

# A Report on Cultural Competency Training for Health Care Professionals in Connecticut

---



U. S. Department of Health and Human Services  
Office of Public Health and Science  
Office of Minority Health

U. S. Department of Health and Human Services  
Office of Public Health and Science  
Office of the Regional Health Administrator Region 1 - New England  
Office of Minority Health



**Disclaimer:** The information in this report was compiled through a collection and review of program information available on the internet, print materials in circulation and personal interviews. Efforts were made to ensure the accuracy of the information presented. However, some information may not be the most current or accurate at this point in time. The information is also not an exhaustive list of cultural competency training resources available in Connecticut. Programs that were not readily identifiable on the internet would be excluded by the nature of the data collection process.

The Connecticut Multicultural Health Partnership has several other data collection projects taking place regarding cultural competency and workforce development in public health and health care. All data and information collected is available on the Partnership's community network <http://cmhp-community.ning.com>.



## CONTENT

<b>Section I. Introduction</b>	Page 4
➤ Connecticut Multicultural Health Partnership	
➤ Education & Training Committee	
➤ CLAS Standards	
<b>Section II. Essential Training Components &amp; Models</b>	Page 8
<b>Section III. Environmental Scan of Connecticut</b>	Page 12
➤ Regional Focus Groups	
➤ Connecticut's Government Agencies	
<b>Section IV. Training Recommendations</b>	Page 26
➤ Education & Training Committee Goals 2010	
<b>Section V. CLAS Organizational Assessment Tools</b>	Page 28
<b>Section VI. Training Opportunities &amp; Resources</b>	Page 32
➤ Organizations that conduct cultural competency training	
➤ Resources to Develop CLAS policies and procedures	
➤ Resources for training in the CLAS Standards	
➤ Other Resources	
Appendix I: Educational & Training Committee Members	Page 45
Appendix II: Cultural Competency Glossary	Page 47



## **Section 1: Introduction to the Connecticut Multicultural Health Partnership**

This Connecticut Multicultural Health Partnership (i.e. referred to as the Partnership) is supported by the U. S. Department of Health and Human Services, Office of Public Health and Science, Office of Minority Health and funded by the U. S. Department of Health and Human Services, Office of Public Health and Science, Office of the Regional Health Administrator Region 1 - New England, Office of Minority Health. The State Partnership Grant Program is designed to facilitate the improvement of minority health and elimination of health disparities in Connecticut. It will assist the State Department of Public Health in improving the health of racial and ethnic minority populations through the development of health policies and programs that address disparities. The Program will support an enhanced infrastructure as the focal point for leadership, policy development and coordination, information exchange, coalition and partnership building, advocacy and awareness, data system improvements, assessments, and development and implementation of programs and interventions. These functions carried out effectively will make a positive difference in reducing disparities in health knowledge, access to care, quality of care received, and, ultimately, morbidity and mortality of racial and ethnic minority populations.

The focus of the Connecticut State Partnership Program will be the formation of a statewide coalition or partnership to develop and support implementation of a comprehensive state plan to address multicultural health. The development of the state plan will primarily be based on the *National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS Standards)*. Though the CLAS Standards are designed specifically for health care, the Partnership is interested in bringing the intent and spirit of the standards to human and social service agencies as appropriate.

### **Mission of the Partnership**

To develop and implement a state plan to identify and address health disparities and multicultural health issues through the effective and systematic collaboration of a diverse, multidisciplinary group (the Partnership). A major focus of the plan will be the implementation of the National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS Standards) in Connecticut.

### **Structure of the Partnership**

#### **Executive Committee**

The central steering body and major workers make up the Executive Committee consisting of the Officers (chair, vice-chairs and secretary), and the Committee Chairs of which there are currently 21 members, including several members-at-large. There are 11 committees as follows: Access, Advocacy, Awareness & Outreach, Communication & Media, Cultural Competency, Data, Surveillance & Evaluation, Education & Training, Faith-based Initiatives, Language Proficiency, Policy & Program Development and Workforce Development. Each committee is charged with making recommendations built



on the foundation of the CLAS Standards for statewide implementation based on their subject area.

### **Leadership Team**

The wider leading group, like a board of directors, is the Leadership Team, which meets twice a year. This group comprises major stakeholders and leaders of agencies and organizations active in multicultural health and committed to eliminate health disparities.

### **General Members**

The General Membership consists of all people who agree to the vision and mission and want to support the work of the Connecticut Multicultural Health (CMH) Partnership. Different people may be able to have different involvement at different times. We respect the variability in members' availability regarding involvement, and welcome everyone in whatever capacity they can engage. All members will be invited to an annual CMH Partnership conference.

### **Project Overview**

The purpose of the Education and Training Committee is to contribute to the overall mission of the Connecticut Multicultural Health Partnership by enhancing the cross-cultural skills of public health and health care professionals through training recommendations, dissemination of training materials and educational forums. Originally the committee designed a semi-structured interview format and a training inventory. It was quickly discovered that no single person or department could speak on workforce development in cultural competency on behalf of the agency represented. Different departments or units were assigned responsibilities related to cultural competency and workforce development but these activities were not coordinated by a single entity. In order to capture what government and nonprofit agencies are doing to train their staff it was decided to host four regional focus groups.

During the first focus group, it was again quickly discovered that no one seems to know or have standardized policies or service protocols that address cultural and linguistic competencies. Therefore, during the focus group, the facilitator utilized a Culturally & Linguistically Appropriate Service (CLAS) Standards self-assessment. Agencies then spoke about what they do both formally and informally to meet the cultural and linguistic needs of the communities they serve. This yielded a fruitful discussion as much is being done at the front-line level to be culturally competent service providers. The same format was used for the other three focus groups, and training recommendations were listed based on these discussions.

To compliment the focus group results, an extensive internet-based search on cultural and linguistic training programs available in the state was conducted. Connecticut's government agencies listed in this document were sent a draft copy of the report and asked to comment or correct the information about their agency. Finally, educational and training resources available across the country were collected through an internet-based search and their contact information was verified. Resources identified in this report also



include assessment tools for individuals and organizations to assess themselves in the CLAS Standards with supporting information to assist with organizational strategic planning towards the implementation of the CLAS Standards.

### **Culturally and Linguistically Appropriate Services (CLAS) Standards**

The Office of Minority Health, a division of the U.S. Department of Health and Human Services, formally adopted the CLAS Standards in March 2001. These standards are primarily directed at health care organizations; however, individual providers are also encouraged to use the standards to make their practices more culturally and linguistically accessible. As stated, the Partnership's goal is to bring these recommendation standards to human and social service organizations as well. The principles and activities of culturally and linguistically appropriate services should thus be integrated throughout an organization and undertaken in partnership with the communities being served.

The 14 standards are organized by themes: Culturally Competent Care (Standards 1-3), Language Access Services (Standards 4-7), and Organizational Supports for Cultural Competence (Standards 8-14). Within this framework, there are three types of standards of varying stringency: mandates, guidelines, and recommendations as follows:

- **CLAS mandates** are current Federal requirements for all recipients of Federal funds (Standards 4, 5, 6, and 7).
- **CLAS guidelines** are activities recommended by OMH for adoption as mandates by Federal, State, and national accrediting agencies (Standards 1, 2, 3, 8, 9, 10, 11, 12, and 13).
- **CLAS recommendations** are suggested by OMH for voluntary adoption by health care organizations (Standard 14).

### **National Standards on Culturally and Linguistically Appropriate Services (CLAS)**

#### **Standard 1**

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

#### **Standard 2**

Health care organizations should implement strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area.

#### **Standard 3**

Health care organizations should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery.

#### **Standard 4**

Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited



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

**Standard 5**

Health care organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.

**Standard 6**

Health care organizations must assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer).

**Standard 7**

Health care organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.

**Standard 8**

Health care organizations should develop, implement, and promote a written strategic plan that outlines clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services.

**Standard 9**

Health care organizations should conduct initial and ongoing organizational self-assessments of CLAS-related activities and are encouraged to integrate cultural and linguistic competence-related measures into their internal audits, performance improvement programs, patient satisfaction assessments, and outcomes-based evaluations.

**Standard 10**

Health care organizations should ensure that data on the individual patient's/consumer's race, ethnicity, and spoken and written language are collected in health records, integrated into the organization's management information systems, and periodically updated.

**Standard 11**

Health care organizations should maintain a current demographic, cultural, and epidemiological profile of the community as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.

**Standard 12**

Health care organizations should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate



community and patient/consumer involvement in designing and implementing CLAS-related activities.

### **Standard 13**

Health care organizations should ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by patients/consumers.

### **Standard 14**

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

## ***Section 2: Essential Training Components and Models: Guidelines for Teaching Culturally Appropriate Health Care***

The Society of Teachers of Family Medicine (STFM) has published curriculum guidelines for teaching culturally sensitive and competent health care to family medicine residents and other health professions students.<sup>1</sup> The guidelines introduce topics related to culture, health, and illness into residency training and graduate medical education. They are based on the premise that health care professionals can develop competencies to recognize bias when it occurs and can use cultural resources to overcome barriers and enhance primary care.

Written in outline form, the guidelines include a suggested list of appropriate *Attitudes, Knowledge, and Skills for Clinicians*; methods of implementing the curriculum into clinical instruction; and bibliographic references and resources for experiential teaching techniques. The format follows curricular guidelines previously published by the American Academy of Family Physicians, but is general enough for adaptation to educational and training programs for a variety of medical specialties, health professionals, and clinical and administrative staff working in health care settings. The Recommended Core Curriculum Guidelines on Culturally Sensitive and Competent Health Care have been endorsed by the American Academy of Family Physicians and the Society of Teachers of Family Medicine Board.<sup>2</sup>

The guideline of suggested attitudes, knowledge and skills for clinicians is presented below because it provides us with guidance on high-quality curriculum elements to consider when selecting or designing cultural competency curricula.

---

<sup>1</sup> <http://www.stfm.org/FAMMED1996%2028%20291-7.pdf>

<sup>2</sup> Address correspondence to Dr Like, University of Medicine & Dentistry of New Jersey-Robert Wood Johnson Medical School, Department of Family Medicine, One Robert Wood Johnson Place. CN 19, New Brunswick, NJ 08903-0019.



➤ **Attitudes: Awareness and Acceptance of Provider Responsibility**

1. Awareness of the impact of socio-cultural factors on patients, practitioners, the clinical encounter and interpersonal relationships.
2. Acceptance of the physician's responsibility to understand the cultural dimensions of health and illness as a core clinical task in the care of all patients.
3. Willingness to make clinical settings more accessible to patients by taking into consideration location of patient residences and costs of transportation, working hours, language and communication needs, disability status and other financial and environmental circumstances.
4. Appreciation of the heterogeneity that exists within and across cultural groups and the need to avoid overgeneralization and negative stereotyping.
5. Recognition of their own personal biases and reactions to persons from different minority, ethnic, and socio-cultural backgrounds and the need to deal with cultural counter-transference.
6. Appreciation of how one's personal cultural values, assumptions, and beliefs influence the clinical care provided.
7. Willingness to understand and explicate one's values, assumptions, and beliefs and to examine how they affect the care provided to patients that share and do not share a similar perspective.
8. Understanding of the limitations of cultural analysis and the roles played by other historical, political, economic, technologic, and environmental forces in shaping the delivery of health care to individuals, families, and communities.
9. Expressing respect and tolerance for cultural and social class differences and their values in a pluralistic society.
10. A moral and ethical obligation to challenge racism, classism, ageism, sexism, homophobia, and other forms of bias, prejudice, and discrimination when they occur in health care settings and society in general.

**LEARN Model**

**L**istening to the patient's perspective  
**E**xplaining and sharing one's own perspective  
**A**cknowledging differences and similarities between these two perspectives  
**R**ecommending a treatment plan  
**N**egotiating a mutually agreed-on treatment plan

➤ **Knowledge: General Socio-Cultural Issues Relating to Health Care**



1. Anthropologic concepts that are essential for the provision of culturally sensitive and competent health care (e.g. kinship and family life, material culture, and religious life and rituals).
2. How all cultural systems, including those of both patients and physicians, are sources of (congruent and incongruent) beliefs about health, communication about symptoms, and treatment.
3. The impact of culture on the recognition of symptoms and behaviors related to illness; how diversity within a culture affects the provision and utilization of care; and how health care systems reflect the prevailing values of the cultures.
4. Developmental models of ethno-sensitivity (e.g., fear, denial, superiority, minimization, relativism, empathy, and integration) in relation to one's own ethnic and socio-cultural background.
5. Cultural Perspectives on medicine and public health/Kleinman's "typology of health sectors" (Popular, Folk, Complimentary/Alternative).
6. Cultural assumptions and their Influence on the US health care system (basic value orientations in relation to human nature, other people, activity, time, and the environment).

➤ **Clinical Skills: Forming and Maintaining a Therapeutic Alliance**

1. Recognizing and appropriately responding to verbal and nonverbal communication.
2. Constructing a medical and psychosocial history and performing a physical examination in a culturally sensitive fashion.
3. Using the bio/psycho/social model in disease prevention/health promotion, the interpretation of clinical signs and symptoms, and illness-related problem solving.
4. Prescribing treatment in a culturally sensitive manner.
5. Using the negotiated approach to clinical care.
6. Berlin and Fowke's LEARN Model.<sup>3</sup>
7. Kleinman's Explanatory Model (EM): Elicitation techniques to *draw out* individual or family ideas about the etiology, onset, prognosis, etc...<sup>4</sup>
8. Pfifferling's Cultural Status Exam.<sup>5</sup>

<sup>3</sup> <http://www.diversityrx.org/HTML/MOCPT2.htm>

<sup>4</sup> <http://www.dshs.state.tx.us/THSteps/cultural/model.shtm>

<sup>5</sup> [http://www.musc.edu/fm\\_ruralclerkship/culture.html](http://www.musc.edu/fm_ruralclerkship/culture.html)



9. Stuart and Lieberman's BATHE Model  
Background/Affect/Trouble/Handling/Empathy:  
Exploring the psychosocial context of the patient's visit to provide social support and as a basis for gaining insight.<sup>6</sup>
10. Utilizing family members, community gatekeepers, translators/interpreters, and other community resources and advocacy groups.
11. Working collaboratively with other health care professionals in a culturally sensitive and competent manner.
12. Working with alternative/complementary medicine practitioners and/or indigenous, lay, or folk healers when professionally, ethically, and legally appropriate.
13. Identifying how one's cultural values, assumptions, and beliefs affect patient care and clinical decision making.

➤ **Administrative Practices**

In addition to the attitudes, knowledge and skills of health care providers, administrative practices are also crucial to express cultural competences within the context of the organization or health care facility. Such administrative practices are as follows:

1. Analyzing the socio-cultural dimensions of one's own practice site and the implications for practice management.
2. Implementing a cultural sensitization training program for office/clinic staff.
3. Promoting cultural competence in health care organizations as part of total quality management and continuous quality improvement activities.
4. Using ethnographic and epidemiological techniques in developing a community-oriented family practice.

### Explanatory Model

1. What do you think caused your problem?
2. Why do you think it started when it did?
3. What do you think your sickness does to you?
4. How severe is your sickness? Do you think it will last a long time, or will it be better soon in your opinion?
5. What are the chief problems your sickness has caused for you?
6. What do you fear most about your sickness?
7. What kind of treatment do you think you should receive?
8. What are the most important results you hope to get from treatment?

---

<sup>6</sup> [http://www.sbm.org/syllabi/archive/pdf/stuart\\_seminar\\_bathe\\_tech.pdf](http://www.sbm.org/syllabi/archive/pdf/stuart_seminar_bathe_tech.pdf)



5. Influencing the cultures of health care organizations and professional groups (e.g., managed care organizations, ambulatory care facilities, hospitals, nursing homes, and specialty societies).

**In selecting or designing basic cultural competence curricula the following themes are presented by the Office of Minority Health:<sup>7</sup>**

- Important and relevant role of culture in health;
- Core cultural issues;
- Definitions of diversity and diverse populations;
- Definitions of culture and cultural competency;
- Self-awareness of one's own cultural background and self-assessment of biases;
- Theoretical models for cultural competence;
- Cultural models of health, disease, and illness;
- Cross-cultural communication skills;
- Working with interpreters;
- Effective interviewing and taking cultural histories;
- Cultural conflicts in the provider-patient relationship;
- Negotiation skills; and
- Understand complementary or traditional medicine practices.

The variety of subject matter associated with cultural and linguistic competencies is substantial and highlights a dynamic system in both theory and practice. This report will recommend cultural competency assessment tools for individuals and organizations who want to plan their own training programs, followed by training program organizations that are available in the state. The curriculum guidance section can be used to help organizations determine the training content that will be most useful for them, based on the results of their cultural competency self-assessment.

### **Section 3: Environmental Scan of Cultural Competency Training in Connecticut**

---

<sup>7</sup> Teaching cultural competence in health care: A review of current concepts, policies and practices Office of Minority Health, US Department of Health and Human Services  
<http://www.omhrc.gov/assets/pdf/checked/em01garcia1.pdf>



## Regional Focus Groups

The purpose of the focus groups was to have a dialogue with health and social service representatives from a variety of government agencies and non-profit organizations who are involved with cultural competency and diversity training of employees. The goal was to capture current practices in cultural competency and diversity training to a wide range of health care providers and public health professionals to meet the multicultural needs of Connecticut residents, and to identify gaps in educational and training needs based on the discussions with focus group participants and a review of the literature. Four focus groups were held across the state during the month of March. Approximately 50 representatives attended the focus groups that met in Harford, Litchfield, Wallingford and Norwich, representing the commonly defined four regions in the state.

Focus group questions were developed by the Educational and Training Committee of the Connecticut Multicultural Health Partnership. Originally the questions were designed for a semi-structured interview of select State Departments and a random sampling of non-profits. In the pilot of the interview questions, it was quickly discovered that one person was unable to provide the answers. For example, if questions were related to hiring practices, Human Resources needed to be consulted and training questions had to be directed to the Training Academy. The Educational and Training Committee decided to modify the questions and hold focus groups for a brush stroke of understanding what state departments and organizations are doing in relation to cultural competency and diversity training.

This also proved difficult because most of the participants in the first focus groups did not have internal cultural competency training programs within their agencies, either required or voluntarily offered to staff, outside perhaps a one to four-hour training during the new-hire orientation program. Attending cultural competency training was up to the individual professional. Therefore, issues such as *how do you assess the effectiveness of your cultural competency training program or assessing the cultural competency needs of staff* was mute.

The facilitator decided to go through the CLAS Standards and have the participants respond to what their organizations do both formally and informally as a way to meet each of the CLAS Standards. This format was followed for the remaining three focus groups.

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

Standard 1 presents a global statement to “set the stage” of health care organizations to accept responsibility for the preparation of staff communicating effectively by being familiar with and understanding of the cultural populations they serve. It was very clear throughout the focus group discussions that staff in direct contact with patients/consumers struggle every day with cultural barriers, particularly language



barriers. The antidotal stories were numerous and consistent through the discussions. Staff *scrambles* to communication with people who do not speak English “at all” or not “very well” and this continues to include those whose primary language is Spanish. It was also stated that many state regional offices are not culturally or consumer “friendly.” Reception staff was particularly described, for both state and nonprofit health and social service agencies, as insensitive to consumer needs. Training in the area of cultural competency was limited to the orientation period ranging from one to four hours and is describe as diversity training.<sup>8</sup> Some agencies are “thinking about” adding a cultural competency component to their orientation.

Some organizations are responding to Standard One informally celebrating multicultural events with the staff, attending multicultural events in the community, and taking the opportunity to discuss diversity and cultural barriers during staff meetings and clinical discussions. One organization stated they have books, videos and other educational materials available for staff use. None of the organizations described a process of collecting feedback on their organization’s educational materials or assessing consumers’ health beliefs and practices.

**Standard 2:** Health care organizations should implement strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area.

Recruitment and hiring a diverse workforce was usually described within the context of Affirmation Action (i.e. quotas) and within the domain of Human Resources for larger organizations and small social service organization were not aware of a standard practice. In one focus group there was discussion about hiring “unqualified” staff because they represent a racial or linguistic minority group. In another focus group, minority status was perceived as an enrichment-even if the qualifications were not the same, giving the organization the ability to represent the community it serves.

Hiring minority staff and faculty is usually done by advertising with minority professional organizations. Sometimes professional positions do require bi-lingual skills. In general, minority staff was overrepresented in the entry level positions and most agency representatives were not aware of programs designed to promote entry-level staff into higher paying position or management or other leadership positions. One community action agency stated they have a program that is designed to identify people on staff and begin to prepare them with educational supports and mentoring for upward mobility.

Particular credentialing requirements, such as for the School of Social Work, require culture competency training of staff and faculty and have expectations of a diverse faculty in the department. Colleges and universities, both private and public, were not

<sup>8</sup> Diversity training focuses on improving relationships among a diverse work force. Cultural competency focuses on improving the quality of care for service delivery to diverse consumer populations.



aware of institutional-wide goals encompassing a diverse workforce or cultural competency training or expectations of staff and faculty working.

It is important to note that focus group participants stated that representing a particular minority group did not necessarily mean the individual was culturally competent; so that training of cross cultural issues was seen as important for everyone to work with a sense of cultural humility and cultural understanding.

**Standard 3:** Health care organizations should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery.

By far the majority of the focus group participants, and the organizations they represented, were not aware of the CLAS standards, including health care organizations, the target group for which the standards were developed. On-going training and education in culturally and linguistically appropriate service delivery doesn't occur for a variety of organizational barriers such as budgetary expenses for staff time away from duties and staff does not seek this type of training on their own time or under their own expense. When cultural competency training is offered as an in-service, it is generally not required.

**Standard 4:** Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.

The language standards (CLAS Standards 4-7) are required for health care organizations that receive federal funding. It is often viewed as an "unfunded" mandate and has largely been ignored by licensing agencies and health care facilities-until recently. Providing *qualified interpreter services* has been gaining acceptance by health care organizations as a responsibility. Focus group participants discussed the use of telephonic and video interpreter services, training bi-lingual staff as interpreters, and a few health care organizations have hired medical interpreters. It seemed that health care organizations are not "advertising" or offering medical interpreter services. One of the community health center's managers stated there needs to be a discussion on the "reasonableness" of the quantity and quality of interpreter services that are expected to be provided, without cost to consumers.

Social service agencies that use community health outreach workers are often able to accommodate Spanish-speaking clients. New or un-aculturated immigrant groups are more difficult to accommodate because hiring staff that represents un-aculturated groups is also very difficult. Front line staff expressed a great deal of frustration with not having a way (i.e., agency protocol) to deal with this situation. This frustration was expressed by all focus group participants, representing both health and social service



organizations. A participant representing a community college stated they do translate or interpret financial aid documents and other paperwork processes for Spanish speaking applicants and offer English classes free of charge for potential student candidates. Otherwise, speaking English is required for entrance into higher education institutions.

**Standard 5:** Health care organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.

Again, it seemed that most health care organizations did not “offer” or provide “notice” that language assistance must be or is provided with no cost to the patient. Social service and health care organizations have common documents translated (e.g. applications, confidentiality notices) in Spanish and may be in a few other languages such as Russian, Polish and Mandarin. However, it seems that internal documents and educational materials are not translated in all languages commonly encountered. One participant stated her organization uses the “I Speak” pins (I Speak Spanish for example) and another agency stated they use picture boards to communicate when necessary. Overall, no one was familiar with their organization having a policy related to this standard.

**Standard 6:** Health care organizations must assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer).

Assessing language skills of bi-lingual employees was generally not done. Hospitals seemed to have moved in the direction of having a policy of not allowing staff to interpret and relying on telephonic interpreters, unless they have had their staff trained. There are several hospitals in the process of assessing language skills and training staff as interpreters with an outside vendor. In practice, however, it was disclosed that family and friends, including minors, continue to be used as interpreters in clinical settings. It is also assumed that telephonic interpreters are qualified and trained. Social service agencies spoke of the difficulty they have meeting language needs unless they were able to afford community health outreach workers.

**Standard 7:** Health care organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area



The literacy level of legal documents, educational materials, agency forms and other written documents are largely not reviewed for patient or consumer understanding prior to their dissemination. No one attending the focus groups piloted their documents and materials with their client populations, whether in English or in another language.

**Standard 8:** Health care organizations should develop, implement, and promote a written strategic plan that outlines clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services.

For the most part, health care organizations, social service organizations, and academic institutions do not have, or the focus group participants were not aware of, their organizations having a strategic plan that is related to cultural and linguistic competence. This included mental health organizations. There may be departmental strategic plans but not a plan that is endorsed and supported by senior management. In fact, it seemed that senior management was unaware of the multiple barriers and frustrations encountered by staff regarding the array of cultures and languages they are working with daily. Some of the organizations stated they have committees looking into these issues as a first start. Some organizations said that diversity is reflected in organizational vision and mission statements

**Standard 9:** Health care organizations should conduct initial and ongoing organizational self-assessments of CLAS-related activities and are encouraged to integrate cultural and linguistic competence-related measures into their internal audits, performance improvement programs, patient satisfaction assessments, and outcomes-based evaluations.

Self-assessments and performance improvement programs are not formalized in a manner that addresses cultural and linguistic competencies. This is expected since most of the participants were not familiar with the CLAS standards. Patient/consumer satisfaction surveys are conducted, review of patient grievances and internal audits are conducted but not directly linked to cultural competence, except for one organization in attendance. In this case, staff are trained and evaluated on cultural competencies and achievement of their students. The results of the patient/consumer assessments that are conducted may or may not be communicated back to staff. Information that is communicated back to staff usually reflects problem areas/negative comments identified by consumers. Surveys were not necessarily available in languages other than English.

**Standard 10:** Health care organizations should ensure that data on the individual patient's/consumer's race, ethnicity, and spoken and written language are collected in health records, integrated into the organization's management information systems, and periodically updated.



Data is routinely collected for funding reports and as required on internal forms that are completed for intake processes. It was mentioned several times that staff is uncomfortable asking patients/consumers to identify their race. Many people working in the field remember when asking about race was not allowed because of discrimination. If people are not filling out the forms themselves, staff usually “guesses” the race or ethnicity. Data at this point is not uniformly categorized or collected, nor used for individual treatment or program planning (i.e. except for grant writing purposes).

**Standard 11:** Health care organizations should maintain a current demographic, cultural, and epidemiological profile of the community as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.

Again, data is collected and analyzed for funding requests and grant applications but does not seem to be systematically collected for strategic planning within organizations. For example, front line staff may be seeing an increase in a particular ethnic group seeking services, and this is not taken as an opportunity to train and prepare staff to effectively work with the new cultural group. Another example presented was a refugee group being re-located to Connecticut and cultural program planning was not done prior to the group’s known relocation date.

Focus group participants were largely not aware of the populations in their agency’s catchment area that represented at least 10% of the total population (the standard for language access services being required for receivers of federal monies).

**Standard 12:** Health care organizations should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and patient/consumer involvement in designing and implementing CLAS-related activities.

Specific initiatives recruit and engage consumer participation to help with program implementation, such as having consumers sit on an advisory board for a new program. Some organizations require or encourage consumers to sit on governing boards. Though consumer participation may be sought by the organization, it was described as difficult to recruit consumers. Most participants in all the focus groups agreed that much more needs to be done to engage consumers in meaningful ways, and that large organizations are less likely to engage consumers than smaller organizations.



It was also stated that it was “hard to hear” community stories and that doing so puts agencies in a “vulnerable” position when organizations know they are not meeting the community’s expectations. On the other hand, a community health center thought they were not meeting the needs of a particularly cultural group, and intentionally sought to engage the community to increase the quality of care the health center offered.

**Standard 13:** Health care organizations should ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by patients/consumers.

No one seemed to feel they address conflict or grievance issues within a cultural or linguistic context. Patient Bill of Rights and other grievance procedures are in existence but are not grounded in cross cultural conflict resolution. Policy guidance on how to handle cross cultural conflict among staff, between patient/consumers and their providers, or when consumers request to change providers because of racial or ethnic issues are not available. Concern was also expressed that grievance procedures may be complex and require the completion of written documents, etc which may be well beyond the capabilities of people who are the most vulnerable.

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

Standard 14 was seen as the *ideal* at this point in time.

## **Summary & Conclusion**

Focus groups were designed to have a dialogue with health and social service representatives from government agencies and non-profit organizations who are involved with cultural competency and diversity training of their employees. The goal was to capture what is currently being done to train a culturally competent and diverse health care workforce and identify gaps in training programs, which will be incorporated in the Connecticut Multicultural Health Care Partnership Statewide Strategic Plan for 2009-2012. Each Executive Committee workgroup will put fourth their recommendations for the plan as well, toward the goal of implementing the CLAS Standards across health care and social service agencies in the state.



Many of the focus groups participants came to the meeting to learn what other organizations are doing in the area of cultural competency training and to meet the growing demands of language needs. The interest of participants in wanting to learn more about cultural competency initiatives, training opportunities and wanting to know the recommended policies put forth by the Office of Minority Health attest to the importance of the Partnership's work. Most of the focus group participants "never heard of" the CLAS Standards and the discussion of what agencies do both formally and informally to meet the cultural needs of its target populations brought to light what some organizations are doing and what many should be doing.

The standards specifically apply to health care organizations, however, the intent of the Partnership to bring the spirit of the standards to all health and human organizations. Furthermore, all agencies that receive federal monies are required to comply with nondiscrimination and equal opportunity statutes, such as Title VI of the Civil Right of 1964.

### **Connecticut's Government Agencies**

An extensive search was conducted on the State of Connecticut's website regarding the government's agencies and how they trained their staff in the area of cultural competency and diversity training. The search did not specifically look at the policies these agencies have regarding the cultural competency of staff or the cultural responsiveness of their programs. In fact, most, if not all health and human service agencies have such polices. Rather, the search was intended to specifically identify cultural competency training programs *that are provided* to staff for their professional development.

Other entities listed on the state's website included Commissions (e.g. Commission on the Permanent Status of Women) and advocacy groups appointed by governor (Juvenile Justice Advisory Committee). Their significance was usually related towards the elimination of racial and ethnic disparities. Cultural competency is certainly an issue, but not necessarily an professional development issue for Commission staff and advocacy or investigated groups because they are charged with assessing the current statue of an issue or minority group and making legislative and strategic recommendations.

### **Court Support Services Division, Judicial Branch of Government [www.jud.ct.gov/cssd/](http://www.jud.ct.gov/cssd/)**

Court Support Services Division (CSSD) division has an intensive training program for its new employees, which includes a day-long training on cultural competency. A modified version of the training is also available as an annual optional in-service training open to CSSD employees and private contractor employees. The training was developed in collaboration with DMHAS.

### **Department of Children & Families Division of Multicultural Affairs [www.ct.gov/dcf/LIB/dcf/multicultural\\_affairs/pdf/MCA\\_service\\_system.pdf](http://www.ct.gov/dcf/LIB/dcf/multicultural_affairs/pdf/MCA_service_system.pdf)**



The Division of Multicultural Affairs was created for the purpose of developing, implementing, and sustaining diversity initiatives and policies designed to support the diverse needs of staff and clients.

A document is available for private contractors and state facilities titled: Assessment Guidelines for Developing a Multicultural Competent Service System for an Organization or Program. This document developed in collaboration with DMHAS and was released in 2002.

### **Training Academy**

#### **Pre-Service Social Work Training**

[www.ct.gov/dcf/cwp/view.asp?a=2540&q=314804#day1](http://www.ct.gov/dcf/cwp/view.asp?a=2540&q=314804#day1)

Pre-service training for social work staff involves a 23-day curriculum with one day devoted to cultural competency. This full day course allows social workers to recognize the diversity of culture in the clients that are served by DCF, examine their own values, beliefs and attitudes and how it impacts their assessments of clients as well as their own decision making. They will also explore how stereotypes are learned and what they can do to unlearn common misconceptions. Participants receive a presentation regarding hate crimes, bigotry and bias. Mandatory and voluntary in-service trainings are provided to DCF staff and cultural competency is offered as a standard course.

#### **Professional Development Plan for Social Work Supervisors**

[www.ct.gov/dcf/cwp/view.asp?a=2540&Q=316910&PM=1](http://www.ct.gov/dcf/cwp/view.asp?a=2540&Q=316910&PM=1)

A comprehensive professional development plan is designed for individual social workers in preparation for a supervisory position and continues throughout their career. DCF has identified 13 critical competencies that supervisors must have to perform at a high level on the job and cultural competency is among them. Thus the development of cultural competency skills is an integral component of professional development that is incorporated into annual performance evaluations.

#### **Department of Developmental Services**

[www.ct.gov/dds/cwp/view.asp?a=2051&q=330502](http://www.ct.gov/dds/cwp/view.asp?a=2051&q=330502)

An introductory level training session is open to Department of Developmental Services (DDS) and private provider employees. The program offers participants from all levels of the organization an opportunity to explore differences in individual and group identity; enhance understanding of discrimination and hate crimes and what protections are available; enhance skills for dealing with inter-personal and inter-group diversity-related conflict; as well as finding a common ground on which to build work relationships and a 'diversity-positive' organizational culture.

DDS also hosts periodic multi-cultural training events open to DDS and private provider employees. These events provide an opportunity to listen and participate in open discussions focusing on cultural considerations and awareness in providing supports and services.



### **Department of Education**

#### **Connecticut Accountability for Learning Initiative**

[www.sde.ct.gov/sde/cwp/view.asp?a=2618&q=322294](http://www.sde.ct.gov/sde/cwp/view.asp?a=2618&q=322294)

Connecticut Accountability for Learning Initiative (CALI) is a statewide model of continuous school and district improvement with the goal of closing Connecticut's achievement gaps. Professional development elements for all educators include: Data-Driven Decision Making/Data Teams, Effective Teaching Strategies, Improving School Climate (ISC) and Scientific Research Based Interventions (also known as Response to Intervention). Differences in student populations or individual differences are defined in terms of learning for example. Cultural awareness or diversity issues are not addressed in the training standards or training content.

### **Department of Higher Education**

[www.ctdhe.org/](http://www.ctdhe.org/)

Professional development is not a structured activity or unit in the Department of Higher Education as seen in other government agencies. Professional or preceptor development opportunities such as sabbaticals or service learning were not listed on the official website.

### **Department of Mental Health & Addiction Services**

#### **Office of Multicultural Affairs**

[www.ct.gov/dmhas/cwp/view.asp?a=2900&q=334780#training](http://www.ct.gov/dmhas/cwp/view.asp?a=2900&q=334780#training)

The purpose of the Office of Multicultural Affairs (OMA) is to enhance the delivery of DMHAS services for mental health and substance use disorders in a way that acknowledges the impact of individual differences on client treatment. The concept of culture represents these differences as race, ethnic or cultural background, age, gender, sexual orientation, and physical or mental status. Treatment needs to occur within the cultural context to be effective and meaningful for the individual client. The Office of Multicultural Affairs strives to assure that cultural competence is an integral quality of all services that DMHAS provides for people of every ethnic/cultural group.

To that end, DMHAS requires its private contractors and state facilities to address organizational and staff culture competencies as part of their strategic planning processes and professional development activities. Technical assistance is available by the Multicultural Leadership Institute. Agencies and facilities that are not in compliance are in violation of their contract and may be required to pay a penalty.

#### *Example of contract language:*

*In accordance with the core values and guiding principles of systems of care, Respite programs shall be developed and implemented in a culturally competent manner. Programs must assure that their policies, practices, staff recruitment, and service delivery are sensitive and responsive to the needs of culturally, racially, and linguistically*



*diverse children and families. In conjunction with Continuous Quality Improvement, programs shall be cognizant of the ethnic, cultural, and socioeconomic subgroups in their respective areas and strive to obtain staff and establish community linkages which are representative of, and effectively support, the cultural, racial, and linguistic needs of clients. In addition, Respite staff should participate in ongoing training and professional development concerning diversity and competence.*

### The Multicultural Training

The Multicultural Training recruits 35 participants annually for 21 full days of multicultural training over a ten-month period. The students must produce a product, which is usually a culturally competent service project for their area of service that can be implemented and replicated in other settings and regions. The persons seek personal awareness of their own culture during class encounters with a diverse body of students and by means of a personal heritage ethnographic search that is reported to the plenary class. Journals recording new cultural experiences are prepared and submitted for study by training staff. The training is open to non-DMHAS professionals. Course participation is on a first-come, first-served basis.

### PACCT Program

The Project for Addictions Cultural Competency Training Program (PACCT) is a Department of Mental Health and Addiction Services (DMHAS) sponsored program for the recruitment and training of a diverse workforce. The purpose is to increase the hiring pool of historically under-represented groups, such as Hispanic/Latino, African Origin, Asian Americans, and Native Americans who are interested in pursuing a career in substance abuse counseling. The goal is to provide substance abuse agencies a pool of qualified addiction counselor candidates who represent underserved populations. Training is tuition-free and applicable to the Connecticut Substance Abuse Counselor Certification process.

### Multicultural Leadership Institute, Inc

The Multicultural Leadership Institute (MLI) is a service available to all DMHAS contractors and state facilities for the planning, implementation and evaluation of their cultural competency strategic plans. This service is free-of-charge. The MLI, Inc is available to agencies and organizations outside of DMHAS generally based on a fee-for-service. Services include: enhancing cultural competence; providing advocacy for African-Origin and Latino communities regarding alcohol, tobacco and other drug abuse or related problems; and developing and supporting the capacity to provide prevention services

### Prevention Training Course Catalog

DMHAS publishes an annual Prevention Course Catalog for substance abuse counselors and other professional in the field of substance abuse that includes a variety of courses that take cultural and linguistic issues into consideration toward the prevention of substance abuse and the promotion of mental health and wellness.



The Planning Branch is responsible for comprehensive health planning services and technical assistance to Department of Health (DPH) staff and local, regional, and state partners. Workforce and Professional Development is one of the four sections within the Planning Branch. The Planning branch provides opportunities for basic public health professional training and continuing education opportunities to improve public health worker competencies.

Cultural competency and diversity training are not specifically identified as an objective for professional development. Such courses are offered periodically and attendance is voluntary.

Multicultural Health Section leads state and local partners in addressing multicultural health issues through the Connecticut Multicultural Health Partnership, which is composed of representatives of non-government organizations, groups representing specific race or ethnic populations such as the National Association for the Advancement of Colored People, community agencies, professional and advocacy organizations, voluntary health organizations, state commissions, policy leaders, government human service agencies, academia, and others.

The Multicultural Health section may provide grants for culturally appropriate health education demonstration projects and apply for, accept, and spend public and private funds for these projects. It also may recommend policies, procedures, activities and resource allocations to improve health among the state's racial, ethnic, and cultural populations.

The office does not address cultural competency training as a professional development activity of its public health workforce.

**Department of Social Services**  
**Office of Organizational and Skill Development**  
**[www.ct.gov/dss/cwp/view.asp?a=2349&q=304642](http://www.ct.gov/dss/cwp/view.asp?a=2349&q=304642)**

The Office of Organizational and Skill Development (OSD) has a Learning Management System, the Department of Social Services (DSS) Learn Center, to support statewide registration for training and create easy access to DSS supported activities. Education and organizational activities are designed to integrate DSS services and cultural competencies to better prepare the organization and its employees at all occupational levels to support individuals & families receiving services. OSD staff are located in both regional offices and the central office in Hartford.

In addition to the emphasis placed on cultural sensitivity in all trainings offered, there are sessions designed to specifically address the issue of cultural competency. All new employees must complete a host of mandatory trainings for their orientation to employment with the agency. One of these mandatory sessions is a full day training entitled "Workplace Diversity and Cultural Responsiveness" which is intended to address the commitment DSS has to assuring that all clients, staff and service providers to DSS are valued and respected equally.



Also, OSD is developing and has begun to deliver a cultural competency series in the Department of Social Services. Efforts have first begun with the Social Work Services Division (approximately 105 social workers and 16 supervisors) and extended into the general managers and administration of the agency at large. The series introduces the concept of bias and discusses its etiology. In addition to:

1. Becoming self aware...knowing how life experiences may shape bias
2. Acquiring Cross-Cultural Knowledge...hearing the life stories of others...not assigning a story to a person based on membership in a social identity group
3. Developing Cross-Cultural Skills...being sensitive to the individuality of each person we encounter, ethnographic interviewing
4. Service Delivery...making it work in a time pressured bureaucracy

The intent is to next develop a one-day training reflecting the basic concepts outlined above for delivery to all DSS staff. Guest speakers and planned celebrations of the diversity of differing social identity groups are already a part of the DSS culture, most notably in the central office of Hartford. The goal of these training efforts is to extend the reach to the regional offices and to better prepare all staff to “hear the stories” of our clients and better meet the need.

### **The Police Academy**

[www.ct.gov/post/lib/post/pdf\\_documents/818\\_basic\\_training\\_curriculum\\_jan\\_09](http://www.ct.gov/post/lib/post/pdf_documents/818_basic_training_curriculum_jan_09)

People interested in becoming a police officer in Connecticut must attend a Basic Training Program, which includes 818 hours of course work. The basic training involves a section on Human Behavior that is 46 hours in length and includes cultural competency and cultural diversity issues.

### **Racial & Ethnic Disparity Commission in Criminal Justice Justice Public Act No. 00-154**

[www.ct.gov/redcjs/cwp/view.asp?a=3014&Q=381870&redcjsNav=|](http://www.ct.gov/redcjs/cwp/view.asp?a=3014&Q=381870&redcjsNav=|)

An Act Concerning Racial Disparity in the Criminal Justice System (2000): Develop a curriculum for *training of all employees at all levels of the juvenile justice system on issues of cultural competency and strategies to address disproportionate minority confinement.*

### **Summary & Conclusion**

Clearly the Department of Mental Health and Addiction Services is the model government agency, providing cultural competency training across the agency’s hierarchy from entry-level staff positions to senior management levels. Furthermore, DMHAS requires its contactors to have clearly identified goals in their strategic plans addressing the cultural and linguistic competency of staff. The cultural responsiveness of government agencies to effectively and appropriately provide services is articulated in mission statements and policy statements. The corresponding professional development activities, that include employee performance goals in relation to their cultural competence skills and client outcomes still needs to be addressed. The CLAS Standards



offer a useful guide for government agencies to assess, monitor, and evaluate the organizational competencies of our government agencies.

#### **Section 4: Training Recommendations for Connecticut**

1. The primary training recommendation is to disseminate and/or implement a basic training in the CLAS Standards across the state and in multiple health and social service environments. Train-the-Trainer Model in the CLAS Standards for a statewide group of trainers, selected competitively and in exchange for providing a specific number of trainings at sites chosen by the Partnership.

Design and implement basic CLAS Standards training for senior management in health and social service administration, health care professionals, front-line employees and their supervisors and consumers

2. Provide a high level, organizational training, to leadership and senior management on the best practices and exemplary models that promote cultural and linguistic competency throughout an organization, representing the spirit and intent of the fourteen CLAS standards. Include assisting managers with developing the “business case” for allocating funds for this process.
3. Provide training to assist agencies with developing standardized protocol to effectively respond to consumers when they do not speak English or speak very little English. Encourage the use of symbols and pictures to describe services and procedures that can be used by staff in reception areas. Arrange to utilize interpreters of other agencies that provide similar services. Present ways to prepare reception areas and offices that display consumer friendly and welcoming environments.
4. Provide training to assist agencies with determining levels of language proficiency for staff to work as interpreters for different points of contact. For example, the highest level of proficiency would be need for clinical interpretation but not to give consumers directions or to help with completing applications. Assess levels of proficiency and assign bi-lingual staff an assessment level that provides guidelines on the conditions in which they may and may not interpreter.
5. Provide training for organizations to incorporate consumer survey data into short and long term planning processes and quality improvement initiatives. Include staff in the dissemination of results, particularly in what the consumers rate the organization as doing well and very well.<sup>9</sup> Include annual population data analyses in organizational catchment areas for planning to determine shifts in demographics and to properly serve language groups/cultures that represent 10% of more the total population.
6. Provide training among similar organizations to establish data collection categories and for purposes in collecting data so that information is useful to share across agencies and/or to compare program outcomes by initiative.

---

<sup>9</sup> Focus group participants stated they most often hear about complaints and low patient survey scores only.



7. Facilitate discussion groups with administration and management on the concepts of “reasonable” and “meaningful” language access services as intended by the Office of Civil Rights. Include a review of the four language access service standards that are required by private practitioners and health care organizations that receive/accept federal monies.
8. Provide training to human resource personnel on the recruitment, retention and promotion of language and cultural groups that represent the communities they serve, as a concept/practice beyond Affirmative Action requirements. Present models currently in practice that identify and support/mentor entry-level employees toward professional advancement.
9. Provide training in developing organizational and educational materials that are easily understood by consumer populations, and that institute an approval procedure with consumer group input before dissemination. Include materials that are in English as well as other languages. Organizational materials include marketing brochures as well as applications, educational materials and documents that need to be completed by consumers.
10. Provide training to organizations in developing and writing grievance procedures that take cross-cultural conflict resolution issues into consideration and that are appropriate to varying levels of literacy.
11. Facilitate the exchange of low literacy educational materials and educational materials translated in multiple languages for easy access of staff members to download and distribute to the populations they serve.
12. Facilitate the exchange of commonly used forms across agencies in multiple languages so the same form does not need to be translated separately by each health care organization. For examples, Authorization to Release Information, HIPPA Notification, and basic intake forms of similar service organizations. This would also allow for uniformity and accuracy in the information that is being released in languages other than English. Create easy access to have new forms or revised form translated for dissemination at the same time the new English form is being released.
13. Widely disseminate training programs in cultural competency that are available to health care and social service professionals that are readily available for self-study and free of charge.

The training recommendations were distributed to the Executive Committee and the full Partnership to select the top three recommendations of importance. Recommendations 1 & 13 were the mostly commonly cited as the priorities. The following work plan will be incorporated into the Multicultural Health Partnership’s Strategic Plan.

Goal: Develop and implement an educational plan targeting providers, educators, administrators, and support staff toward the assessment and implementation of CLAS Standards



Objectives: 1) Implement Train-the-Trainer Model in the CLAS Standards for a statewide group of trainers, selected competitively and in exchange for providing a specific number of trainings at sites chosen by the Partnership. 2) Trainers implement a basic training in the CLAS Standards across the state and in multiple health and social service environments reaching 100 professionals annually.

Activities: 1) Determine qualifications and procedures to recruit and select trainers and determine evaluation criteria for both the trainers and their participants. 2) Design and implement basic CLAS Standards training for advisory and governing boards, senior management and administration in health and social service.

Outcome: Training is provided for 100 leaders and senior managers on the best practices and exemplary models that promote cultural and linguistic competency throughout an organization.

Evaluation: 1) Eighty-five percent of those trained as trainers feel prepared to teach senior managers. 2) Eight-five percent of the manger participants agree the training met their expectation and achieved the stated objectives. 3) Seventy-five percent of the manager participants report they are able to develop a “business case” for allocating funds for implementation of the CLAS Standards.

Goal: Promote the use of initial and continuous organizational self-assessment of CLAS related activities.

Objectives: Present recommendations on ways to integrate CLAS related activities into quality assurance processes.

Activity: CLAS assessment tools are posted on the virtual community network.

Outcome: Connecticut’s health care and social service organizations will have easy access to organizational and individual self-assessment tools.

Evaluation: 1) Visitors will evaluate the usefulness of the page and if they intend or have implemented a CLAS assessment. 2) Forty-five percent of those who join the virtual community network will view the Education page.

## ***Section V. CLAS Organizational Assessment Tools***

**Cultural Competence Health Practitioner Assessment**  
**National Center for Cultural Competence**  
**[www.gucchd.georgetown.edu/nccc/pa.html](http://www.gucchd.georgetown.edu/nccc/pa.html)**

The Cultural Competence Health Practitioner Assessment (CCHPA) was developed at the request of the Bureau of Primary Health Care (BPHC), Health Resources and Services Administration (HRSA), U.S. Department of Health and Human Service (DHHS). The CCHPA captures a wide range of data in its six subscales including: Values & Belief Systems, Cultural Aspects of Epidemiology, Clinical Decision-Making,



Life Cycle Events, Cross-Cultural Communication and Empowerment/Health Management. The assessment is taken on-line.

Assessment of practitioners is only one aspect of examining cultural and linguistic competence within an organization, and should not be used in isolation. For more information about self-assessment tools & processes see:  
<http://gucchd.georgetown.edu/nccc/selfassessment.html>

**Culturally & Linguistic Appropriate Services (CLAS) Standards Assessment Tool**  
**901 Mopac Expressway South**  
**Barton Oaks Plaza Two, Suite 200**  
**Austin, Texas 78746-3799**  
**1-800-725-9216**  
**[www.tmf.org](http://www.tmf.org)**

This brief assessment tool presents each of the fourteen CLAS Standards with items or indicators representing each standard to assess whether or not they are being practiced in the particular health or social service setting. The assessment tool does not quantify or measure the level of competency but gives the agency a guide for discussion in terms of how well the organization meets the national cultural competence guidelines. It also helps organizations to identified actions steps to become more culturally and linguistically competent.

**Cultural and Linguistic Competence Policy Assessment (CLCPA)**  
**National Center for Cultural Competence (2006)**  
**[www.clcpa.info](http://www.clcpa.info)**

The Cultural and Linguistic Competence Policy Assessment (CLCPA) was developed by the National Center for Cultural Competence (NCCC) at the request of the Bureau of Primary Health Care (BPHC), Health Resources and Services Administration (HRSA), U.S. Department of Health and Human Service (DHHS) to assist community health centers to advance and sustain cultural and linguistic competence.

The CLCPA is intended to support health care organizations to:

- Improve health care access and utilization
- Enhance the quality of services within culturally diverse and underserved communities
- Promote cultural and linguistic competence as essential approaches in the elimination of health disparities.

The NCCC has also developed a companion Guide for Using the Cultural and Linguistic Competence Policy Assessment Instrument that provides step-by-step instructions on how to conduct an organizational self-assessment process.

**Conducting a Cultural Competence Self-Assessment**  
**Dennis Andrulis, SUNY/downstate Medical Center**  
**Brooklyn NY**  
**[www.erc.msh.org/provider/andrulis.pdf](http://www.erc.msh.org/provider/andrulis.pdf)**



This self-assessment process has five steps and generally takes three to five weeks to complete. The steps include: preparing the organization, completing the questionnaire, conducting interviews, evaluating results, and developing a report and action plan. The self-assessment document is available on line and free of charge. Is a comprehensive document that includes the survey and interview question and describes how to use the data to develop an action plan.

The protocol allows organizations to score responses and then place themselves on a five-point spectrum of cultural competence, ranging from inaction to a fully realized "learning" organization. The protocol can serve as a formal organization-wide review tool or as a department- or clinic-specific assessment instrument.

**Consolidated Culturalogical Assessment Tool Kit (C-CAT)**  
**Multiethnic Advocates for Cultural Competence**  
**691 North High Street, Suite 304. Columbus,**  
**Ohio 43215. Download C-CAT Order Form**  
**[www.ccattoolkit.org/Contact.html](http://www.ccattoolkit.org/Contact.html)**

The toolkit for organizational assessment in mental health includes training materials, promotional materials, a facilitator's guide, user workbook, assessment tools and a database. It can be used by a variety of shareholders. The toolkit must be purchased at a cost of \$750 or higher, depending on the number of licenses purchased.

**Health Research and Educational Trust Disparities Toolkit**  
**Hasnain-Wynia, R., Pierce, D., Haque, A., Hedges Greising, C., Prince, V., Reiter, J.**  
**(2007)**  
**<http://www.hretdisparities.org>**

The HRET toolkit is a web-based tool that provides hospitals, health systems, clinics, and health plans information and resources for systematically collecting race, ethnicity, and primary language data from patients. Registration is free. Development of the toolkit included input from a National Advisory Panel.

By using this toolkit, health care organizations can assess their organizational capacity to collect this information and implement a systematic framework designed specifically for obtaining race, ethnicity, and primary language data directly from patients/enrollees or their caregivers in an efficient, effective, and respectful manner.

**Improving Communication—Improving Care: The Ethical Force Program Toolkit.**  
**American Medical Association**  
**[www.EthicalForce.org](http://www.EthicalForce.org)**  
**For information on cost/ordering: [https://catalog.ama-assn.org/Catalog/product/product\\_detail.jsp?productId=prod1180003?checkXwho=done](https://catalog.ama-assn.org/Catalog/product/product_detail.jsp?productId=prod1180003?checkXwho=done)**



This toolkit includes the assessment instruments (surveys) and protocols, analysis guide and data tools, and ideas for how to improve performance based on specific results to be a catalyst for productive organizational change.

1. Intended to help health care organizations meet the needs of a diverse patient population.
2. Assesses how effectively the organization communicates
3. Can help organizations improve communication with all patient
4. Questions focus on common communication problems, such as culture, language and health literacy gaps.

**Indicators of Cultural Competence in Health Care Delivery Organizations: An Organizational Cultural Competence Assessment Profile  
Carr, W. and Willis, J (2002) for U.S. Department of Health and Human Services, Health Resources and Services Administration Group (2002),**

This detailed, practical assessment tool was created to contribute to the methodology of cultural competence assessment. It builds upon previous work in the field, such as the National Standards for Culturally and Linguistically Appropriate Services (CLAS) and advances the conceptualization and practical understanding of how to assess cultural competence at the organizational level.

The Assessment Profile is an analytic framework for assessing cultural competence in health care delivery organizations and identifies specific indicators that can be used in connection with this framework. It provides organizations with the ability to systematically assess their cultural competence. In addition to its use in structured quality assurance and other performance measurement activities, the value of the Profile as a "readiness" tool in helping organizations respond to standard mandates and prepare for accreditation visits.

**One Size Does Not Fit All: Meeting the Needs of a Diverse Health Care Population  
Wilson-Stronks, A. et al (2008) for The Joint Commission  
[www.jointcommission.org/PatientSafety/HLC/one\\_size\\_meeting\\_need\\_of\\_diverse\\_populations.htm](http://www.jointcommission.org/PatientSafety/HLC/one_size_meeting_need_of_diverse_populations.htm)**

Both a tool and a report on a tool, this detailed report provides a framework and self-assessment tool for hospitals to develop and employ practices for meeting diverse patient needs.

**Race Matters: Organizational Self-Assessment  
The Annie E. Casey Foundation  
701 St. Paul Street, Baltimore, MD 21202  
410-547-6600  
[racematters@aecf.org](mailto:racematters@aecf.org)**

This is a two-page questionnaire on staff competencies and organizational operations to assess racial equity within an organization. The assessment is scored followed by a "next steps" analysis. It also suggests tools for improvement.



**Speaking Together, National Language Services Network Measures  
National Center for Cultural Competence (2006)**  
**[www.speakingtogether.org/measures/measures](http://www.speakingtogether.org/measures/measures)**

The George Washington University Department of Health released the language services performance measures, being piloted and tested in its learning collaborative. The measures, developed at the request of the Robert Wood Johnson Foundation, allow hospitals to examine how they communicate with non-English-speaking patients, and focus attention on how hospital staff can better structure and manage language services programs to have effective, efficient and timely communications with patients with limited English proficiency (LEP).

***Section VI. Training Opportunities and Resources***

**Organizations that Conduct Cultural Competence Training**

The following resources based in Connecticut were collected from a web-based search, email request and phone inquiry. Resources outside of Connecticut were taken from *The Manager's Guide to Cultural Competence Education for Health Care Professionals*, prepared by The California Endowment.<sup>10</sup> Training organizations are "listed alphabetically and while intended to be helpful, it is not exhaustive.

**The Center for Cross-Cultural Health**  
**34 Thirteenth Avenue NE, Suite B002B**  
**Minneapolis, MN 55413**  
**612- 331-3311**  
**email: [ccch@crosshealth.com](mailto:ccch@crosshealth.com)**  
**[www.crosshealth.com](http://www.crosshealth.com)**

**Core Professional Training Modules**

These modules are designed for professionals who are seeking to improve their cultural and linguistic knowledge and skills. The core professional modules that the Center provides include:

- **Cross-Cultural Communication:**  
Explores the importance of effective cross-cultural communication to the patient/provider relationship.
- **Cultural Competence I:**  
Introduces care providers to cultural competence in health care.

---

<sup>10</sup> [http://www.calendow.org/uploadedfiles/managers\\_guide\\_cultural\\_competence\(1\).pdf](http://www.calendow.org/uploadedfiles/managers_guide_cultural_competence(1).pdf)



- **Cultural Competence II:**  
Advances the care provider's knowledge and application of cultural competence in health care.
- **Working with an Interpreter:**  
Examines the need for language services and qualified interpreters to reduce medical errors, increase patient compliance, increase patient satisfaction, and improve primary care utilization.
- **Introduction to Cultural and Linguistically Appropriate Service (CLAS) Standards:**  
Explores the CLAS mandates, legal implications, and provides strategies for implementing the standards within medical organizations.
- **Health Disparities I:**  
Presents research evidence about health outcome differences for diverse populations that still persist even when health access differences are accounted for.
- **Collecting Race and Ethnicity Data:**  
Describes how to collect demographic data on race and ethnicity in a culturally competent manner.
- **Making the Business Case:**  
Examines the rationale and financial implications for creating culturally competent organizations.

### Train-the-Trainer Modules

The above Core Professional Training Modules are also available as Train-the-Trainer Modules. These modules are designed for staff members who are responsible for providing education and training to health care professionals, care givers, and other staff within their organizations. In addition to all the applicable instructional materials, each Train-the-Trainer module provides practical tips and techniques for cross-cultural training. The Center's instructors provide participants with highly interactive instruction that includes: didactic exercises, video vignettes, and group discussions.

### Consulting and Organizational Development Services

The Center provides a survey to enable health care organizations to assess their overall compliance with CLAS standards. The Center works with organizations to deliver the survey, and provide a statistical summary of results. The Center uses these results to make recommendations that help the organization develop strategies and specific behaviors that move the organization toward greater cultural and linguistic competence.

Continuing education unites are available for Allied Health Professionals and training programs are customized to meet the particular needs of different organizations and the populations they serve.

**The Center for Health Families and Cultural Diversity**  
**Department of Family Medicine,**  
**UMDNJ - Robert Wood Johnson Medical School,**  
**1 Robert Wood Johnson Place, New Brunswick, NJ 08903**  
**732-235-7662**  
**email: [like@umdnj.edu](mailto:like@umdnj.edu)**  
**[www2.umdnj.edu/fmedweb/chfcd](http://www2.umdnj.edu/fmedweb/chfcd)**



### Technical Assistance/Consultation

- Serving as a multicultural education resource center for information about family-centered health care and ethnic and cultural diversity.
- Assisting health care organizations (e.g., managed care organizations, hospitals, ambulatory care facilities, and home health care agencies) in the delivery of culturally and linguistically appropriate services to diverse populations.
- Collaborating with local communities to assess their health care needs and strengths/assets and to develop culturally-responsive service delivery programs.
- Advising state and local government in the development and implementation of policies and procedures relating to culturally and linguistically appropriate health care.

### Education and Training

- Integrating multicultural education into health professions curricula.
- Infusing multicultural education into residency and fellowship training programs in hospital and ambulatory care settings.
- Providing cultural diversity workshops and seminars for faculty, administration, and staff.
- Offering clinical cultural competency courses, workshops, and programs to practicing physicians and other health care professionals.

### Research and Evaluation

- Evaluating the effectiveness of clinical cultural competency training programs for physicians and other health care professionals.
- Evaluating the effectiveness of organizational cultural competency training programs for health care organizations.
- Conducting outcomes research on selected health and illness problems in various racial, ethnic, and socio-cultural groups.
- Conducting health services and policy research relating to culturally competent health care.

**The Center for Immigrant Health**  
**New York University School of Medicine**  
**550 First Avenue, New York, NY 10016**  
**212- 263-7300**  
**email: [cihinfo@med.nyu.edu](mailto:cihinfo@med.nyu.edu)**  
**[www.med.nyu.edu/cih](http://www.med.nyu.edu/cih)**

### Research, outreach and education, information dissemination

At the *community level*, the Center builds capacity for health work among community-serving organizations by training community members to provide outreach, education, and screening in a variety of topical areas, ranging from cancer to tuberculosis, to health system access. The Center works with the ethnic media and with key community leaders to ensure that health promoting messages and programs are broadly delivered, in a culturally and linguistically appropriate manner. Special effort is made to reach those immigrants and refugees who are recent arrivals and who are undocumented. The community actively informs our work.



At the *practitioner level*, there is ongoing provider education in caring for immigrant and refugee populations, cross-linguistic and cross-cultural healthcare delivery, and immigrant and refugee epidemiologic issues. The Center has an active Roundtable and Conference Program, as well as a social marketing program. Scholarly immigrant health publications are developed.

At the *systemic/institutional level*, technical assistance is provided to institutions in the development of institutional immigrant receptivity, and in culturally and linguistically accessible healthcare. Innovative medical interpretation systems have been developed and are being implemented. Dynamic cultural competence trainings are being implemented.

Technological solutions to education and health access are designed, tested, and disseminated.

Research is being conducted in a number of arenas, including language and healthcare access, epidemiology, and community-based strategies for practitioner and community education and access.

**Center for Eliminating Health Disparities among Latinos, Hispanic Health Council**  
**175 Main Street**  
**Hartford, CT 06106**  
**[www.hispanichealth.com](http://www.hispanichealth.com)**  
**860- 527-0856 X267**

#### Training Goal

To establish the foundation of knowledge, attitudes, and skills needed for participants to interact effectively with patients/clients of diverse backgrounds.

#### Training Approach

The training approach utilized in the Cross-Cultural & Diversity Inclusiveness Training (CC &DIT) curriculum is participatory, and utilizes a variety of training methods, each selected for its effectiveness in teaching about a particular topic or facilitating the development of a specific skill.

#### Training Objectives

By the end of the training, participants will...

1. Be able to define cultural competence and understand the conceptual framework of cultural competence;
2. Understand racial and ethnic health disparities, and the importance of cross-cultural skills development as a strategy toward eliminating these inequalities;
3. Understand how issues of oppression, such as “Blaming the Victim” and “Internalized Oppression,” create barriers to the successful use of health and human services, and to socio-economic opportunities and overall well-being;
4. Have developed a series of skills needed for effective interaction with diverse populations; and
5. Have assessed their personal cultural competence and have developed a personal action plan for continued development of cultural competence.



### Target Audience

This training targets people working or studying in the health or human service field and is tailored for participants at a range of educational levels.

### Training Length

In its entirety, the curriculum requires 12-15 hours to complete. The training sessions are scheduled to accommodate the time availability of specific groups of participants, and training content is modified based on their needs and priorities. The length of the curriculum may be modified to accommodate groups with more limited time availability.

### Training Location

The training location is flexible depending on the needs of the participant group. The Hispanic Health Council's training facility in Hartford is available.

### Training Cost

Any cost charged for the training is determined based on the magnitude of the project and specific costs the Hispanic Health Council incurs in order to deliver it.

## **The Cross Cultural Health Care Program**

**1200 12<sup>th</sup> Ave  
Seattle, WA 98144  
206-621-4161  
[www.xcult.org](http://www.xcult.org)**

### Cultural Competency Workshops

- Building culturally competent community partnerships
- Building culturally Competency health care systems
- Effective cross-cultural communication systems
- Building culturally competent language services

### Train-the-Trainer

There is a train-the-trainer course in cultural competency.

### Resources and Training Materials

Comprehensive library of tools including assessments teaching modules, and community research booklets on many cultural groups in the United States

### Medical Interpretation

*Bridging the Gap* medical interpreter training course and compendium of support materials for interpreters and translators



**Intercultural Communication Institute**  
**8835 S.W. Canyon Lane**  
**Portland, OR 97225**  
**503-297-4622**

The Intercultural Communication Institute (ICI) offers a certificate program at three levels acknowledging exposure to state-of-the-art theory and practice, completion of a balanced curriculum, knowledge of intercultural practices, and growth as an intercultural professional. The certificate program reflects your learning through ICI activities and your commitment to the professional standards maintained by ICI trainers and faculty. These certificate programs are conducted during the Summer Institute.

- Intercultural Foundations Certificate
- Intercultural Practitioner Certificate
- Intercultural Professional Certificate

This certificate represents a higher level of achievement, including completion of an extensive curriculum of courses and workshops, and receipt of individualized feedback on intercultural competence and professional accomplishments. Holders of this certificate will have received comprehensive practical training and extensive intercultural assessment. Evaluation fee: \$2,000

**Millennia Consulting**  
**28 E. Jackson, Ste. 1700**  
**Chicago, IL 60604-2214**  
**312.922.9920**  
**[www.ConsultMillennia.com](http://www.ConsultMillennia.com)**

Millennium Consulting facilitates the organizational change process needed to develop goals and objectives for cultural and linguistic competence. They make the business case for achieving cultural and linguistic competence in nonprofit health care agencies and organizations.

**National Center for Cultural Competency**  
**Georgetown University for Child and Human Development**  
**[www.ncccurrricula.info/overview/index.html](http://www.ncccurrricula.info/overview/index.html)**

The Center offers a wide variety of on-site trainings and can create training for a variety of health care professional audiences. It maintains a consultant bank, archived by US



geographical area and training specialty, and a Cultural & Linguistic Competence Resources Database.<sup>11</sup>

### Curricula Enhancement Module Series

Overview and purpose of the module series:

- Cultural and linguistic competence: rationale, conceptual framework and values
- Cultural awareness
- Cultural self-assessment
- The process of inquiry: communicating in a multicultural environment
- Public health in a multicultural environment

### Other Resources

- Promising Practices: a listing of evidence-based promising policies, structures, and practices that exemplify cultural and linguistic competence in many healthcare and mental health programs.
- Publications: materials developed by the NCCC, including policy briefs, checklists, guides, articles, tools monographs, and multimedia products.
  - *Guide to Planning and Implementing Cultural Competence Organizational Self-Assessment*
  - *Planners Guide for Infusing Principles, Content and Theme Related to Cultural and Linguistic Competence into Meetings and Conferences*
  - *Guide to Bridging the Cultural Divide in Health Care Settings: The Essential Role of Cultural Broker Programs!*

### **US Department of Health & Human Services (HRSA)**

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

This website contains educational and training materials under the following categories: Cultural/Language Specific; Disease/Condition Specific; Children with Special Health Care Needs; Health Professional Education; Special Populations, and Technical Assistance

### **US Department of Health & Human Services**

**Office of Minority Health**

**<https://cccdpcr.thinkculturalhealth.org/>**

### **Implementing CLAS at Every Phase of a Disaster**

In OMH's ongoing effort to reduce the number of racial and ethnic health disparities in the United States, a new e-learning program was launched, the Cultural Competency Curriculum for Disaster Preparedness and Crisis Response (CCC-DPCR). The four

---

<sup>11</sup> Resource Database: [www4.georgetown.edu/research/gucchd/nccc/app/resources/index.cfm](http://www4.georgetown.edu/research/gucchd/nccc/app/resources/index.cfm)



courses are designed to equip disaster and crisis volunteers and personnel with the awareness, knowledge, and skills needed to provide culturally and linguistically appropriate services to diverse communities during all phases of disaster. The curriculum is grounded in the Office of Minority Health's CLAS Standards, which are grouped into three themes: Culturally Competent Care, Language Access Services, and Organizational Supports. The course takes approximately 9 hours and CMEs are available.

### **Resources for Developing CLAS Policies and Procedures:**

#### **DiversityRx: Models & Practices** **[www.diversityrx.org/HTML/models.htm](http://www.diversityrx.org/HTML/models.htm)**

Offers practical information on how to design programs that address linguistic and cultural barriers to health care, based on the past and evolving experiences of individuals and organizations. Learn about medical interpretation issues such as training, testing, certification, ethics, and roles, as well as information geared towards providers who work with multicultural populations, such as training in the use of interpreters, language education programs, and cultural competency curricula.

#### **Health Care Language Services Implementation Guide:** **[www.hclsig.thinkculturalhealth.org/user/home.rails](http://www.hclsig.thinkculturalhealth.org/user/home.rails)**

The US Department of Health and Human Services, Office of Minority Health has sponsored the development of this guide to help healthcare organizations implement effective language access services (LAS) to meet the needs of their patients with limited English proficiency (LEP), thereby increasing their access to health care.

As your community and your organization evolve over time, this guide can assist you with the evolution of your LAS. As such, your healthcare organization can continue on your mission to provide quality health care to all of the patients who seek your assistance, regardless of their language ability.

The guide lays out the basic steps for implementing LAS, and the process for carrying out each step is explained in detail and supplemented with links to resources and tips on alternative ways to complete the step. It is a web-based guide and free to access.

### **Resources for Training Individuals in CLAS Standards**

**Connecticut AHEC Program**  
**Medical Interpreter Training Program**  
**One Sylvandale Road**  
**Jewett City, CT 06351**  
**860-705-44232**



[www.easternctahec.org](http://www.easternctahec.org)

*Instructor Qualifications:* Trainers are qualified by Northern Virginia AHEC after extensive testing and training.

*Modality:* It is highly interactive and includes practice sessions and role-plays. The training program accommodates up to 15 participants to ensure individual participant assessment and feedback. The course is “language neutral” allowing any *target language* to participate in the course. Participants undergo a comprehensive language assessment to verify language proficiency before acceptance into the program. Exit requirements for certification include mid-term and final exams with a grade of 85% or higher and a post-observation follow-up during an actual interpreting encounter.

*Length/Cost of Training:* The interpreter course involves 40-hours of class time and approximately 8-10 hours of homework. Course fees are posted on the website for individuals and employer groups. Scholarships may be available.

*Other Notes:* In-Service seminars are available free of charge for health care administrators and health care providers. Topics include implementing language access services, understanding language access laws and liabilities, how to address the need for an interpreter and how to work with an interpreter. CMEs are available.

**Cross Cultural Health Care Program**  
**4700 42nd Ave. SW, Suite 580**  
**Seattle, Washington 98116**  
**(206) 860-0329**  
**e-mail: [iras@xculture.org](mailto:iras@xculture.org)**  
**[www.xculture.org](http://www.xculture.org)**

*Instructor Qualifications/Experience:* Ira SenGupta was the principal investigator on best practices for the national CLAS standards for the U.S. Department of Health and Human Services, Office of Minority Health. She conducts over 900 hours of such training each year, and is also directs various community-based research projects. The name of the course is *Building Cultural Competency in Health and Social Services*.

*Modality:* A combination of didactic and experiential teaching techniques is utilized in this training. Skill building occurs through active role playing as well as small group activities. Instruction is case-based and participants enhance their training and facilitation skills through teach-back sessions. The training can be brought to your state or organization.

*Length/Cost of the Training:* Five-day training with a three hour post training consultation. Cost of the training is \$3000, and includes all of the training manuals/materials. Fee does not include travel and accommodations for the trainer.



*Other Notes:* It appears that they hold these trainings annually in Washington State. This is a “Training of Trainers” event. A PDF brochure can be found at the following website:

<http://www.xculture.org/files/CC%20TOT%20Brochure%202008%20v.3.pdf>

**Unified Health Communication 101: Addressing Health Literacy, Cultural Competency, and Limited English Proficiency**  
**U.S. Department of Health and Human Resources**  
**Health Resources and Services Administration**  
[www.hrsa.gov/healthliteracy/training.htm](http://www.hrsa.gov/healthliteracy/training.htm)

*Instructor Qualifications/Experience:* N/A.

*Modality:* Online five module course

*Length/Cost of the Training:* Estimated to take 5-hours and is free.

*Other Notes:* CEU's and CME's are available with this training.

**Curricula Enhancement Module Series**  
**National Center for Cultural Competence**  
**Georgetown University Center for Child and Human Development**  
[www.ncccurricula.info/modules.html](http://www.ncccurricula.info/modules.html)

*Instructor Qualifications/Experience:* N/A.

*Modality:* Online course with four modules

*Length/Cost of the Training:* Estimated to take 5-hours and is free

*Other Notes:* CEU's and CME's are available with this training. Register at:  
<http://www.hrsa.gov/healthliteracy/training.htm>

**Education Works Consulting Services**  
**East Haven, CT**  
**203-469-3939**  
[www.educationworkscs.com/default.htm](http://www.educationworkscs.com/default.htm)

*Instructor Qualifications/Experience:* N/A

*Modality:* In-person training.

*Length/Cost of the Training:* Unknown.



Other Notes: Education Works conducts training on cultural competency & diversity, ethnic specific learning, employee relations & staff development, and diversity & cultural bias. They provide in-service onsite education and training services, and they also host workshops on cultural bias. If more information is needed, they encourage you to *contact them directly*.

**Diversity and Cultural Competency in Public Health Settings - Basic Level  
South Central Public Health Partnerships  
<http://lms.southcentralpartnership.org/scphp?productID=prdct000000000001007>**

Instructor Qualifications/Experience: N/A

Modality: Web-based training.

Length/Cost of the Training: Free.

Other Notes: The purpose of this course is to provide public health practitioners with the awareness and knowledge to incorporate diversity and cultural competency concepts, tools, and techniques into their daily work. It is expected that by the end of this course that each participant will be conversant in issues related to culture and health, health disparities, and community health models designed to close the gap in health disparities. No CEUs are offered.

**Managing Diversity Begins with You  
South Central Public Health Partnerships  
[www.lms.southcentralpartnership.org/scphp?productID=prdct000000000001011](http://www.lms.southcentralpartnership.org/scphp?productID=prdct000000000001011)**

Instructor Qualifications/Experience: N/A

Modality: Web-based training

Length/Cost of the Training: Free

Other Notes: The purpose of this intermediate course is to acquire a conceptual framework with tools to manage diversity in the workplace as a way of improving service delivery, quality, and accessibility. It is expected that each participant will be able to identify their role in their own organization with respect to diversity and cultural competency and to position their organization as a leading organization in the delivery of culturally competent services. No CEUs offered.

**Multicultural Leadership Institute  
100 S. Turnpike Rd. Suite C  
Wallingford, CT 06492  
203- 793-1952  
[www.mli-inc.org](http://www.mli-inc.org)**



Instructor Qualifications/Experience: N/A

*Modality:* Workshop—activities, dialogue, and information and resource exchanges.

*Length/Cost of the Training:* Three hours of training for individual working in a DMHAS funded prevention setting in behavioral and/or mental health. Technical assistance is provided to management of DMHAS funded programs/agencies to develop strategic plans regarding cultural and linguistic competencies as required by DMHAS of its contractors. The cost is free.

MLI will provide consulting and technical assistance to non-DMHAS contractors on a fee-for-service basis.

*Other Notes:* Workshop topics include, but not limited to the following: cultural competency principles and theories; cultural competency definitions, continuum and learning processes; planning for organizational cultural competency, personal action planning in cultural competency as lifelong learning.

### **The Multicultural Training**

#### **DMHAS/OMA**

**410 Capitol Avenue. 4th Flr., MS14 OMA**

**P.O. Box 341431**

**Hartford, Ct 06134**

**[www.ct.gov/dmhas/cwp/view.asp?A=2900&Q=334780#training](http://www.ct.gov/dmhas/cwp/view.asp?A=2900&Q=334780#training)**

Instructor Qualifications: Instructors are brought in as guest speakers to represent culturally/ethnically specific populations.

*Modality:* Highly interactive workshops, journaling, and ethnography assignment.

*Length/Cost of Training:* Twenty-one days over a 10 month period. The training is free and people outside the DMHAS system are eligible to apply. The training takes place once a-year for a cohort of 35 students.

*Other notes:* The students must produce a product which is usually a culturally competent service project for their area of service which can be implemented and replicated in other settings and regions. The persons seek personal awareness of their own culture not only in the class encounter with a diverse body of students but also by means of a personal heritage ethnographic search which is reported to the plenary class. Journals recording new cultural experiences are prepared and submitted for study by training staff.



## Other Resources

### **Videos**

#### *Disability is Natural*

<http://www.disabilityisnatural.com/store/index.html>

This video is used as a training tool for a wide audience, including parents, people with disabilities and their families, policy makers, and providers. According to their Web site, “the messages in this video question today’s conventional wisdom, pose provocative questions, and describe positive scenarios that can occur when we realize disability is natural. The combination of these revolutionary ideas coupled with the inspirational music creates an unforgettable experience.” See

#### *Quality Interactions: A Patient-Based Approach to Cross-Cultural Care*

[www.criticalmeasures.net](http://www.criticalmeasures.net).

The Manhattan Cross Cultural Group, a training and research organization headed by three physicians, Joseph Betancourt, Emilio Carrillo, and Alexander Green, has developed an interactive, 2-hour e-learning course, *Quality Interactions: A Patient-Based Approach to Cross-Cultural Care*. Based on curricula taught at several leading medical centers, the course allows users to obtain continuing medical education credits. It responds directly to the recommendations of the IOM reports *Unequal Treatment* and *Crossing the Quality Chasm*. The course is being made available by Critical Measures, LLC

#### *That’s Not What I Meant: Language, Culture, and Meaning*

Two videos presenting content on language, culture, and resolving misunderstanding. See

[http://www.georgetown.edu/faculty/tannend/videos.htm#Thats\\_Not\\_What\\_I\\_Meant\\_Language](http://www.georgetown.edu/faculty/tannend/videos.htm#Thats_Not_What_I_Meant_Language).

#### *Videos From Kaiser Permanente*

Kaiser Permanente, in collaboration with The California Endowment, has developed a set of 20 trigger videos that focus on a variety of issues in cross-cultural communication with patients in a variety of clinical settings. The topics include problems encountered in using untrained interpreters, initial clinician reluctance to use telephonic interpreting, communication around sensitive issues such as domestic abuse, gestational diabetes, prostate exams, sexually transmitted diseases (STDs), gay adolescents, alternative medicine use, literacy, somatization, end-of-life decision making, and traditional folk medical practices and concepts of healing. Each video is accompanied by contextual background materials and a facilitator’s guide for debriefing the video. Each trigger video and materials can be used for a training session of 30–45 minutes.

The set of 20 trigger videos and accompanying materials sells for \$105. For information and order forms, contact Gus Gaona at (323) 259-4776 or by mail: Gus Gaona, Kaiser



Permanente National Video Communications and Media Services, 825 Colorado Boulevard, #301, Los Angeles, CA 90041.

### **Connecticut Data Sites**

CT Health Community Health Data Scan Site: [www.data.cthealth.org](http://www.data.cthealth.org)

DPH CT Health Disparities Project (see DPH Policy on collecting sociodemographic data): [www.ct.gov/dph/cwp/view.asp?a=3132&q=396418](http://www.ct.gov/dph/cwp/view.asp?a=3132&q=396418)

### **HRSA Resources**

Health information in more than 40 languages covering nearly 250 topics:  
[www.nlm.nih.gov/medlineplus/languages/languages.html](http://www.nlm.nih.gov/medlineplus/languages/languages.html)

HRSA Health Literacy and Cultural Competency Resource Link:  
<http://www.ahrq.gov/browse/hlites.htm>

Health Literacy and Cultural Competency Resource Links at:  
[www.ahrq.gov/browse/hlites.htm](http://www.ahrq.gov/browse/hlites.htm)



## Appendix 1 Educational & Training Committee Members

With special thanks to:

***Karen D'Angelo & Ellen Boynton***

**Catherine Russell, EdD, Co-Chair**

Executive Director, Eastern AHEC, Inc.  
Jewett city, CT 06351  
860-705-4423  
russell@easternctahec.org

**Natalie Achong, MD**

President, Connecticut Society, National  
Medical Association  
Assistant Clinical Professor, Department  
of Obstetrics and Gynecology  
Yale University School of Medicine  
203-912-2264  
mnachong@yahoo.com

**Barbara Berger**

Director, CT Office of Rural Health,  
Northwestern CT Community College  
860-738-6378  
bberger@nwcc.commnet.edu

**Ellen Boynton**

Training Program Coordinator  
Office of Multicultural Affairs  
DMHAS  
860-418-6806  
ellen.boynton@po.state.ct.us

**Rosa Browne**

CAP Program Coordinator  
Yale-New Haven Hospital  
Health Committee Vice Chair, NAACP  
203- 688-2219  
rosa.browne@ynhh.org

**Bruce Gould, MD, Co-Chair**

Associate Dean for Primary Care, CT  
AHEC Program Director  
University of Connecticut Health Center  
860-679-4322  
gould@adp.uhc.edu

**Thomas Buckley**

Pharmaceutical Representative,  
UCONN  
860-693-9206  
thomas.e.buckley@uconn.edu

**Karen Bullock**

Associate Professor, UCONN, School of  
Social Work  
860-570-9148  
karen.bullock@uconn.edu

**Karen D'Angelo**

Cross-Cultural Trainer  
NIH Center for Eliminating Health  
Disparities Among Latino  
Hispanic Health Council  
860-527-0856 x 267  
karend@hispanichealth.com

**Pedro Delgado**

Training and Technical Assistance  
Coordinator, The Multicultural  
Leadership Institute  
203-793-1952  
pdelgado@mli0inc.org



**Anne Elwell**

Director of Quality Improvement,  
Qualidigm  
860- 632-6322

**Catherine Havens**

Director of MSW Program, UCONN  
860-570-9141  
catherine.havens@uconn.edu

**Michele Kelvey-Albert**

Health Educator, Qualidigm  
860-632-6322  
aelwll@ctqio.sdps.org

**Velendy Manohar, MD**

Adult Mental Health Services,  
Community Health Center, Middletown  
860-347-6971 ext 3400  
*Velandy\_manohar\_md@comcast.net*

**Suzanne A. Rosenberg**

Hospice Performance Improvement  
Coordinator  
CT VNA, CT Assoc. for Home Care and  
Hospice Inc.  
203-265-9931  
skehan@cahch.org

**Andrea Silber, MD**

Medical Oncologist, Attending  
Physician, Medical Director, Yale  
Oncology,  
Father McGivney Cancer Center,  
Hospital of St. Raphael  
203- 867-5426  
asilber@srhs.org

**Jessica Washko**

Community-Based Education Specialist,  
UCONN Health Center  
860-679-6295  
washko@uchc.edu



## Appendix II. Cultural Competency Glossary

**Acculturation** means the process of adopting the cultural traits or social patterns of a group other than one's own. In regard to immigrant groups, acculturation is the process of incorporating values, beliefs and behaviors from the dominant culture into the immigrants' cultural worldview.

**Assimilation** means the process of taking on the cultural traits and characteristics of another distinct group; absorption of a new or different culture into the main cultural body; to make like; to cause to resemble.

**Bicultural** means the ability to understand and function effectively in two cultural environments. An individual who is bicultural is not necessarily culturally competent.

**Bilingual** means the ability to effectively speak two languages.

**CLAS Standards** means a set of 14 Culturally and Linguistically Appropriate Services, published under the title: *Assuring Cultural Competence in Health Care: Recommendations for National Standards and an Outcomes-Focused Research Agenda*, by the Office of Minority Health, U.S. Department of Health and Human Services, in the *Federal Register*, December 22, 2000 (Volume 65, Number 247), pp. 80865-80879. It recommends adoption of a nationwide set of standards.

**Comparability of access or benefits** means meaningfully equal access and benefits across all populations served, including any adaptations necessary to achieve equality.

**Cultural broker or Culturally-informed consultant** means a person serving in a non-clinical or non-professional capacity who is recognized by the client's cultural or linguistic community as one who has knowledge of a particular culture or language and its definition of health, mental health, and family dysfunction and who is used by service providers and organizations to assist in providing culturally and linguistically-appropriate service. The term should not be confused with a professional consultation between a mainstream provider and a culturally-specific provider. There are no established criteria for certifying when an individual is culturally informed, but the organization may establish a test to determine a consultant's usefulness in facilitating positive client outcomes. An organization that uses cultural consultants to facilitate face-to-face client encounters may use feedback from clients and families.

**Cultural competence or Culturally competent** means the capability and will of a provider or service delivery organization to respond to the unique needs of an



individual client, which arise from the client's culture and to use the client's cultural strengths as a tool in the healing or helping process. In this document, *culturally competent* indicates the ability to work across multiple cultures and is, therefore, distinct from *culturally specific* which refers to capability with one particular culture. For example, an African American psychologist may be competent to provide culturally-specific services to African American clients but would not be culturally competent unless she has demonstrated success in treating clients of at least one other culture.

Cultural competence means: (1) the attainment of knowledge regarding beliefs and values (e.g., related to health, mental health, or child rearing), and disease incidence and prevalence; (2) the ability to communicate effectively for the thorough and accurate exchange of information, perception, instruction, and preferences with regard to the client's presenting condition and related history; and (3) skills and behaviors that will enable practitioners and systems to provide appropriate service for the diverse populations. The word culture is used to imply the integrated pattern of human behavior that includes thoughts, communication, actions, customs, beliefs, values, and institutions of a racial, ethnic, religious, or social group. **For the organization or service delivery system**, cultural competence means the ability to provide equal access and quality of services to individuals from each cultural and linguistic population served, based on an understanding of each population's distinct needs. **For the individual professional**, cultural competence additionally means the ability to use the client's culture as a resource or tool to aid in the service or treatment process and to aid in addressing human needs. Such ability will depend, in part, upon knowledge of specific cultures, skills in cross-cultural and culturally-specific clinical practices, and proficiency in clients' languages.

**Cultural consultation** means advice from an individual knowledgeable about a particular group's culture but not necessarily knowledgeable in the professional field or discipline.

**Culturally competent provider** means a service professional who understands, and can utilize to the client's benefit, the client's culture either because he or she is of the same cultural or ethnic group or because the provider has developed the knowledge and skills through training and personal growth to provide high-quality service to diverse clients. The term can be used in a practical sense to indicate success in achieving positive outcomes for clients. At this time, DHS has not adopted criteria to certify or measure cultural competence.

**Culturally-specific intervention** means interventions or treatments that are common to or are especially effective with a specific population or services provided by practitioners who are characteristically found within a particular population.



Expectations of high service quality remain.

**Culturally-specific provider** means one who is characteristically found or proven especially effective within a particular cultural and linguistic population.

**Culture** means (a) the integrated pattern of socially transmitted human behavior that includes thoughts, communication, actions, customs, beliefs, values, and institutions, and all other products of human work or thought, characteristic of a particular community or population. (b) Cultural defines the preferred ways for meeting needs.[139] (c) Culture is created by people as a dynamic adaptive mechanism, continuously changing to allow a more effective adaptation to new circumstances. (d) Culture is a set of guidelines, both explicit and implicit, which individuals inherit as members of a particular society, and which tells them how to view the world, how to experience it emotionally, and how to behave in relation to other people, to supernatural forces and gods, and to the natural environment." [140] (e) Culture also involves the historical circumstances leading to a group's economic, social, and political status in the social structure. (f) Culture involves the circumstances and experiences associated with developing certain beliefs, norms, and values.[141] Culture provides the "big story." This story, repeated from generation to generation, provides both individuals and the group with their reason for being. If the story is not passed on by families to children, the children will make up compensatory—and typically less satisfying—stories out of deep-felt, if unconscious, necessity. [142]

Cultural is the most broad and overarching fabric of the social environment. It may include racial, ethnic, religious, or social communities or populations. Race is separate from culture. Culture is more about behavior than biology. Emphasizing culture when discussing how human services workers develop cultural competency—and removing race from that discussion—helps to focus on the behaviors, attitudes, and practices needed in order to effectively serve diverse cultural communities. [143]

**Culture-bound behaviors or culture-bound syndrome** means culture-specific behaviors, conditions, and diseases that affect a person's health and well-being. For example, in some cultures, a person can become ill and suffer "soul loss" because another person has cursed them. In some cultures, women breast-feed babies until they are two or three years old while in others, women learn that bottle feeding is more appropriate. In some cultures, a person who sees a vision can be a gifted healer while, in others, she may be labeled schizophrenic. In some cultures, young women are circumcised when they reach puberty; in others, baby boys are circumcised.

**Cultural Transference-Counter transference** is constructed by patient and analyst together, and reflects interpersonal relations as well as internalized self-object representations. Transference-counter transference enactments between patient and



analyst are conceived as embodying aspects of the historical relations between their respective cultures.

**Disparity** means inequality in outcome or condition between cultural groups or differences in outcomes or conditions between cultural groups that are not predictable based on the number of group members present in the general population.

**Diverse populations** means distinct groups including, but not limited to, racial and ethnic minorities, persons of color, American Indians, gay, lesbian, bisexual, and transgender cultures, deaf culture, disabilities culture, economic class cultures, and immigrants.

**Diverse staff** means organization workers who are representative of the demographic characteristics of the service area. The concept focuses on recruitment and retention. It is distinct from the concept of “culturally competent staff,” which focuses on issues of education and training to achieve greater skills and knowledge. The diversity of an organization’s staff is a necessary, but not sufficient, condition for providing culturally and linguistically appropriate services. [144]

**Dynamics of Difference** means the interpersonal interactions that occur in a cross-cultural encounter. When one culture interacts with the population of another, both may misjudge the other’s actions based on learned expectations. Each party brings to the relationship unique histories with the other group and the influence of the current political relationship between the two groups. Both will bring culturally-prescribed patterns of communication, etiquette, and problem solving. Either may bring stereotypes or underlying feeling about serving—or being served by—someone who is “different.” Such tension is part of the cross-cultural encounter. Both professionals and clients should be vigilant against misinterpretation and misjudgment. [145]

**Ethnic** means designating basic groups or divisions of human beings as distinguished by customs, a common language, a common history, a common religion, or other such characteristics.

**Ethnographic interview** means a meeting with a person of another culture in order to begin understanding his or her worldview, beliefs and life situation. It is a way to examine the patterned interactions and significant symbols of specific cultural groups to identify cultural rules that direct behaviors and the meaning people ascribe to such behaviors. Ethnographic interviewing helps a person understand another culture while avoiding stereotyping. An ethnographic interviewer is in control of the structure of the event, while the interviewee is in control of the cultural content of the event. The interviewer is the learner and the interviewee is the teacher.



**Healer** means an individual who has demonstrated success in healing or preventing health or mental health problems or conditions using practices that are based in, and recognized by, the culture of the client, and who is acknowledged by peers as a competent practitioner, whether or not licensed or certified by law.

**Health disparities** are avoidable differences in incidence, prevalence, mortality and burden of disease and other adverse health conditions that exist among specific population groups.

**Health care disparities** are unexpected differences in the quality of care that are not due to access-related factors or clinical needs, preferences, and appropriateness of interventions

**Health equity** is the absence of systematic disparities in health (or in the major social determinants of health) between groups with different levels of underlying social advantage/disadvantage—that is, wealth, power, or prestige. Inequities in health systematically put groups of people who are already socially disadvantaged (for example, by virtue of being poor, female, and/or members of a disenfranchised racial, ethnic, or religious group) at further disadvantage with respect to their health; health is essential to wellbeing and to overcoming other effects of social disadvantage. Equity is an ethical principle; it also is consonant with and closely related to human rights principles.

**Interpreter** means an individual trained and/or certified in facilitating oral, written, or manual communication between two or more people of different languages. For the purpose of these Guidelines, a qualified interpreter possesses in-depth knowledge, not only of the language, but also of cultural values, beliefs, and verbal and non-verbal expressions. A technically proficient interpreter who is lacking specific cultural knowledge can work in conjunction with a culturally informed consultant (also known as a *cultural broker*).

**Limited English proficiency (LEP) or persons with LEP**, means individuals who cannot speak, read, write or understand the English language at a level that permits them to interact effectively with health care providers and social service agencies. (Note: This may not be easy to identify. Some people may know enough English to manage basic life skills but may not speak, read, or comprehend English well enough to understand in a meaningful way some of the more complicated concepts they may encounter in the health and human services systems.)

**Managed care organization (MCO)** means an organization that manages and provides health care in exchange for monthly prepayments for each of its members or enrollees. It is used interchangeably with *health maintenance organization (HMO)* or



health plan.

**Meaningful access** means the ability to use services and benefits comparable to those enjoyed by members of the mainstream cultures. It is achieved by eliminating communication barriers and ensuring that the client or potential client can communicate effectively. An organization must ensure that the LEP person: is given adequate information; is able to understand the services and benefits available, is able to receive services for which he or she is eligible, can effectively communicate the relevant circumstances of his or her situations to the service providers and receives language assistance at no cost.

**OCR Guidance** means the federal language assistance requirements as defined in *Title VI of the Civil Rights Act of 1964; Policy Guidance On The Prohibition Against National Origin Discrimination As It Affects Persons With Limited English Proficiency*, published by the Office of Civil Rights, Federal Register, Vol. 65, No. 169, August 30, 2000, pp. 52762 through 52774.

**Organization** means both the entity that determines access to services and the entity that performs services. For example, it would include both a county social services agency and its contracted vendors and service providers. Additionally, it would include both a managed care organization (and health maintenance organization—HMO) and its network of physicians and other clinical professionals.

**Persons eligible to be served or likely to be directly affected** means clients and applicants in a program's approved geographic service area that are eligible for services or benefits. OCR will address this standard on a case-by-case basis. See the OCR Guidance, page 52767, online at <http://www.hhs.gov/ocr/lep/guide.html> for further discussion.

**Preferred language** means the self-identified language, which the client prefers to use in a service or clinical encounter.[148] The preferred language need not be the client's native or primary language if the client indicates sufficient proficiency in English and prefers to use English.

**Sovereignty** means, for the purposes of this document, the American Indian tribal right of self-government that is inherent in Indian tribes and nations and that does not depend upon any federal or state law for its existence. This legal concept has significant impact upon how state and local governments must relate to tribes.

**Title VI of the Civil Rights Act of 1964** means federal law found at 42 U.S.C. 2000d



et. seq. and its implementing legislation at 45 CFR Part 80.

***Unduly burdensome*** means the level of cost or time beyond which the translation of documents will not be required by the federal government. The Office of Civil Rights (U.S. Department of Health and Human Services) will determine the extent of an organization's obligation to provide written translations of documents on a case by case basis. According to the OCR Guidance: "OCR recognizes that recipient/covered entities in a number of areas, such as many large cities, regularly serve LEP persons from many different areas of the world who speak dozens and sometimes over 100 different languages. It would be unduly burdensome to demand that recipient/covered entities in these circumstances translate all written materials into dozens, if not more than 100 languages."