SUMMER 2004

CURRICULA ENHANCEMENT MODULE

National Center for Cultural Competence

Georgetown University Child Development Center
University Center for Excellence in Developmental Disabilities

Cultural Self-Assessment

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SECTION A.
OVERVIEW & PURPOSE OF MODULE SERIES

Responding to the Vision

MCHB Mission Statement

To provide national leadership, in partnership with key stakeholders, to improve the physical and mental health, safety and well-being of the maternal and child health (MCH) population which includes all of the nation's women, infants, children, adolescents, and their families, including fathers and children with special health care needs. (MCHB, 2003)

The vision of the Health Resources and Services Administration's Maternal and Child Health Bureau (MCHB) is for a future America in which "… there is equal access for all to quality health care in a supportive, culturally competent environment, which is family-centered and community-based; and health disparities by racial, ethnic, geographic area and economic status have been eliminated." The MCHB revised its mission statement and carefully crafted a 5-year strategic plan in pursuit of its vision. The plan includes goals, key strategies, performance measures, and annual priorities.

MCHB Strategic Plan for 2003-2007

Key Strategy	Performance Measure
Develop and promote health services and systems of care designed to eliminate disparities and barriers across the MCH population.	The degree to which MCHB-supported programs have incorporated cultural competence elements into their policies, guidelines, contracts, and training.
Key Strategy	**Performance Measure**
Train an MCH workforce that is culturally competent and reflects an increasingly diverse population.	The degree to which MCHB long-term training grantees include cultural competency in their curricula and training. (http://www.mchb.hrsa.gov/about/stratplan03-07.htm)

The Division of Research, Training and Education (DRTE) plays a central role in supporting both the vision and mission of MCHB through its funded programs. These programs promote interdisciplinary leadership training and new knowledge development to ensure capacity within this nation's current and future MCH workforce. The DRTE has strategic goals and objectives that focus on enhancing cultural competence in student and faculty recruitment and retention, in professional development and continuing education, in evidence-based knowledge and practice, and in cultivation of leadership within the field of public health, particularly in maternal and child health.

Supported through a grant from the DRTE, the National Center for Cultural Competence (NCCC) is assisting the MCHB in realizing its vision and achieving stated goals, with a particular focus on the essential role of cultural and linguistic competency in health care. The NCCC created resources to respond to Goal 3 of the MCHB Strategic Plan that addresses the elimination of health barriers and disparities.

Enhancing Capacity in MCH Training Programs

The NCCC conducted interviews with DRTE grantees to discover interests and needs related to cultural and linguistic competence. Grantees expressed a critical need for instructional materials, curricula, model programs, and multimedia products to augment current training methodologies. In response, the NCCC developed a curricula enhancement module series to increase the capacity of DRTE-funded programs to incorporate principles and practices of cultural and linguistic competence into all aspects of their leadership training. This series includes preservice, inservice, continuing education, and other training activities. In consultation with the DRTE, the NCCC assembled an interdisciplinary work group to identify and reach consensus on core content areas for the module series. The work group membership represented academicians, selected DRTE grantees, health providers, leaders in health care policy and practice, and experts in cultural and linguistic competence.

The module series centers on four core content areas selected by the work group and deemed vital to culturally and linguistically competent health care policy and practice:

Cultural Awareness
Cultural Self-Assessment
The Process of Inquiry -- Communicating in a Multicultural Environment
Public Health in a Multicultural Environment

This curricula enhancement module series is designed to:

- Assist faculty in incorporating five key content areas into existing curricula that are important to cultural and linguistic competence in public health;
- Provide a set of defined areas of knowledge, skills, and awareness related to each core content area;
- Offer relevant materials, articles, publications, and other multimedia resources for each core content area; and
- Provide faculty with instructional and self-discovery strategies.

The NCCC acknowledges the work group for its expertise and wise counsel in supporting this project.

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SECTION B.
CULTURAL & LINGUISTIC COMPETENCE: RATIONALE, CONCEPTUAL FRAMEWORKS, AND VALUES

1. Purpose
This section of the module is to provide faculty with a basic foundation in the philosophy, values, and conceptual frameworks of cultural and linguistic competence.

2. Rationale for cultural and linguistic competence in health care
The NCCC identified several compelling reasons why health care systems should focus on cultural and linguistic competence, adapted as follows from its Policy Brief series for this curricula enhancement module series:

- To understand and respond effectively to diverse belief systems related to health and well-being;
- To respond to current and projected demographic changes in the United States;
- To eliminate long-standing disparities in the health and mental health status of diverse racial, ethnic, and cultural groups; and
- To improve the quality and accessibility of health care services.

Creating and sustaining cultural and linguistic competence will require leadership in every aspect of health care including, but not limited to, health care training and education, public health policy, state public health agencies, research, health care financing, practice and service delivery, workforce development, community engagement, and advocacy. The DRTE is committed to developing such leadership within its training programs.

(See Policy Brief series on NCCC's Web site at http://www.georgetown.edu/research/gucdc/nccc/products.html)

3. Rationale for infusing content related to cultural and linguistic competence into health care training and programs
There are numerous reasons to infuse content related to cultural and linguistic competence into health care training and programs. Though not intended to be all-inclusive, the following list reflects contextual realities and provides reasons that are substantiated in the research literature in this area:

- To address historical issues in health care, such as those issues relating to racism, discrimination, access to care, and significant disparities in health outcomes;
- To address the fact that the formal education of many faculty and staff has not prepared them to incorporate cultural and linguistic competence into teaching and research methodologies;
- To ensure that students develop prerequisite areas of awareness, knowledge, and skills in cultural and linguistic competence;
- To facilitate workforce diversity, both for its reflection of the population served and for its inherent strengths;
- To prepare the future workforce to lead, teach, develop, and administer public health policy and to practice in a multicultural environment;
- To respond to legislative, regulatory, and accreditation mandates; and
- To serve the institution's and professional's best interests by providing a competitive edge in (1) recruiting and retaining faculty and students and (2) obtaining grant funding for teaching, service, research, and other initiatives.

4. Suggested strategies for incorporating cultural and linguistic competence into MCH training programs
To incorporate successfully cultural and linguistic competence into all aspects of MCH training programs, the following strategies are suggested:

- **Create a structure.** Convene a work group with the sole purpose of determining how core concepts relating to cultural and linguistic competency can be integrated into all aspects

of the MCH training program. This group will serve as the primary body for conceptualizing, planning, and framing the way in which this integration takes place. The work group membership should be diverse and should include such key stakeholders as faculty, staff, students, and community partners.

- **Clarify values and philosophy.** Each MCH training program will need to establish its own philosophy and values of cultural and linguistic competence. This approach is essential for creating a shared vision among faculty and staff to guide all efforts in this area.

- **Develop a logic model for cultural and linguistic competence.** There are numerous concepts and definitions for cultural and linguistic competence. (See Conceptual Frameworks/Models, Guiding Values and Principles developed by the NCCC at http://gucchd.georgetown.edu/nccc/framework.html). Reach consensus on a definition or framework for cultural competence and linguistic competence within the context of the MCH training program and/or department. The term logic model refers to a visual schematic that summarizes the relationship between the resources, activities, and outcomes of a culturally and linguistically competent system of care (Santiago, 2003). For more information, see the Kellogg Foundation Logic Model Development Guide, available directly from http://www.wkkf.org/Pubs/Tools/Evaluation/Pub3669.pdf. See also a PowerPoint presentation providing an introduction to the use of logic models (Dr. Rachele Espiritu's "Developing a Logic Model").

- **Adapt or create curricula.** The logic model and framework should be used to guide the adaptation or creation of curricula that infuse content on principles, values, and practices of cultural and linguistic competence that have been determined by the work group.

- **Determine faculty and staff development needs and interests.** Conduct an initial assessment of faculty and staff to determine what they perceive as their training or professional development needs and interests related to cultural and linguistic competence. The assessment should query faculty and staff on the preferred methods, approaches, and formats for increasing awareness and acquiring new skills and areas of knowledge. Such an assessment should be repeated periodically as the group acquires knowledge and skills. Ensure that resources are budgeted to support this effort.

- **Conduct faculty and staff development.** Knowledge of cultural and linguistic competence will vary among faculty and staff. Assessment results should be used to inform strategies for faculty and staff development. Plan and conduct ongoing faculty and staff development activities based on individual needs and preferences. Careful consideration should be given to the fact that faculty and staff will have different levels of comfort with this content area. Appropriate supports should be provided and may include: (1) provide opportunities for faculty and staff to meet informally to share opinions and engage in discussions; (2) create a book club that is dedicated to exploring themes and issues of culture, race, and ethnicity that are often difficult or controversial to discuss solely on an interpersonal level; (3) convene facilitated sessions to address major issues or concerns; and (4) offer mediation and conflict resolution as warranted by specific circumstances.

- **Create a refuge for sharing and learning.** It is critical to provide a safe, non-judgmental forum to explore honestly cultural considerations—their own and those of the constituency groups they serve. Creating such a structure provides a much-needed venue to support faculty, staff, and students in their journey toward cultural and linguistic competence.

- **Conduct an evaluation.** Develop an evaluation strategy that measures at a minimum:(1) the extent to which faculty and staff have increased the incorporation of cultural and linguistic competence into all aspects of the MCH training program; (2) the extent to which students have increased awareness, knowledge, and skills in cultural and linguistic competence; (3) student perspectives on the effectiveness of the faculty and training program in incorporating principles and practices of cultural and linguistic competence; and (4) the extent to which key consumers benefit from the culturally and linguistically competent approaches employed by the MCH training program.

5. Conceptual frameworks, definitions, and guiding values and principles

There is no one definition of either cultural competence or linguistic competence. Definitions of cultural and linguistic competence vary considerably. Such definitions have evolved from diverse perspectives, interests, and needs and are incorporated into state legislation, federal statutes and programs, non-governmental organizations, and academic settings. See the "Resource Section" of this module for additional definitions of cultural and linguistic competence as well as other terms.

Definition and conceptual framework of cultural competence

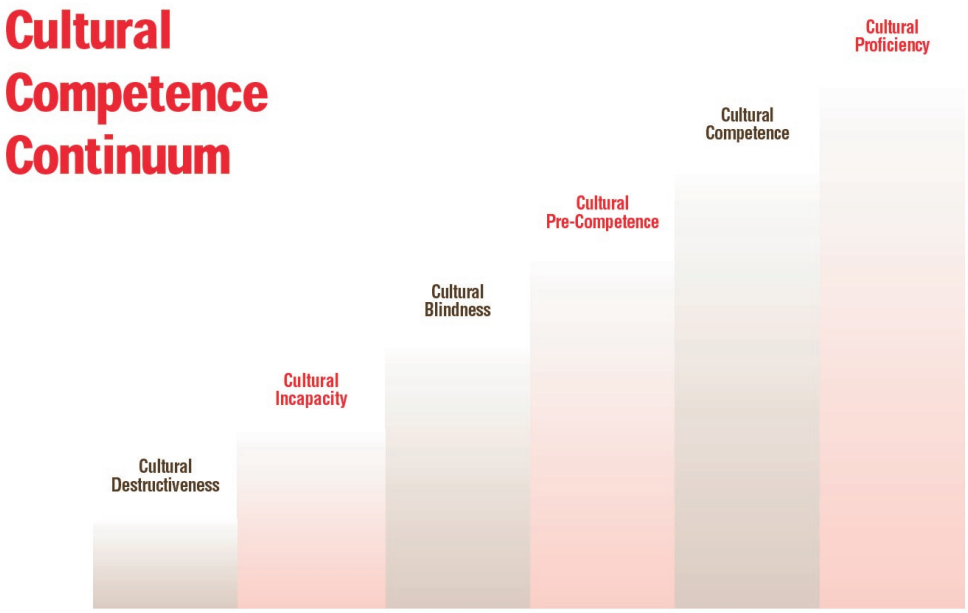
The NCCC embraces a conceptual framework and model for achieving cultural competence based on the work of Cross, Bazron, Dennis, and Isaacs (1989). The NCCC uses this framework and model as a foundation for all of its activities. Cultural competence requires that organizations:

- have defined values and principles, and demonstrate a congruent set of behaviors, attitudes, policies, and structures that enable them to work effectively cross-culturally;

- have the capacity to (1) value diversity; (2) conduct self-assessment; (3) manage the dynamics of difference; (4) acquire and institutionalize cultural knowledge; and (5) adapt to diversity and the cultural contexts of the communities they serve; and

- incorporate the above in all aspects of policy making, administration, practice, and service delivery and involve systematically consumers, key stakeholders, and communities.

Cultural competence is a developmental process that evolves over an extended period. Both individuals and organizations are at various levels of awareness, knowledge, and skills along the cultural competence continuum (adapted from Cross et al., 1989).



For information on characteristics of organizations along the entire continuum, please see Selected Characteristics along the Cultural Competence Continuum (adapted by Tawara Goode, 2004).

Definition of linguistic competence

Definitions of linguistic competence vary considerably. Such definitions have evolved from diverse perspectives, interests, and needs and are incorporated into state legislation, federal statutes and programs, private-sector organizations, and academic settings. The following definition, developed by Goode and Jones (2003), of the NCCC, provides a foundation for determining linguistic competence in health care, mental health, and other human service delivery systems. It encompasses a broad spectrum of constituency groups that could require language assistance oe other supports from an organization or agency, or provider.

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

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

✓ translation services including those of:
- legally binding documents (e.g., consent forms, confidentiality and patient rights statements, release of information, and applications)
- signage
- health education materials
- public awareness materials and campaigns; and

✓ ethnic media in languages other than English (e.g., television, radio, Internet, newspapers, and periodicals).

The organization must have policy, structures, practices, procedures, and dedicated resources to support this capacity.

Cultural and linguistic competence are inextricably linked. There are federal statutes and guidelines governing language access for individuals with limited English proficiency and those with disabilities. For more information, see Policy Brief 2 at http://gucchd.georgetown.edu/nccc/documents/Policy_Brief_2_2003.pdf; National Health Law Program Web site at http://www.nhelp.org/race.shtml#ling; the Office of Civil Rights Web site concerning persons with limited English proficiency at http://www.hhs.gov/ocr/lep/; and for information from the Department of Justice on the Americans with Disabilities Act, see http://www.usdoj.gov/crt/ada/adahom1.htm.

Selected characteristics of organizations striving to achieve cultural competence and cultural proficiency

The following list is designed to highlight selected characteristics that organizations may demonstrate along the cultural competence continuum. These characteristics have been adapted and expanded from the original work of Cross et al. (1989) in several ways: (1) to include principles and practices of linguistic competence, (2) to incorporate mental health as an integral and inseparable aspect of health care, (3) to include salient items that address organizational policy from the NCCC's Policy Brief series, and (4) to reflect evidence-based and promising practices that have emerged in the field of cultural and linguistic competence.

Cultural Competence

- Create a mission statement for your organization that articulates principles, rationale, and values for cultural and linguistic competence in all aspects of the organization.
- Implement specific policies and procedures that integrate cultural and linguistic competence into each core function of the organization.
- Identify, use, and/or adapt evidence-based and promising practices that are culturally and linguistically competent.
- Develop structures and strategies to ensure consumer and community participation in the planning, delivery, and evaluation of the organization's core function.
- Implement policies and procedures to recruit, hire, and maintain a diverse and culturally and linguistically competent workforce.
- Provide fiscal support, professional development, and incentives for the improvement of cultural and linguistic competence at the board, program, and faculty and/or staff levels.
- Dedicate resources for both individual and organizational self-assessment of cultural and linguistic competence.
- Develop the capacity to collect and analyze data using variables that have meaningful impact on culturally and linguistically diverse groups.
- Practice principles of community engagement that result in the reciprocal transfer of knowledge and skills between all collaborators, partners, and key stakeholders.

Cultural Proficiency

- Continue to add to the knowledge base within the field of cultural and linguistic competence by conducting research and developing new treatments, interventions, and approaches for health and mental care in policy, education, and the delivery of care.
- Develop organizational philosophy and practices that integrate health and mental health care.
- Employ faculty and/or staff, consultants, and consumers with expertise in cultural and linguistic competence in health and mental health care practice, education, and research.
- Publish and disseminate promising and evidence-based health and mental health care practices, interventions, training, and education models.
- Support and mentor other organizations as they progress along the cultural competence continuum.
- Develop and disseminate health and mental health promotion materials that are adapted to the cultural and linguistic contexts of populations served.
- Actively pursue resource development to continually enhance and expand the organization's capacities in cultural and linguistic competence.
- Advocate with, and on behalf of, populations who are traditionally unserved and underserved.
- Establish and maintain partnerships with diverse constituency groups, which span the boundaries of the traditional health and mental health care arenas, to eliminate racial and ethnic disparities in health and mental health.

Guiding Values and Principles

Careful consideration should be given to discovering and reaching consensus on the values and principles of cultural and linguistic competence that are chosen as a foundation for health care training programs. The following values and principles are those that guide the NCCC's philosophy and all aspects of its work.

Organizational

- ✦ Systems and organizations must sanction, and in some cases mandate, the incorporation of cultural knowledge into policy making, infrastructure, and practice.*
- ✦ Cultural competence embraces the principles of equal access and non-discriminatory practices in service delivery.*

Practice, Services, and Supports

- ✦ Culturally competent organizations have a service delivery model that recognizes mental health as an integral and inseparable aspect of primary care. For more information, see the Surgeon General's report on Mental Health at http://www.surgeongeneral.gov/library/mentalhealth/home.html and the President's New Freedom Initiative Final Report at http://www.mentalhealthcommission.gov/.
- ✦ Cultural competence is achieved by identifying and understanding the needs and help-seeking behaviors of individuals and families.*
- ✦ Culturally competent organizations design and implement services that are tailored or matched to the unique needs of individuals, children, families, organizations, and communities served.*
- ✦ Culturally competent practice in service delivery systems is driven by client-preferred choices, not by culturally blind or culturally free interventions.*

Community Engagement

- ✦ Cultural competence extends the concept of self-determination to the community.*
- ✦ Cultural competence involves working in conjunction with natural, informal support and helping networks within culturally diverse communities (e.g., neighborhood, civic, and advocacy associations; local/neighborhood merchants and alliance groups; ethnic, social, and religious organizations; and spiritual leaders and healers).*
- ✦ Communities determine their own needs.
- ✦ Community members are full partners in decision making.
- ✦ Communities should benefit economically from collaboration.
- ✦ Community engagement should result in the reciprocal transfer of knowledge and skills between all collaborators and partners. (Taylor & Brown, 1997)

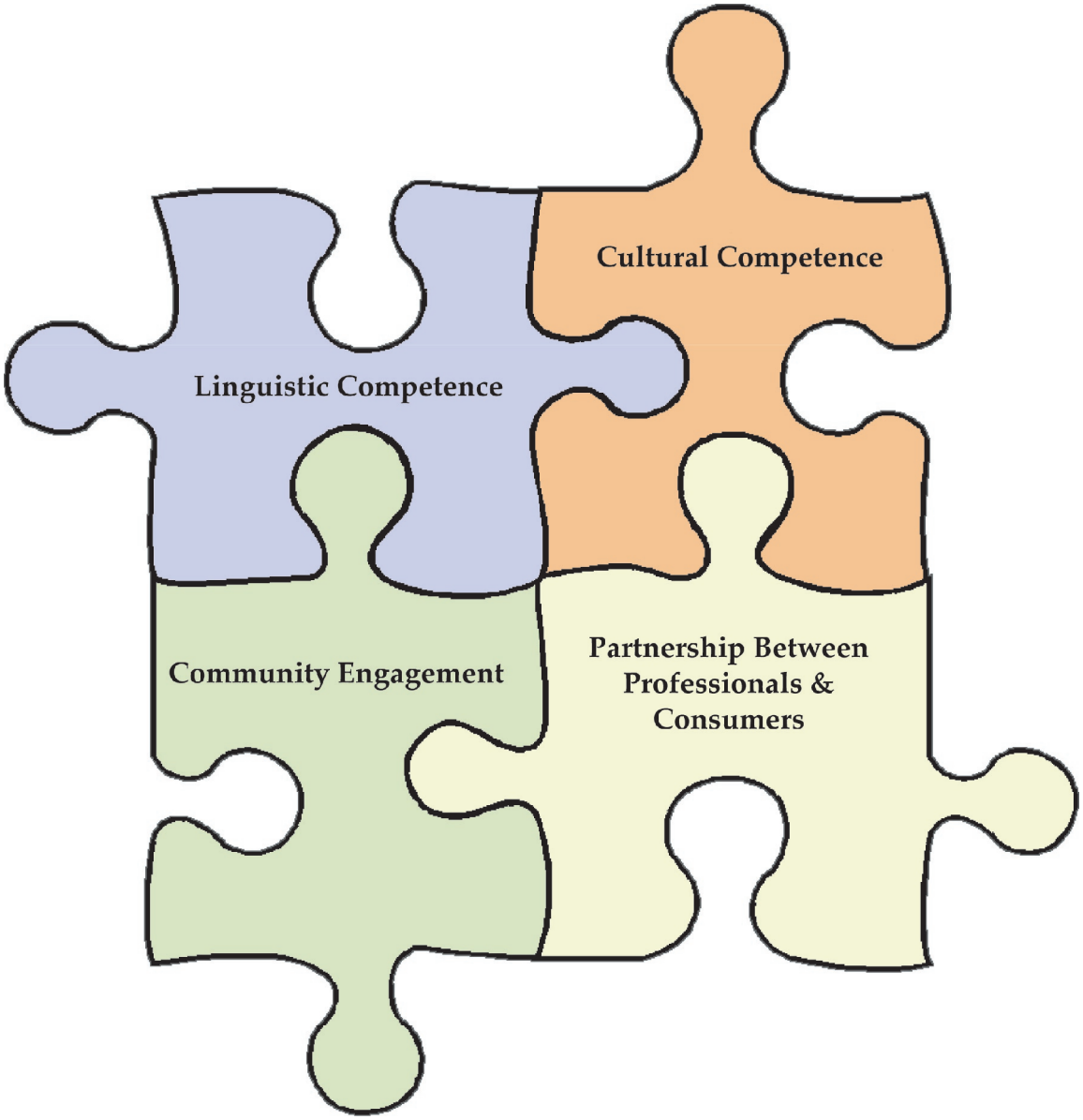
Family and Consumers

✦ Family is defined differently by different cultures.

✦ Family as defined by each culture is usually the primary system of support and preferred intervention.

✦ Family/consumers are the ultimate decision makers for services and supports for their children or themselves (Goode, 2002).

*Adapted from Cross et al., 1989



SECTION C.
CULTURAL SELF-ASSESSMENT

Section C presents a rationale for the critical importance of cultural self-assessment in health training programs as well as key content areas for incorporation into curricula.

Introduction and Rationale

Academic institutions and other health care training programs have an essential role in preparing personnel who have values, knowledge, and skills sets to work effectively cross-culturally. All aspects of the current health care system must undergo fundamental change to respond effectively to the diverse people who comprise American society today. The NCCC embraces a conceptual framework and model for achieving cultural competence adapted from the work of Cross et al. (1989). An essential element of cultural competence is the capacity to engage in self-assessment at the individual and organizational levels.

Assessing attitudes, practices, policies, and structures of organizations and their personnel is a necessary, effective, and systematic way to plan for and incorporate cultural and linguistic competence into organizations. Both individuals and organizations are at various levels of awareness, knowledge, and skills along the cultural competence continuum. Cultural self-assessment is particularly relevant for health care training programs because many are in the initial stages of addressing both diversity and cultural and linguistic competency within their academic institutions (Albritton & Wagner, 2002; Barzansky & Etzel, 2003; Flores, Gee, & Kastner, 2000; Shapiro, Hollingshead, & Morrison, 2002). Moreover, there is an established body of literature on the correlation between a practitioner's capacity to provide culturally and linguistically competent care and improved health outcomes (Betancourt, Green, & Carrillo, 2002; Brach & Fraser, 2000; Flores et al., 2000; Kehoe, Melkus, & Newlin, 2003; Smedley, Stith, & Nelson, 2002). Self-assessment is emerging as an important method to address attitudes, bias, prejudice, and racism in health care delivery at the practitioner level (Godkin & Savageau, 2003; Godkin & Savageau, 2001; "Healthcare narratives from diverse communities—a self-assessment tool for healthcare providers," 2001; Paniagua, O'Boyle, Tan, & Lew, 2000; Shaw-Taylor & Benesch, 1998).

The NCCC is examining the use of a self-assessment instrument for health practitioners to promote cultural and linguistic competence and to contribute to the goal of eliminating racial and ethnic disparities in health.

Key content areas in self-assessment

1. List benefits, values, and guiding principles of self-assessment;
2. Describe processes and tools for self-assessment at the individual and organizational levels; and
3. Discuss the relevance of self-assessment to public health policy.

1. Benefits, values, and guiding principles of self-assessment

Benefits of Self-Assessment

The capacity to engage in cultural self-assessment helps individuals and organizations to:

- ✧ gauge the degree to which they are effectively addressing the needs and preferences of culturally and linguistically diverse groups;
- ✧ establish partnerships that will involve families, consumers, and key community stakeholders in a meaningful way;
- ✧ improve family/consumer access to and utilization of health care services and related supports;
- ✧ increase family/consumer satisfaction with the array of services and supports received;
- ✧ plan strategically for the systematic incorporation of culturally and linguistically competent policy, structures, and practices;

✧ allocate personnel and fiscal resources to enhance the delivery of health care services and related supports that are culturally and linguistically competent; and
✧ determine individual and organizational strengths and areas for growth
(Goode, Jones, & Mason, 2002).

Values and Guiding Principles

It is important to discover and reach consensus on a set of values and principles to guide all self-assessment activities undertaken by the health care training program. Optimally, this process would involve a diverse group of program and departmental faculty and staff, other faculty and staff within the school and university, students, and key stakeholders in the community at large. The following are values and guiding principles developed by the NCCC that you may want to consider.

✧ ***Self-assessment is a strengths-based model.*** The purpose of self-assessment is to identify and promote growth among individuals and within organizations that enhances cultural and linguistic competency. Self-assessment should emphasize strengths at all levels of an organization, often identifying and acknowledging the internal assets of personnel that in many instances are inadvertently overlooked.

✧ ***A safe and non-judgmental environment is essential to the self-assessment process.*** Self-assessment is most productive when conducted in an environment that (1) offers participants a forum to give honest answers about their level of awareness, knowledge, and skills related to cultural and linguistic competence; (2) provides an opportunity for participants to share their individual perspectives in a candid manner; and (3) ensures that information provided will be used to effect meaningful change within the organization. The NCCC embraces the concept that cultural and linguistic competence is developmental and occurs along a continuum (Cross et al., 1989). It matters not where an individual or organization starts, so long as there is continued progression toward the positive end of the continuum.

✧ ***A fundamental aspect of self-assessment ensures the meaningful involvement of consumers, community stakeholders, and key constituency groups.*** Principles of self-determination and cultural and linguistic competence ensure that consumers are integrally involved in processes to plan, deliver, and evaluate the services they receive. These principles extend beyond the individual to the community as a whole. Self-assessment must solicit and value the experiences of consumers and families who receive services. Similarly, opinions should be sought from key stakeholders and constituency groups who are involved with, or affected by, the organization. An inclusive self-assessment process can forge alliances and partnerships that have long-lasting benefit for the individuals, organizations, and the larger community. Self-assessment processes should be designed for ease of input from these various constituencies.

✧ ***The results of self-assessment are used to enhance and build capacity.*** The intent of the self-assessment process is neither to render a score or rating nor to label an individual or an organization. Rather, it is intended to provide a snapshot of where an individual or organization is along the continuum at a particular point in time. Results should be used to plan strategically both short- and long-term objectives to enhance the organization's cultural and linguistic competency at all levels. The NCCC's experiences with self-assessment have demonstrated that comparisons between professionals and among organizations are of little benefit. The greatest benefit is derived from individual and organizational self-comparisons over extended periods of time to ascertain the extent to which growth has occurred.

✧ ***Diverse dissemination strategies are essential to the self-assessment process.*** Self-assessment results should be shared with participants and key stakeholders in a manner that meets their unique needs. Optimally, this information sharing would involve identification of the audiences and presentation of the data in formats that are most useful and accessible to them. The need for information will vary for faculty, students, policy makers, administrators, practitioners, consumers, and other key stakeholders.

2. Processes and tools for self-assessment at the individual and organizational levels

The process of cultural self-assessment is as important as the outcomes. The process should reflect the guiding principles and values that have been chosen as a foundation to the self-assessment and should provide opportunities for organizational change and sustainability. It should also provide opportunities for self-reflection, meaningful growth, and change at the individual level.

✧ ***At the individual level.*** Cultural assessment at the individual level provides an opportunity to reflect on and gauge personal levels of cultural and linguistic competency. There are a variety of methods for individual cultural self-assessment. Checklists, rating scales, instruments, and other tools are typically used in health care, mental health, and human services. Other methods such as self-reflection and self-discovery through journal writing, videotaping, and role playing also are reported, particularly in academic settings and inservice training. An important consideration for choosing a method or tool for self-assessment is to decide first the desired outcome or purpose. There are tools designed:

- to raise awareness of cultural differences, biases, and stereotypes;
- to assess attitudes, perceptions, and assumptions;
- to promote knowledge and skill acquisition and use items that are suggestive of best and promising practices (Crandall, George, Marion, & Davis, 2003; Dolhun, Muñoz, & Grumbach, 2003; Mason, 1996; Mutha, Allen, & Welch, 2002; NCCC, 2004); and
- to be discipline specific or broadly focus on culture or language.

Other considerations include reliability and validity data for standardized tools and instruments and the general applicability of the tool for the intended user or audience. Cultural and linguistic competency is a relatively young field, and the evidence base is still emerging, including the literature on self-assessment.

✧ ***At the organizational level.*** Individual self-assessment, only one aspect of examining cultural and linguistic competence within an organization, should not be used in isolation. Individuals in organizations may feel that their ability to provide culturally and linguistically competent care is compromised by obstacles stemming from organizational values, policies, structures, and practices. Cultural and linguistic competence must be assessed and incorporated at every level of an organization including policy making, administration, practice/service delivery, and consumer and community levels (modified from Cross et al., 1989). Although the NCCC has found the following steps to be beneficial components of the self-assessment process for health care organizations, they are universally applicable to other organizations, including academic settings.

❒ **Cultivate leadership.** The leadership of the organization should establish a rationale for and promote self-assessment as an organizational goal and priority. Optimally, emphasis should be placed on encouraging personnel to assume leadership roles at all levels of the organization. Shared power is an integral principle of leadership development (Covey, 1996; Kouzes & Posner, 1990; Lipman-Blumen, 1996; Melaville & Blank, 1991).

❒ **Get "buy-in."** It is important to establish a shared vision that conveys the importance of the self-assessment process to the overall organization, its personnel, and the key stakeholders. A major benefit of this shared vision is the formation of a coalition of people who are informed and prepared to affect and sustain change to improve the health care system.

❒ **Structure support for the assessment process.** Convening a committee, work group, or task force clarifies the roles and responsibilities for the self-assessment process. This group should have representation from diverse program and departmental faculty and staff, other faculty and staff within the school and university, students, and key stakeholders in the community at large. As the primary entity charged with planning and implementing the self-assessment process, this group should have ready access to decision makers or should have the authority to make their own decisions.

❒ **Ensure community collaborations and partnerships.** A major principle of cultural and linguistic assessment involves getting the input of natural, informal support and helping

networks within diverse communities (Cross et al., 1989). In this process, it is important to recognize that individuals and groups will choose different levels of involvement or ways to participate, which may include serving on task forces or work groups, participating in focus groups, making in-kind or other fiscal contributions, or subcontracting for specific services like meeting facilities or other accommodations. It is essential that the contributions of each community partner be valued and respected.

❒ **Allocate personnel and fiscal resources.** Conducting a self-assessment process is resource intensive, and the successful outcome of the process requires well-crafted allocation of personnel and fiscal resources. That is, it requires a dedicated budget and level of effort for organizational personnel and, in some cases, for key stakeholders in the larger community. There may be costs for interpretation and translation; consultants/facilitators; meeting or conference facilities; stipends/honoraria for consumer participation; and printing, mailing, and other dissemination activities. In particular, consideration should be given to the necessary level of effort for personnel who have responsibility for the process, which may require deferment or reassignment of current workload/duties.

❒ **Manage the logistics.** It is vital to coordinate effectively the numerous logistical tasks during the self-assessment process. The work group or task force needs to ensure sufficient time to plan and prepare; information must be disseminated in a timely manner to all involved; and a calendar or schedule of activities should be developed.

❒ **Analyze and disseminate the data.** Work group or task force members need to determine and plan for their involvement in data collection, analysis, interpretation, presentation, and dissemination. This approach is commensurate with culturally competent and participatory action designs in research and evaluation (Brant et al., 1999, revised May 2000; Caldwell, Jackson, Tucker, & Bowman, 1999; Goode & Harrison, 2000).

❒ **Take the next steps.** The self-assessment process can yield a wealth of information about organizational strengths and areas for growth. Careful consideration should be given to:
- establishing organizational priorities,
- developing a strategic plan with goals and objectives to sustain strengths and address growth areas,
- allocating necessary resources to accomplish strategic plan goals,
- sustaining and maintaining partnerships with community stakeholders, and
- incorporating self-assessment results into all levels of the health care system.

A list of tools for individuals and organizational self-assessment can be found in Appendix A. In addition, please see the Guide to Organizational Self-Assessment, at http://gucchd.georgetown.edu/nccc/documents/ncccorgselfassess.pdf.

3. Relevance of self-assessment to public health policy

Public health policy is not limited to the highest federal levels of governance. Rather, public health policy can include guidelines, standards, and policy statements from professional associations, state governments, and family and advocacy organizations. In addition, public health policy can be greatly influenced by such cutting-edge research as the Institute of Medicine's groundbreaking report, Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care (Smedley et al., 2002).

Although the use of cultural self-assessment in the development or implementation of public health policy is not well documented, a literature review (using a keyword search of Pubmed available at http://www.ncbi.nlm.nih.gov/PubMed/ and other Internet resources) regarding the role of self-assessment in public health policy yielded the following:

Batalden and Stoltz (1994) offer a framework for health care leaders that included self-assessment to assist leaders in fostering continual improvement within their organizations.

The Institute of Medicine recommended the use of a self-assessment tool to develop clinical practice guidelines (Lohr, 1992).

Gomberg and Sinesi (1994) describe the use of self-assessment to implement a new policy of shared governance for professional nurses.

The Center for Public Health Practice, University of California at Berkeley School of Public Health, developed a pre-internship self-assessment for students (Practice, 2000), available at http://ist-socrates.berkeley.edu/~cphpweb/Documents/pdfs/PISA2000.pdf. It includes questions on cultural competence (under "Leadership Skills and Abilities").

The literature revealed emerging innovations in merging the concepts of cultural self-assessment, cultural competence, and public health policy and practice. The challenge for future leadership in this area is to develop an evidence base that will validate cultural self-assessment as an integral component of policy development and implementation in public health.

A recent study by Armstrong, Doyle, and Bennett (2003), published in Academic Medicine, suggests that challenging and highly supportive professional development programs that emphasize experiential and participatory activities can "change behaviors in significant ways, and that these changes endure over time" (abstract). Cultural self-assessment is consistent with this model of experiential and participatory methodology and holds great promise for effecting behavioral change. Cultural self-assessment could be incorporated into ongoing professional development for faculty and staff at all levels. Additionally, it could be a requirement in interdisciplinary health care training programs.

SECTION D.
TEACHING TOOLS, STRATEGIES, & RESOURCES

This section provides an overview of areas of awareness, knowledge, and skills in cultural self-assessment that students in health care training programs need to acquire. It also offers several instructional tools and strategies such as vignettes, exercises in self-assessment and self-discovery, and guidance for faculty.

Areas of Awareness, Knowledge, and Skills

The NCCC selected the following areas of awareness, knowledge, and skills to highlight in this self-assessment curricula enhancement module. This list is not exhaustive. Faculty are encouraged to adapt and enhance the following characteristics based on the needs, interests, and areas of focus within their respective disciplines and training programs.

Awareness of

- ✧ that one's perceptions of other cultures are influenced by one's own world view;
- ✧ that cultural biases may be at a conscious or subconscious level;
- ✧ of values, beliefs, and practices related to health, health care, illness, and well-being:
  - one's own
  - prevailing society norms
  - among culturally diverse individuals, groups, and communities
  - within health care systems and institutions;

- ✧ of health and mental health disparities among racial and ethnic groups;
- ✧ of social, economic, and environmental factors that impact the health and well-being of communities; and
- ✧ that self-assessment and reflection can have a positive impact on capacity for cultural and linguistic competence, for individuals and organizations.

Knowledge of

- ✧ conceptual frameworks for cultural and linguistic competence;
- ✧ benefits of cultural self-assessment, particularly to public health;
- ✧ current self-assessment literature and emerging trends in research;
- ✧ specific purpose and audiences for self-assessment;
- ✧ criteria to select self-assessment tools or instruments for use with individuals;
- ✧ criteria to select self-assessment tools or instruments for use with organizations; and
- ✧ fundamental steps to conduct an organizational self-assessment.

Skills in

- ✧ planning, conducting, and/or facilitating an organizational self-assessment process;
- ✧ planning, conducting, and/or convening focus groups for culturally and linguistically diverse groups as a component of organizational self-assessment;
- ✧ conducting group facilitation processes as a component of self-assessment;
- ✧ analyzing self-assessment data, both qualitative and quantitative;
- ✧ using data to develop written reports; and
- ✧ using self-assessment results to conduct strategic planning processes for organizations.

Vignette

The state health department is interested in conducting an organizational cultural self-assessment. Leaders indicate that changes in demographics and public health priorities are reasons cited to undergo such a process. Additionally, a self-assessment process and outcomes would be instrumental in planning for the State Title V Block Grant application. There are 1,500 employees in the health department and eight different regions. The department provides basic public health functions and contracts to county and local organizations and individual practitioners for an array of services.

The university has been awarded a contract to conduct the self-assessment process. You have been appointed to the leadership team for this effort.

1. Develop a plan for the overall process. Include level of effort, time frames, resources, partners, key constituency groups, instrumentation, and other components to implement successfully the self-assessment process.

2. From your perspective, describe the leadership challenges for such an effort.

Faculty Guidance for Vignette
The following are suggested questions to guide faculty in evaluating the plan and leadership challenge developed by students.

1. The Plan

- Does the planning process include:
  - a work group, committee, or task force that is representative of the employees within the state health department and the eight regions?
  - key stakeholders and constituencies that are representative of the cultural and linguistic diversity within the state?
  - dedicated time and effort of staff and the resources necessary to support participation in the process?
- Are the tools and process for self-assessment strengths based?
- Did the work group, committee, or task force select tools and assessment strategies appropriate to their context and purpose?
- Do assessment strategies make use of forums and other approaches to ensure the meaningful inclusion of diverse voices from all segments of the community?
- Can the results of the self-assessment be used for strategic planning?

2. The Leadership Challenge
The vignette presents a number of leadership challenges that will need to be addressed to conduct a successful self-assessment process. At a minimum, are the following challenges considered?

- The appointed leadership team will need to get buy-in and acceptance for a self-assessment process from state health department staff and contractors.
- State health department staff and contractors may be particularly sensitive to or feel threatened by the process of cultural self-assessment.
- Leaders and credible voices within diverse communities in the state will need to be identified.
- Meaningful participation and mutual respect between community leaders and the state health department must be ensured.
- Provisions for addressing potential conflict and agitation that may arise from the self-assessment process must be made in a timely and respectful manner.
- Leadership must be prepared that issues of racism, discrimination, and bias within the public health system may be identified in the self-assessment process.

The following literature is suggested to support learning related to the issues presented in this vignette.

Bellman, G. M. (1992). *Getting things done when you are not in charge.* New York, NY: Simon & Schuster.

Couto, R. A., & Eken, S. C. (2002). *To give their gifts: Health, community, and democracy* Nashville, TN: Vanderbilt University Press.

Dreachslin, J. L., & Hunt, P. L. (1996). *Diversity leadership*. Chicago: Health Administration Press.

Fisher, R., & Ury, W. (1991). *Getting to yes: Negotiating agreement without giving it*. Penguin USA.

Goode, T. (2001). Policy Brief 4: *Engaging communities to realize the vision of one hundred percent access and zero health disparities: A culturally competent approach.* Washington, DC: National Center for Cultural Competence, Georgetown University Center for Child and Human Development.

Heifetz, R. A. (1994). *Leadership without easy answers*. Cambridge, MA: Belknap Press.

Marsh, D.S., Daniel, M.H. & Putnam, K. (2003) *Leadership for Policy Change*, a publication of Policy Link, available from http://www.policylink.org

Kouzes, J. M., & Posner, B. Z. (1990). *The leadership challenge*. San Francisco: Jossey-Bass.

Ponterotto, J., & Pederson, P. (1993). *Preventing prejudice: A guide for counselors and educators*. Thousand Oaks, CA: Sage.

Senge, P. M., Ross, R., Smith, B., Roberts, C., & Kleiner, A. (1994). *The fifth discipline fieldbook: Strategies and tools for building a learning organization*. New York: Currency & Doubleday.

Senge, P. M. (1990). *The fifth discipline: The art and practice of the learning organization*. New York: Currency & Doubleday.

Self-Discovery Exercises

✦ Write about an experience when you had an encounter with someone from a different cultural group that resulted in conflict.
- What were the things that triggered me in this conflict?
- How would I normally handle such a conflict?
- What assumptions did I make?
- Were these assumptions warranted?
- If it happened again today, how could I handle it differently?

✦ Complete a cultural self-assessment tool.
- How comfortable are you in giving honest answers to the questions?
- How did you react to areas in which you felt you did well? Were you satisfied or did you feel challenged to do more?
- How did you react to areas in which you feel you did poorly?
- What did you learn about yourself from the self-assessment process?

✦ Role play a medical or mental health encounter in which neither party can speak the language of the other.
- How much information were you able to exchange?
- Was a full diagnosis achieved?
- Were rapport and trust achieved?
- How confident did you feel about the quality of the information exchange?

Faculty Guidance

- Determine with the students whether the exercises should be conducted individually or within a group setting.
- Create an environment that is safe and non-judgmental so that students are comfortable participating in self-discovery exercises.
- Acknowledge the strengths of each student. If this is a group activity, encourage students to identify the strengths of others.
- Identify areas of growth and learning opportunities for each student. Provide resources and suggestions to sup port this approach as a developmental process.
- Assist the student in evaluating the value and efficacy of the tools selected for this exercise.

Self-Assessment Exercise

The following items are excerpts from a guide developed by the NCCC to elicit the extent to which principles of cultural and linguistic competence were incorporated into curricula and training experiences within DRTE-funded programs. It can be used to engage faculty and staff in a self-assessment process. It can also be used to determine professional development and inservice training needs and interests for faculty and staff. Items may be modified or adapted to address the type and scope of your training program.

Curriculum Development

1. To what extent do curricula currently offered by your training program include content related to cultural and linguistic competence?

- ❒ not at all
- ❒ barely
- ❒ fairly well
- ❒ very well

2. Please list/describe examples of curricula content areas and how cultural and linguistic competence are incorporated.

3. Do curricula support the acquisition of knowledge and skills in the following areas?

- ❒ cultural awareness/sensitivity
- ❒ cultural diversity
- ❒ confronting stereotyping, bias, discrimination, and racism in health and social service systems
- ❒ culturally defined values and belief systems related to health and mental health
- ❒ cultural influences on health care decision making among individuals and families
- ❒ cultural influences of spirituality and religiosity on perceptions of health and well-being
- ❒ cultural perspectives of illness and disability
- ❒ cultural aspects of epidemiology
- ❒ culturally influenced health protective/preventive factors
- ❒ disparities in health and mental health among racial and ethnic groups
- ❒ complex array of biologic, economic, environmental, social, and cultural factors that are known to contribute to health and mental health disparities of racial and ethnic groups
- ❒ health and mental health status among refugee and immigrant populations
- ❒ cultural strengths, assets, and resiliencies within diverse populations and communities
- ❒ cross-cultural communication
- ❒ working effectively with interpreters (foreign language and sign)
- ❒ pharmacological properties that may vary by race, gender, and cultural factors
- ❒ other:
- ❒ cultural implications of:
  - ❒ assessment, diagnosis, treatment, and intervention
  - ❒ treatment, discharge planning, and referral to appropriate services/programs
  - ❒ genetic testing and counseling
  - ❒ health promotion and prevention

4. What approaches do you use to prepare students, interns, and fellows to interact effectively within diverse communities and/or with people from diverse racial, ethnic, cultural, and linguistic groups?

- ❒ service learning
- ❒ practicum/field placement experiences in multicultural settings
- ❒ practicum/field placement experiences in ethnic-specific settings
- ❒ problem-based learning
- ❒ shadowing a family/long-term case management
- ❒ supervision

❒ other:

5. If not offered by your training program, are opportunities provided for students, interns, and fellows to enroll in courses related to cultural competence in other schools/departments within the university/college?

❒ yes
❒ no

6. What resources might enhance your capacity to incorporate effectively cultural and linguistic competence into curricula?

❒ examples of culturally competent values, principles, constructs, and practice models
❒ examples of linguistically competent statutes, guidelines, and practice models for working with interpreters
❒ ibliographic references
❒ participatory action and culturally competent research methodologies
❒ multimedia materials
❒ Web sites
❒ consultation for curricula review and modification
❒ consultants and guest lecturers
❒ professional development for faculty and staff
❒ "buy-in" and support of deans, and other faculty and staff
❒ other:

Other Training Experiences

7. Do field placement, practicum, and service learning assignments provide students, interns, and fellows with opportunities to interact with individuals, children, and families from diverse racial, ethnic, cultural, and linguistic groups?

❒ not at all
❒ barely
❒ fairly well
❒ very well

8. Does your approach to supervision provide students, interns, and fellows with methodologies that enhance the development of their values, attitudes, knowledge, and skills related to cultural competence?

❒ not at all
❒ barely
❒ fairly well
❒ very well

9. Does your approach to supervision provide students, interns, and fellows with methodologies that enhance the development of their values, attitudes, skills, and knowledge related to linguistic competence?

❒ not at all
❒ barely
❒ fairly well
❒ very well

10. Are students, interns, and fellows exposed to faculty from diverse racial, ethnic, and cultural backgrounds?

❒ not at all
❒ sometimes
❒ fairly often
❒ very often

Faculty Development

11. Have you participated in continuing education, coursework, professional development, or other training activities related to cultural competence?

- ❒ never
- ❒ seldom
- ❒ sometimes
- ❒ regularly

12. Have you participated in continuing education, coursework, professional development, or other training activities to help you address stereotyping, bias, discrimination, and racism within health, mental health, and social service systems?

- ❒ never
- ❒ seldom
- ❒ sometimes
- ❒ regularly

13. Does your organization or university support and/or facilitate your participation in these training activities?

- ❒ no
- ❒ yes

If so, how?

_____
_____
_____

14. Which best describes your participation in such activities?

- ❒ within the last 3 years
- ❒ within/in the last 4–6 years
- ❒ within/in the last 7–10 years
- ❒ more than 10 years

15. Have you participated in continuing education, coursework, professional development, or other training activities related to linguistic competence?

- ❒ never
- ❒ seldom
- ❒ sometimes
- ❒ regularly

16. Does your organization/university support and/or facilitate your participation in these training activities?

- ❒ no
- ❒ yes

If so, how?

_____
_____
_____

17. Is there a structure in place that facilitates the exchange of knowledge, skills, and resources related to cultural and linguistic competence among faculty within the following venues?

- ❒ MCHB-funded training program
- ❒ department/school
- ❒ university
- ❒ grantee organization
- ❒ other:

18. Do any professional associations of which you are a member have committees, work groups, task forces, and councils that focus on cultural diversity or cultural competence?

❒ no
❒ yes
❒ If yes, do you participate?

Recruitment and Retention

19. How well have culturally diverse students, interns, and fellows been recruited and retained for the MCHB-funded training programs?

❒ not at all
❒ barely
❒ fairly well
❒ very well

20. What factors do you feel contribute to this?

21. To what extent are culturally/ethnically diverse individuals represented in the following? Check all that apply.

Personnel Categories	not at all	barely	fairly well	very well
MCH training program faculty				
MCH training program staff				
Department/school faculty				
Department/school staff				
University faculty				
Organization's professional personnel				
Organization's support/clerical personnel				
Other:				
Other:				

Resources for the Curricula Enhancement Module Series

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Culhane-Pera, K. A., et al. (Eds.). (2003). *Healing by heart: Clinical and ethical case stories of Hmong families and Western providers.* Nashville: Vanderbilt University Press.

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Fadiman, A. (1997). *The Spirit catches you and you fall down: A Hmong child, her American doctors, and the collision of two cultures.* New York: Farrar, Straus & Giroux.

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http://www.calendow.org/pub/frm_pub.htm

Institute of Medicine (2004). *In the nation's compelling interest: Ensuring diversity in the health care workforce.* Washington, DC: National Academies Press.

Smedley, B. D., Stith, A. Y., & Nelson, A. R. (2002). *Unequal treatment: Confronting racial and ethnic disparities in health care*, Institute of Medicine. Available from http://books.nap.edu/catalog/10260.html

Sue, D. W., & Sue, D. (2003). *Counseling the culturally diverse: Theory and practice* (4th ed.): Indianapolis, IN: Wiley.

Thandeka. (1999). *Learning to be white: Money, race, and God in America.* New York: Continuum.

U.S. Surgeon General. (2001). *Mental health: Culture, race and ethnicity. A supplement to Mental health: A Report of the Surgeon General.* Summary available online at http://www.surgeongeneral.gov/library/mentalhealth/cre/default.asp

Resources - Definitions
Key definitions

Cultural competence definitions

Broad definition of linguistic competence, see
http://gucchd.georgetown.edu/nccc/documents/Definition_of_Linguistic_Competence.rtf
See additional definitions in Compendium of Cultural Competence Initiatives in Health Care (2003). Kaiser Family Foundation. Available at http://www.kff.org/uninsured/6067-index.cfm

Building Linguistic and Cultural Competency: A Tool Kit for Managed Care Organizations and Provider Networks that Serve the Foreign-Born (1998). Wendy Siegel, Millennia Consulting, with Aida Gaichello, University of Illinois. Supported by the Mid-America Institute on Poverty. Available at http://www.consultmillennia.com/documents/Building%20Linguistic%20&%20Cultural%20Competency.pdf

Introducing Behavioral and Social Sciences into Medical School Curricula, current Project of the Institute of Medicine, Board on Neuroscience and Behavioral Health. For more information, see http://www.iom.edu/project.asp?id=3891

Multimedia Resources

Videos

Blue-Eyed, a video demonstrating the effects of stereotyping others, by California Newsreel, see www.newreel.org

Centers of Excellence in Culturally Competent Care (2003). Kaiser Permanente. To order, contact the Kaiser Permanente National Diversity Hotline at (510) 271-6663.

Cultural Issues in the Clinical Setting. Teaching video vignettes with facilitator's guide, 2003, 2004. Kaiser Permanente Multimedia Productions and The California Endowment. To order, contact: Gus Garona, Kaiser Permanente National Media Communications, Media Distribution, at (323) 259-4776.

The Culture of Emotions. A Cultural Competency and Diversity Training Program. Mental Health.To order, contact: Harriet Koskoff at (415) 864-0927.

Race: The Power of an Illusion, a video by California Newsreel, see www.newsreel.org Companion Website sponsored by PBS at http://www.pbs.org/race/000_General/000_00-Home.htm

Worlds Apart: A Four-Part Series on Cross-Cultural Healthcare (2003), by Maren Grainger-Monsen, M.D., and Julia Haslett, Stanford University Center for Biomedical Ethics. Available from Fanlight Productions at www.fanlight.com

Web Sites

UCLA Center for Health Policy Research at www.healthpolicy.ucla.edu. In particular, note publications under "Population Focus."

Cross Cultural Health Care Program at http://www.xculture.org/

National Center on Minority Health and Health Disparities, National Institutes of Health, see http://ncmhd.nih.gov/

Self-Assessment Resources

A Youth Leader's Guide to Building Cultural Competence, Chapter 2: Self-Assessment. Downloaded January 2004 from www.advocatesforyouth.org/publications/guide/chapter2.htm

Afterthoughts on "A World Waiting to be Born: Strategies to Eliminate Racial and Ethnic Health Disparities" Conference. November 2003 electronic newsletter from the Connecticut Health Foundation. Available at http://www.cthealth.org/matriarch/

Appendix C: Strengths, Opportunities, Challenges and Barriers, Roundtable National Analysis from Canada, Voice in Health Policy, Downloaded September 2003 from http://www.projectvoice.ca/Roundtable_Report_AppendixC.html

Dolhun, E. P., Muñoz, C., & Grumbach, K. (2003). *Cross-cultural education in U.S. medical schools: Development of an assessment tool.* Academic Medicine, 78(6), 615–622.

Robins, L. S., Alexander, G. L., Wolf, F. M., Fantone, J. C., & Davis, W. K. (1998). *Development and evaluation of an instrument to assess medical students' cultural attitudes.* Journal of the American Medical Women's Association, 53(Suppl. 3), 24–127.

Sedlacek, W. E., & Kim, S. H. (1995). *Multicultural assessment.* ERIC Digest. Downloaded March 2003 from ERIC database.

The National Center for Cultural Competence, including self-assessment checklists for Promoting Cultural Diversity and Cultural Competence, at http://www.georgetown.edu/research/gucdc/nccc/products.html Other links of interest are at http://www.georgetown.edu/research/gucdc/nccc/links.html

Appendix A.
Selected tools for self-assessment of cultural and linguistic competence

Agency Cultural Competence Checklist (1992). Dana, R. H., Behn, J., & Gonway, T. See description in Dana, R. H. (1998). Cultural competence in three human service agencies. Psychological Reports, 83, 107–112.

California Brief Multicultural Competence Scale (no date given). Gamst, G., Dana, R., Der-Karabetian, A., Aragon, M., Arellano, L., Morrow, G., & Martenson, L. A CBMCS user's manual is available upon request from Glenn Gamst, e-mail: gamst@ulv.edu

Cross-Cultural Counseling Inventory Revised (CCCI-R) (1991). LaFramboise, T., Coleman, H., & Hernandez, A. Contact Dr. LaFramboise at http://www.stanford.edu/~lafrom/main.html

Cultural Competence Program Self-Assessment (1995). Claudia Dengler, Amherst Wilder Foundation. Contact at http://www.wilder.org

Cultural Competence Self-Assessment Instrument (2002) revised, Child Welfare League of America. Contact at http://www.cwla.org/pubs/pubdetails.asp?PUBID=8404

Cultural Competence Self-Assessment Protocol for Health Care Organizations and Systems (no date given) developed by Dennis Andrulis, Thomas Delbanco, Laura Avakian, and Yoku Shaw-Taylor. Available at http://erc.msh.org/provider/andrulis.pdf

Cultural Competence Self-Assessment Questionnaire (1996). James Mason, Chemeketa Community College, 4000 Lancaster Drive, NE, P.O. Box 14007, Salem, OR 14007.

Language Assistance Self-Assessment and Planning Tool for Recipients of Federal Financial Assistance (2002). Interagency Working Group on LEP, Civil Rights Division, Department of Justice. Available at http://www.lep.gov/selfassesstool.pdf

Multicultural Cultural Competence Survey (2001). Association of University Centers on Disabilities (AUCD). Available for download with instructions from http://www.aucd.org/councils/multicultural/resources.htm

Massachusetts Cultural Council Organizational Self-Assessment Tool (2003). Available at http://www.masscultcouncil.org/services/org_assessment.pdf

Organizational Self-Study on Cultural Competence for Agencies Addressing Child Abuse and Neglect (1991). Terry Cross, National Indian Child Welfare Association, Inc. Contact organization at http://www.nicwa.org/

Switzer, G. E., Scholle, S. H., Johnson, B. A., & Kelleher, K. J. (1998). *The Client Cultural Competence Inventory: An instrument for assessing cultural competence in behavioral managed care organizations.* Journal of Child and Family Studies, 7, 483–491.

Toward Culturally Competence Care: A Toolbox for Teaching Communication Strategies. (2002). Mutha, S., Allen, C., & Welch, M. Center for the Health Professions, University of California, San Francisco. See http://www.futurehealth.ucsf.edu/cnetwork/resources/curricula/diversity.html

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Barzansky, B., & Etzel, S. I. (2003). *Educational programs in US medical schools, 2002-2003.* Journal of the American Medical Association, 290(9), 1190–1196.

Batalden, P. B., & Stoltz, P. K. (1994). *Fostering the leadership of a continually improving healthcare organization.* The Quality Letter for Healthcare Leaders, 6(6), 9–15.

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Brach, C., & Fraser, I. (2000). *Can cultural competency reduce racial and ethnic health disparities? A review and conceptual model.* Medical Care Research and Review, 57(Suppl. 1), 181–217.

Brant, J., Ishida, D., Itana, J., Kagawa-Singer, M., Palos, G., Phillips, J., et al. (1999, revised 2000, May). *Multicultural outcomes: Guidelines for cultural competence:* Oncology Nursing Society.

Caldwell, C. H., Jackson, J. S., Tucker, M. B., & Bowman, P. J. (1999). *Culturally-competent research methods in African American communities: An update.* In R. Jones (Ed.), Advances in African American Psychology (pp. 101–127). Hampton, VA: Cobb & Henry Publishers.

Center for Public Health Practice, University of California at Berkeley School of Public Health. (2000). *Pre-internship self-assessment.* Available from http://ist-socrates.berkeley.edu/~cphpweb/Documents/pdfs/PISA2000.pdf

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The mission of the National Center for Cultural Competence (NCCC) is to increase the capacity of health care and mental health programs to design, implement, and evaluate culturally and linguistically competent service delivery systems. The NCCC conducts an array of activities to fulfill its mission including: (1) training, technical assistance, and consultation; (2) networking, linkages, and information exchange; and (3) knowledge and product development and dissemination. Major emphasis is placed on policy development, assistance in conducting cultural competence organizational self-assessments, and strategic approaches to incorporating systematically culturally competent values, policy, structures, and practices within organizations.

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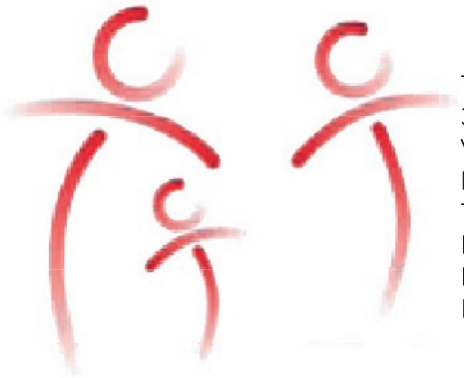

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