats including translated texts, community newsletters, Web sites, and by “word of mouth.”
<p>Compensation for participation</p>	<ul style="list-style-type: none"> • Consumers who participate in focus groups should receive a stipend or honoraria for the valuable service they provide. Be aware that some consumers may have cultural beliefs that equate the acceptance of honoraria as a “pay off or bribe” for making positive statements. • The amount should be determined according to community norms. • Consider providing compensation in cash or gift cards (may be donated by local businesses). • Determine if cultural norms preclude giving cash based on gender, family position or age. • To ensure full participation by a wide variety of consumers, additional reimbursement may be needed for transportation, childcare costs, or respite care for adult dependents.
<p>Provision of interpretation and translation services</p>	<ul style="list-style-type: none"> • Notices of focus groups, directions to the site, and questions asked during the focus groups should be translated into languages other than English based on need and preferences of participants. • Preference for interpreter services should be indicated by the participant, and not assigned by someone else, no matter how well intentioned. • Interpreters can be those used by the health center in their normal course of business with the exception of staff who serves as interpreters. • All interpreters should be oriented by the focus group facilitator about the objectives and should discuss how the interpretation should take place. • Ensure that the interpreter understands terms used by the facilitator, and colloquialisms that may be used by participants. • Have a discussion with the interpreter to mitigate the influence of cultural biases on the process. • In small communities, interpreters may need to be sought from outside the area to promote the comfort level of participants. If this is not possible, participants should be informed of the interpreter’s responsibility for confidentiality. • Hold a review with the interpreter periodically to be sure that information is not being filtered.

<p>Starting the focus group</p>	<ul style="list-style-type: none"> • The focus groups should not include any staff. • Participants must receive assurances that their comments will be confidential and that no one will be able to trace their comments back to them. • Focus group, participants may be concerned that the information will be used to discontinue the funding for the health center. This erroneous belief must be dealt with at the beginning of the focus group. • All participants should sign a consent that is available in the language of their preference, and has been explained to them if they cannot read. (A sample consent form is provided in the Appendix 3, “Sample Consent Form for Focus Group.”) • Flyers and the agenda should clearly state whether there will be a time for registration and refreshments before the actual focus group begins. This point addresses the differences in the way people approach tasks and time. Someone oriented to punctuality will show up at the scheduled time, ready to work. Others, who are more socially oriented, will come, and use the time to eat and socialize as a way to get acclimated and ready to work. In order to honor the value of time for the first group, the agenda should clearly state that the first half hour will be for registering registration and refreshments.
<p>During the focus group</p>	<ul style="list-style-type: none"> • Information should be available in a variety of formats so that the needs of participants with low literacy are accommodated. Information may need to be presented orally. • Jargon and complex statements should be avoided. • Assure that all information presented is accessible to people with disabilities (e.g., sign language interpretation, Braille, large print, and simple explanations).
<p>Logistics</p>	<ul style="list-style-type: none"> • Select times and locations that will allow maximum participation of consumers. • In some communities, it may be necessary to select sites other than the health centers that are considered neutral. • Consider collaborating with schools of social work, psychology, public health, or public policy as interns, and faculty may be a ready resource for this type of data collection. • Multiple focus groups may be required so that the number of participants per group does not exceed 15 or to accommodate multiple linguistic groups.
<p>Other considerations</p>	<ul style="list-style-type: none"> • Avoid a debate of ideas. Be sure that all participants understand that the variability of ideas is important to the data. • Pay particular attention to tension that may arise based on race, ethnicity, culture, language, sexual orientation and identity, class, or other factors. Some people may feel more comfortable discussing highly charged issues within homogeneous groupings. See http://www.evaluationtoolsforracialequity.org, Tip Sheet 4b.TS1, for other suggestions.

3. Interviews

Data collected by interviewing the executive director, members of the senior management team, and members of the Board of Directors can be important for analysis.

Staff focus groups or interviews

The planning group may want to consider conducting a staff focus group or interviews before distributing self-assessment instruments. These groups may elicit questions about the purpose of organizational self-assessment that administrators thought had been answered, or may uncover other issues not directly associated with cultural competence, but that could present barriers to systems change.

Sample Interview Questions

- What do you believe is your health centers’ greatest strength related to the delivery of culturally and linguistically competent health care services?
- What are some approaches that have assisted you in making progress?
- What are some of the barriers that limit your progress in the development of culturally and linguistically competent services and supports?
- What additional resources are needed, including non-fiscal resources?

Post-assessment focus group or interview

In the event of conflicting data from instruments or focus groups, reconvening some members or eliciting information from a different source may clarify some information. Apparent conflicts can also be followed up as part of the strategic planning process.

4. Demographic information

The demographic information reviewed by the committee or task force early in the process needs to be included in the final analysis. It is useful for the analysis to include the following factors:

- Does the health center serve a population reflected in the diversity of census data?
- Are there trends in health disparities that need to be addressed?

5. Organizational records

The health center's mission statement, policies and reports, and marketing material should all be included in the data collection process.

■ Data analysis

The organization or consultant chosen to conduct the data analysis will review data generated from five primary sources: (1) the CLCPA instrument completed by policy makers, administrators, practice, service delivery, and support staff; (2) consumer focus groups; (3) interviews with the agency executive directors, administrators, staff, and the health center governing board; (4) demographic information about the geographic area of service delivery; and (5) organizational records.

1. Self-Assessment instrument data

A variety of statistical software packages can be used to analyze both qualitative and quantitative data. The number of assessment instruments to be analyzed and the depth of statistical analysis will dictate the statistical software package selected. A spreadsheet is appropriate when there are fewer than 20 instruments that require analysis and if analysis is limited to a frequency count. SPSS or SAS will be needed for larger data sets and greater testing capacity. The most important consideration is that the organization or consultant needs to have experience using the statistical package and is familiar with its assets and liabilities. A process for data entry needs to be established so that data are entered consistently and accurately. Personnel resources to accomplish this task must be planned in advance.

The following steps are useful in performing the data analysis:

- A. Generate individual subscale means.
- B. Rank subscales from high to low.
- C. Repeat the process within each subscale.
- D. Examine the numbers within the subscale, looking at what is high. Generate the subscale mean. Items below the subscale mean may indicate areas that need enhancement.
- E. Report areas of strength that fall above the mean. These are the areas that the organization can likely build on.
- F. Differences in knowledge between groups (administrators vs. staff) may indicate that some groups within the organization have access to information that others do not. For example, clinical staff may have knowledge of diverse groups through day-to-day contact, whereas administrators may not have this knowledge because their daily functions are removed from direct patient contact. Conversely, administrators may be engaged in interagency and community collaborations that are unknown to clinical staff. These differences may indicate that there is a

need for clear policy, or that staff need to be made aware of existing policy, or that staff are failing to follow policies that are in place.

The CLCPA includes several questions that are open ended, and there are opportunities for respondents to include comments. Respondents may even write their comments in the margins. On the basis of the NCCC's experience, it is important to capture these data, because they may provide information about the atmosphere of an organization, including barriers to achieving cultural and linguistic competence. For example, one health center's staff made frequent comments suggestive of racial hostilities.

Some questions and items can be considered "high impact." For example, the majority of respondents may give the same response to an item. However, if 25% of respondents give different responses, it may indicate that a significant subset of employees views the organization very differently. It may be indicative that some employees do not have sufficient information about an organization's policy, or it may indicate a group whose attitudes and values contrast with the majority of the organization. These types of findings merit further exploration such as conducting a post-assessment focus group to gain greater clarity. At times, the numerical data may not support precise conclusions. It is important in these situations for the organizations or consultants conducting the data analysis to remember that their role is to guide the organization to seek additional information rather than to assign a particular meaning to the data.

At least two individuals should analyze the data, looking for consensus, differences, or ambiguity. Themes and interpretive statements emerge from these data. Any differences in interpretation need to be resolved. If consensus cannot be reached, consider conducting post-assessment interviews or focus groups.

Each CLCPA question has a companion question about the existence of policy to support this activity, and the respondent's knowledge of such policy. Most organizations need to spend time developing policies that support cultural and linguistic competence, orienting staff to such policies, and ensuring that managers are supervising compliance. The NCCC's experience has shown that policy may be written, but not disseminated, or that staff may simply not implement existing policy.

2. Focus group data

Using a similar process, at least two individuals should develop an initial analysis of the focus group data. Comments should be analyzed for common trends within and between diverse groups, and for comments that note different experiences between groups. For example, one health center had a long history of serving diverse racial, ethnic, and cultural groups and the majority of focus group participants reported positively about the support they received in accessing services. One fairly new immigrant group, however, did not report the same level of satisfaction because the health center had not developed a network of supports for this group. Focus group data are also used to compare the quantitative data of the CLCPA with those of patient experiences. For example, if the organization rated itself highly in the provision of interpretation services, but the focus group participants do not, there may be several explanations. The health center staff do not consistently refer patients for interpretation services; interpretation services have not been evaluated by the patients who use them; insufficient interpreters are available during peak hours; or staff are overrating themselves.

3. Interviews

The NCCC has found it useful to conduct interviews with selected health center staff including, but not limited to, the Chief Executive Officer, Chief Financial Officer, Medical Director, Director of Human Resources, and Board Chair or Executive Committee. The questions can address issues germane to the organization or community that are not specifically addressed by the CLCPA. The organization or consultant conducting the self-assessment process in collaboration with the planning committee or work group should craft questions. These data should be analyzed using the same methods as those gleaned from the focus groups. Interview results may give a broader view of the organization's commitment and capacity to develop and administer policy that supports culturally and linguistically competent care.

4. Demographic data

The demographic data collected and reviewed in Phase 1 should be analyzed for trends and related information that will assist in interpreting data from the CLCPA and those derived from the focus groups.

5. Organizational records

The organization or consultant will review the health center's mission statement, policies, annual and other technical reports, and marketing material to determine the extent to which these documents address and support culturally and linguistically competent policy and practice. This is a subjective process, so it is useful to provide clear examples of indicators that support findings. For example, in a mission statement, the term "cultural and linguistic competence" may be used. Is the mission statement supported by policies that ensure language access, integrate cultural information in approaches to patient assessments, and support staff involvement in the communities served?

■ Report development

The development of the report must adhere to the philosophy that organizational cultural and linguistic competence is a strengths-based process that is non-threatening. Areas of program strengths need to be identified along with suggestions for program enhancement. As the results of each subscale are discussed, information obtained from focus groups should be incorporated into these results that either supports the quantitative data or provides contrast. Organizations may desire very detailed reports along with brief executive summaries, PowerPoint presentations, or simple fact sheets that will assist with the dissemination of results to diverse audiences.

■ Dissemination of results of the self-assessment

It is critical that the self-assessment results be reported to focus group participants, staff, the Board of Directors, and other community partners. The format in which information is shared may differ with each group. The Board of Directors may prefer a succinct executive summary, oral presentation, and PowerPoint multimedia presentation, while the health center's administrative team may require a very detailed report. A variety of dissemination strategies should be considered for consumer and other community organizations. These strategies may include detailed reports, summaries, and oral and multimedia presentations. There may be a need to translate and/or present information in languages other than English and to accommodate individuals with disabilities. Last, adaptations may be needed to address issues related to literacy and health literacy.

Self-assessment results should be disseminated broadly in a variety of venues. These venues can include information that is available at the health center, information posted on the health center's Web site with links to partner agencies and organizations, presentations at conferences and community meetings, Webcasts, and press releases to mainstream and ethnic media sources.

PHASE 4 Develop an Action Plan

The CLCPA and self-assessment process yields a wealth of information, including the extent to which cultural and linguistic competence is integrated into such areas as: organizational mission, policies, structures, and procedures; staffing patterns; position descriptions and personnel performance measures; clinical practice, services, and other supports; community engagement, outreach, and dissemination approaches; composition of advisory boards and committees; and professional development and inservice training activities. This information is intended to assist health centers in identifying strengths and areas of growth for the development and administration of organizational policy that underpins cultural and linguistic competence. The fourth phase of the process involves using this information to develop an action plan that delineates organizational goals and priorities to be achieved within a specified period of time. A well-developed plan will ensure that the organization has a fully detailed map for the journey it is undertaking and that all involved will be knowledgeable of their roles and responsibilities. This next phase will require a skilled facilitator to guide the development of the action plan.

Differentiate an action plan from a strategic plan

Many health centers have strategic plans that delineate broad directions for the organization over an established period of time, typically for 5 or more years. This strategic plan may or may not address cultural and linguistic competence. The action plan, as described in this guide, is not a substitute for a health center's strategic plan because its functions and purposes differ. The action plan is offered as an effective tool for using the self-assessment results to plan for organizational change specifically related to cultural and linguistic competence.

Action planning process

An action plan is a tool for moving forward on an event or project that has already been agreed on or about which there is already some consensus, such as how to implement needed change identified by the cultural and linguistic competence self-assessment process. This action planning process:

- clarifies and delineates the task;
- aligns creativity, capabilities, interests, and resources of the group;
- decides necessary actions, roles, and responsibilities;
- builds group trust, support, enthusiasm, and consensus;
- creates an implementation timeline to accomplish the task; and
- coordinates actions and assignments (Institute of Cultural Affairs, 2000).

Consensus planning

There are numerous planning processes, and each has unique features, advantages, and outcomes. This guide describes the consensus planning workshop method as a strategy for action plan development.

Developing a plan that is fully inclusive of all stakeholders is the best assurance for its success. However, ensuring full participation and inclusion is not a simple task. The NCCC has successfully used the consensus planning workshop method to assist many health organizations in developing plans for the infusion of cultural and linguistic competence in service delivery systems. Careful thought and preparation have to go into developing the protocols and processes for such a planning event, including who will participate. A consensus planning workshop provides an excellent opportunity to include, at a minimum, community partners, consumers, board members, policy makers, and diverse staff from all levels of the organization. It is important that this group have active participation from organizational leadership with decision-making authority.

A consensus planning workshop can range from simple to complex. The infusion of cultural and linguistic competence through a complex task is made manageable and achievable through this active planning process that involves:

- collecting the ideas of all participants,
- identifying broad patterns through dialogue,
- summarizing the group's insights, and
- reaching consensus on a resolution (Stanfield, 2002).

The consensus planning workshop method entails five steps: (1) creating a shared context for the group, (2) brainstorming ideas, (3) grouping or clustering the ideas, (4) naming the cluster/group, and (5) resolving to implement the results. Creating a common context of shared experiences for the group is critical. This step can be done in many ways, such as reviewing the accomplishments of the health center in the last several years, identifying challenges and barriers, or articulating the health and mental health issues endemic to a particular community. One of the most meaningful ways to build a shared context, once an organizational self-assessment has been completed, is to review strengths of the health center and desired areas of growth as identified in the report.

Components of an action plan

Create a plan of action, based on the results of the organizational self-assessment, which identifies priorities. Determine the specific strategies/activities, partners, resources, timetables, and responsible parties, and establish benchmarks to monitor and assess progress at regular intervals.

Conclusion

The process of conducting an organizational self-assessment is resource and time intensive. The energy and drive to continue the momentum will require leadership that is focused on the development of policies, identification of resources, encouragement and support provided to staff, and active engagement of diverse consumers and the communities in which they live. The process of self-assessment will become integral to planning, implementing, and evaluating all aspects of service delivery as health centers continue the journey toward achieving cultural and linguistic competence.

Citations

Cross, T., Bazron, B., Dennis, K., & Isaacs, M. (1989). *Towards a culturally competent system of care* (Vol. 1). Washington, DC: National Technical Assistance Center for Children's Mental Health, Georgetown University Center for Child and Human Development.

Goode, T., Jones, W., & Mason, J. (2002). *A guide to planning and implementing cultural competence organization self-assessment*. Washington, DC: National Center for Cultural Competence, Georgetown University Center for Child and Human Development.

ToP(r) Group Facilitation Methods: Action Planning (c), The Institute of Cultural Affairs, 1991,1994,1996, and 2000, Phoenix, AZ.

Healthy People 2010 at <http://www.healthypeople.gov/Document/pdf/uih/2010uih.pdf>

Miriam-Webster Online Dictionary, 2006

National Center for Cultural Competence Web site at <http://guchd.georgetown.edu/nccc/>

Stanfield, R. B. (2002). *The workshop book: From individual creativity to group action*. British Columbia, Canada: New Society Publishers.

Webster's Collegiate Dictionary, 1985

APPENDIX 1: Definitions

Cultural Competence

The National Center for Cultural Competence (NCCC) embraces a conceptual framework and model of achieving cultural competence based on the Cross et al. (1989) definition. 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 (1) value diversity, (2) conduct self-assessment, (3) manage the dynamics of difference, (4) acquire and institutionalize cultural knowledge, and (5) adapt to the diversity and cultural contexts of the individuals, families, and communities they serve; and
- incorporate the above in all aspects of policy making, administration, practice, and service delivery and systematically involve consumers, families, and communities.

Linguistic Competence

Definitions of linguistic competence vary considerably. Such definitions have evolved from diverse perspectives, interests, and needs and are incorporated into state legislation, Federal statutes and programs, private sector organizations, and academic settings. The following definition, developed by the NCCC, provides a foundation for determining linguistic competence in health care, mental health, and other human service delivery systems. It encompasses a broad spectrum of constituency groups that could require language assistance or other supports from an organization, agency, or provider.

The capacity of an organization and its personnel to communicate effectively and convey information in a manner that is easily understood by diverse audiences including persons of limited English proficiency, those who have low literacy skills or are not literate, and individuals with disabilities. Linguistic competency requires organizational and provider capacity to respond effectively to the health literacy needs of populations served. The organization must have policy, structures, practices, procedures, and dedicated resources to support this capacity. This may include, but is not limited to, the use of:

- bilingual/bicultural or multilingual/multicultural staff;
- cross-cultural communication approaches;
- cultural brokers;
- foreign language interpretation services including distance technologies;
- sign language interpretation services;
- multilingual telecommunication systems;
- videoconferencing and telehealth technologies;
- TTY and other assistive technology devices;
- computer-assisted real-time translation (CART) or viable real-time transcriptions (VRT);
- print materials in easy-to-read, low-literacy picture and symbol formats;
- materials in alternative formats (e.g., audiotape, Braille, and enlarged print);
- varied approaches to share information with individuals who experience cognitive disabilities;
- materials developed and tested for specific cultural, ethnic, and linguistic groups;

- translation services including those of:
 - legally binding documents (e.g., consent forms, confidentiality and patient rights statements, release of information, and applications)
 - signage
 - health education materials
 - public awareness materials and campaigns; and
- ethnic media in languages other than English (e.g., television, radio, Internet, newspapers, and periodicals).

(Developed by Tawara D. Goode and Wendy Jones, 8/00, Revised 6/06.)

Culture

Culture is an integrated pattern of human behavior, which includes, but is not limited to, thought, communication, languages, beliefs, values, practices, customs, courtesies, rituals, manners of interacting, roles, relationships, and expected behaviors of a racial, ethnic, religious, social, or political group; is the ability to transmit the above to succeeding generations; and is dynamic.

Dialect

A regional variety of language distinguished by features of vocabulary, grammar, and pronunciation from other regional varieties and constituting together with them a single language (Merriam-Webster Online Dictionary, 2006)

Health Disparities

There are many definitions for health disparities. For the purposes of this instrument, the NCCC adopted the following definition of health disparities: population-specific differences in the presence of disease, health outcomes, or access to health care.

Health Literacy

The degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.

<http://www.healthypeople.gov/Document/pdf/uih/2010uih.pdf>

Organizational Culture

Organizational culture is a pattern of shared basic assumptions that the group learned as it solved its problems of external adaptation and internal integration that has worked well enough to be considered valid and, therefore, to be taught to new members as the correct way to perceive, think, and feel in relation to those problems (Schein, 1985).

Policy

Policy is defined for the purposes of this instrument as a high-level overall plan embracing the philosophy, general goals, and acceptable procedures within an organization (Webster's Collegiate Dictionary, 1985). Additionally, formal policy is written and codified. Informal policy is shared and understood verbally; however, compliance may or may not be enforceable and adherence may vary.

APPENDIX 2: Resource List

The following is a selection of resources, abstracts and links.

Demographic Data

Maternal and Child Health Bureau—State Priority Health Areas (by state and region)

<https://perfddata.hrsa.gov/mchb/mchreports/Search/program/prgsch01.asp>

Data Resource Center for Child & Adolescent Health (home of searchable databases on the National Survey of Children's Health and on the National Survey of Children with Special Health Care Needs)

<http://www.childhealthdata.org/content/Default.aspx>

U.S. Census Bureau—American FactFinder (a wealth of Census-related information by county, state, and nation)

http://factfinder.census.gov/home/saff/main.html?_lang=en&_ts=

Modern Language Association (searchable data center with Census data on languages spoken and on the numbers of speakers; these data are available by age categories)

http://www.mla.org/census_compare&source=county

The Association of Religious Data Archives

<http://www.thearda.com>

Kaiser Family Foundation Health Facts (state and national health facts including infant mortality, HIV/AIDS, child and adult immunizations, cardiac disease, and cancer)

<http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi>

National Indian Child Welfare Association (fact sheets provide tribal information by state and regional contacts)

<http://www.nicwa.org/resources/factsheets/index.asp>

U.S. Department of Homeland Security, Office of Immigration *Statistics*—*Yearbook of Immigration Statistics* (compendium of tables that provide data on foreign nationals who, during a fiscal year, were granted lawful permanent residence [i.e., admitted as immigrants or became legal permanent residents], were admitted into the United States on a temporary basis [e.g., tourists, students, or workers], applied for asylum or refugee status, or were naturalized)

<http://www.uscis.gov/graphics/shared/statistics/yearbook/index.htm>

U.S. Department of Agriculture—State Fact Sheets (provides statistics on urban and rural populations by state)

<http://www.ers.usda.gov/statefacts>

Urban Institute—Publications (provides materials that report on the numbers and status of undocumented citizens in the United States)

<http://www.urban.org/publications/1000587.html>

Plan Development

Disparities and quality improvement: Federal policy levers. (2005, March-April), by Nicole Lurie, Minna Jung, and Risa Lavizzo-Mourey, *Health Affairs, The Policy Journal of the Health Sphere* (Millwood), Volume 24, No. 2, 354-364. Available from <http://content.healthaffairs.org/cgi/content/full/24/2/354>

Improving Care for Children with Special Health Care Needs from Diverse Cultural Backgrounds: An Action Plan. (1999), by Theora Evans, Ann Garwick, and Peggy Mann Rinehart. For more information, call National Maternal and Child Health Clearinghouse at (888) 434-4624.

This monograph presents recommendations and strategies on how to improve care for children with special health care needs from diverse cultural backgrounds.

Building Cultural Competence: Guidelines for Action. (2001), by the Washington Department of Health; Multicultural Work Group. For more information, contact Ruth Abad, Health Educator, at <http://www3.doh.wa.gov/here>.

This resource was developed by the Multicultural Work Group of the Washington Department of Health. The group has worked since 1991 to integrate cultural competency at program and system levels. This resource documents their efforts and provides examples of strategies to operationalize concepts of cultural competence in a meaningful way for the health care staff and to aid programs with long-range planning in protecting and improving the health of Washington state residents.

Building Systems of Care: A Primer. (2002, Spring), by Sheila Pires.

This primer is intended for use with training in systems of care. It integrates concepts of cultural competence throughout the exploration and planning of structures of systems of care. Sponsoring Organization: Child, Adolescent and Family Branch, Center for Mental Health Services, Substance Abuse and Mental Health Services Administration (DHHS).

Available from http://gucchd.georgetown.edu/products_publications.html

National Technical Assistance Center for Children's Mental Health
Georgetown University Center for Child and Human Development

3300 Whitehaven Street, N.W., Suite 3300

Box 571485

Washington, DC 20057-1485

Tel.: (202) 687-5000

Fax: (202) 687-8899

Crafting Logic Models for Systems of Care: Ideas into Action. (2003),

by Mario Hernandez and Sharon Hodges.

This monograph presents an introduction to theories of change. It is designed to assist mental health Systems of Care stakeholders in developing a logic model that will aid at all levels of planning and implementation. It can be adapted to use with diverse community stakeholders for a more culturally competent organization and to encourage the development of culturally relevant outcome measures. Developing a logic model with a broad range of stakeholders can be part of an organizational cultural self-assessment process. Available from

<http://cfs.fmhi.usf.edu/TREAD/CMHseries/IdeasIntoAction.html>

Cultural Competency Strategic Planning Process: Narrative and Appendices (HIV Client Services).

(2001), by the Washington State Department of Health.

This report describes a year-long process to develop a plan to improve the cultural competence of HIV Client Services, a small program of the Washington State Department of Health. Appendices outline

the strategic plan and provide background documents (including NCCC Policy Brief 1). This report is available with or without appendices. For copies of either version, contact: HIV Client Services, PO Box 47841, Olympia, WA 98504-7841, (360) 236-3426.

Human Resources

In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce. (2004), by the Institute of Medicine. Washington, DC: The National Academies Press. See www.nap.edu

Disparities in Patient Experiences, Health Care Processes, and Outcomes: The Role of Patient-Provider Racial, Ethnic, and Language Concordance. (2004), by Lisa Cooper and Neil Powe.

This July 2004 report, supported by the Commonwealth Fund, reviewed the literature in race discordant relationships between physicians and patients to determine whether this factor had an effect on outcomes for the patient. "Race-discordant" means when patients from ethnic groups are treated by professionals from a different ethnic background. From the abstract: "The research reviewed here documents ongoing racial and ethnic disparities in health care and links patient/physician race and ethnic concordance with higher patient satisfaction and better health care processes. Based on this research, the authors issue the following recommendations: 1) health policy should be revised to encourage workforce diversity by funding programs that support the recruitment of minority students and medical faculty; 2) health systems should optimize their providers' ability to establish rapport with minority patients to improve clinical practice and health care delivery; 3) cultural competency training should be incorporated into the education of health professionals; and 4) future research should provide additional insight into the mechanisms by which concordance of patient and physician race, ethnicity, and language influences processes and outcomes of care." See publications of the Commonwealth Fund available from <http://www.cmf.org>

Fostering Diversity: Some Major Hurdles Remain, by Mary P. Rowe.

This brief contains strategies to promote and maintain diversity, particularly in academic settings. See <http://aad.english.ucsb.edu/docs/Change6.html>

Promoting Cultural Competence in Children's Mental Health Services. (1998), by Mario Hernandez and Mareasa R. Isaacs, from the Systems of Care for Children's Mental Health Series, edited by Beth Stroul and Robert Friedman.

This book focuses on the implications of critical areas for growth of cultural competence for systems of care in children's mental health, including, but not limited to (1) the need to develop organizational infrastructures to support and enhance cultural competence; and (2) recruitment, retention, and training of staff. See bookstores such as www.amazon.com

Recruiting and Retaining Diverse Parent Representation on Interagency Councils. (2004), by the National Early Childhood TA Center (NECTAC).

This brief presents the recommendations of the NECTAC-sponsored meeting in Chapel Hill to discuss cultural and linguistic diversity in early childhood education. "Although it specifically concerns parent members, this paper can be useful for general recruitment to achieve diverse representation"

(Introductory letter by Pascal Trohanis, Director of NECTAC).

<http://www.nectac.org/~pdfs/pubs/nnotes17.pdf>

Clinical Practice

Cultural competence of nurse practitioner students: A consortium's experience. (2005, May), by Benkert R, Tanner C, Guthrie B, Oakley D, Pohl JM, *Journal of Nursing Education*, Volume 44, No. 5, 225-233.

Cultural competency and quality of care: Obtaining the patient's perspective. (2006), by Quyen Ngo-Metzger, Joseph Telfair, Dara H. Sorkin, Beverly Weidmer, Robert Weech-Maldonado, Margarita Hurtado, and Ron D. Hays, published by The Commonwealth Fund, see http://www.cmwf.org/usr_doc/Ngo-Metzger_cultcompqualitycare_963.pdf

Improving care and interactions with racially and ethnically diverse populations in healthcare organizations. (2004, July-August), Reynolds D., *Journal of Healthcare Management*, Volume 49, No. 4, 237-249.

Social work and the house of Islam: Orienting practitioners to the beliefs and values of Muslims in the United States. (2005, April), by Hodge DR, *Social Work*, Volume 50, No. 2, 162-173. (Review). http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&list_uids=15853193&dopt=Abstract

Cultural issues in palliative care. (2005, February), by Kemp C, *Seminars in Oncology Nursing*, Volume 21, No. 1, 44-52. (Review). http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?db=pubmed&cmd=Retrieve&dopt=AbstractPlus&list_uids=15807056&query_hl=2&itool=pubmed_docsum

A course on the transition to adult care of patients with childhood-onset chronic illnesses. (2005, April), by Hagood JS, Lenker CV, Thrasher S, *Academic Medicine*, Volume 80, No. 4, 352-355. (Review). http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&list_uids=15793019&dopt=Abstract

Enhancing cultural competencies of advanced practice nurses: Health care challenges in the twenty-first century. (2004, Fall), by Ndiwane A, Miller KH, Bonner A, Imperio K, Matzo M, McNeal G, Amertil N, Feldman Z, *Journal of Cultural Diversity*, Volume 11, No. 3, 118-121. http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?db=pubmed&cmd=Retrieve&dopt=AbstractPlus&list_uids=15689146&query_hl=8&itool=pubmed_docsum

Cultural caring in nursing practice: A meta-synthesis of qualitative research. (2004, Fall), by Coffman MJ, *Journal of Cultural Diversity*, Volume 11, No. 3, 100-109. http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?db=pubmed&cmd=Retrieve&dopt=AbstractPlus&list_uids=15689144&query_hl=11&itool=pubmed_docsum

Cultural competence now mainstream medicine. Responding to increasing diversity and changing demographics. (2004, December), by Cole PM, *Postgraduate Medicine*, Volume 116, No. 6, 51-53. (Review). http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?db=pubmed&cmd=Retrieve&dopt=AbstractPlus&list_uids=15620127&query_hl=14&itool=pubmed_docsum

Agenda dissonance: Immigrant Hispanic women's and providers' assumptions and expectations for menopause healthcare. (2005, February), by Esposito N, *Clinical Nursing Research*, Volume 14, No. 1, 32-56. http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?db=pubmed&cmd=Retrieve&dopt=AbstractPlus&list_uids=15604227&query_hl=17&itool=pubmed_docsum

Budget Allocation

A Guide to Developing and Using Performance Measures in Results-Based Budgeting. (1997), by Mark Friedman; The Finance Project.

This paper is part of a series of papers published by The Finance Project on the subject of results accountability. A previous paper, *A Strategy Map for Results-Based Budgeting*, embedded the challenge of this paper of holding programs accountable for the best possible performance, while ensuring that their performance is aligned with, and supports, overall efforts to improve results, in other words, how to create performance accountability within a results framework. http://eric.ed.gov/ERICDocs/data/ericdocs2/content_storage_01/0000000b/80/11/99/e6.pdf

Assessment of the Total Benefits and Costs of Implementing Executive Order 13166: Improving Access to Services for Persons with Limited English Proficiency. (2002, March 14), by the Office of Management and Budget (OMB), Report to Congress.

This report by OMB reflects that Office's cost-benefit analysis of implementing the contested Executive Order (E.O.) 13166. Highlights: (1) calls for clear and uniform standards for implementation, (2) cites substantial benefits to "improve health and quality of life of many LEP individuals and families. Moreover, language-assistance services may increase the efficiency of distribution of government services to LEP individuals and may measurably increase the effectiveness of public health and safety programs," (3) encourages a focus on Spanish language as the most frequent language spoken in the United States other than English, (4) predicts that provision of language services will be most costly for the healthcare sector, and (5) estimates a cost between \$1 billion and \$2 billion to implement E.O. 13166. See <http://www.whitehouse.gov/OMB/infoereg/lepfinal3-14.pdf>

Shortchanging America's Health: A State-by-State Look at How Federal Public Health Dollars are Spent. (2005), by the Trust for America's Health.

The Robert Wood Johnson Foundation sponsored a report just released (February 7, 2005) that gives information, by state, on (1) the difference between dollars spent on medical care/treatment versus health promotion; (2) defines the Federal agencies that have a role in public health (hint: the total is surprising); (3) charts per state give percentage of *adults* with asthma, diabetes, obesity, cancer, heart disease, West Nile disease, AIDS; *children* with asthma, overweight, fully immunized, infant mortality, rate of Low Birth Weight CDC funds per line item of cancer prevention; chronic disease prevention/health promotion; diabetes control; environmental health; HIV prevention; immunization; infectious disease, with totals and per capita as well as state rank; (4) bio-terrorism preparedness spending from the CDC and HRSA and the totals; (5) HRSA spending from Ryan White, Maternal and Child Health Block grant; and Health Professionals Grant; and (6) the number of primary care health professions shortage areas. See <http://healthyamericans.org/reports/budget05>

Role of the Planning Process

The Role of Self-Assessment in Achieving Cultural Competence. (2001), by Tawara Goode. Available for direct download from the NCCC Web site at <http://www11.georgetown.edu/research/gucchd/nccc/documents/selfassessment.pdf>

The Cultural Competence Self Assessment Protocol for Health Care Organizations and Systems, developed by Dennis Andrulis, Thomas Delbanco, Laura Avakian, and Yoku Shaw-Taylor. Available from <http://erc.msh.org/mainpage.cfm?file=9.1g.htm&module=provider&language=English>

A Manager's Guide to Cultural Competence Education for Health Care Professionals. (2003), edited by M. Jean Gilbert and prepared for the California Endowment. See http://www.calendow.org/reference/publications/pdf/cultural/TCE0217-2003_A_Managers_Gui.pdf

Example of a cultural competence plan from the California Department of Mental Health (includes administration goals and structures). See <http://www.dmh.ca.gov/multicultural/CC-Plans.asp>

Health sector reform and public sector health worker motivation: A conceptual framework. (2002, April), by L. M. Franco, S. Bennett, and R. Kanfer, *Social Science Medicine*, Volume 54, No. 8, 1255-1266.

Creating an Internal Management Structure for the Process

The NCCC Policy Brief series discusses organizational structures as a key part of cultural and linguistic competence. These policy briefs are available at <http://gucchd.georgetown.edu/nccc/products.html> or <http://www11.georgetown.edu/research/gucchd/nccc/resources/publicationstype.html#policy>

There is some general information on establishing a diversity committee at <http://www.casnet.org/program-management/diversity/cultural-competence.htm>

The Contra Costa Health Services for Contra Costa County in California (see www.cchealth.org) developed an organizational plan to address health disparities by infusing cultural and linguistic competence. See *Reducing Health Disparities: Diversity & Cultural and Linguistic Competence*. Available online at http://www.cchealth.org/topics/publications/pdf/reducing_health_disparities_article_nov03.pdf

Office of Multicultural Services, South Carolina Department of Mental Health, developed a cultural competence plan, which is available online at http://www.state.sc.us/dmh/cultural_competence/cultural_plan.htm

Identifying Fiscal and Personnel Resources

Assessment of the Total Benefits and Costs of Implementing Executive Order 13166: Improving Access to Services for Persons with Limited English Proficiency, by OMB. Report to Congress. See <http://www.whitehouse.gov/OMB/inforeg/lepfinal3-14.pdf>

Pay now or pay later: Providing interpreter services in health care. (2005, March-April), by L. Ku, G. Flores; Center on Budget and Policy Priorities, *Health Affairs: The Policy Journal of the Sphere* (Millwood), Volume 24, No. 2, 435-444. Federal civil rights policy obligates health care providers to supply language services, but wide gaps persist because insurers typically do not pay for interpreters, among other reasons. Health care financing policies should reinforce existing medical research and legal policies: Payers, including Medicaid, Medicare, and private insurers, should develop mechanisms to pay for interpretation services for patients who speak limited English” Excerpt from abstract. Available from http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?db=pubmed&cmd=Retrieve&dopt=AbstractPlus&list_uids=15757928&query_hl=24&itool=pubmed_docsum

Reducing disparities through culturally competent health care: An analysis of the business case. (2002, Summer), by C. Brach and I. Fraser, *Quality Management in Health Care*, Volume 10, No. 4, 15-28. See http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&list_uids=12938253&dopt=Abstract

The Role of Self-Assessment in Achieving Cultural Competence. (2001), by Tawara Goode. This is an excerpt from the Cultural Competence Exchange newsletter of 2001 that identifies fiscal and resource benefits of self-assessment by identifying and utilizing current staff knowledge and skills more effectively, for example, those with multiple language skills, experience, and credibility with communities. Available directly from the NCCC Web site at <http://www11.georgetown.edu/research/gucchd/nccc/documents/selfassessment.pdf>

Identifying Collaborating Partners and Engaging Community Members in the Process

Policy Brief 4: Engaging Communities to Realize the Vision of One Hundred Percent Access and Zero Health Disparities: A Culturally Competent Approach. (2001), by Tawara Goode. Available for download directly from the NCCC Web site at <http://www11.georgetown.edu/research/gucchd/nccc/documents/ncccpolicy4.pdf>

Bridging the Cultural Divide in Health Care Settings: The Essential Role of Cultural Broker Programs. (2003), by Tawara Goode, Suganya Sockalingam, and Lisa Lopez-Snyder. Available for download directly from the NCCC Web site at http://www11.georgetown.edu/research/gucchd/nccc/documents/Cultural_Broker_Guide_English.pdf

The Contra Costa Health Department developed a guide for community building, *Healthy Neighborhoods Project: A Guide for Community Building and Mobilizing Around Health*. This guidebook presents a strategy that health departments and other agencies can use to improve community health. It presents the asset-based, community-building model of the Healthy Neighborhoods Project and how it has been implemented in Contra Costa County. See http://www.cchealth.org/topics/publications/pdf/healthy_neighborhoods_guidebook.pdf

Keys to Access: Encouraging the Use of Mediation by Families From Diverse Backgrounds. (1999), by Anita Engles, Cathy Fromme, Diane LeResche, and Philip Moses; Consortium for Appropriate Dispute Resolution in Special Education.

This resource, designed for professionals in special education, provides guidance on understanding “why some families may not participate in mediation, and strategies for increasing the participation from diverse backgrounds...practical recommendations. to develop the knowledge, positive attitudes, skills and strengths necessary for genuine collaboration” (p. 3). See http://eric.ed.gov/ERICDocs/data/ericdocs2/content_storage_01/0000000b/80/10/a2/88.pdf

Community-based research partnerships: challenges and opportunities. (2005, June), by M. Minkler, *Journal of Urban Health*, Volume 82, No. 2, Suppl. 2, ii3-ii12. Epub 2005, May 11.

ABSTRACT: “The complexity of many urban health problems often makes them ill suited to traditional research approaches and interventions. The resultant frustration, together with community calls for genuine partnership in the research process, has highlighted the importance of an alternative paradigm. Community-based participatory research (CBPR) is presented as a promising collaborative approach that combines systematic inquiry, participation, and action to address urban health problems. Following a brief review of its basic tenets and historical roots, key ways in which CBPR adds value to urban health research are introduced and illustrated. Case study examples from diverse international settings are used to illustrate some of the difficult ethical challenges that may arise in the course of CBPR partnership approaches. The concepts of partnership synergy and cultural humility, together with protocols such as Green et al.’s guidelines for appraising CBPR projects, are highlighted as useful tools for urban health researchers seeking to apply this collaborative approach and to deal effectively with the difficult ethical challenges it can present.” See http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&list_uids=15888635&dopt=Abstract

Building on leadership and social capital to create change in 2 urban communities. (2005, April), by S. A. Farquhar, Y. L. Michael, and N. Wiggins, *American Journal of Public Health*, Volume 95, No. 4, 596-601.

ABSTRACT: This project addressed health disparities in the African American and Latino communities by enhancing community-level social capital. The article contains “specific examples of how this intervention uses community health workers and popular education to reduce language and cultural barriers and enhance community social capital. Although the communities share fundamental challenges related to health disparities, the ways in which the Latino and African American communities identify health concerns, create solutions, and think about social capital vary.” See http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&list_uids=15798115&dopt=Abstract

Using community-based participatory research methods to reach women with health messages: Results from the North Carolina BEAUTY and Health Pilot Project. (2005, April), by L. A. Linnan, Y. O. Ferguson, Y. Wasilewski, A. M. Lee, J. Yang, F. Solomon, and M. Katz, *Health Promotion Practice*, Volume 6, No. 2, 164-173. This study used a community-based participatory research approach to recruit and train five licensed cosmetologists from two beauty salons to deliver health promotion messages to their customers. ABSTRACT: “At 12 months, 55% of customers reported making changes in their health because of the conversations they had with their cosmetologist. Customers who spoke more often with their cosmetologists about health also reported a higher percentage of self-reported behavior changes. It appears that trained licensed cosmetologists are effective in promoting health messages to their customers.” See <http://hpp.sagepub.com/cgi/content/abstract/6/2/164>

Community Engagement in Public Health. (2006, March), by Mary Anne Morgan and Jennifer Lifshay. This paper introduces a conceptual framework for community engagement in public health. It highlights the examples of the Contra Costa (California) Health Services' community engagement program. See http://www.cchealth.org/topics/publications/pdf/community_engagement_in_ph.pdf

To Equalize Power Among Us, We Need to Keep Ourselves in Check in Whatever Ways We Have Privilege

- from *Breaking Old Patterns Weaving New Ties* by Margo Adair & Sharon Howell of Tools for Change. <http://www.toolsforchange.org/resources/pamphlets/to-equalize-power.pdf>

Tip sheets for **Evaluation Tools for Racial Equity**, see <http://www.evaluationtoolsforracialequity.org>

- Is the group developing a common understanding of the ways racism, power, and privilege affect issues on which it is working?
- Is the group developing a process to work together that includes people who are affected by the issue, is reflective of different cultures and different perspectives, and has inclusive decision-making and leadership?
- Is the group identifying other organizations doing work on this issue? Is the group collaborating with others in the community?

Flipping the Script: White Privilege and Community Building

Maggie Potapchuk, MP Associates, Inc

Sally Leiderman, Center for Assessment and Policy Development

See <http://www.capd.org/pubfiles/pub-2005-01-01.pdf>

Planning and Conducting Consumer Focus Groups

A New Use for Focus Groups—Building and Empowering a Culturally Diverse Team. (1996, November-December), by Sandra Hellman and Lynn Baker, *Best Practices and Benchmarking in Healthcare*, Volume 1, No. 6, 297-300. See http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&list_uids=9192595&dopt=Abstract

Evaluation Tools for Racial Equity, see <http://www.evaluationtoolsforracialequity.org>

- How can we design focus groups to give us the best information possible?

Community-Based Participatory Research. (2004, July), by the Agency for Healthcare Research and Quality (AHRQ); Evidence-Based Practice Program.

[Full citation: Viswanathan M, Ammerman A, Eng E, Gartlehner G, Lohr KN, Griffith D, Rhodes S, Samuel-Hodge C, Maty S, Lux L, Webb L, Sutton SF, Swinson T, Jackman A, Whitener L. Community-Based Participatory Research: Assessing the Evidence. Evidence Report/Technology Assessment No. 99 (Prepared by RTI-University of North Carolina Evidence-based Practice Center under Contract No. 290-02-0016). AHRQ Publication 04-E022-2. Rockville, MD: Agency for Healthcare Research and Quality. July 2004.] See <http://www.ahrq.gov/downloads/pub/evidence/pdf/cbpr/cbpr.pdf>

Families as Full Research Partners: What's in it for Us? (1999, August), by Ann Vander Stoep, Marilyn Williams, Robert Jones, Linda Green, and Eric Trupin, *Journal of Behavioral Health Services & Research*, Volume 26, No. 3, 329-344. See http://datatrends.fmhi.usf.edu/summary_12.pdf

Hearing their Voices: Lessons from the Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA), Focus Group Findings from California. (2004, Fall), by the Kaiser Family Foundation. See <http://www.kff.org/womenshealth/7146.cfm>

Mexican-Origin Mother's Experiences Using Children's Health Care Services (2002), by Lauren Clark, *West J Nurs Res.* March, 2002, Vol 24 (2):159-79. See http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?db=pubmed&cmd=Retrieve&dopt=AbstractPlus&list_uids=11858347&query_hl=39&itool=pubmed_docsum

Responsible Research with Communities: Participatory Research in Primary Care: A Policy Statement. (1998), by N. Gibson (Editor). This is a policy statement on participatory research at the North American Primary Care Research Group (NAPCRG) Annual Membership Meeting. <http://napcrg.org/exec.html>

Developing Guidelines for Data Analysis and Report Development

W.K. Kellogg Foundation Evaluation Handbook. (1998), by W.K. Kellogg Foundation
This handbook was designed by the Kellogg Foundation staff in order to make evaluation techniques more useful to organizational and program development. According to the introduction, this handbook "provides a framework for thinking about evaluation and outlines a blueprint for designing and conducting evaluations, either independently or with the support of an external evaluator/consultant." The process explicitly calls for addressing "real issues" in the community and creating a participatory process. When infused with principles of cultural and linguistic competence, this tool can be used to evaluate health and mental health systems for the diversity that exists in the United States. Call (800) 819-9997 for a free copy or see <http://www.wkkf.org/Pubs/Tools/Evaluation/Pub770.pdf>

Step into my zapatos, doc: Understanding and reducing communication disparities in the multicultural informed consent setting. (2005, Winter), by C. M. Simon and E. D. Kodish, *Perspectives in Biology and Medicine*, Volume 48, 1 Suppl., S123-138.

ABSTRACT: "Current informed consent standards are aimed at promoting an equitable and ethical environment for conducting research across diverse patient populations. This paper explores the possible effects of ethnicity and culture on the consent process for pediatric cancer clinical trials. Informed consent discussions were observed, recorded, transcribed, and coded. Question asking by parents and clinician/parent word ratios were used to create an interactivity measure, or "I-score." Visual analog scales were used to rate the clarity of specific explanations. Cases were sorted into two groups on the basis of parents' self-reported ethnicity: Caucasian (n=79, 56%) and minority (predominantly Latino) parents (n=61, 44%). Chi-square and t-tests were used to compare the groups. A series of logistic regression analyses (controlling for ethnicity and SES) were run for variables that showed statistically significant differences ($p < 0.05$). Our findings suggest that the content and quality of the informed consent process is linked to parental ethnicity, or clinician attitudes toward parental ethnicity. These findings are discussed in terms of current perspectives on culture and "cultural competence" in health care. Further research is needed to understand how cultural factors affect outcomes such as parental understanding, decision making, mutual trust, and satisfaction within the informed consent process." See http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?db=pubmed&cmd=Retrieve&dopt=AbstractPlus&list_uids=15842091&query_hl=41&itool=pubmed_docsum

Developing a cultural competence assessment tool for people in recovery from racial, ethnic and cultural backgrounds: The journey, challenges and lessons learned. (2005, Winter), by T. E. Arthur, I. Reeves, O. Morgan, L. J. Cornelius, N. C. Booker, J. Brathwaite, T. Tufano, K. Allen, and I. Donato, *Psychiatric Rehabilitation Journal*, Volume 28, No. 3, 243-250.

ABSTRACT: "In 1997, Maryland implemented a new managed care mental health system. Consumer satisfaction, evaluation and cultural competency were considered high priorities for the new system. While standardized tools for measuring consumer satisfaction were readily available, no validated, reliable and standardized tool existed to measure the perception of people from minority groups receiving mental health services. The MHA*/MHP* Cultural Competency Advisory Group (CCAG) accepted the challenge of developing a consumer assessment tool for cultural competency. The CCAG, composed of people in recovery, clinicians and administrators used their collective knowledge and experiences to develop a 52-item tool that met standards for validity and reliability. Consultation from a researcher helped to further develop the tool into one possessing tremendous potential for statewide implementation within Maryland's Public Mental Health System. Recognizing the limitations of the study and the need for further research, this instrument is a work in progress. Strategies to improve the instrument are currently underway with the Mental Hygiene Administration's Systems Evaluation Center of the University of Maryland and several national researchers." See http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?db=pubmed&cmd=Retrieve&dopt=AbstractPlus&list_uids=15690737&query_hl=43&itool=pubmed_docsum

Developing Suggested Best Practices for Disseminating the Results of the Self-Assessment

Innovative Self-Assessment and Strategic Planning: Addressing Health Disparities in Contra Costa County. Promising Practices series from the NCCC, see

<http://www11.georgetown.edu/research/gucchd/nccc/documents/Contra%20Costa.pdf>

Infusing Cultural & Linguistic Competence into Health Promotion Training (DVD). See <http://www11.georgetown.edu/research/gucchd/nccc/projects/sids/dvd/index.html>

Tip sheet from **Evaluation Tools for Racial Equity**, <http://www.evaluationtoolsforracialequity.org/evaluation/tip/doc/6a01.PDF>

- How can we avoid "blaming the victim" when we present information on poor outcomes for different racial, ethnic, language or immigrant groups in our community?

Changing Channels and Crisscrossing Cultures: A Survey of Latinos on the News Media. (2004), by Roberto Suro; Pew Hispanic Center.

From the Introduction: "This report shows that the news media powerfully influence the twin processes of cultural change at work in the Hispanic population: the assimilation of American attitudes and the formation of a distinct ethnic identity. Even as the English-language media purveys values and cultural expressions drawn primarily from the experience of the native born, the Spanish-language media reflects the immigrant experience and reinforces ties to the home country. Nearly half of the adult Hispanic population crisscrosses between the two, getting some of its news in both languages." <http://pewhispanic.org/reports/report.php?ReportID=27>

The value of engaging stakeholders in planning and implementing evaluations. (2002, June), by A. Gilliam, D. Davis, T. Barrington, R. Lacson, G. Uhl, and U. Phoenix, *AIDS Education and Prevention*, Volume 14, No. 3, Suppl. A, 5-17.

ABSTRACT: "Stakeholder participation in evaluation has surfaced as a major factor contributing to the effectiveness of HIV prevention programs. In recognition of the multiple benefits, the Centers for Disease Control and Prevention (CDC), has used a framework to involve stakeholders in the evaluation of its programs. This article describes the framework used by the CDC and provides examples of four studies that involved various stakeholders from health departments, community-based organizations, and community planning groups to national and regional organizations in designing and implementing evaluations that yielded results useful for program improvement. The participatory process involved stakeholders in each of the four phases of the framework: evaluation planning, implementation, development of action plans, and dissemination. Lessons learned include the importance of having a facilitator to coordinate activities and ongoing communication with those involved in the evaluation. Stakeholders shared that using the evaluation results for action planning was beneficial for improving their programs. Despite many challenges faced in the stakeholder evaluation process, most stakeholders agreed that many benefits grew out of the multiple perspectives presented and understanding of the service agencies." See http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?db=pubmed&cmd=Retrieve&dopt=AbstractPlus&list_uids=12092937&query_hl=46&itool=pubmed_docsum

Policy Brief 3. Cultural Competence in Primary Health Care: Partnerships for a Research Agenda. (2000), by Tawara Goode and Sharonlyn Harrison. This brief includes strategies for dissemination. See <http://www11.georgetown.edu/research/guchd/nccc/documents/Policy%20Brief%203.pdf>

Cardiovascular health among Asian Indians (CHAI): A community research project. (2004, November), by S. L. Ivey, S. Patel, P. Kalra, K. Greenlund, S. Srinivasan, and D. Grewal, *Journal of Interprofessional Care*, Volume 18, No. 4, 391-402.

ABSTRACT: "The object of this research was to assess cardiovascular (CV) risks in Asian Indians in California. We conducted eight focus groups and a pilot survey using community-based participatory research (CBPR) methods. Focus groups were held in six communities. Surveys were conducted by telephone or in person in areas selected for high population densities of Asian Indians. We selected focus group subjects by snowball sampling (n = 57). We held six English and two Punjabi groups. We used a surname-based phone list from three area codes for telephone interviews (n = 254). We added 50 in-person interviews for comparison (total n = 304) and did 50 interviews in Punjabi. We held community meetings for dissemination. Focus groups discussed CV risks; themes developed aided survey development. In-person and telephone surveys were feasible. Telephone surveys were more gender-balanced and people more often answered alcohol, tobacco, and income questions. Self-reported prevalences for hypertension, hypercholesterolemia, and diabetes were 20.4, 35.3 and 10.6%, respectively. Only 11.9% of persons reported ever smoking cigarettes. It was concluded that CBPR methods were effective in this exploratory study assessing CV risks in Asian Indians. Hypertension, high cholesterol, and diabetes were more prevalent in participants than the population average; other risk factors were less common (tobacco)." See http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?db=pubmed&cmd=Retrieve&dopt=AbstractPlus&list_uids=15801554&query_hl=48&itool=pubmed_docsum

‘Imi Hale—the Native Hawaiian cancer awareness, research, and training network: Second-year status report. (2003, Winter-Spring), by K. L. Braun, J. Tsark, L. A. Santos, and L. Abrigo; Native Hawaiian Cancer Awareness Research and Training Network, Asian American and Pacific Islander Journal of Health, Volume 10, No. 1, 4-16.

ABSTRACT: “PURPOSE: The purpose of this paper is to describe ‘Imi Hale, a program developed and managed by Native Hawaiians to increase cancer awareness and research capacity among Native Hawaiians. This US subgroup of indigenous people of the Hawaiian islands has disproportionately high rates of cancer mortality and low rates of participation in health and research careers.

METHODS: As a community-based research project, ‘Imi Hale spent its first year gathering data from Native Hawaiians about their cancer awareness and research priorities. These findings guide ‘Imi Hale’s community and scientific advisors, a community-based Institutional Review Board, Na Liko Noelo (budding researchers), and staff in developing and carrying out projects that address these priority areas. Emphasis is placed on transferring skills and resources to Native Hawaiians through training, technical assistance, and mentorship. A biennial survey assesses the extent to which community-based participatory research principles are being followed. PRINCIPAL FINDINGS: By the end of the school year, statewide and island-specific awareness plans were produced, and 9 funded awareness projects are supporting the development and dissemination of Hawaiian health education materials. Research accomplishments include the enrollment of 42 Native Hawaiian Na Liko Noelo (budding researchers), 22 of which are involved in 14 funded research projects. The biennial evaluation survey found that 92% of our advisors felt that ‘Imi Hale was promoting scientifically rigorous research that was culturally appropriate and respectful of Native Hawaiian beliefs, and 96% felt that ‘Imi Hale was following its own principles of community-based participatory research.

CONCLUSION: ‘Imi Hale’s community-based approach to promoting cancer awareness will result in a sustainable infrastructure for reducing the cancer burden on Native Hawaiians.” See http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?db=pubmed&list_uids=15352771&cmd=Retrieve&indexed=google

The East Side Village Health Worker Partnership: Integrating research with action to reduce health disparities. (2001, November-December), by A. J. Schulz, B. A. Israel, E. A. Parker, M. Lockett, Y. Hill, and R. Wills, Public Health Reports, Volume 116, No. 6, 548-557.

ABSTRACT: “This article describes the work of the East Side Village Health Worker Partnership as a case study of an initiative that seeks to reduce the disproportionate health risks experienced by residents of Detroit’s east side. The Partnership is a community-based participatory research and intervention collaboration among academia, public health practitioners, and the east side Detroit community. The Partnership is guided by a steering committee that is actively involved in all aspects of the research, intervention, and dissemination process, made up of representatives of five community-based organizations, residents of Detroit’s east side, the local health department, a managed care provider, and an academic institution. The major goal of the East Side Village Health Worker Partnership is to address the social determinants of health on Detroit’s east side, using a lay health advisor intervention approach. Data collected from 1996 to 2001 are used here to describe improvements in research methods, practice activities, and community relationships that emerged through this academic-practice-community linkage.” See <http://www.pubmedcentral.nih.gov/picrender.fcgi?artid=1497386&blobtype=pdf>

APPENDIX 3: Sample Consent Form for Focus Group

(Date)

Dear Focus Group Participant:

(Health Center name) is conducting an assessment of how well **(Health Center name)** meets the health care needs of its clients. It is important to hear from you about the successes and challenges you face in seeking health care services.

As part of this self-assessment, focus groups are being conducted. The focus group will 1) seek your views about services you are receiving and 2) make recommendations to improve services and supports. If you agree to participate in the focus group, you will receive a stipend of **(insert amount here)**. Language interpreters will be available.

Please be assured that your responses to the questions will be confidential. A summary of comments will be provided to **(Health Center's name)** in a report. Your name will not appear on the report. The report will be used to assist the health center in improving the way services are delivered to clients from culturally diverse groups.

If you agree to participate, please sign your name in the space provided.

Thank you.

(Signature) (Date)

APPENDIX 4: Sample Focus Group Protocol

Introduction

- Moderator or co-facilitator welcome participants and conduct introductions._
- Explain what a focus group is—like an opinion survey, but very general, broad questions with no right or wrong, good or bad answers. Express the importance of their presence and input.
- Guide for background information and purpose of group discussion:

We are from _____. We are working with the _____ to assist them in developing and implementing services that meet your health care needs both in a cultural and linguistic context.

The health center is very interested in finding out how the health center's policies and practitioners respond to the health care needs and preferences of diverse individuals. Of particular importance to them are the successes and challenges you have faced.

- Guide for explaining the letter of Agreement/Consent Form:

Voluntary participation: This form states that participation by consumers is voluntary.

Documentation Procedure & Confidentiality: Some individuals observing the focus group will be taking notes for submission in a report to the health center. Comments made by participants will be summarized; however, no one will be identified by name. Some direct quotes will be used.

Honoraria: An honorarium to each participating consumer.

- Ask for questions and distribute Agreement to Participate forms.
- Thank participants and disseminate honoraria forms or checks after the focus group.

REFERENCES:

1. Opportunities for Professionals and Families to Understand Strategies for Cross-Cultural Communication (OPUS) Project "Focus Group Protocol." Southwest Communication Resources, P.O. Box 788, Bernalillo, NM 87004; phone: (505) 867-3396 and fax: (505) 867-3398.
2. National Institute on Aging *Focus Group Moderator's Guide*.



About the National Center for Cultural Competence

The NCCC provides national leadership and contributes to the body of knowledge on cultural and linguistic competency within systems and organizations. Major emphasis is placed on translating evidence into policy and practice for programs and personnel concerned with health and mental health care delivery, administration, education and advocacy. The NCCC uses four major approaches to fulfill its mission including (1) web-based technical assistance, (2) knowledge development and dissemination, (3) supporting a “*community of learners*” and (4) collaboration and partnerships with diverse constituency groups. These approaches entail the provision of training, technical assistance, and consultation and are intended to facilitate networking, linkages and information exchange. The NCCC has particular expertise in developing instruments and conducting organizational self-assessment processes to advance cultural and linguistic competency.

Mission

The mission of the National Center for Cultural Competence (NCCC) is to increase the capacity of health care and mental health care programs to design, implement and evaluate culturally and linguistically competent service delivery systems.

The NCCC is a component of the Georgetown University Center for Child and Human Development (GUCCHD) and is housed within the Department of Pediatrics of the Georgetown University Medical Center. It is funded and operates under the auspices of Cooperative Agreement #U93-MC-00145 and is supported in part from the Maternal and Child Health program (Title V, Social Security Act), Health Resources and Services Administration, U.S. Department of Health and Human Services (DHHS). The NCCC conducts a collaborative project under the auspices of another Cooperative Agreement with the GUCCHD and the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, DHHS. Additionally the NCCC contracts with governmental and non-governmental organizations for specific scopes of work at the local, state and national levels.

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