Cardinal Innovations Healthcare
Cultural Competency Provider Network Plan
2016-2020

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Executive Summary

Cardinal Innovations Healthcare is known for its forward and innovative thinking. Recognizing the value of the integration of culturally competent service provision is one example. As a managed care organization, quality outcomes for members are paramount. Recognizing and respecting the health beliefs and traditions of all whom we serve is a key component of managing a network that delivers the right service at the right time.

Cardinal Innovations’ cultural competence model focuses on enhancing the cultural competence awareness, skills, and knowledge of providers within the network. This plan approaches cultural and linguistic competence from an organizational perspective while considering the local impact of the communities we serve. The core competency areas are interwoven and integrated to complement a model that can be implemented into sustainable practice.

This plan is designed to be used as a resource for providers to successfully implement responsive and respectful care for all members. The core competency areas within the plan create a roadmap to accomplish this task. The core competency areas are: infrastructure; policies, procedures, and practices; personnel practices; organizational composition and climate; programs and services; skills and training; and communication. These are the basic standards and expectations for network providers. As noted in the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care, individuals and organizations can go beyond the competency areas established by Cardinal Innovations. The body of literature related to culturally competent care is expansive. The focus on these core areas provides a target approach to implementation and monitoring. For ease of plan development and cultural competence monitoring, the core competency areas are reflected consistently across all Cardinal Innovations materials related to cultural competence.

Implementing cultural competence should be viewed as an enhancement to the services currently provided. Providers are encouraged to consider how services can be improved and enhanced to meet the needs of all members. Some areas may require a more critical review and analysis than others.

The Cardinal Innovations Healthcare Cultural Competency Provider Network Plan should be seen as a roadmap to improved member/provider relationships, improved treatment and outcomes, and improved member engagement.
Section 1: Introduction to Cultural Competence
Section 1: Introduction to Cultural Competence
Chapter 1: Purpose

By 2050, the United States will be a “majority minority” nation. The minority population will be the majority of the citizens of the United States. There will be no one population that will reach 50 percent of the population. This shift has been occurring over the past several years. According to the U.S Census Bureau, California, Hawaii, New Mexico, Texas and Washington, D.C. now have populations which are majority minority. The demographics of our country, states and communities are changing.

According to the 2015 Cardinal Innovations Provider Capacity, Community Needs Assessment and Gaps Analysis, 46 percent of members served (including 6 percent other/unknown) represented a minority group. Approximately 8 percent of Orange County identified as Asian or Pacific Islander. African Americans represented 41 percent of the population in the Five County service area, serving Franklin, Granville, Halifax, Warren and Vance counties. Five County also reflected a slightly higher concentration of American Indian/Alaskan Natives than other Cardinal Innovations geographic areas. Union County had the highest number of individuals who self-identified as Hispanic. Chatham and Alamance counties reflected the highest percentage of Hispanics. According to the 2014 Mecklenburg County Capacity Study conducted by Cardinal Innovations, the county is comprised of 40.3 percent of individuals who identify as African American, Asian, American Indian, and other races while 12.6 percent of the county identified as Hispanic or Latino.

The population shift affects many business markets. Many companies and organizations have begun targeting diverse markets for the delivery of services and goods. As the market shifts, needs and desires change. This is causing a heightened awareness of trends within these markets. These trends often play a strategic role in the strategic planning of an organization.

Our market is healthcare. Diverse populations have always had and will continue to have healthcare needs and concerns. Concerns related to mental health, substance use disorder, or intellectual or developmental disabilities affect diverse populations, too. With the demographic shifts in population, these concerns are becoming more visible. As the nation’s demographics shift, so will the needs of the individuals we serve.

Providing culturally responsive and respectful care is one of the cornerstones for meeting the needs of all individuals. Individuals and families have specific health beliefs and customs that may affect how they seek and receive services. Providing culturally competent care creates the path for meeting those needs in the most efficient and effective way.

The world is changing. We have to be ready for this change.
Chapter 2: History/Background

Cardinal Innovations is the largest specialty health plan in the country, serving 875,000 members through its Medicaid, state and county funded plans. Using a community-based model of care management, Cardinal Innovations seeks to improve the health and wellness of individuals with complex needs by collaborating with local providers and stakeholders.

In the winter of 2005, Cardinal Innovations began a Cultural Competence Initiative as part of a commitment made in the 2002 Local Business Plan. The commitment stated that Cardinal Innovations and its Provider Network would move toward developing a culturally competent system that is responsive and sensitive to the cultural needs of its members.

In January 2005, a combination of input from a Cultural Competence Study Group and a provider survey were the basis for Cardinal Innovation’s original Three Year Cultural Competence Plan launched in January 2006.

In the fall of 2009, the second Provider Network Assessment was completed to assess system improvements. This resulted in the second Cardinal Innovations Cultural Competence Plan for 2011-2014.

In 2015, Cardinal Innovations completed its third Cultural and Linguistic Competence Assessment. This assessment consisted of a Provider Survey, a Stakeholder Survey, focus groups from the local Consumer Family Advisory Councils (CFAC) and local providers. This assessment was utilized as a basis for Cardinal Innovations Cultural Competency Plan for 2016-2020. This plan covers the Norther Region (Alamance, Caswell, Chatham, Franklin, Granville, Halifax, Orange, Person, Warren and Vance counties), the Southern Region (Cabarrus, Davidson, Mecklenburg, Rowan, Stanly and Union counties). The plan duration is July 2016 to June 2020. It covers seven core competency areas that complement a quality management review process that will assess for improved member/provider relations, member engagement, and treatment retention and outcomes annual reviews of this plan will occur at the corporate and regional levels.
Chapter 3: What is Cultural Competence?

There is no one definition of cultural competence. They have evolved over time. However, these definitions express the core concept of integrating cross-cultural understanding systematically into practice.

“Cultural Competence is the understanding of the social, linguistic, ethnic and behavioral characteristics of a community or population and the ability to systematically translate that knowledge into practices in the delivery of behavioral health services. Such understanding may be reflected, for example, in the ability to identify and value differences; acknowledge the interactive dynamics of cultural differences; continuously expand cultural knowledge and resources with regard to populations served; collaborate with the community regarding service provisions and delivery; and commit to cross-cultural training of staff and develop policies to provide relevant, effective programs for the diversity of people served.”

Cultural Competence is also defined by a set of congruent behaviors, attitudes and policies that come together in a system, agency or professional and enable that system, agency or professional to work effectively in cross-cultural situations.

Cultural competence requires that organizations:

- Have a defined set of values and principles, and demonstrate behaviors, attitudes, policies and structures that enable them to work effectively cross-culturally.
- Have the capacity to (1) value diversity, (2) conduct self-assessment, (3) manage the dynamics of difference, (4) acquire and institutionalize cultural knowledge and (5) adapt to diversity and the cultural contexts of the communities they serve.
- Incorporate the above in all aspects of policymaking, administration, practice, service delivery and involve systematically members, 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)
Chapter 4: What is Linguistic Competence?

According to the National Center for Cultural Competence at Georgetown University, linguistic competence is 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, individuals with disabilities, and those who are deaf or have hearing loss. Linguistic competency requires organizational and provider capacity to respond effectively to the health and mental health literacy needs of populations served. The organization must have policy, structures, practices, procedures, and dedicated resources to support this capacity. This may include, but is not limited to, the use of:

- Bilingual/bicultural or multilingual/multicultural staff
- Cross-cultural communication approaches
- Cultural brokers
- Foreign language interpretation services including distance technologies
- Sign language interpretation services
- Multi-lingual telecommunication systems
- Videoconferencing and telehealth technologies
- TTY and other assistive technology devices
- Computer assisted real time translation (CART) or viable real time transcriptions (VRT)
- Print materials in easy to read, low literacy, picture and symbol formats
- Materials in alternative formats (e.g., audiotape, Braille, 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, applications)
- Signage
- Health education materials
- Public awareness materials and campaigns
- Ethnic media in languages other than English (e.g., television, radio, Internet, newspapers, periodicals).
Chapter 5: Why is Cultural Competency Important in Healthcare?

The late Enterprise Rent-A-Car business management guru Peter Drucker is known for the phrase “Culture Eats Strategy for Breakfast.” The term refers to the assertion that culture should be considered while strategy is being developed. Enterprise Rent-A-Car not only expanded its business in non-traditional ways but has been recognized numerous times by J.D Power for customer service, a culture focused on the customer. Enterprise Rent-A-Car maintains at the top of its market for car rentals. Understanding the role of culture played a critical part of its business strategy. Many companies and organizations, nationally and globally, recognize diversity and inclusion as an important part of their organizational strategy. Evidence suggests that organizations with a more diverse and better trained workforce provide higher-quality care and experience greater patient satisfaction scores (The Sullivan Commission on Diversity in the Healthcare Workforce, 2004; IOM, 2003).

Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare (2003) concluded that through recent medical research “racial and ethnic minority patients tend to receive a lower quality of care than non-minorities, even when they have the same types of health insurance”. Three reasons are noted to be the cause of this disparity. They are:

- The way healthcare systems are organized and operate can contribute to differences.
- Members’ attitudes and behaviors can contribute to disparities
- Health care providers’ biases, prejudices, and uncertainty when treating minorities can contribute to health care disparities.

Cultural beliefs and traditions can affect help-seeking behavior for the individuals we serve. Culturally responsive care can support an approach to working with members that is essential to healing. It also affords service providers the opportunity to explore the impact of culture (A Treatment Improvement Protocol: Improving Cultural Competence, TIP 59, Substance Abuse and Mental Health Services Administration, 2015)

The Affordable Care Act is a national initiative that mandates enhanced culturally responsive services. For example, health insurance plans must provide summaries of benefits in other languages when 10 percent or more of the population living in the member’s county are literate only in the same non-English language. (Andrulis, et al. The Affordable Care Act & Racial and Ethnic Health Equity Series, Report No. 1 Implementing Cultural and Linguistic Requirements in Health Insurance Exchanges, Texas Health Institute, 2013).
The National Center for Cultural Competence (Goode & Dunne, 2003) states that providing culturally and linguistically appropriate services in healthcare are important:

- To respond to current and projected demographic changes in the United States.
- To eliminate long-standing disparities in the health status of people of diverse racial, ethnic, and cultural backgrounds.
- To improve the quality of services and primary-care outcomes.
- To meet legislative, regulatory, and accreditation mandates.
- To gain a competitive edge in the market place.
- To decrease the likelihood of liability/malpractice claims.

Cultural competence also is consistent with patient-centered care. Patient-centered care and cultural competence began as a guide for personal interaction. Patient-centered care is delivered universally, becoming more equitable. Cultural competence enhances the ability of healthcare systems and providers to address individual patient’s preferences and goals, becoming more patient-centered (Mary Catherine Beach, Somnath Saha & Lisa A. Cooper, The Role and Relationship of Cultural Competence and Patient-Centeredness in Health Care Quality, 2006).
Chapter 6: How is Cultural Competence Achieved?

Achieving cultural and linguistic competence and implementing it into practice in a practical way on the administrative, organizational, provider, and individual levels can be challenging, but is possible.

The article Taking Cultural Competence from Theory to Action (Ellen Wu & Martin Martinez, California Pan-Ethnic Health Network, 2006) shares practical principles that can be considered when implementing cultural competence within a system or organization. These principles were based on years of research engaging service providers. These principles can be used at multiple levels throughout the organization, with funders, regulators, and accreditation bodies.

Principles:

1. Community representation and feedback are essential at all levels.
2. Cultural Competency must be integrated into all existing systems of a health care organization, particularly quality improvement efforts.
3. Changes made must be manageable, measurable and sustainable.
4. Making the business case is a critical element for a change.
5. Commitment from leadership is a key factor to success.
6. Staff training is necessary on an ongoing basis.

In addition to the these practical guidelines, an enhanced version of The National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS) was released in April 2013 by the Office of Minority Health, U.S Department of Health and Human Services. These standards are intended to advance health equity, improve quality, and help eliminate health care disparities by establishing a blueprint for health and health care organizations. Cardinal Innovations has used these standards as a guide in achieving cultural competence within the provider network. They are incorporated in the regional cultural competency plans and the Cultural Competency Monitoring Tool, which is administered as a quality monitoring measurement tool. The CLAS standards can be used broadly across healthcare services and provide additional guidance for the implementation of cultural and linguistic competence. Additional information, including copies of the CLAS Standards can be retrieved at http://minorityhealth.hhs.gov/omh/browse.aspx?lvl=2&lvlid=53.

Principle Standard

- Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.
Section 1: Introduction to Cultural Competence

Governance, Leadership, and Workforce
- Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.
- Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.
- Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

Communication and Language Assistance
- Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.
- Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.
- Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.
- Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

Engagement, Continuous Improvement, and Accountability
- Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization’s planning and operations.
- Conduct ongoing assessments of the organization’s CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.
- Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.
- Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.
- Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.
- Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.
- Communicate the organization’s progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.
Chapter 7: Clinical Design and Cultural Competence

Cardinal Innovations strives to embrace the philosophy of cultural and linguistic competence as a critical piece of the design of our clinical process. Culture is considered throughout the entire process beginning with the initial contact with a member or family member, through the assessment phase, treatment, and discharge. Mental health needs, substance use disorder, and intellectual and developmental disabilities have many connotations in various cultures. Often, stigma and disparities exist within marginal communities. This may affect help-seeking behavior.

Cardinal Innovations’ clinical process is designed to provide equal access to services for diverse communities. This is impacted on the service development and delivery levels. Developing a skillset to design and deliver culturally and linguistically competent care benefits the member and his or her family. Understanding how culture and language affect treatment modalities and best practices sets the environment for better cultural understanding and member outcomes.
Chapter 8: Cardinal Innovations’ Cultural Competence Model

The Cardinal Innovations Cultural Competency Provider Model is based on collaboration and partnerships between Cardinal Innovations, our provider network, and the community. This model brings together providers who work in collaboration across regions. Cardinal Innovations business units also work alongside network providers and the community to bring awareness, knowledge, and skill building toward cultural competency. The highlights of the model are:

- Systemic approach
- Integrative model
- Strategic process
- Executive support
- Years of proven effectiveness
- Local implementation with local, community and corporate impact
- Member, stakeholder and provider partnerships and collaborations
- Alignment with national standards/best practices

The Cultural Competence Advisory Council (CCAC) is a forum for collaborating, planning, developing, implementing, monitoring, oversight, and leadership in promoting cultural competence within Cardinal Innovations and its Network of Providers. The council consists of providers and Cardinal Innovations business units. The Director of Cultural Competence is the chair of this council. The council meets monthly and reports to Cardinal Innovation’s Executive Leadership Team.

The Cultural Competence Provider Council (CCPC) is forum for collaboration, development, implementation, monitoring, oversight, and leadership in promoting cultural competence within local community and with local network of providers. This council is a subcommittee of the local Network Council. The chair of the council is selected by providers and serves as a member of the Cultural Competence Advisory Council. Each service region has an established Cultural Competence Provider Council that represents that region. The CCPC has a representative from Cardinal Innovations Network Operations department in addition to the Director of Cultural Competence to support and guide its development and implementation of cultural competency. This council has ad hoc representatives from additional Cardinal Innovations business units based on defined goals. Each service region has written a Cultural Competency Plan. These plans were designed to provide a guide for providers serving that region. They are included in this document.
The Cultural Competence Advisory Council and the Cultural Competence Provider Councils are monitored by yearly work plans that measure goals. These goals have included literature reviews on cultural and linguistic competence, development, administration, and completion of a cultural and linguistic competence assessment, the development and implementation of a Cultural Competence Monitoring tool, and the development of the current Cardinal Innovations Provider Cultural Competency Plan.

This model is similar to other integrative models within Cardinal Innovations. It promotes inclusiveness and diversity by bringing together diverse employees, providers, members and the community.
Chapter 9: Cultural and Linguistic Competence Assessment Summary 2015

During March 2015 through May 2015, Cardinal Innovations conducted a Cultural & Linguistic Competence Assessment. The assessment consisted of 10 focus groups with network providers and members of the Consumer and Family Advisory Councils (CFAC) and surveys with community stakeholders and network providers. The focus groups were held in the five Cardinal Innovations service regions with 155 individuals participating.

The stakeholder survey was completed by community stakeholders in the five service regions of Cardinal Innovations. There were 867 stakeholder surveys sent to community stakeholders and 212 were completed for a 24 percent response rate.

The provider survey was completed by network providers in Cardinal Innovations five service regions. There were 827 surveys sent to network providers and 270 were completed for a 33 percent response rate.

The overall findings were used in the development of the regional cultural competence plans. The common themes from the focus groups and surveys were:

1. Need for additional education and training of providers, members, community and staff related to cultural and linguistic competence
2. Health literacy of members to be considered when communicating with members
3. Developing and implementing of cultural competence plans that cover essential areas, according to CLAS Standards
4. Finding qualified interpreters and translation services and the cost associated with these services
5. Increasing the collaboration and partnerships between communities, stakeholders and providers
6. Promoting culturally and linguistically competent care and understanding what it means clinically
7. Considering the cultural needs of the special populations in our communities -- refugee, immigrant, undocumented, military, LGBTQ, etc.

The 2015 Cultural and Linguistic Competence Assessment can be found at www.cardinalinnovations.org.
Chapter 10: Cultural Competency Plans

Developing an organizational cultural competency plan is an organized way to deliver culturally responsive services to our members. Cardinal Innovations network providers are contractually required to have a cultural competency plan for their organization. This document serves as a guide for developing a plan. The included regional cultural competence plans offer specific local information that has been tailored to the specific region including the demographics of that region. The regional plans offer suggestions for how to implement cultural competency in seven key areas: infrastructure; policies, procedures, and practices; personnel practices; skills and training; organizational composition and climate; and programs and services. Best practice guidelines and examples are included as suggestions. Organizations are as diverse and unique as the members they serve. This should be recognized and respected. Therefore, when developing a cultural competence plan, it should be unique to the organization and the members served.

The regional plans were written by the local Cultural Competence Provider Councils with assistance from Cardinal Innovations Cultural Competence Advisory Council. Provider organizations can review and use information from the regional plans that is appropriate for their organizations. A wealth of information and resources can be found in all of the plans. Network providers can also use www.cardinalinnovations.org as a resource for information as they develop their cultural competence plan.
Section 2: Core Competency Areas
Chapter 1: Cultural Competence Monitoring Tool

The Cultural Competence Monitoring was developed and implemented in September 2009. In 2011, it was suspended during the expansion of Cardinal Innovations. This was a time of significant growth and change. The tool was revised by the Cultural Competence Advisory Council and the Quality Management department of Cardinal Innovations in 2016. It will be re-instated as part of the routine monitoring process in September 2016 within the Cardinal Innovations provider network. The tool will be used as a quality measure of the implementation of cultural and linguistic competence. The tool is designed to be consistent with areas of an organization’s cultural competence plan. Provider organizations are encouraged to extend their plan beyond the core areas defined in the monitoring and the cultural competency plan. However, the core areas defined in the monitoring tool and this plan should be the minimum requirement.

The Cultural Competence Monitoring Tool also is designed to be a guide for the development and implementation of regional plans. Organizations are as diverse as the members they serve. The Cultural Competence Monitoring Tool respects the diversity of the organization while maintaining a standard model for the development of cultural competency.

A few items to remember:

- Cultural Competency reviews will occur during routine provider monitoring
- Providers will receive technical assistance during their first review year
- Following the initial review year, Cultural Competency review scores will be combined with the routine provider monitoring score
- Monitoring data will be reviewed quarterly by the Cultural Competence Advisory Council and the Cultural Competence Provider Councils
- Additional trainings will be developed and scheduled based on monitoring data and provider needs
# Chapter 2: Cultural Competency Core Competency Areas

<table>
<thead>
<tr>
<th>Core Competency</th>
<th>Areas Covered</th>
<th>CLAS Standards</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infrastructure</td>
<td>• Mission and/or Vision Statement</td>
<td>1,2,3,4,9,10</td>
</tr>
<tr>
<td></td>
<td>• Cultural Competency plan</td>
<td></td>
</tr>
<tr>
<td>Policies, Procedures, and Practices</td>
<td>• Ratified policies on multi-culturalism, anti-racism, anti-stigma, ethnic intimidation, employment equity, service equity, and access</td>
<td>2,9</td>
</tr>
<tr>
<td></td>
<td>• Processes are in place for disciplinary or corrective actions if these policies are violated.</td>
<td></td>
</tr>
<tr>
<td>Personnel Practices</td>
<td>• Job Recruitment</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>• Job Postings</td>
<td></td>
</tr>
<tr>
<td>Skills and Training</td>
<td>• Training</td>
<td>1,2,4,9</td>
</tr>
<tr>
<td></td>
<td>• Professional Development</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Staff Orientation</td>
<td></td>
</tr>
<tr>
<td>Organizational Composition and Climate</td>
<td>• Workforce Reflective of Members and Community</td>
<td>1,3,12, 13</td>
</tr>
<tr>
<td></td>
<td>• Welcoming Environment</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Professional yet Informal Relationships</td>
<td></td>
</tr>
<tr>
<td>Programs and Services</td>
<td>• Partnerships and Collaborations including Nontraditional Relationships</td>
<td>1,11,12,13,15</td>
</tr>
<tr>
<td></td>
<td>• Data Collection</td>
<td></td>
</tr>
<tr>
<td>Communication</td>
<td>• Interpretation and Translation Services</td>
<td>5,6,7,8</td>
</tr>
</tbody>
</table>
Section 3: Cardinal Innovations Cultural Competency Regional Plans
Chapter 1: Alamance-Caswell County Cultural Competency Provider Plan

Introduction
The Alamance-Caswell Cultural Competence Provider Council consists of providers from a variety of provider organizations types representing all disciplines. The council has worked diligently over the past 18 months to develop an understanding of cultural and linguistic competence and how it is implemented into service provision. Working in a collaborative manner, the council has created a cultural competency plan for Alamance-Caswell providers. This plan served as a guide and a resource to providers in developing organizational plans. Included are resources that will assist providers in developing a greater understanding of the impact of culturally responsive care.

Alamance County is located in the Piedmont region of North Carolina. The county has a total area of 435 square miles, of which 424 square miles is land and 11 square miles is water. As of the 2010 census, there were 151,131 people, 59,960 households, and 39,848 families residing in the county. The racial makeup of the county was 71.1 percent White, 18.8 percent African-American, 0.7 percent Native American, 1.2 percent Asian, 0.02 percent Pacific Islander, 6.1 percent from other races, and 2.1 percent from two or more races, 11 percent of the population was Hispanic or Latino of any race. The population density was 347.4 people per square mile.

Caswell County is located in the Northern Piedmont area, bordering Virginia. The county has a total area of 428 square miles; of which 425 square miles is land and 3.3 square miles is water. According to the 2010 census, there were 23,501 people, 8,670 households, and 6,398 families residing in the county. The population density was 55 people per square mile. The racial makeup of the county was 61.07 percent white, 36.52 percent African American, 0.19 percent Native American, 0.15 percent Asian, 0.03 percent Pacific Islander, 1.17 percent from other races, and 0.86 percent from two or more races (1.77 percent of the population was Hispanic or Latino of any race).

According to the 2015 Cardinal Innovations Cultural & Linguistic Competence Assessment Provider Survey, respondents were asked to indicate which cultural population(s) their agency served. Of the 25 respondents from the Alamance-Caswell region, 21 provided a response. All respondents (100 percent) reported that their agency served African-Americans. The next most cited group served by agencies were Latino/Hispanic Americans (81 percent), followed by military/veterans (52 percent), Asian Americans (48 percent), those who are deaf and have hearing loss (48 percent), LGBTQ (35 percent), and Native Americans (29 percent). One tenth of respondents served groups that were categorized as “Other” which includes Caucasians.
According to Cardinal Innovations Healthcare 2015 Provider Capacity, Community Needs Assessment and Gaps Analysis,

| Medicaid Members Served in Alamance-Caswell | 4,562 |
| Medicaid Eligible                           | 33,062 |
| Penetration Rate                            | 13.8% |

Members Served by Race and Ethnicity

<table>
<thead>
<tr>
<th>Geographic Area</th>
<th>American Indian/Alaska Native</th>
<th>Asian/Pacific Islander</th>
<th>Black/African American</th>
<th>Multiracial</th>
<th>Other/Unknown</th>
<th>White</th>
<th>Total</th>
<th>Hispanic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alamance</td>
<td>22 (0.4%)</td>
<td>19 (0.3%)</td>
<td>1,574 (28%)</td>
<td>41 (0.7%)</td>
<td>417 (7%)</td>
<td>3,515</td>
<td>5,588</td>
<td>168 (3%)</td>
</tr>
<tr>
<td>Caswell</td>
<td>3 (0.4%)</td>
<td>1 (0.1%)</td>
<td>230 (30%)</td>
<td>4 (0.5%)</td>
<td>24 (3%)</td>
<td>504</td>
<td>766</td>
<td>4 (1%)</td>
</tr>
</tbody>
</table>

Alamance-Caswell provider focus group defines culture as community, traditions, celebrations, how we self-identify, our belief systems, and generational culture. Fifty percent of survey provider participants in the Alamance-Caswell area have a cultural competency plan (Cardinal Innovations Cultural & Linguistic Competence Assessment 2015)

**INFRASTRUCTURE**

Achieving cultural competence is optimized when it is integrated into the structure and fabric of an organization. As providers of behavioral health services, there are specific tasks that can assist in developing an organization’s infrastructure. Board and executive leadership establishes the foundation for integrating cultural competence through established policies and procedures, which can flow into a cultural competence plan for the organization.

*Mission and Vision*

A company’s mission and/or vision statement can centralize an organization around core values. The mission and/or vision statement should promote equity and a commitment to culturally responsive care for all individuals served. Organizations can begin by reviewing these statements and making modifications if necessary. Support and commitment by the board, executive, and senior leadership can make this review meaningful. Most importantly, the organization’s position on cultural competence should be communicated to members, staff, and the community. This shows a level of awareness, consideration, and respect for a range of cultures.

*Organizational Self-Assessment*

An organizational self-assessment can be helpful for organizations to assess how well they are doing with cultural competence. Self-assessments can be found on various websites including the National...
Center for Cultural Competence at Georgetown University. In addition to self-assessments for cultural competence, there are resources and tools available for a variety of service types. [http://nccc.georgetown.edu/]

Developing and Implementing the Cultural Competence Plan
Cardinal Innovations providers are contractually required to have a cultural competence plan that is unique to their organization. This plan should address the categories in the regional plans and complement the National Standards for CLAS in Health and Health Care. It should be a dynamic plan with the ability to be reviewed at least annually and modified as necessary. Every plan should have actionable tasks and activities that can be measured and monitored.

Annual reviews of the cultural competence plan can occur through an established committee such as a cultural competence committee, continuous quality improvement or at the executive or board level. This will encourage regular discussion of how services are delivered to culturally diverse populations.

POLICIES, PROCEDURES and PRACTICES
In addition to strong leadership support, including an organization’s core values that reflect cultural competence, policies, procedures, and practices must be reflective of a system void of discrimination, inequality, lack of access, and racism, and stigma. Organizations should make time to self-audit, review policies, procedures and compare them to day-to-day practice and implementation. This will ensure that policies and procedures are implemented in a culturally competent manner. It also offers an opportunity to conduct a critical analysis of what is working well and what is not working well within an organization. Once policies and procedures are reviewed, compare practices with possible gaps that may exist. If there is a need to develop new policies and/or revise the current policies and procedures, this is the time to do so.

Policy in Motion
As an organization reviews its policies and procedures, they may discover that they are not fully meeting the needs of individuals who are deaf and experiencing hearing loss, illiterate, or speak a language other than English. Unintended discrimination may be occurring due to lack of access for these populations. Review and revision of policies would remedy this issue resulting in better access to all individuals regardless of their individual culture. In addition, policies and procedures should have a clear protocol when they are violated. Discrimination, ethnic-intimidation, anti-racism, and anti-stigma are a few policies and procedures that should be covered.

PERSONNEL PRACTICES
Recruitment and hiring of diverse staff suggests higher quality care and greater patient outcomes (The Sullivan Commission on Diversity in the Healthcare Workforce, 2004; IOM, 2003). The more diverse the
staffs are and the more training the staff has with respect to age, gender, physical ability, race, religion, and ethnicity, the better the program will serve all members. Organizations should carefully consider hiring policies and practices to encourage the consideration and hiring of applicants from diverse cultures for a variety of positions throughout the organization. For example, Alamance County has the second highest Spanish-speaking population in the Cardinal Innovations Healthcare service area. Caswell County is primarily a rural area.

In addition, organizations should consider posting vacant positions in various media outlets that reach a diverse group of people in the community. Consider non-traditional publications like posting in reliable periodic publications newsletters and pamphlets. Examples of local publications are Que Pasa, Hola Noticias, and La Noticia. Try publicizing through different ethnic radio stations and television networks. Social media is a more recent but enormously effective method of mass communication.

Diversity related questions can be included in the interview process to underline the importance of culture as a vital core value of the organization. The interview process can also be a critical piece of hiring. Organizations can incorporate the organization's culture of diversity, inclusion, and respect into the interview process as a part of interview questions. The National Society of Human Resources Management can be a great resource to assist with specific interview questions.

**SKILLS AND TRAINING**

Developing culturally competent skills is an ongoing, dynamic process. Skill development occurs through continuous training. Organizations should consider a training plan as a part of their cultural competence plan. This plan should include training that focuses on the application and implementation of clinically competent care. Training should range from in-service, professional development, and training offered by outside organizations. Seek opportunities to integrate cultural competence, diversity, and inclusive language in current and ongoing training and discussions. Staff orientations and meetings can be used to convey and demonstrate the importance of ongoing education to staff.

Assessing cultural competence at the individual and organizational level will require a form of measurement that can be tracked. Multicultural assessment tools that can provide guidance are available online. Maintaining and reporting this information can be done through careful documentation. A Cultural Competence Committee within the organization can be a valuable addition, addressing cultural shifts. The committee could also assist with reviewing training materials, policies and procedures. Seek opportunities to integrate cultural competence, diversity, and inclusive language in current and ongoing training and discussions. Staff orientations and staff meetings can be used to convey the importance of ongoing education to staff. In addition, executive and senior management training should be held to address cultural competence within the organization.
The National Center for Cultural Competence (http://nccc.georgetown.edu) can be a good place for providers to start. Additional websites on building a training program may include:

- Building a Diversity Training Program
  http://www.diversityjournal.com/1973buildingadiversitytrainingprogram/
- Cultural Competency in Health and Human Services
  http://xculture.org/culturalcompetencyprograms/culturalcompetencytraining/
- Cultural Enhancement Module Series from the National Center for Cultural Competence
  (http://nccccurricula.info/)
- Introduction to Cultural Competency and Title VI
  http://nciph.sph.unc.edu/tws/HEP_CULTCr/certificate.php

Partnering with local groups in the area can give organizations an opportunity to learn more about various cultures that exist in the local community. Suggestions for collaborating with local groups: National Coalition Building Institute, Alamance Caswell Department of Social Services System of Care What’s Up Breakfast, National Alliance for the Mentally Ill, schools, churches and the United Way.

**ORGANIZATIONAL COMPOSITION AND CLIMATE**

An organization’s composition and climate is composed of several elements that continue to be important in providing culturally competent services. Organizations are encouraged to employ a workforce that is reflective of the community in which they serve. For example, if the community at large has a higher population of Hispanic/Latino people, Hispanic staff should also be a part of that organization. It can be reassuring when the staff reflects a culture that is similar to the members’ culture. At times, this may not be possible, but every effort should be made for staff selections to be reflective of the community at-large.

An organization’s office space recognizes universal differences by the design of its culturally diverse décor. Visual and audible resources remain respectful of the population served. Providing a welcoming environment for members sets the atmosphere. Having magazines, brochures, newsletters, and signs in various languages, cultural resources, bulletin boards, holiday celebrations, and a universal smile can be extremely welcoming for members. Entering a space that has familiar items can create an atmosphere of ease and comfort. Imagine traveling to China and realizing that your waiter speaks English or finding a familiar magazine in English in the hotel lobby. Small, unspoken efforts tend to extend past words spoken.

Informal relationships with other organizations in the community are very important to working collaboratively on behalf of members. For example, below is a list of education resources in Alamance-Caswell County, which includes EFS (English as a Foreign Language classes, GED Programs, Vocational Skills, etc.)
• Alamance Community College (GED, Trade Classes, Associate Degree, English as a Foreign Language)
• Provider Network Council and Forum meetings (opportunity for providers to collaborate)
• Piedmont Community College (Trade Classes, Associate Degree)
• Goodwill Industries
• United Way (Resource List, Community Event Notices)
• Allied Churches (Drop-in Center, Food Pantry)
• Elon University (Multicultural Event Center and Sponsorship)

**PROGRAMS AND SERVICES**
Community engagement, partnerships and collaborations are extremely important part of culturally and linguistically competent care. Organizations should continuously seek ways to engage community organizations, particularly around identified target populations. These relationships can be formal, informal, through participation on boards, committees, and advisory councils. They also can be a part of consultant relationships for identified target populations. The most important goal is to establish relationships that are intentional and beneficial to the members served.

In addition, having informal relationships with nontraditional organizations in the community such as churches, synagogues, mosques, natural healings can be a resource as many cultures may use these resources often as part of symptom management.

Data collection is an additional key strategy. Collecting data has the potential to recognize trends that can be useful in designing services for various cultural groups. This can be important when making data informed decisions.

Cultural competence should be evident throughout the entire service delivery continuum. This includes intake calls, documents and materials, meetings, trainings, office/lobby atmosphere, the complaint process, even the discharge procedures. Over half of the respondents of the Alamance Caswell Consumer Family Advisory Council focus group felt: culture was not considered in the delivery of services, some even felt they were looked down upon due to cultural difference. To serve people in a culturally competent manner, organizations are encouraged to know who you serve and how they identify themselves.

**Demographics**
Retrieve demographic information for the population your organization currently serves from a reputable source, such as census data. Demographics should include but are not limited to: gender, age, ethnicity, religion, culture. Knowing who you serve is important. Once you know the population
you serve, compare it with the demographics of the communities that your organization serves. In Alamance County, the population is: 71 percent white, 19 percent African-American, and 11 percent Hispanic. The Caswell County population is 61 percent white, 36.5 percent African-American, and 2 percent Hispanic. Are the demographics of the people you serve comparable? Are there underserved populations in your community? What can your organization do to reach out to the underserved populations? In the 2015 focus group with Alamance/Caswell Consumer Family & Advisory Council members, partnerships with churches in the Latino/Hispanic community are an important method of outreach. (Cardinal Innovations 2015 Network Capacity Study & 2010 US Census)

*Outreach and Partnerships*
Community engagement, partnerships and collaborations are extremely important part of culturally and linguistically competent care. Organizations should continuously seek ways to engage community organizations, particularly around identified target populations.

These relationships can be formal and informal, through participation on boards, committees, volunteer projects, and advisory councils. They also can be a part of consultant relationships for identified target populations. The most important goal is to establish relationships that are intentional and beneficial to the members served.

In addition, having informal relationships with nontraditional organizations in the community such as churches, synagogues, mosques, and natural healings centers can be a resource as many cultures may use these resources as part of symptom management.

*Using Community Resources*
Alamance/Caswell community resources to consider:

*Schools and Universities*
- Alamance Community College
- Elon University
- Piedmont Community College

*Religious Organization*
- Salvation Army
- Blessed Sacrament Catholic Church
- Centro La Communidad [http://catholiccharities.dioceseofraleigh.org](http://catholiccharities.dioceseofraleigh.org)
- FaithAction International House [www.Faithaction.org/servives/id_initiative](http://www.Faithaction.org/servives/id_initiative)
- Life’s Journey United Church of Christ
Data collection is an additional key strategy. When collecting data, there is the potential to recognize trends in service delivery for various cultural groups. Members can be the source of data. By conducting formal and informal interviews and/or surveys, organizations discover what is working well and opportunities for improvement. Data informed decision-making is a best practice.

COMMUNICATIONS

Organizations will face major challenges serving members who speak a different language if they are unable to communicate with individuals and families supported. Is the language within your materials understandable? Is the material only available in one language? Does it use lots of acronyms, medical or unfamiliar words and terms? Building a process to communicate effectively with individuals who may need interpretation or translation services is the key to building an effective working relationship. The ability to be able to communicate effectively with those around us is important. Consider this: While vacationing in a place where the dominant language is not English, you experience a medical emergency and are unsure how to access services. In addition, the need for an interpreter to assist with understanding the directions and instructions given to you by the physician is not an option. In this scenario, you are familiar with the language but not enough to fully understand it. Imagine how frustrating this would be. You simply want to feel better and get the assistance you need in this time of crisis, but your inability to communicate in the dominant language renders it very difficult if not impossible.

This scenario is no different for many members that we serve. The use of an interpreter or the translation of documents is highly beneficial. In the 2015 Cultural Competence Assessment, many providers said they offer translation and interpretation services. In Alamance County, 11 percent of the population identifies as Hispanic/Latino and in Caswell County 1.75 percent identify as Hispanic/Latino. Alamance County has a population of 5.89 percent of non-English speaking individuals which is 1.08 percent higher than the North Carolina state average of 4.81 percent of non-English speaking individuals. Preparing your organization to serve a culturally diverse community prepares everyone to serve linguistically diverse population members.

Organizations should first determine the demographics of the populations served. By determining this, your organization will be better equipped to develop a communication plan. It is beneficial to keep in mind that communication consists of face-to-face interactions, promotional literature provided to the community, and clinical documents. The best plan will embrace a variety of resources that can assist you with a multicultural population. It is also important to note translation occurs when a document is
translated from one language to another. Interpretation is the spoken language from one person/language to another person/language verbally. Interpreters or translators should be carefully chosen. Organizations are encouraged to seek qualified individuals who have received the necessary training to interpret or translate documents accurately. Family members and children should not be used as this poses many ethical dilemmas for all who are involved. Organizations are encouraged to use “I speak” cards to assist in the identification of the language spoken by members. A clear policy and procedure should be established to ensure that staff is fully informed of the protocol.

**Interpretation/Translations Services**

- Gateway Languages [www.gatewaylanguages.com](http://www.gatewaylanguages.com)
- Translation AZ [www.translationaz.com](http://www.translationaz.com)
- Fluent Language Services [www.fluentls.com](http://www.fluentls.com)
- Clear Messaging Interpretation Services (CMIS) [www.cmisinc.org](http://www.cmisinc.org)

Organizations should also consider members who may have low literacy levels and those who may use braille as a form of communication. The ability to communicate is essential to accessing service. Thus, health literacy is another important aspect of communication. Documents, regardless of the method, should be written in language that the member and their family members can understand.

Creativity is the key to combat the barriers that often exist for organizations. Cost is one of those barriers. Collaborations, partnerships in addition to hiring bilingual staff are critical in these areas being successful. Organizations should establish a relationship with other providers and colleagues as a method of connecting to resources in the community. Sharing resources, including interpreters and translators can be valuable to the community as a whole.

**Strategies to remember when working with linguistically diverse members:**

- Do not assume the level of an individual English proficiency. There happens to be a great variation in English proficiency.
- Seek clarification for statements that seem irrelevant or unclear.
- Work toward sensitivity to cultural differences on communication patterns, meaning of words and concepts may fall apart when the idea is transferred from one person to another.
- Do not overemphasize a language barrier. Hand gestures can help to relay concepts.
- Speaking in a louder tone or slowing you speech will not help your member understand, but may result in a negative effect.
- Avoid using jargon, slang or idioms in your speech that may not translate successfully.
- Do not assume you are being understood just because the listener nods in agreement or does not question you.
• Communicating effectively with linguistically diverse members is essential as it affects the quality of the service and the relationship, which can determine success.

**Alamance-Caswell Provider Council Strategies for Implementation**

1. Seek opportunities to partner with community organizations regarding the use of interpreters and translators
2. Develop a training and educational plan for providers on topics related to cultural and linguistic competence, health beliefs, and traditions.
3. Develop TIP, educational, sheets.
4. Developed a local resource list to be placed on the Cardinal Innovations website.
5. Develop a plan for in-service training opportunities for providers at the Network Council and Provider Forums. Training can include topics such as how to engage Spanish-speaking members in therapy, working with veterans and LGBTQ members.

**Alamance –Caswell Cultural Competence Provider Council**

Amy Chapman  Lindley Habilitation Services  
Aftan Freeman-Winters  Ralph Scott Life Services, Inc.  
Garry Wiley  Universal MH/DD/SA  
Granville Simmons  Burlington Police Department  
James Strickland  Solutions Community Support Agency, LLC  
Linda Jones  Alamance Department of Social Services  
Solow Williams  OE Enterprises & Company, Inc.  
Thomas Lesniak, Chair  RHA Health Services  
Jodi Meacham  Cardinal Innovations Healthcare – Alamance-Caswell
Chapter 2: Five County Cultural Competency Provider Plan

Introduction
Cardinal Innovations Healthcare and the Five County Provider Network are committed to developing a culturally competent system of care. Cultural Competency is defined by a set of congruent behaviors, attitudes and policies that come together in a system, agency or professional and enable that system, agency or professional to work effectively in cross-cultural situations. (Cross et al, 1989)

Cardinal Innovations Healthcare in partnership with the Five County Cultural Competence Provider Council is responsible for the development, implementation, and oversight of the local cultural competency plan. This cultural competency provider plan incorporates best practices, the National Standards for Cultural and Linguistically Appropriate Services (CLAS) and provider, stakeholder, and member feedback. It is intended to be used as a guide for providers to develop a cultural competency plan that is specific to their organization.

The Five County Cultural Competence Provider Council, covering Franklin, Granville, Halifax, Vance and Warren counties, includes representation from Licensed Independent Practitioners (LIP) and agencies such as Daymark Recovery Services, Freedom House Recovery Center, Vision Behavioral Health Services, DD Residential Services, Statewide Mental Health & Disability Services, and a representative from Cardinal Innovations Consumer Family Advisory Committee (CFAC).

The 2015 Cardinal Innovations Cultural Competence Provider survey indicated the majority of respondents surveyed in the Five County region were small agencies with less than 20 employees with 13 percent identifying their business as minority-owned. The majority of providers in the Five County region are located in Vance and Franklin counties, the fewest in Warren and Halifax counties. Five County’s population, according to the 2010 US Census reports, show that the African-American population is 41 percent of the total. It also reflects a slightly higher concentration of American Indian/Alaskan Natives. An example is the Haliwa-Saponi Tribe, where 62 percent live on the Warren and Halifax county border in northeastern North Carolina http://haliwa-saponi.com/about/

According to the 2015 Provider Capacity, Community Needs Assessment and Gaps Analysis:

- The overall female to male ratio is 50 percent, respectively.
- 16.3 percent of the Cardinal Innovations service area in Fiscal Year 2013-2014 lived below the poverty line, which is between the national poverty rate of 15.4 percent and the state poverty
rate of 17.5 percent for the same period. The Five County rate exceeded both national and state poverty rates at 21.7 percent.

<table>
<thead>
<tr>
<th>Medicaid Members Served in Five County</th>
<th>8,014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid Eligible</td>
<td>57,827</td>
</tr>
<tr>
<td>Penetration Rate</td>
<td>13.9%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Geographic Area</th>
<th>American Indian/Alaska Native</th>
<th>Asian/Pacific Islander</th>
<th>Black/African American</th>
<th>Multiracial</th>
<th>Other/Unknown</th>
<th>White</th>
<th>Total</th>
<th>Hispanic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Franklin</td>
<td>9 (0.4%)</td>
<td>4 (0.2%)</td>
<td>729 (35%)</td>
<td>13 (0.6%)</td>
<td>94 (4%)</td>
<td>1,253 (60%)</td>
<td>2,102 (100%)</td>
<td>37 (2%)</td>
</tr>
<tr>
<td>Granville</td>
<td>4 (0.2%)</td>
<td>3 (0.2%)</td>
<td>646 (37%)</td>
<td>12 (0.7%)</td>
<td>103 (6%)</td>
<td>967 (56%)</td>
<td>1,735 (100%)</td>
<td>19 (1%)</td>
</tr>
<tr>
<td>Halifax</td>
<td>156 (5%)</td>
<td>5 (0.2%)</td>
<td>1,810 (59%)</td>
<td>5 (0.2%)</td>
<td>101 (3%)</td>
<td>996 (32%)</td>
<td>3,073 (100%)</td>
<td>13 (0.4%)</td>
</tr>
<tr>
<td>Vance</td>
<td>12 (0.4%)</td>
<td>6 (0.2%)</td>
<td>1,591 (57%)</td>
<td>14 (0.5%)</td>
<td>98 (4%)</td>
<td>1,077 (38%)</td>
<td>2,798 (100%)</td>
<td>36 (1%)</td>
</tr>
<tr>
<td>Warren</td>
<td>52 (5%)</td>
<td>1 (0.1%)</td>
<td>576 (57%)</td>
<td>2 (0.2%)</td>
<td>36 (4%)</td>
<td>345 (34%)</td>
<td>1,012 (100%)</td>
<td>9 (1%)</td>
</tr>
</tbody>
</table>

**Infrastructure**

One of the primary opportunities for organizations to strengthen their infrastructure is to ensure that executive and senior leadership is fully engaged in providing culturally competent care. The National Culturally & Linguistically Appropriate Standards (CLAS) pose two key questions for organizational leadership to consider in an effort to encourage cultural competency throughout the organization.

- Has the organization’s Board of Directors, executive, or senior leadership set goals to improve diversity, provide culturally competent care, and eliminate disparities in care as part of the strategic plan?
- Is diversity awareness and cultural competency training strongly encouraged for all senior leadership, management, staff and volunteers?

More specific areas for organizations to consider are:

- Developing a mission and vision statement that is reflective of the organization serving all individuals,
- A cultural competence self-assessment, and
- Developing and implementing a cultural competence plan
Mission/Vision Statement
A mission and vision statement defines the overall purpose and direction of an organization. It is a clear statement that expresses the organization’s primary focus and mission. The mission and vision statement should be included and clearly demonstrated in the organization’s written materials, (i.e. brochures, program descriptions, and annual reports) and communicated to all staff (i.e. staff and board meetings, internal newsletters, and social media) as well as external stakeholders.

Self-Assessment
A cultural competence organizational self-assessment can be used by an organization for the development and implementation of cultural competence within the organization. It is an opportunity to assess an organization’s level of providing culturally competent care and determine opportunities for improvement. The assessment can be used as the basis for the development of a cultural competence plan for the organization.

Cultural Competence Plan
The Cultural Competence Plan is specific to each organization and should clearly demonstrate awareness and respect for diversity in clients, employees, stakeholders and partners. The organization should demonstrate how the cultural competence plan has been implemented at all levels throughout the organization. This demonstration can take place in the form of training, policies, hiring practices, and staff meetings. A plan should include specific activities with timelines and responsibilities for implementation.

Stakeholder and provider surveys, in addition to provider and member focus groups, were conducted as part of the 2015 Cultural & Linguistic Competence Assessment. The provider survey was designed to gain input and insight, from the provider perspective, into the delivery of culturally and linguistically competent care within the Cardinal Provider network. The stakeholder survey was designed to gather information from local stakeholders regarding: perceived resources in the MH/I-DD/SA system, barriers to services, and the perception of the overall mental health, intellectual and developmental and substance use disorder system’s level of cultural competency. The data from these assessments was specific to the Five County region. Some of the recommendations from the assessment were as follows:

- Promote and encourage increased use of Peer Support Specialists and health care navigators in diverse communities.
- Cardinal Innovations and network providers should seek opportunities to partner with diverse communities to provide education on mental health needs, intellectual and developmental disabilities and substance use disorder.
- Seek opportunities for representatives from diverse communities to serve on boards and committees
• Promote cultural awareness and education including the culture of poverty
• Increase opportunities for training and education about cultural and linguistic competence and how to incorporate it into practice delivery
• Train providers to create effective cultural and linguistic competence plans with measurable goals and outcomes
• Train providers to increase the effective use of interpretation and translation services
• Seek and support opportunities for community collaborations and partnerships to work within diverse communities

While the concept of cultural competency is not new to most providers, developing and implementing a cultural competency plan unique to the organization may be new to some organizations. The tools presented are intended to make the process easier.

**Policies, Procedures and Practices**
Organizations are encouraged to develop policies and procedures that reflect multiculturalism, employment equity, and equity in service delivery. These policies should be communicated to all staff and externally as needed. Policies should include a clear procedure and/or protocol regarding noncompliance of the policy if not followed as written. Examples include job descriptions for direct, administrative and support staff with emphasis on training requirements, employee performance review tools, and grievance policies. In addition, employee orientation materials should also include the organization’s vision on cultural competency and diversity. The effectiveness of the policies, procedures and practices can be monitored as part of Continuous Quality Improvement (CQI), employee on-boarding, the appraisal processes or other operational processes within the provider organization. In addition, it is recommended that these policies and procedures be reviewed and/or revised regularly, reflecting necessary modifications based on organizational change.

**Personnel Practices**
Organizations should carefully assess staffing needs. The recruitment and employment practices and strategies are designed to promote cultural diversity. The interview process can be used to recruit and emphasize diversity. One way this can be done is through appropriate interview questions, orientation, performance appraisal and disciplinary processes as well as ongoing training for staff. Consider placing recruitment announcements in the targeted language that you seek. Job advertising resources can include culturally diverse media and national websites such as [www.diversityworking.com](http://www.diversityworking.com), local health and job fairs, college and university bulletin boards, and local community organizations such as:

• Ker-Tar Council of Government
• Local chamber of commerce
Skills and Training
Training and education for all staff, including orientation materials for new staff, should contain information that supports and encourages cultural diversity and sensitivity with regard to age, gender, sexual orientation, socioeconomic status, spiritual beliefs and language. The training should “emphasize sensitivity to variations within populations as well as among populations, including individual variation in beliefs, expectations and preferred modes of communication.” Training examples can include mediated conflict, group curriculums and training on communities such as LGBTQ and the military. In addition to training available within the organization, organizations can use relevant materials found online. Examples may include:

- NC Office of Minority Health & Disparities http://www.ncminorityhealth.org
- NC AHEC www.Med.unc.edu\AHEC
- Racial Equity Institute www.rei.racialequityinstitute.org
- NC Program on Health Literacy www.nchealthliteracy.org

Training materials should be reviewed periodically to ensure that the information is accurate and current. They should be updated often. Pre-tests and post-tests can be used to assess the retention of training information. The trainings and skills program can be reviewed as part of the Continuous Quality Improvement Process (CQI) and the strategic planning process.
Organizational Composition and Climate

The organizational composition and climate is reflective of both its members and the community or geographic area receiving services. The creation of a warm and welcoming environment can have a positive impact on the quality of the relationship between the provider and its members. There are several ways an organization can create a warm and welcoming environment. They include having diverse magazines, brochures, pictures, images, decorations, toys, and play accessories. Informational boards, which display a variety of cultural activities, also are useful. Celebrating holidays and events with culturally diverse foods is another option. Organizations should demonstrate how community needs are assessed and how the feedback is used to improve service delivery, programming, staff training and workforce recruitment. Examples of how an organization can demonstrate this include:

- Involvement with the local chamber of commerce, Department of Social Services, schools, and hospitals to help identify community needs and trends
- Collaboration with other organizations to broaden the continuum of care of both agencies members
- Town hall meetings for members, families and external stakeholders
- Regular communication with the Managed Care Organizations around needs assessment surveys

The organization's climate and environment should be one that is inclusive of cultural diversity not only for staff but also for the population served.

Programs and Services

The continuum of care includes community partnerships and resources that promote a holistic approach to meeting the needs of the population served. Non-traditional partnerships with faith-based organizations, senior citizen homes, local school districts, early intervention and family services, tribal councils, the LGBTQ community and NC Program on Literacy are some examples of local organizations that provide opportunities to promote a holistic approach to meeting the needs of the population served.

Data

Organizations are encouraged to have mechanisms in place to gather data. These can include staff and member surveys. Feedback from surveys can be communicated to staff as part of the organization’s Continuous Quality Improvement (CQI) process and integrated into new or established outcome measures. Data analysis should consider various factors including but not limited to stratification of race, ethnicity, and grievance data.
Communications
An important component of developing and implementing cultural competence is employing or having access to resources to provide interpreter and translation services. This will assist clients in understanding their care and service options in the language of their choice. It also encourages members to actively participate in treatment planning. Client safety increases along with a reduction in errors due to miscommunication or inadequate communication.

Examples of resources and partnerships can include

- A community resource list
- Collaborative relationships with agencies via a Memorandum of Agreement (MOA) or informal agreement

Materials and appropriate signage should be made accessible in all treatment locations indicating regularly encountered languages. Language assistance should be advertised to members. Having bilingual staff present is one of the most effective methods. Using external language services may be necessary.

All persons providing interpretive services should be proficient to interpret in the language stated. A Treatment Improvement Protocol 59: Improving Cultural Competence published by Substance Abuse and Mental Health Services Administration offers guidance on the selection of interpreters.

Translation of documents is an area not to be overlooked. Essential documents should be translated and made available to members. When in doubt, organizations should refer to Title VI for guidance on interpretation and translation requirements for populations present in the communities served. A few local and national resources are:

- NC Division of Services for the Blind [http://www.ncdhhs.gov/divisions/dsb](http://www.ncdhhs.gov/divisions/dsb)
- Carolina Children’s Communicative Disorders Program (CCDP) [www.unchealthcare.org](http://www.unchealthcare.org)
- Division of Services for the Deaf & Hard of Hearing [www.ncdhhs.gov/dsdhh](http://www.ncdhhs.gov/dsdhh)

Five County Cultural Competence Provider Council

Strategies for Implementation

1. Work in collaboration with Cardinal Innovations to develop a training plan for providers on plan development and a monitoring tool.
2. Collaborate with and support Cardinal Innovations’ Member Engagement department to offer guidance and educational opportunities on engaging the participation of diverse communities on advisory boards and committees for provider organizations.
3. Collaborate with and support Cardinal Innovations’ Community Engagement department to offer training on reducing stigma in diverse communities. Extend these training opportunities to local community leaders and organizations, including EMS and crisis agencies.

4. Provide cultural competence training/educational opportunities as a part of the quarterly meetings of Five County Provider Forums.

5. Create educational documents, TIPs, related to cultural competence for the provider network.

**Five County Cultural Competence Provider Council**

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Chapter 3: Mecklenburg County Cultural Competency Provider Plan

Introduction

“Located in southwestern North Carolina, Mecklenburg County borders the South Carolina state line, is 523 square miles of land and ranks 38th in size of all North Carolina counties. It has the largest population and is the most densely populated county in the state (Cardinal Innovations 2014 Mecklenburg Network Capacity Study).”

Mecklenburg County is classified as primarily urban with a few rural areas. It is the fastest growing county in North Carolina according to the U.S. Census Bureau as of July 2012, and makes up for about 10 percent of North Carolina’s total population (Cardinal Innovations 2014 Mecklenburg Network Capacity Study).

Mecklenburg County residents represent various races and ethnicities - white, black/African-American, American-Indian and Alaska Native, Asian/Pacific Islander, Hispanic or Latino, and people who reported two or more races. According to information reported by Mecklenburg County Department of Social Services, approximately 17.8 percent of residents or 171,678 people are Medicaid recipients as of July 2012. “Approximately 151,068 (15.7 percent) of Mecklenburg County’s general population was determined living with mental health, intellectual or developmental disabilities, or substance use disorder diagnosis (2014 Mecklenburg Network Capacity Study).”

Providers in the Cardinal Innovations Network, who participated in the Cultural & Linguistic Competence Assessment Provider Survey, which was administered in 2015, reported serving a diverse number of people of various cultural populations, ages, and disability groups. This reflects Mecklenburg County. (Cultural & Linguistic Competence Assessment, Provider Survey, Section 1, 2015).

The majority of the providers who completed the survey (64 percent) have been in the behavioral field for 10 or more years. Participants in the provider survey provide services in Mecklenburg County (Cultural & Linguistic Competence Assessment, Provider Survey, Section 1, 2015).

Fifty percent of provider focus group participants in Mecklenburg County do not have a cultural competence plan (Cultural & Linguistic Competence Assessment, Provider Focus Group, 2015).
Infrastructure

Mission and/or Vision
Cultural Competence begins with the infrastructure of each organization. The mission and/or vision statement of the organization and the cultural competence plan are the foundation of this essential component. Each organization is unique in the composition of the members served, staff, location, policies, and procedures. The organization’s mission and/or vision statement should be exceptional to each organization and communicate the culturally sensitive needs of the population served.

Creating Your Mission/Vision
The organization’s mission and/or vision statement should promote cultural diversity, cultural competency, and linguistic competence. An ideal mission and/or vision statement should strive to meet the principal standard of the 2013 National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care. According to the National standards, the 15 CLAS standards are met if the principal standard is present. The principal CLAS standard is: “Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.”

Living Your Mission/Vision
The organization’s mission and/or vision statement should be communicated both internally and externally to members served, staff, community members, stakeholders, and partners. Evidence should be present in written material such as training information, brochures, reports, and other printed materials. The organization’s mission and/or vision statement should be easy to locate.

A mission and/vision should be infused throughout the organization. It should be present in written material as well as evidenced in the organization’s practices and operations. Organizations should have appropriate goals, management accountability, suitable policies, and allocated resources that all support the mission and/or vision.

Cultural Competency Plan
A cultural competency and diversity plan is a written plan that demonstrates an awareness of, and respect for, and attention to the diversity of the members served, staff, families/caregivers, stakeholders, and partners, and articulates how it will embrace diversity, promote a culturally respectful environment, and help its staff acquire the knowledge, skills, and behaviors to work effectively cross-culturally by understanding, appreciating, and respecting differences, and similarities in beliefs, values, and practices within and between cultures. An organization’s cultural competence plan should include strategies and time lines for goal completion.
Mecklenburg Consumer Family Advisory Council (CFAC) focus group participants reported the following as areas of improvement: respect for family structure, empathy, judgment, and biases. In addition, they identified that provider education on cultural and linguistic competence was a need. Overall, there was a lack of confidence in providers valuing culture and integrating it into service delivery (Cultural & Linguistic Competence Assessment, Provider Focus Group, 2015, Question 4).

The following are strategies that stakeholders listed as “willing to consider” to improve the working relationship with the mental health system. They are listed in order of the most cited strategy to the least: continue to improve collaboration, partnership or referrals, training, education, workshops, and awareness of services, more feedback, communication, or sharing information, continue to improve networking, interactions, meetings, or involvement, ongoing strategies, and integration (Cultural & Linguistic Competence Assessment, Provider Focus Group, 2015, Section 4).

Of the 60 stakeholders who participated in the Cultural Competence survey, 94 percent of respondents reported that their office is located in Charlotte, N.C., and 98 percent provide services in Mecklenburg County. Stakeholder participants were overwhelmingly from Mecklenburg County.

**Developing Your Cultural Competency Plan**
A cultural competency plan should begin with identifying the cultural needs of the population served. Organizations should be aware of the diversity and needs of its members. Tools such as assessments can be used to gather information about the preferences of the individual served such as preferred language, dietary needs, spiritual beliefs, etc. Existing tools and resources that the organization uses may be able to provide this evidence.

**Monitoring Your Cultural Competence Plan**
Once the information has been acquired, the agency should provide evidence and communicate the knowledge gained from the information and how it will be used. Examples are hiring staff members representative of the people the agency serves, identifying the need for interpreters, considering diversity in treatment plans and/or services, modifying training, using community resources, and any other examples the agency can provide to indicate that the information proves useful in quality improvement.

A cultural competence plan should be reviewed and approved at least annually by its governing body. Evidence of review and approval should be documented.

A cultural competence plan is ongoing. It involves continuous learning and maintaining an open mind about the various cultures represented in a diverse environment. It is identifying the needs and preferences of the members served, and accommodating them to the best of an agency’s ability within the agency’s practices and capabilities.
Favorable results from identified needs should be reflected. Results can be documented uniquely for each agency. For example, interviews with families/caregivers, staff, members served, stakeholders, partners, satisfaction surveys, etc. If methods implemented prove to be ineffective, they should be revised to improve outcomes and best support individuals served.

**Using Community Resources**

Mecklenburg County is a hub of cultural resources. The Charlotte Culture Guide lists various events and resources that can be filtered by type of event, location, and date. The Charlotte Observer, La Noticia, and Creative Loafing are only a few of the many examples of periodicals that share local cultural events. Sharing resources that can be useful to the organization and its members is a great way to collaborate with existing organizations. Other tools for information sharing and gathering can be through the use of local colleges and universities such as University of North Carolina at Charlotte, Central Piedmont Community College, Johnson C. Smith University, Wingate University, etc. Charlotte-Mecklenburg Schools and local churches also host fairs and events, which are great partnership opportunities. The organization also may consider networking and participating in events hosted by the local chamber of commerce and other organizations that may lead to further connections and collaboration.

**Policies, Procedures and Practices**

An organization’s policies and procedures are essential because it is the formal documentation of guidelines and steps that each individual organization creates that set the framework of expectations. Policies and procedures can be used to communicate those expectations to the people in the organization. Having standard procedures in place communicates good faith and consistency that everyone will be treated fairly and equally. The ability to demonstrate the organization’s practice of its policies and procedures is most valuable.

**Policies**

Organizations should have policies that support all people. Staff members, people served by the agency, and advisory committees should all be included in the organization’s written policies. Policies should reflect that organizations will not discriminate based on race, color, religion, sex, national origin, ethnic group, or sexual orientation. Ratified policies should address the following areas: multiculturalism, anti-racism, anti-stigma, ethnic intimidation, employment equality, service equity and access.

Multiculturalism is the idea that multiple cultures exist and are accepted within the organization. Anti-racism is the practice of opposing racism and promoting racial tolerance. Anti-stigma is the idea that negative and unfair beliefs about a particular group of people will not be supported. Ethnic
intimidation refers to the fact that the intent to maliciously harass or intimidate a person based on their race, color, religion, gender, or national origin is unacceptable. Employment equality is present when there is no discrimination against employees. Service equity and access refers to the rules and customs of each organization that demonstrate that services are fair, impartial, and accessible.

Goals for eliminating barriers, and non-tolerance for any form of discrimination and harassment should be included in the organization’s policies. In the event that these policies are violated, disciplinary or corrective action steps should be included to promote a culturally competent environment. Policies should be communicated internally and externally to individuals served, stakeholders, and partners.

Procedures and Practices
Written policies should not only be written but also be reflected in the organization’s procedures and practices. The organization should be able to provide evidence on the results of the practices. If policies prove to be ineffective, they should be revised to best meet the needs of the members served, staff, committees, stakeholders, and partners.

**Personnel Practices**
Bringing diversity awareness into the organization’s personnel practices assists in the delivery of culturally competent care for its members. It is always best practice to have a personnel policy that not only conforms to employment and labor laws, but promotes awareness, acceptance and respect of our diverse population.

Organizations that diversify their workforce have a distinct advantage over those that do not as they are better prepared to serve a multicultural community. The more diverse the staff is with respect to age, gender, physical ability, race, religion, and ethnicity, the more able the program will be to serve all members. A program needs to make special efforts to hire and maintain culturally competent staff. This can be done on several different levels. (Kossek, Ellen Ernst (2009). Employee and Labor Relations Manual: Aligning and Managing Work/Life Relationships in Organizations; Society for Human Resource Management.)

*Identify your staffing needs*
The organization’s openness to cultural differences should be communicated clearly to its members. This will encourage the member to better assist in defining their needs. Ask yourself the following:

- Who are the members in our organization?
- What is their background?
- What attributes does staff need to best represent and/or work with our members?
Job Recruitment and Job Posting

It is important to recruit staff whose background is similar to the members being served. Job postings should be tailored to the members’ needs and be made available to culturally diverse organizations. For example, most colleges have a Career Center and diverse student organizations that can be targeted. Faith-based organizations can also be helpful in posting job opportunities, and there are local multi-cultural and diversity job fairs that are always seeking active recruiters.

Maintaining a file of recruitment resources can be most valuable to an HR team. Posting vacancies on a company website, in the local paper or on a job search website (Indeed, Monster, Career Builders, etc.) are always good places to start, but there are more creative places to post that may attract the types of applicants you seek. Some examples include:

- LaNoticia (http://www.lanoticia.com/Pages_E/adverti.htm) is a Spanish Language newspaper that serves the Charlotte area
- The Bugler (http://deafncevents.com/Bugler/index.htm) is a non-profit magazine written for the deaf in NC. It has an online advertising page to post jobs.
- Diversity Working (http://www.diversityworking.com/) is one of the largest online diversity job boards. They have categories to post jobs for the LGBTQ community, senior citizens, veterans, Native Americans and people with disabilities
- CPCC, Johnson C. Smith University, UNCC, Queens University and Wingate University are just a few of the colleges that have Career Centers. Johnson C. Smith will even pre-screen your applicants and send you only those who fit your specific need.
- Metrolina Provider Network MPN http://www.mpinc.org/

It is important to make clear through your advertising and on your website that you are an equal opportunity employer, and that you welcome all persons. Give contact information to those applicants who may need assistance or accommodations with applying. Removing all perceived barriers from the application process encourages a diverse workforce.

Respondents to the Mecklenburg Provider Focus group indicated a barrier in finding bilingual/bilingual clinical staff with like backgrounds (Question 4). As a provider, consider developing a plan to encourage potential clinical staff to enter the field through internships, or look at providing incentives and a clear path to internal staff who want to advance their education and career. (National Standards for Culturally and Linguistically Appropriate Services in Health and Health CLAS, Standard 4)
Interview
It is possible to measure cultural competence through the interview process. During an interview, applicants can be asked to discuss what diversity means to them. Applicants can be encouraged to speak in detail about their experiences working with diverse members.

The Society for Human Resource Management (SHRM) is a national certification organization for HR professionals. They are also a good resource for HR tools. SHRM has published some sample Diversity Interview questions on their website to assist the hiring manager in assessing an applicant’s sensitivity to cultural diversity. To access that list, go to http://www.shrm.org/templates/tools/samples/interviewquestions/pages/diversity.aspx. (National Standards for Culturally and Linguistically Appropriate Services in Health and Health, CLAS Standard 4)

Building a culturally sensitive workforce includes the direct support staff or clinicians who align themselves with the member’s needs, yet it also includes an administrative team who will respond to that workforce in kind. An ideal workforce is where staff and members both feel accepted and respected regardless of their cultural backgrounds. Culturally diverse items can be distributed in the community but displayed prominently in your office to help serve as a reminder.

Skills and Training
Organizations are encouraged to have a high impact Cultural Competence training program that not only raises awareness but develops the depth of understanding needed to affect attitude and build skills. Training should offer the type of insight into diversity and inclusion that will bring staff’s own personal values and beliefs to the surface for self-evaluation. A good training program will bridge awareness, attitude, knowledge and skills that can be taken into the community and used in a practical way.

Beginning with new hires, an agency’s orientation manual and on boarding process should reflect its vision, mission, policies and procedures related to cultural competence. (National Standards for Culturally and Linguistically Appropriate Services in Health and Health CLAS Standards 1,2,9). Staff may go through a general diversity awareness program or have a tailored plan of training, depending on their client base. The best program would encompass both experiences and address diversity in terms of culture, age, gender, sexual orientation, spiritual beliefs, socioeconomic status and language (National Standards for Culturally and Linguistically Appropriate Services in Health and Health CLAS Standard 4).

General diversity training as part of an organization’s curriculum could be viewed as an introductory overview. Building a lesson plan can be as simple as pulling information from the internet, providing
historical context and changing demographics, and by giving participants an opportunity to participate in a forum. The curriculum may look something like this:

- Fundamentals of Cultural Competence
- Increasing Awareness
- Strategies for Resolving Cross Cultural Conflicts

Suggested websites for more information on building a training program may include:

- Building a Diversity Training Program (http://www.diversityjournal.com/1973-building-a-diversity-training-program/)
- Cultural Competency in Health and Human Services (http://xculture.org/cultural-competency-programs/cultural-competency-training/)
- Cultural Enhancement Module Series from the National Center for Cultural Competence (http://ncccccurricula.info/).

More advanced classes may be structured around a specific member receiving services or culture. For example, classes may be offered on TBI or Autism, or you may want to consider offering an overview of their religious affiliation. The College of Direct Support (www.collegeofdirectsupport.com) is a valuable resource for providers, and the Employers Association (https://www.employersassoc.com/) offers a wide range of classes and materials that providers may be able to use. In addition, executive and senior management training held to address cultural competence within the organization should not be overlooked.

Assessing your cultural competence at the individual and organizational level will require a form of measurement that can be tracked. Multicultural assessment tools can provide guidance and are found online. Maintaining and reporting this information can be done through careful documentation. A Cultural Competence Committee within the organization can be a valuable addition to and address cultural shifts. The Committee could also assist with reviewing training materials, policies and procedures.

Understanding needs and the needs of your members is first and foremost in developing and implementing a good cultural competency training program. The curriculum does not have to be costly as most information can be found online. The National Center for Cultural Competence (http://nccc.georgetown.edu) may be a good place for providers to start.

**Organizational Composition and Climate**

The organizational composition and climate is fundamental in the process of assessing and evaluating the organization’s cultural competence, which can be measured through various avenues. As indicated in the National Culturally and Linguistically Appropriate Services (CLAS) standards, ensuring that
appropriate training and maintenance of policies and practices, which reflect cultural competence, is
the main provision of culturally competent services. Organizational members, to include the governing
body, should receive training and actively practice culturally sensitive behaviors and decisions. As
referenced in the Cultural Competence Monitoring Tool, participation of diverse individuals on internal
boards and committees provide for a much diversified group. When individuals of various ethnic,
racial, geographic, and socioeconomic backgrounds work together, the results may be quite
advantageous.

Continuous appraisal of the Physical Environment, Materials and Resources are key components in this
purview. It is important to ensure that individuals are physically and mentally comfortable in the
environment. Individuals receive comfort through familiarity, particularly individuals who experience
difficulty adapting to a setting that is not their own. Making the extra step to take everyone’s
preferences and/or needs into consideration is beneficial. For example, when lunch is provided at
events, a person may feel appreciative if the vegan option is available simply because his or her dietary
preferences were thoughtfully considered and included.

Visual presentation is a principal mean of reflecting cultural competency. An organization’s office
space, which recognizes universal differences by the design of culturally diverse décor, artwork, and/or
pictures placed around the office appears diverse. Maintaining the accessibility and availability of
publications, brochures, and magazines, which reflect assorted themes (Essence, Sports Illustrated,
Good Housekeeping, etc.) is also another way of assuring that dissimilar preferences are met. Placing
disparate play materials/accessories in therapy rooms or waiting areas, which reflect variations, such
as gender (by provision of dolls, trucks), and mental levels (by provision of picture books and
storybooks) are always beneficial.

Validating that visual and audible resources remain respectful of the populations served (i.e. substance
and alcohol users, those with mental or emotional challenges, and/or individuals diagnosed with
developmental disabilities) are also essential. Displaying cultural sensitivity, more than likely, will assist
with minimizing or avoiding feelings of disconnection and/or un-appreciation of the individuals served.
Taking measures to corroborate that the literature available are easily comprehended by the
members/families visiting the facility will also prove to be valuable for individuals with varied literacy
levels. It’s also thoughtful to provide brochures in the preferred language of the members served (i.e.
Hispanics) if a large percentage of persons served are Hispanic. Individuals should not feel targeted or
experience bias/prejudice as a result of their phenotypes, belief system, or circumstances.
It’s also important that the members served are aware that their provider(s) collaborate with other
providers, organizations, or associations in the community. The distributions of brochures, contact
information, community resources and/or invitations to community events of other bodies are
progressive approaches of exhibiting local collaboration within the community. Sometimes just
ensuring that families are cognizant of local community resources will be empowering. For example, here’s a list of educational resources in Mecklenburg County which includes ESL classes, GED Programs, Vocational Skills, etc.

- Bridge Jobs Program (GED)
- Central Piedmont Community College (GED, High School Diploma, Associate Degree, and Vocational Skill Building Courses)
- Goodwill Industry of Southern Piedmont (Trade Classes)
- Mi Casa Su Casa (free ESL classes)
- Urban League of the Central Carolinas (GED, Money Management)
- Q Foundation (GED)
- Refugee Office (free ESL classes)
- Vocational Rehabilitation Services
- Recovery Hub (client training on various topics)

In conclusion, organizational composition and climate requires a large number of factors. An under-welcoming environment (i.e. physically unkempt; temperature is too cold; tend to favor one race or gender over the other; staff is disrespectful, etc.) is not as receptive to the general public as the opposite. The ability to maintain a level of continuous respect for each individual is vital. Every feature and facet is pulled into the big picture - from the members of the organizational team, the physical environment, to the attitudes and beliefs of everyone involved plays a role in the holistic atmosphere. Education and culturally competent practices are necessary to maintain a successful culturally competent environment.

**Program and Services**

Review your service delivery timeline from intake to discharge. You can probably identify many points at which you can demonstrate cultural competence or at least avoid cultural incompetence.

Before all else, review the demographics of the population you serve. It is challenging to be competent without knowing the cultural context of your members. Get demographic information and compare the demographics of your current client base to the demographics of those to whom you want to expand your services. Find the gap, identify the cultures occupying the gap, and make sure your outreach efforts are informed by their cultural preferences.

Demonstrate community partnerships by surveying other support agencies (if their annual reports are public, these are often a good place to start). Do the populations you serve overlap (National Standards for Culturally and Linguistically Appropriate Services in Health and Health CLAS Standard 12.) It is
helpful to know if your members also receive services from other agencies, these connections can create a map of the support community in which your agency exists.

Staff suggestion boxes can be helpful for collecting frank observations about shortcomings in your program’s cultural competence, observations that staff may feel uncomfortable sharing verbally (National Standards for Culturally and Linguistically Appropriate Services in Health and Health CLAS Standard 10). Have specific questions on answer cards to pursue any nagging questions you may have already identified about your program. Ask your staff for feedback about where your program’s shortfalls occur, as well as where your program excels. For real insight, ask your staff for specific incidents they may have witnessed. Specific incidents often yield more usable information than generalized overview questionnaires.

Hire with diversity in mind (National Standards for Culturally and Linguistically Appropriate Services in Health and Health CLAS Standard 2). Make sure your hiring managers know what that means for your agency. Does your staff reflect the cultural, ethnic, racial, and religious orientation of those you serve? Do they reflect the orientation of the population(s) to whom you hope to expand your services? Offer incentives for staff willing to learn second languages (including American Sign Language) to the degree that they can help interact with other language speakers. Obviously, this would not replace certified interpreters (National Standards for Culturally and Linguistically Appropriate Services in Health and Health CLAS Standard 6, 7), but it demonstrates staff-level commitment to linguistic diversity and can help make non-English speakers feel more at home in your program. The make-up of your staff is probably the most powerful demonstration of your agency’s cultural competence. It shows you walk the walk.

Find out what your staff knows about the cultures of those they work directly with. Can they identify non-dominant cultures? Do your staff and leadership go further than simply acknowledging non-dominant cultural preferences – do they initiate engagement with them? Are you sending female staff to provide in home skill-building services to a family whose cultural orientation might require a male? Are you addressing your family communications with the traditional head of the family? On a larger scale, how do your agency’s community affairs events resonate with non-dominant cultures? For example, many fundraising events consist of food-by-the-plate cookouts. Does the flyer promoting it do so in more than one language? Did the cookout date fall on Chinese New Year, Passover, and Ramadan? Does it offer an alternative to pork barbeque in case that food is taboo to some stakeholders? Or is there an equivalent alternative food event, on a different date, to appeal to stakeholders excluded from your barbeque?

Review your event decorations with a fresh eye, especially any mascot imagery. Be aware of stereotypical/caricature depictions of people and symbols. Commonly overlooked but tricky ones
include the depiction of Native Americans in Thanksgiving decorations and the Irish in St. Patrick’s Day decorations.

Do your program descriptions, description of services, intake forms, and consent forms contain industry-specific jargon or euphemisms that could confuse secondary English-speakers? Aside from promotional materials, essential documents regarding the business component of receiving services should be written and verbally explained in clear, simple language (CLAS Standard 8). Be aware that both you and your staff may be so familiar with health and human services industry-specific language that you may not recognize words or phrases that confuse others. “Suspension of services,” “referral,” “intake,” “revoke,” “HIPAA” are just a few examples of words and phrases that seem obvious to those in this industry, but may confuse not only stakeholders, but interpreters from outside health and human services. They also can confuse native English-speakers at lower literacy levels.

Invite leaders of neighboring cultural centers to review your agency’s marketing and intake paperwork for problems or oversights that you may have missed. Get their feedback about usability and understandability (National Standards for Culturally and Linguistically Appropriate Services in Health and Health CLAS Standard 8, 13).

Your agency can establish relationships with area cultural resources by attending their community events and inviting their leadership to your events. Research their events calendar to educate you and your staff about non-dominant holidays and observances, then show up to them. Attend their cookouts, parades, parties, and fundraisers wearing your agency name tag. Ask to leave your agency’s promotional materials in their lobby and invite them to leave their marketing material in yours. Your program can establish a sense of rapport with new clients if they encounter familiar community images on their first trip to your location.

Promote community cultural events on your agency’s social media. Post pictures of your staff at cultural events on your Facebook and Instagram accounts. Retweet relevant announcements (in multiple languages) from community resource groups on your agency’s Twitter feed. Incorporate existing cultural activities from established community resources into your agency’s online and brick and mortar environment. Situate your agency within the cultural activities in your local community.

Ask your stakeholders. Ask clients what they think you are doing right and what is missing. Anonymous suggestion boxes are good for this as well, but be sure to ask probing, meaningful questions that lead to usable answers. An example of a question that is too broad to produce a thoughtful answer is, “ABCservices.org does a good job respecting cultural diversity. Check ‘yes’ if you agree.” The following example may generate more meaningful feedback:
• List three holidays, observances, or celebrations you would like to see ABCservices.org participate in.
• Describe an instance when you felt marginalized at ABCservices.org. Describe how you think that instance should have been handled.
• Describe the last ABCservices.org event you declined to attend, and explain why you chose not to go to the event.

Demographics change over time so, your program must be flexible and responsive to changing needs (National Standards for Culturally and Linguistically Appropriate Services in Health and Health CLAS Standard 11). Your agency’s awareness of these changes relies on continuous outreach to your stakeholders and community resource leaders. Review your cultural competence plan often and be prepared to update it often.

**Communication**

Building a process to communicate effectively with individuals who may need interpretation or translation services is the key to building a solid clientele. Preparing your organization to serve a culturally diverse community prepares the staff of provider organizations to serve linguistically diverse population members.

First, determine the demographics of the populations served. Your organization will be better positioned to develop a communication plan. Keep in mind that communication itself can consist of face-to-face, the promotional literature provided to the community, and clinical documents. The best plan will embrace a variety of resources that can assist you with a multicultural population. Several ideas to consider as resources include:

*Local Interpretation/Translation Services*

There are many local, established businesses that offer these services. Using interpretation and translation service companies may be more realistic for providers who are not able to keep a full-time interpreter on their payroll. Below are a few examples of translation and interpretation companies. This is not an endorsement. Providers are encouraged to seek additional companies to compare services.

- Choice Translating, a local, provides both interpretation and translation, services: [http://choicetranslating.com/](http://choicetranslating.com/)
- Fluent Language Solutions, local, provides both interpretation and translation services: [http://www.fluentls.com/](http://www.fluentls.com/)
- Niki’s International Ltd. provides document translation only: [http://nilservices.com/](http://nilservices.com/)
Natural Supports

Natural supports can assist in communicating and explaining general information about your organization and the services you provide including access to an interpreter.

Providers

Establishing a relationship with other providers and colleagues can be valuable in collaborating and connecting to resources in the community. Sharing resources, including interpreters and translators can also be a valuable resource.

Strategies to include when working with linguistically diverse members:

- Do not make assumptions about a person’s language proficiency. There is a great variation in English proficiency.
- Always seek clarification for statements that seem irrelevant or unclear.
- Be sensitive about the effects of cultural differences on communication patterns, meaning of words and concepts. A message may fall apart when the idea is transferred from one person to another.
- Do not overemphasize the language barrier. Hand gestures can help relay concepts.
- Speaking in a loud tone or slowing your speech will not help your client understand, but may result in a negative effect.
- Avoid using jargon, slang or idioms in your speech that may not translate well; do not assume you are being understood just because your listener nods in agreement or does not question you.

Communicating effectively with linguistically diverse clients is essential as it affects the quality of the service and underlies the relationship, which can determine success. As providers develop a communication strategy, they should keep in mind this is not an area for shortcuts.

Mecklenburg Cultural Competence Provider Council Strategies for Implementation

1. Develop an understanding of the cultural groups and populations within Mecklenburg County.
2. Develop and provide education on best practice protocols, ethical codes, current events and treatment modalities for Mecklenburg County’s diverse populations in the form of live trainings, forums, and other educational modalities.
3. Receive education on the interpretation and translation needs of members and their family members.
4. Develop and provide training on best practice protocols for the use of translation and interpretation services.
5. Develop additional strategies to support the implementation of cultural competence for agencies and licensed independent practitioners within the network.
Mecklenburg Cultural Competence Provider Council

Adria Massey  LifeSpan, Inc.
Ashley Jacobs, Chair  Therapeutic Services Group, Inc.
Beth James  InReach
Christina James  Family First Community Services, LLC
Dammeon Chisholm  Total Care & Concern
Denise Derkowski  Community Alternatives NC
Eduardo Villavicencio,  InnerVision, Inc.
Eve Coker  New Hope Carolinas
Hugh Grant  Family Innovations
Melani Campos,  Maxim Health
Micah Cockerham  Total Care & Concern, Inc.
Michelle LaPierre,  LifeSpan, Inc.
Rosanny Crumpton, Co-Chair  DDR, Inc.
Susan Bruton  Maxim Health
Timothy McCoy  The Right Choice MWM, Inc.
Trenita Crouch  ProCure Therapeutic Agency
Victor Armstrong  Carolinas Healthcare System
Chapter 4: Orange, Chatham, and Person County Cultural Competency Provider Plan

Introduction
This best practice guide is meant to assist organizations in developing a cultural and linguistic competency plan. The plan aligns with the Cardinal Innovations Healthcare Cultural Competence Monitoring Tool and references the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care, CLAS Standards (https://www.thinkculturalhealth.hhs.gov/content/clas.asp) as the framework and the foundation. The discussion of cultural competence should be done with an understanding that it is a continuum. Your organization should work continuously and consistently toward cultural competence by updating the plan so that it addresses the diverse cultures and populations your organization serves.

Providing culturally competent care is not only good practice, it is a smart business move and marketing strategy. By addressing the specific needs of the community you serve, you can appeal to many individuals and provide the care they need. These types of practices may help increase the potential number of members your organization serves and increase your patient retention rate.

Understanding the members that live in the area your organization serves is important. Orange, Person and Chatham counties are unique counties in North Carolina. Provided below are population statistics for the three counties. This data can help assist you when developing policies, procedures and plans, as well as meeting the needs of the community through programs and services offered.

Orange County:
- **Current population**: 133,801
- **Projected Population in 2020**: 154,000
- Orange County’s population has grown by 13 percent since 2000.
- **Median Age**: 33
- **Population Structure**: 52.2 percent female
- **Population Distribution**: 57 percent urban 43 percent rural
- **Demographics**: 76.8 percent Caucasian; 12.2 percent African American; 8.4 percent Hispanic or Latino; and 7.7 percent Asian

The percent of African-Americans in Orange County is half that of the North Carolina average, the remaining demographics are roughly comparable to the percentages across the state.

Note: Unique to Orange County is the number and diversity of immigrants and refugees. The largest number of immigrants includes Latinos from various countries, refugees from Burma,
and members of the Chinese, Asian-Indian, and Korean communities. Recent immigrants and refugees in Orange County face special challenges in accessing healthcare due to barriers in language, health insurance, cost of care, and need for healthcare orientation and education. The Burmese face challenges of Post-Traumatic Stress Disorder (PTSD) and stress-related issues due to the adjustment to a new culture. The largest minorities differ in the three main municipalities. Hillsborough’s largest minority group is African-American. Carrboro has a larger Hispanic or Latino population. Chapel Hill has the largest Asian-American population.

Person County:
- **Current Population:** 39,464
- **Median Age:** 41.4
  (This is four years older than the North Carolina population as a whole. The U.S. Census predicts the overall population in Person County is going to grow by 10 percent between 2010 and 2030, with the population of individuals age 65 and older increasing by 62 percent.)
- **Population Structure:** 52 percent female
- **Demographics:** 69.9 percent Caucasian; 27.3 percent African-American; 4.2 percent Hispanic or Latino

Chatham County:
- **Current population:** 63,505
- **Median Age:** Chatham County has an aging population with about 15 percent of the population ages 45 to 54.
- **Population Structure:** 52 percent female
- **Population Distribution:** Chatham County is fairly rural
- **Demographics:** 82 percent Caucasian; 13 percent African-American, 12.8 percent Hispanic or Latino
  (Northeast Chatham County and Siler City have the highest density of residents identifying themselves as Hispanic or Latino.)

Additional resources on the residents of Orange, Person, and Chatham counties:

- 2014 Person County Community Health Assessment [http://publichealth.nc.gov/lhd/cha/docs/chareports/Person2014CHAFinal%28Feb32015%29.pdf](http://publichealth.nc.gov/lhd/cha/docs/chareports/Person2014CHAFinal%28Feb32015%29.pdf)
Reviewing the above population statistics and other reports available on each county, as well as partnering with community organizations can assist in acquiring an accurate depiction of your members and their needs. These resources can be used to develop targeted services for your community and also can be helpful in the development of your organization’s cultural competence plan.

A Cultural & Linguistic Competence Assessment of the OPC region was conducted in 2015 by Cardinal Innovations Healthcare. Some of the findings were as follows:

**Consumer Family Advocacy Council (CFAC) Focus Groups**
- Rural areas often struggle with access-related issues such as missed appointments due to lack of transportation
- Family members should be brought into treatment
• Provider organizations should explore how the understanding of culture is used during service delivery
• Cardinal Innovations and service providers should seek opportunities to better integrate an individual’s culture
• Providers should seek representatives from diverse communities to serve on their boards.

Provider Focus Groups
• Should be a better understanding of how to balance and respect the culture of the agency and the culture of the staff
• More opportunities for training and education about cultural and linguistic competence and how to incorporate into practice delivery
• Consider partnering with community organizations to better serve individuals in rural communities.

Provider Survey
• Encourage providers to have diverse members on committees and/or boards; use members as resources when appropriate
• Acknowledge that members’ and families’ responses to and understanding of MH/IDD/SUD is heavily influenced by their culture, including their religious and spiritual beliefs
• Recognize and consider folk beliefs and alternative methods for diagnosis and treatment of MH/IDD/SUD

Stakeholder Survey
• Members’ fear of discrimination was a major barrier to accessing MH/IDD/SUD services
• Increased need for education and support for members and their families
• Awareness, acknowledgment, and knowledge of alternative approaches to treatment
• Encourage collaboration and close communication around the development of natural supports and treatment outcomes between stakeholders and providers.

Infrastructure
Infrastructure refers to the policy framework and formal documents that an organization creates to embody its commitment to provide effective, equitable and respectful services, and its plan of action to ensure that this commitment is brought to fruition within the organization. The two central components that are part of this infrastructure are the mission/vision statement for the organization and its cultural competency plan. This section provides guidance on creating or refining these documents to reflect the current National Standards for culturally and Linguistically Appropriate Services in Health and Health Care, CLAS Standards.
Mission and/or Vision Statement
Most organizations already have a written mission and/or vision statement. The organization’s leadership team (and board of directors) is encouraged to review the mission and/or vision statement to ensure that it reflects the commitment to providing culturally competent care. When undertaking this review, consider the following:

- Ensure the language is inclusive and reflects the diverse stakeholders served by the organization (members, staff, community partners, etc.)
- Seek examples from other organizations. The CLAS standards provide several examples including this one from the American Public Health Association, whose mission is to “Improve the health of the public and achieve equity in health status”
- Ask for input from community partners to ensure the mission/vision feels inclusive and resonates with the populations served before finalizing the statement
- Once it is finalized, include the mission/vision statement in written materials produced by the organization (annual reports, brochures, etc.)
- Review the mission statement and discuss how the organization embodies the mission in staff trainings, meetings and new staff orientations
- Share the mission statement with outside stakeholders and community partners, perhaps in the form of a new brochure or as part of the organization’s website

Cultural Competency Plan
An organization’s cultural competency plan is a document that describes the ways in which the cultural and linguistic components of the mission statement are brought to life. The purpose of the plan is to ensure that the CLAS standards are incorporated at every level of the organization, the necessary resources are available, and accountability is clearly defined to ensure it is implemented. A sample cultural competency plan can be found at the end of the documents. If you have an existing plan, then:

- Review it annually and update it as needed. Document the date of each review.
- Have the plan approved by your board or other governing body
- Conduct an organizational self-assessment formally or informally
- Ensure that the plan demonstrates your organization’s recognition of the diversity of not only the members served but also staff members, members’ families, community partners, etc.
- Include descriptions of how your organization embraces diversity while promoting a respectful environment
- Describe training activities and initiatives related to cultural competency
- Establish guidelines for how your organization documents implementation of the plan (satisfaction surveys, interviews with members and/or other stakeholders, notes or treatment
Section 3: Cardinal Innovations Cultural Competency Regional Plans

plans discussing how cultural issues were addressed, outlines from completed trainings, committee minutes from meetings that demonstrate focus on these issues, etc.)

• Incorporate National CLAS Standards into plan development, goals, and implementation

POLICIES, PROCEDURES & PRACTICES

Reviewing your organization’s manuals, policies, procedures and practices is a good place to start creating a culturally competent organization. The organization as a whole should be working together to create an environment of cultural respect.

There are several steps you can take to start moving your organization toward cultural competence. These include:

• Ensuring your organization has written policies addressing several key cultural competence issues
• Setting goals to eliminate barriers and non-tolerance for any form of discrimination and harassment
• Having processes in place for disciplinary or corrective actions if policies are violated

Community partners may have policies addressing these areas already written that they would be willing to share. Your organization may have to make minor changes to policies by adding keywords or phrases.

This should not be a one-person job. A group of individuals are encouraged to come together to offer their perspectives. It is important to include staff from all areas of your organization as well as board members because these individuals will have different perspectives. This can form a sense of community and inclusiveness and will likely lead to better engagement and implementation of the changes. Also, consider the demographics of your community when developing policies, procedures, cultural competence plans and addressing the needs of the community through programs and services offered.

Review Written Policies

Begin the process by reviewing the written policies that are already in place to see if the specific areas listed below are addressed as they relate to staff. Diversity-based analysis should be a common thread woven from beginning to end throughout the entire policy process and should NOT be seen as an add-on section. Some policies may at first glance appear not to have diversity implications; however, it is good practice to keep diversity in mind throughout the review and development of your policies and procedures

**Multiculturalism:** The coexistence of diverse cultures, where culture includes racial, religious or cultural groups.

**Key words to consider:** multicultural, diverse, diverse community, inclusive, culturally diverse

**Examples of policies:**
- (Name of Organization) strives to ensure that the healthcare needs of our culturally and linguistically diverse MH/IDD/SUD communities are addressed in the delivery of our services.
- (Name of Organization) values the cultural and linguistic diversity of the MH/IDD/SUD communities we serve and strives to provide the best care and meet the needs of individuals from these diverse backgrounds.
- (Name of Organization) embraces cultural and linguistic diversity in its staffing and among its board members and will represent the community’s diverse cultural backgrounds through staffing and board nominations/selections.

**Anti-discrimination:** the policy or practice of opposing unjust or prejudicial treatment of others and promoting tolerance.

**Key words to consider:** anti-racism, anti-discrimination, integration

**Examples of policies:**
- (Name of Organization) prohibits discrimination or harassment of their members, staff and board members.
- (Name of Organization) protects their rights to be free from hate-activity based on age, ancestry, citizenship, creed, race, disability, ethnic origin, family status, gender identity, level of literacy, marital status, place of origin, sexual orientation or any other personal characteristics by or within the organization.

**Anti-stigma:** promote acceptance and actively challenge social stereotypes (i.e. related to mental illness, sexual orientation, gender).

**Key words you could use:** anti-stigma, acceptance

**Examples of policies:**
- (Name of Organization) endorses a society that is free from stigma and discrimination. The organization is an “equal opportunity employer and service provider.” The organization will not discriminate and will take action to ensure against discrimination in employment and service delivery. This includes: recruitment, compensation, termination, promotion and other
conditions of employment against any employee or job applicant or offering services to individuals on the basis of age, race, creed, color, national origin, disability, medical conditions (mental or physical), gender, gender identity, genetic information, sex, sexual orientation, or veteran status.

Develop goals for eliminating barriers and non-tolerance
First, review the information that your organization has. Your organization’s policy manual and/or strategic plan can be reviewed to see if there are goals for eliminating barriers, non-tolerance, discrimination, and harassment. This is an opportunity to make changes if necessary.

If your organization does not have goals in place focused on improving access and eliminating barriers, now is the time to develop them. To do this, think about goals that can be developed to address the topics above.

An example is:
“The foundation of our organization’s diversity policies rests on zero tolerance for discrimination, harassment and retaliation and requires a commitment to goals that must be clearly communicated to our employees and potential employees. These goals include:

- Educating managers, supervisors, employees and board members by providing training on the diversity of the communities served by the organization and the importance of valuing and managing diversity
- Recruiting a diverse workforce by developing and using targeted recruitment plans to expand the pool of qualified applicants and diverse employees
- Retaining a workforce that reflects diversity, monitoring employee development and promotion practices to ensure equal access to opportunities by all employees
- Reaching out to and partnering with organizations in the community that work with the culturally and linguistically diverse MH/IDD/SUD populations present in the service area

Develop procedures for disciplinary or corrective actions for policy violations
What will happen if the policies are violated? Do you already have procedures in place? If not, simply add these topics into the general statement and follow the procedures accordingly. If you don’t have procedures in place to deal with disciplinary or corrective actions if the policies are violated, now is the time to develop them. Make sure there is a CLEAR system in place that individuals can follow if anyone has been subjected to discrimination or harassment. It is important to clarify that your organization is a safe space and that individuals will not be penalized for voicing their concerns or reporting problems.
Examples of procedures:

- Reporting an issue: Clearly identify the process for employees, members or board members to report concerns if they feel they have experienced discrimination or harassment OR if they have witnessed discrimination or harassment?
- Management response to report: Clearly define the action management will take once a report is received. Will the supervisor interview each party? Will they be able to determine corrective action/disciplinary action? What is the corrective or disciplinary action (are there varying degrees of offense severity – spell those out)? If this is a larger issue, to whom should they send the report?
- Notifying Appropriate Executives: Should this be a larger issue than a manager feels they can handle, what is the process to move this higher? To whom should the report be sent? Is further investigation necessary?
- Maintaining confidentiality, keeping records and monitoring compliance: Clearly define the process for ensuring the confidentiality of discrimination or harassment reports. How will records be kept? How will you follow up to ensure compliance to corrective/disciplinary action AND to ensure the work environment continues to be a safe space?

Communication of Policies, Procedures and Practices

Once policies and procedures have been updated, be sure to communicate them to staff, stakeholders, partners and others to make them aware of the changes. This can be done during staff meetings. Acquiring signatures can serve as a record of this communication and can be kept in personnel files. Policies and procedures also can be placed in a location that is easily accessible to staff should they have questions.

PERSONNEL PRACTICES

Personnel practices are a vital part of an organization’s operating structure. One strategy for organizations to promote a culturally diverse environment is through job postings and recruitment. This may include connecting with culturally diverse organizations within the community to assist with job recruitment and job postings.

When reviewing the job posting and recruitment strategies ensure that culturally diverse media is used. Examples may include:

- Diverse community newspapers, websites, and radio stations
- National websites such as www.diversityinc.com
- Job fairs in diverse communities
- Networks linked to staff members or professional organizations
- Community leaders from key organizations or institutions (i.e. universities, colleges, faith-based organizations)
When selecting a potential applicant to begin the interview process, it is appropriate to ask the candidate if they need any specific arrangements such as physical access, interpreters, etc. prior to the schedule interview. Some examples to demonstrate cultural competency during the interview process may include:

- Ask consistent, fair and relevant questions or engage in a dialog that would allow candidate to express what they can offer the organization
- Be mindful of requirement and avoid stereotype or discriminatory language
- Include a diverse group of employee as part of the hiring decision if possible
- Ask direct questions about the potential employee’s needs so that you will be able to effectively communicate with them once they arrive

**SKILLS AND TRAINING**

Ensure that your organization has the skills and expertise necessary to implement its cultural competency plan effectively. The skills and training provided should:

- Include education and training for people at every level of your organization, including your board of directors, senior leadership, administrators, clinical staff, front-line staff, trainees, and volunteers. This helps ensure that every contact a member has within your organization will reflect your commitment to effective, respectful and equitable care.
- Be offered on an ongoing basis in different ways to address different learning styles.
- Indicate that cultural competency is an organizational priority in terms of both time and money.
- Cover topics specifically relevant to the populations served by your organization, including issues like health literacy and cultural health beliefs held by local groups.
- Be documented with training session records maintained in personnel files to reflect completed trainings by both staff members and volunteers.
- Gather evidence of the effectiveness of the trainings, through the use of pre- and post-tests or other means.
- Incorporate training into your Quality Improvement (QI) process, focusing on aspects of cultural competency that your QI measures indicate may be weak. For example, in member satisfaction surveys consider including questions with a range of responses like the ones listed below. Then analyze the data along with your member demographic data to determine if your organization should focus efforts on meeting the needs of segments of your member population.

<table>
<thead>
<tr>
<th>The people who work here are helpful.</th>
</tr>
</thead>
<tbody>
<tr>
<td>I feel safe here.</td>
</tr>
<tr>
<td>The people who work here are polite.</td>
</tr>
<tr>
<td>The people who work here understand my needs.</td>
</tr>
</tbody>
</table>
The people who work here treat me with respect.
The people who work here are easy to talk to.
The people who work here respect my cultural beliefs.

- Including main cultural competency initiatives (mission, cultural competency plan, relevant policies, etc.) in new staff orientations. Make sure copies of relevant documents are in your orientation manual and that you have written evidence that you have covered these topics with specific handouts, checklists or slides.

Your organization does not have to create all of the trainings you offer. In addition to a vast array of online training and written materials offered through national organizations (i.e. CDC, DHHS, etc.), in the OPC area there is a wealth of resources. Many local organizations offer training and/or speakers who will come to meetings. Some examples (not an exhaustive list) include:

- NC Office of Minority Health and Health Disparities [http://www.ncminorityhealth.org/services/culturaldiversity.htm](http://www.ncminorityhealth.org/services/culturaldiversity.htm)
- NC AHEC ([https://www.med.unc.edu/ahec/community/spanish.htm](https://www.med.unc.edu/ahec/community/spanish.htm))
- LGBTQ Center at UNC ([https://lgbtq.unc.edu/programs-services/request-presentation](https://lgbtq.unc.edu/programs-services/request-presentation))
- NC Program on Health Literacy ([http://nchealthliteracy.org/services.html](http://nchealthliteracy.org/services.html))

**ORGANIZATIONAL COMPOSITION AND CLIMATE**

Organizational composition and climate as it relates to culturally competent organizations refers to establishing a work environment of diverse staff, creating an inviting and welcoming environment for members, and developing informal relationships in the community. Interfacing with diverse populations internally and externally makes an organization culturally rich, by building coalitions to identify and create solutions. Participating in committees within the communities provides an organization with opportunities to become acquainted with the cultural needs of its community. Here are suggestions on where to begin:

- Review the organizational structure and composition; seek opportunities to increase diversity, which may include reviewing the makeup of the organization as well as boards and committees
- Encourage staff members to participate on community boards/committees
- Encourage formal and informal relationships to develop a holistic approach to treatment (i.e. religious groups, music/art therapy, acupuncture, reiki, or other alternative therapy)
• Sponsor or participate in health fairs, community college fair and cultural festivals

Creating a welcoming and inviting environment can make a difference in the relationship established between a provider and a member. Suggestions for promoting a warm space are:

• Diverse magazines, brochures, and other materials
• Pictures, images or decorations
• Toys and play accessories that are culturally diverse
• Bulletins or informational boards that display information that represents different interests and cultures
• Celebrations of holidays or events
• Diverse food at events or in residential programs
• Be mindful of scents or smells and use a neutral scent
• Be sensitive and appropriate toward others especially when in a shared room (i.e. food that may not be prepared according to your custom or different texture or scent
• Identify restrooms that are not gender specific
• Create a sacred or quiet environment that promotes a place for others to meditate, pray or use for lactation daily

PROGRAMS AND SERVICES

Developing a broad array of formal and informal partnerships and collaborations with other local organizations that represent the diversity of your area is an important part of ensuring that you are providing culturally competent services. Most organizations have a variety of relationships with other groups so the focus may be on documenting relationships, analyzing gaps in the network of relationships, and seeking out new relationships. Key elements to consider include:

• Documenting relationships either through agreements, Memorandum of Agreements MOAs, meeting minutes, or other evidence
• Initiating new relationships, and documenting those efforts. This may include meetings that staff members attend, outreach efforts, etc.
• Gathering data internally regarding the populations that you serve, and analyzing this data to determine gaps. These may include services or programs that your members need that you are not providing (such as services in other languages, gender-specific services, or programs focused on the whole family), barriers to services for your member population (such as transportation), or populations in your service area that you are not currently reaching.
• Including information about program or service gaps in your QI process (such as asking about any barriers to care and/or unmet service needs), and documenting your efforts to address the gaps.
In the OPC area, many organizations that represent specific population groups or that strive to meet community needs. Networking with these groups, inviting them to present at your staff meetings, or initiating other communication can be a great way to expand your community partnerships. Some ideas of groups to contact are listed below. This list is by no means exhaustive. It merely offers an overview of the diversity of organizations in the OPC area.

- Communities in Schools of Chatham County ([http://cischatham.org/who-we-are/about-cis-chatham/](http://cischatham.org/who-we-are/about-cis-chatham/))
- Compass Center ([http://compassctr.org/](http://compassctr.org/))
- Early Intervention and Family Services of Person County ([http://eifs.person.k12.nc.us/cms/One.aspx](http://eifs.person.k12.nc.us/cms/One.aspx))
- KidSCope ([http://chtop.org/Programs/KidSCope.html](http://chtop.org/Programs/KidSCope.html))
- LGBTQ Center at UNC ([https://lgbtq.unc.edu/](https://lgbtq.unc.edu/))
- NAACP ([https://chapelhillcarboronaacp.wordpress.com/](https://chapelhillcarboronaacp.wordpress.com/))
- NAMI Orange County ([https://www.nami.org/Local-NAMI/Programs?state=NC](https://www.nami.org/Local-NAMI/Programs?state=NC))
- North Carolina Program on Health Literacy at UNC ([http://nchealthliteracy.org/index.html](http://nchealthliteracy.org/index.html))
- Orange County Skills Development Center ([http://www.orangecountync.gov/skills_development_center/index.php](http://www.orangecountync.gov/skills_development_center/index.php))
- Person County ESL services ([http://www.person.k12.nc.us/departments/e_s_l_english_as_a_second_language](http://www.person.k12.nc.us/departments/e_s_l_english_as_a_second_language))
- SHAC (Student Health Action Coalition) clinic at UNC ([https://www.med.unc.edu/shac](https://www.med.unc.edu/shac))
- Smart Start and Partnerships of Young Children (in Orange, Chatham and Person) ([http://www.smartstart.org/smart-start-in-your-community/#prettyPhoto](http://www.smartstart.org/smart-start-in-your-community/#prettyPhoto))
- Spanish and Mandarin bilingual programs in the CH schools ([http://www.chccs.k12.nc.us/academics/academic-programs/dual-language](http://www.chccs.k12.nc.us/academics/academic-programs/dual-language))

**COMMUNICATION**

Organizations that are working with diverse members should have processes to adequately communicate with members who need interpretation/translation services. This includes, but is not limited to, having community resource lists, collaborative relationships with agencies, communication
that strengthens members’ health literacy and options for access to interpretative services for staff and individuals (either via phone or actual interpreter).

Language assistance services are mechanisms used to facilitate communication with individuals who do not speak English, those who have limited English proficiency and those who are deaf or hard of hearing (National CLAS Standards). These can include bilingual staff, remote interpreting services, in-person interpreters, and the translation of written materials or signage, sign language or braille materials. Remember, individuals may have communication needs that are unrelated to a language barrier. Examples include: individuals who are deaf or hard of hearing, disabled, visually impaired or individuals with low health literacy.

Knowing facts and demographics about the communities where you operate can assist in developing these materials and determining which groups to develop relationships with to assist members best. Here are some basic facts to keep in mind about our region when developing the communication piece of your cultural competence plan.

**Common Non-English Languages Spoken**

**Orange County:**
Burmese, Karen and Spanish

**Person County:**
Spanish

**Chatham County:**
Spanish

*Interpretation versus Translation*

Interpreters and translators do similar tasks related to language. An interpreter takes spoken word from one language and converts it to another language. A translator takes written materials from one language and converts them to another language. ([http://www.bls.gov/ooh/media-and-communication/interpreters-and-translators.htm#tab-2](http://www.bls.gov/ooh/media-and-communication/interpreters-and-translators.htm#tab-2))

*Developing a communication process for Limited English Proficiency members*

An organization interested in providing interpretation and translation services will need to plan, including having a plan to support these services financially. This plan should include:

*Interpretation*

- Determine the amount of funding available to budget toward services
- Identify the patient population and understanding their needs (language barrier, deaf/hard of hearing, disabled, low literacy/health literacy)
• Ask about language preferences or special needs. Document these findings in patient charts so the patient’s needs and preferences are clear to staff and healthcare professionals
• Identify resources available such as staff skills – bilingual, sign language, etc.
• Identify community resources
• Provide interpreters: Will you use in-person services? Who is available and when? Are they certified? What criteria are you seeking for interpreters? Will you use remote services? Which companies provide these services? What expectations do you have for these companies?

Translation
• Provide easy to understand print, multimedia and signage in languages common in your community (including Braille for individuals who are blind)
• Ensure that all materials essential to members’ access to your organization are translated. This includes administrative and legal documents, clinical information, health education and community outreach information.

Competence of individuals providing language assistance
• The use of untrained individuals and minors should be avoided
• The National CLAS Standards Standard #7 provides a list of skills and qualifications for interpreters and translators

Making members aware of the services available
• At various points in a member’s experience with your organization, the member should be made aware of/reminded of the availability of language assistance services and the specific type of services available.
• Signs and educational materials should be created in languages commonly used in the community and at a level individuals can easily understand. Staff should be made aware of these materials and to direct members to them. Signs should be placed in easily visible areas so that everyone sees them. Also, Braille should be used and staff should make individuals aware of the availability of these services.

Resources in the Orange, Chatham, Person counties to assist your organization:
• NC DHHS Refugee Services: http://www.ncdhhs.gov/assistance/refugee-services
• The Refugee Support Center: http://refugeesupportcenter.org/
• El Pueblo: http://elpueblo.org/eng
• EL Centro: http://www.elcentronc.org/health.html
• NC Karen Community: http://nckarencommunity.org/home
• Center for Latino Health: http://www.med.unc.edu/pediatrics/specialties/generalpeds/the-center-for-latino-health-celah
• Latino Health Coalition (led by Orange County Health Department)
• Refugee Health Coalition (led by Orange County Health Department)
• The North Carolina Refugee Assistance Program: http://qa.dhhs.state.nc.us/dss/refugee/index.htm
• NC Farmworker Health Program: http://www.ncfhp.org/home.aspx
• National CLAS Standards: https://www.thinkculturalhealth.hhs.gov/content/clas.asp
• North Carolina Interpreter & Transliterator Licensing Board www.ncitlb.org (Deaf & Hard of Hearing)

Examples of Health Education materials:
• http://www.orangecountync.gov/departments/health/immigrant_refugee_health.php (Under Health Education Resources)

Onsite Review of Communications
Ensure all staff is aware of the language assistance services your organization offers to members. Materials and signage should be developed in languages commonly used in your community and should be displayed so that they are visible and easily accessible. Finally, remind staff that a language assistance service does not only include interpretation and translation services but also services for individuals who are blind or hard of hearing.

Orange, Person, Chatham Cultural Competence Provider Council Strategies for Implementation
1. Understand the region’s diverse population, implement, and provide trainings on best practice protocols and treatment modalities for OPC’s diverse populations.
2. Develop and consolidate OPC area resources making them available via Cardinal Innovations website.
3. Education and training of the MH/IDD/SUD needs of the immigrant and refugee population
4. Create TIP sheets on transportation access, health literacy, interpretation, and translation.
### Orange, Person, Chatham Cultural Competence Provider Council

<table>
<thead>
<tr>
<th>Name</th>
<th>Organization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amanda Everett, Co-Chair</td>
<td>Person Industries, Inc.</td>
</tr>
<tr>
<td>Edward Binanay, Chair</td>
<td>UNC Center for Excellence in Community Mental Health</td>
</tr>
<tr>
<td>Kim Andringa</td>
<td>UNC Horizons</td>
</tr>
<tr>
<td>Marika Whack</td>
<td>Community Alternatives</td>
</tr>
<tr>
<td>Melanie Thomas</td>
<td>Freedom House</td>
</tr>
<tr>
<td>Shannon Gallagher</td>
<td>UNC School of Nursing</td>
</tr>
<tr>
<td>Jennifer Munch</td>
<td>Cardinal Innovations Healthcare-OPC</td>
</tr>
<tr>
<td>Elliot Clark</td>
<td>Cardinal Innovations Healthcare – OPC</td>
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</table>
Chapter 5: Piedmont Cultural Competency Provider Plan

Introduction
Cultural and linguistic competence is a vital necessity for service provision. Cardinal Innovations, specifically the Southern Region, is dedicated to developing culturally competent environments that support and embrace cultural diversity and effectual growth in cross-cultural situations. The Southern Region consists of the following counties: Cabarrus, Davidson, Rowan, Stanly, and Union. According to Cardinal Innovations Healthcare 2015 Provider Capacity, Community Needs Assessment and Gaps Analysis,

| Medicaid Members Served in Southern Region | 17,162 |
| Medicaid Eligible                      | 127,702 |
| Penetration Rate                        | 13.4%  |

Members Served by Race and Ethnicity

<table>
<thead>
<tr>
<th>Geographic Area</th>
<th>American Indian/ Alaska Native</th>
<th>Asian/ Pacific Islander</th>
<th>Black/ African American</th>
<th>Multiracial</th>
<th>Other/ Unknown</th>
<th>White</th>
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<td>26</td>
<td>663</td>
<td>32</td>
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<td>8</td>
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<td>12</td>
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<td>3,305</td>
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<tr>
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<td>1,172</td>
<td>29</td>
<td>374</td>
<td>3,192</td>
<td>4,810</td>
<td>155</td>
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</tbody>
</table>

The Piedmont Cultural Competence Provider Committee encompasses members from contracted provider agencies or LIP/Clinicians from the mental health, intellectual and developmental disabilities and substance use disorder communities.

Infrastructure
A culturally competent environment is measured by the degree to which organizations engage in observable actions and attitudes reflective of cultural responsiveness and sensitivity. Organizations engaging in ongoing self-analysis can identify any biases. They can view life through the lens of others while increasing sensitivity to the values and life challenges of other groups. Participating in training...
opportunities encourages opportunities to engage in cultural activities and interactions that produce sensitivity and awareness.

Organizations are encouraged to take responsibility for developing culturally responsive services. Cultural competence is only as effective as the commitment and the support that it receives throughout an organization. Diversity can be exhibited through administrative practices, policies, staffing, programming, and community involvement. The development of cultural competency begins with the executive and senior leadership. It should be viewed as an asset. Executive and senior leadership is encouraged to commit to providing resources that will impact organizational change. Resources can include human capital as well as time and effort in the development, revision and implementation of policies and procedures that pertain to providing culturally competent care.

Treatment Improvement Protocols (TIP) 59 for Improving Cultural Competence (SAMHSA) offers these suggestions for organizations to adopt to fully develop and integrate cultural competence:

1. Develop, review and update vision, mission, and value statements. This is important for creating a conceptual framework that promotes an atmosphere of culturally responsive treatment. This would include defining the overall culture of the organization as well as the culture of the surrounding community. The community can support the achievement of the mission and vision statement.

   • Address cultural competence as part of the strategic planning process. Strategic planning offers an opportunity to assess the current needs of the community.
   • Assign senior leadership to oversee the development of culturally responsive practices and services. Senior leadership with the authority to implement change should oversee the development process of planning, evaluating, and implementation of culturally responsive administrative and clinical services.
   • Develop governing and advisory boards that are diverse. Senior leadership on governing and advisory boards and committees are educated about and invested in the organization’s mission and plan. Representations should include clients, family members, and community-based organizations, and institutions.
   • Establish a cultural competence committee that represents racial, ethnic, and organizational diversity.
   • Engage clients, staff, and the community in the planning, development, and implementation of culturally responsive services.
   • Develop a cultural competence plan. The plan should have a narrative introduction that covers community demographics and history, organizational self-assessment and other evaluation tools, the rationale for providing culturally responsive services, and the organization’s strengths and need for improvement in providing culturally competent care, strategies for recruiting, hiring, retaining, and promoting qualified diverse staff, resources and policies to support
language services, approaches to amending facility design and operations to present a culturally congruent atmosphere, and fiscal planning. The plan should also include the core competency areas that Cardinal Innovation endorses.

- Develop and review policies and procedures to ensure culturally responsive organizational practices.
- Create a demographic profile of the community clientele, staff, and board/advisory council
- Conduct organizational self-assessment of cultural competence
- Create a training curricula that addresses cultural competent training topics
- Provide culturally congruent clinical supervision. Agencies should endorse and implement culturally responsive services in their policy and procedures, reflecting the commitment in job descriptions and staff evaluations across all levels of the organization.
- Develop outreach strategies that improve access to care. The following are some examples: referring clients to community resources, collaborating with other community services, creating a one-stop facility, eliciting support from the community and employing outreach workers, and support services such as transportation and child care.

POLICIES, PROCEDURES and PRACTICES
Policies and procedures are written standards that form a foundation for ensuring that expectations and accountability are clear throughout the organization. They are rules of governance. Written policies should integrate cultural competency standards expressing zero tolerance for discrimination and harassment. Cultural competency policies should not be developed in a vacuum of top management. The involvement of many levels of an organization is ideal. Corrective action should be clearly stated and implemented when standards are breached.

Policies should be clear and concise regarding non-discrimination based on race, color, national origin, religion, age, disability, gender, sexual orientation, veteran status, marital status, genetic information or any other factors protected by federal, state or local law. Organizations should share policies, procedures and practices with staff, stakeholders, and board members. Staff should be able to articulate the organization’s commitment to cultural competency, understand its meaning and be aware that policies and procedures are reviewed continually to meet current standards and trends. Policies should be evaluated at least annually to ensure that they are relevant and that accountability practices are in place.

PERSONNEL PRACTICES
Successfully integrating cultural competency into personnel practices is vital to ensuring that staff understands its importance and values diversity. To ensure that the organizational composition represents the community, it is critical that organizations are aware of the community in which they provide services. Community and organizational demographics are important in the recruitment,
hiring, and training of staff. This helps the organization to be informed about the unique needs of the community served.

Once an assessment of the demographics of the community has been made, organizations should assess their staffing patterns to ensure that they are culturally diverse. Should gaps be present, organizations are encouraged to increase efforts to enhance diversity.

Identifying culturally diverse media and other organizations within the community can be beneficial throughout the recruitment process. Tapping into non-traditional recruitment methods such as posting at community centers, places of worship, community health fairs, and health departments may provide a talent pool that has been overlooked previously. Current staff also may be a good resource to find new potential employees. Outlets for seeking prospective hires also may include NC Works, social media boards such as LinkedIn, and community providers such as Goodwill, United Way and local colleges and universities.

Job descriptions should be reviewed carefully prior to recruitment to ensure that language is nondiscriminatory, promoting diversity throughout the organization. Ensure that policies regarding employment, performance evaluations and promotions reflect the value of cultural competency. Working well across cultures is an asset of an employee.

Assess the proficiency of existing staff and new hires regarding languages and communication skills. Organizations should use the services of interpreters, translators, and other alternative forms of communication when appropriate.

Orientation and on-going training should encompass cultural competency. Organizations are encouraged to collaborate with other organizations within their communities. Web-based training can be used along with written and web-based resources and articles. Use the talents and skills of staff to offer cultural competency training and education throughout the organization.

It is important to regularly assess the shifting demographics of a community and ensure that the organization is aware of the community demographics. Collecting and analyzing this data on a regular basis will ensure that the provider is accountable to cultural competency.

**SKILLS AND TRAINING**

An effective cultural competence training curriculum should include awareness (understanding of a member’s background, provider role, attitudes), knowledge (culturally relevant assessments, treatment plans, and skills (communicating effective across cultures and providing culturally responsive treatment) development. Training can occur in a variety of teaching methods including direct/live
instruction, role-playing, case studies, facilitated group discussions, and web-based instruction. Training for clinical staff is an essential component of the core education of any cultural competency plan to promote effective interactions with the members served.

Effective training programs allow participants to examine their personal cultural values and their interpersonal strengths and weaknesses. Participants are open to recognizing that differences in language, age, culture, socio-economic status, political and religious beliefs, sexual orientation and gender identity and life experiences add challenging dimensions to the dynamics of cross cultural interactions.

Suggested training topics can include the following:

- Factors that define cultural differences among racial/ethnic populations
- Psychosocial stress and trauma related to diverse members
- Effects of acculturation
- Class, ethnicity, social status and racism influence behavior, attitudes, and values
- Difference in symptom expressions within diverse communities
- Impact of psychosocial stressors
- Help seeking behaviors of diverse members
- Differences in the attribution of mental illness (religious, supernatural) and how it is integrated in treatment
- Dynamics of language use and conceptual frameworks
- Differences in the acceptability and effectiveness of various treatment modalities
- Use of natural community supports and other community resources
- Use of culturally informed individuals, including family members when appropriate
- Personal and cultural biases of staff and how they may affect benefits and service design
- Communicating and listening effectively across cultures
- Assessing members with an understanding of cultural differences in symptom expression
- Creating and implementing multidimensional services
- Demonstrating attitudes that indicate a willingness to work with culturally, ethnically, and racially diverse populations

Organizations should also ensure that orientations of staff include a review of the mission, vision, values, policies and procedures. Appreciation and recognition of differences are other principles to include in the orientation of newly hired staff.
ORGANIZATIONAL COMPOSITION AND CLIMATE
Components to consider when enhancing the composition and climate of an organization include creating a diverse workforce, establishing a welcoming environment and establishing informal relationships in the community. Diversity is an appreciation of differences. Many studies indicate that cultural diversity in work place settings promotes creative solutions to problems. An organization’s workforce should be a reflection of the community in which they serve. Organizations are encouraged to assess the community demographic while assessing the level of diversity with the company. Make efforts to have a reflection that is thoughtful and intentional.

Creating a welcoming environment starts before a member enters into the physical space of an organization. Do the organization’s advertisements reflect diversity? Does the organization make a concerted effort to work with all individuals who need the services that you offer? When entering the office or service location, is the reception received by members welcoming. Are language options available and visible for members? These are a few suggestions for creating a welcoming environment in your organization.

Effective and responsive culturally competent care engages the local community through the establishment of informal relationships. These relationships support members in the community. Establishing a supportive relationship offers the opportunity for collaborative relationships that support healing and wellness for members.

PROGRAMS AND SERVICES
Programs and services encompass several areas for provider organizations to consider in the development of cultural competence. Examples include: the establishment of nontraditional relationships in the community in addition to data collection and analysis; nontraditional religious and spiritual organizations that may be a supportive part of a member’s life; and cultural community organizations such as Greek organizations or civic and social groups. Consider the organizations in the community that members interact with daily.

Data collection occurs within most organizations. Consider stratifying data to recognize trends. These trends can validate the level of services offered. Data also can assist in making data-informed decisions that could enhance the services and ultimately the outcomes for members. Data review can occur at the intake, service delivery, and/or the discharge stages including grievances and complaints. Data from member satisfaction surveys also can be used to support data-informed decisions.

COMMUNICATION
The ability to communicate effectively is a core area of responsive and effective linguistic competence. There are many components of effective communication. Language translation and interpretation, in addition to communicating effectively with individuals who are deaf and hard of hearing and illiterate should be considered as part of competent communication.
Interpretation services should be accessible for a member and their family. It is the spoken language that is shared between the provider and the member. Providers are encouraged to develop a plan prior to an expressed need by a member. The plan should include what languages are accessible and the process by which they can be accessed. This plan should be communicated throughout the organization and established within the policy and procedures. Organizations should ensure that members and potential members are informed of the language assistance that is available and how to access it. This includes proper signage displaying the spoken languages and other language assistance that is available.

Critical and necessary documents should be translated to the language of the member. This includes the availability of Braille for members. Providers are encouraged to understand the language and interpretation expectations outlined in Title VI of the Civil Rights Act of 1964. The cultural competency plan should clearly outline the availability of access to spoken and written language assistance. All information shared with members should be considerate of literacy levels. This is an area often overlooked. If someone is not literate in their native language, they may not be literate when information is translated to that language. In addition, members who speak English as their first language may not read English well. Consider the grade level and the health literacy of all individuals that are served.

“Tip 59: Improving Cultural Competence,” published by SAMHSA in 2015 is a resource to further assess that your organization’s language and communication needs and ensure your plan meets the federal guidelines set forth in Title VI of the Civil Rights Act of 1964. Remember: good communications is associated with better member satisfaction, better adherence to treatment recommendations and improved health outcomes.

**Strategies for Implementation of the Piedmont Cultural Competency Plan**

1. Update the Piedmont Cultural Competence Resource Guide. The update resource guide will be available on the Cardinal Innovations website [www.cardinalinnovations.org](http://www.cardinalinnovations.org)
2. Develop and provide trainings and educational opportunities to the provider network on the implementation of cultural competence.
3. Create educational documents, such as TIPs, related to cultural competence for the provider network to support implementation.
# Piedmont Cultural Competence Provider Council

<table>
<thead>
<tr>
<th>Name</th>
<th>Organization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alisa Russell</td>
<td>Community Specialized Services, Inc.</td>
</tr>
<tr>
<td>Angie Banther</td>
<td>Path of Hope</td>
</tr>
<tr>
<td>Arlana Sims</td>
<td>Sim’s Counseling and Consulting, Inc.</td>
</tr>
<tr>
<td>Dee Pankey</td>
<td>GHA Autism Supports</td>
</tr>
<tr>
<td>Diana Duncan, Chair</td>
<td>Diana’s Home Care, Inc.</td>
</tr>
<tr>
<td>Susanna Dean</td>
<td>Adept Nonprofit Services, Inc.</td>
</tr>
<tr>
<td>Teresa McKeon</td>
<td>The Arc of Davidson</td>
</tr>
<tr>
<td>Jennifer Russell</td>
<td>Cardinal Innovations Healthcare</td>
</tr>
</tbody>
</table>
Section 4: Resources


A Treatment Improvement Protocol: Improving Cultural Competence, TIP 59, Substance Abuse and Mental Health Services Administration, 2015
http://store.samhsa.gov/product/SMA15-4849


Cardinal Innovations Healthcare
www.cardinalinnovations.org


Limited English Proficiency www.lep.gov

National Center for Cultural Competence at Georgetown University http://nccc.georgetown.edu/

Appendix A:
Sample Template for Cultural Competency Plan Developed by Cardinal Innovations
OPC Cultural Competence Provider Council

Name of Organization:              Date Effective/Date of Revision:
Date of Most Recent Review:       Date of Most Recent Board Review & Approval:

I. INTRODUCTION
   a. Community Demographics
   b. Organizational self-assessments
   c. Rationale and basis for providing culturally responsive services
   d. Overview of current priorities, goals and tasks

II. INFRASTRUCTURE
   a. Mission/Vision Statement
   b. Explicit statement of inclusionary practices/non-discrimination
   c. Procedure for reviewing and updating plan

III. POLICIES, PROCEDURES & PRACTICES
   a. Relevant policies that at a minimum address the following:
   b. Multiculturalism; Anti-Stigma; Anti-Racism; Ethnic Intimidation; Employment Equity;
      Service Equity; Access to Services
   c. Procedures for reviewing and updating policies as needed
   d. Goals for organizational improvement in one or more these areas and information
      about how the goals will be pursued and progress measured
   e. Oversight to ensure that policies are followed and actions that will be taken if
      policies or procedures are not followed

IV. PERSONNEL PRACTICES
   a. Statement of non-discrimination in hiring
   b. Methods of recruiting for available positions to attract a diverse applicant pool
   c. Strategies for building a work force that reflects the population served and the local
      community
   d. Demographics of current work force and goals for future hiring

V. SKILLS & TRAINING
   a. Training in cultural competence at all levels of the organization, topics covered in
      trainings (formal and informal) and frequency. Examples of recent trainings.
   b. Evidence of effectiveness of training
   c. Staff orientation
VI. **ORGANIZATIONAL COMPOSITION and CLIMATE**
   a. Demographics of members and staff members (including board members, trainees and volunteers) and how these compare to local population
   b. Analysis of physical environment: What do member see and experience when they are at your location? How is physical accessibility, public transportation, linguistic accessibility, child-friendliness, diversity of décor/art work and diversity of printed materials, etc.?  
   c. Organizational culture: Staff and Member satisfaction – How is this measured? What current reports related to this topic are there? Organizational celebrations and events, internal communications

VII. **PROGRAMS and SERVICES**
   a. Partnerships and collaborations in the community  
   b. Outreach activities, including nontraditional community partners  
   c. Data on populations served and analysis of gaps in services/underserved groups

VIII. **COMMUNICATION**
   • Strategies for addressing linguistic barriers (interpreters/translators)  
   • Health literacy - how it is measure and addressed within the organization

IX. **CULTURAL COMPETENCE GOALS FOR UPCOMING YEAR**
Appendix B:
Cultural Competence Self-Assessment

*** Additional Cultural Competence Self-Assessments can be found in “Tip 59: Improving Cultural Competence”

PROMOTING CULTURAL DIVERSITY AND CULTURAL COMPETENCY
Self-Assessment Checklist for Personnel Providing Behavioral Health Services and Supports to Children, Youth and their Families

Please select A, B, or C for each item listed
A = Things I do frequently
B = Things I do occasionally
C = Things I do rarely or never

<table>
<thead>
<tr>
<th>PHYSICAL ENVIRONMENT, MATERIALS and RESOURCES</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I display pictures, posters and other materials that reflect the cultures and ethnic backgrounds of children, youth and families served by my program or agency.</td>
</tr>
<tr>
<td>2. I ensure that magazines, brochures, and other printed materials in reception areas are of interest to and reflect the different cultures of children, youth and families served by my program or agency.</td>
</tr>
<tr>
<td>3. When using videos, films, CDs, DVDs, or other media resources for mental health prevention, treatment or other interventions, I ensure that they reflect the cultures of children, youth and families served by my program or agency.</td>
</tr>
<tr>
<td>4. When using food during an assessment, I ensure that meals provided include foods that are unique to the cultural and ethnic backgrounds of children, youth and families served by my program or agency.</td>
</tr>
<tr>
<td>5. I ensure that toys and other play accessories in reception areas and those, which are used during assessment, are representative of the various cultural and ethnic groups within the local community and the society in general.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>COMMUNICATION STYLES</th>
</tr>
</thead>
<tbody>
<tr>
<td>6. For children and youth who speak languages or dialects other than English, I attempt to learn and use key words in their language so that I am better able to communicate with them during assessment, treatment or other interventions.</td>
</tr>
<tr>
<td>7. I attempt to determine with familial colloquialisms used by children, youth and families that may impact assessments, treatment or other interventions.</td>
</tr>
<tr>
<td>Section 4: Resources</td>
</tr>
<tr>
<td>----------------------</td>
</tr>
<tr>
<td><strong>8.</strong> I use visual aids, gestures, and physical prompts in my interactions with children and youth who have limited English proficiency.</td>
</tr>
<tr>
<td><strong>9.</strong> I use bilingual or multilingual staff or trained/certified interpreters for assessment, treatment and other interventions with children and youth who have limited English proficiency.</td>
</tr>
<tr>
<td><strong>10.</strong> I use bilingual staff or multilingual trained/certified interpreters during assessments, treatment sessions, meetings, and for other events for families who would require this level of assistance.</td>
</tr>
</tbody>
</table>
| **11.** When interacting with parents who have limited English proficiency I always keep in mind that:  
  - Limited English proficiency is in no way a reflection of an individual’s level of intellectual functioning  
  - Limited ability to speak the language of the dominant culture has no bearing on an individual’s ability to communicate effectively in his or her language of origin.  
  - The parents may or may not be literate in their language or origin or English. |
| **12.** When possible, I ensure that all notices and communication with parents, families and caregivers is written in their language of origin. |
| **13.** I understand that it may be necessary to use alternatives to written communication for some families, as word of mouth may be a preferred method of receiving information. |
| **14.** I understand the principles and practices of linguistic competency and:  
  - apply them within my program or agency  
  - advocate for them within my program or agency |
<p>| <strong>15.</strong> I understand the implications of health/mental health literacy within the context of my roles and responsibilities. |
| <strong>VALUES AND ATTITUDES</strong> |
| <strong>16.</strong> I use alternative formats and varied approaches to communicate and share information with children, youth and/or their family members who experience disability. |
| <strong>17.</strong> I avoid imposing values that may conflict or be inconsistent with those of cultures or ethnic groups other than my own. |
| <strong>18.</strong> In group therapy or treatment situations, I discourage children and youth from using racial and ethnic slurs by helping them understand that certain words can hurt others. |
| <strong>19.</strong> I screen books, movies, and other media resources for negative cultural, ethnic, or racial stereotypes before sharing them with children, youth and their parents served by my program or agency. |</p>
<table>
<thead>
<tr>
<th></th>
<th>Statement</th>
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<tbody>
<tr>
<td>20</td>
<td>I intervene in an appropriate manner when I observe other staff or parents within my program or agency engaging in behaviors that show cultural insensitivity, bias or prejudice.</td>
</tr>
<tr>
<td>21</td>
<td>I understand and accept that family is defined differently by different cultures (e.g. extended family members, fictive kin, godparents).</td>
</tr>
<tr>
<td>22</td>
<td>I recognize and accept that individuals from culturally diverse backgrounds may desire a varying degree of acculturation into the dominant or mainstream culture.</td>
</tr>
<tr>
<td>23</td>
<td>I accept and respect that male-female roles in families may vary significantly among different cultures (e.g. who makes major decisions for the family, play and social interactions expected of male and female children).</td>
</tr>
<tr>
<td>24</td>
<td>I understand that age and life cycle factors must be considered in interactions with individuals and families (e.g. high value placed on the decisions of elders or the role of the eldest male in families).</td>
</tr>
<tr>
<td>25</td>
<td>Even though my professional or moral viewpoints may differ, I accept the family/parents as the ultimate decision makers for services and supports for their children.</td>
</tr>
<tr>
<td>26</td>
<td>I recognize that the meaning or value of behavioral health prevention, intervention and treatment may vary greatly among cultures.</td>
</tr>
<tr>
<td>27</td>
<td>I recognize and understand that beliefs and concepts of emotional well-being vary significantly from culture to culture.</td>
</tr>
<tr>
<td>28</td>
<td>I understand that beliefs about mental illness and emotional disability are culturally-based. I accept that responses to these conditions and related treatment/interventions are heavily influenced by culture.</td>
</tr>
<tr>
<td>29</td>
<td>I understand the impact of stigma associated with mental illness and behavioral health services within culturally diverse communities.</td>
</tr>
<tr>
<td>30</td>
<td>I accept that religion, spirituality and other beliefs may influence how families respond to mental or physical illnesses, disease, disability and death.</td>
</tr>
<tr>
<td>31</td>
<td>I recognize and accept that folk and religious beliefs may influence a family’s reaction and approach to a child born with a disability or later diagnosed with a physical/emotional disability or special health care needs.</td>
</tr>
<tr>
<td>32</td>
<td>I understand that traditional approaches to disciplining children are influenced by culture.</td>
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<tr>
<td>33</td>
<td>I understand that families from different cultures will have different expectations of their children for acquiring self-help, social, emotional, cognitive, and communication skills.</td>
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<tr>
<td><strong>34.</strong></td>
<td>I accept and respect that customs and beliefs about food, its value, preparation, and use are different from culture to culture.</td>
</tr>
<tr>
<td><strong>35.</strong></td>
<td>Before visiting or providing services in the home setting, I seek information on acceptable behaviors, courtesies, customs and expectations that are unique to families of specific cultures and ethnic groups served by my program or agency.</td>
</tr>
<tr>
<td><strong>36.</strong></td>
<td>I seek information from family members of other key community informants that will assist in service adaptation to respond to the needs and preferences of culturally and ethnically diverse children, youth, and families served by my program or agency.</td>
</tr>
<tr>
<td><strong>37.</strong></td>
<td>I advocate for the review of my program’s or agency’s mission statement, goals, policies, and procedures to ensure that they incorporate principles and practices that promote cultural diversity and cultural and linguistic competence.</td>
</tr>
<tr>
<td><strong>38.</strong></td>
<td>I keep abreast of new developments in pharmacology particularly as they relate to racially and ethnically diverse groups.</td>
</tr>
<tr>
<td><strong>39.</strong></td>
<td>I either contribute to and/or examine current research related to ethnic and racial disparities in mental health and health care and quality improvement.</td>
</tr>
<tr>
<td><strong>40.</strong></td>
<td>I accept that many evidence-based prevention and intervention approaches will require adaptation to be effective with children, youth and their families from culturally and linguistically diverse groups.</td>
</tr>
</tbody>
</table>

**How to use this checklist**

This checklist is intended to heighten the awareness and sensitivity of personnel to the importance of cultural diversity and cultural competence in human service settings. It provides concrete examples of the kinds of values and practices that foster such an environment. There is no answer key with correct responses. However, if you frequently responded “C”, you may not necessarily demonstrate values and engage in practices that promote a culturally diverse and culturally competent service delivery system for children and youth who require behavioral health services and their families.

Tawara D. Goode – Georgetown University Center for Child & Human Development
University Center for Excellence in Developmental Disabilities Education, Research & Service
PROMOTING CULTURAL DIVERSITY AND CULTURAL COMPETENCY
Self-Assessment Checklist for Personnel Providing Services and Supports to Children with Disabilities & Special Health Needs and their Families

Directions: Please select A, B, or C for each item listed below.
A = Things I do frequently, or statement applies to me to a great degree
B = Things I do occasionally, or statement applies to me to a moderate degree
C = Things I do rarely or never, or statement applies to me to minimal degree or not at all

### PHYSICAL ENVIRONMENT, MATERIALS & RESOURCES

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### COMMUNICATION STYLES

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<tr>
<td>9</td>
<td>I use bilingual staff or trained/certified interpreters for assessment, treatment and other interventions with children who have limited English Proficiency.</td>
</tr>
<tr>
<td>10</td>
<td>I use bilingual staff or trained/certified interpreters during assessments, treatment sessions, meetings, and for or other events for families who would require this level of assistance.</td>
</tr>
<tr>
<td></td>
<td>When interacting with parents who have limited English proficiency I always keep in mind that:</td>
</tr>
<tr>
<td>---</td>
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</tr>
<tr>
<td>11.</td>
<td>* limitations in English proficiency is in no way a reflection of their level of intellectual functioning.</td>
</tr>
<tr>
<td></td>
<td>* their limited ability to speak the language of the dominant culture has no bearing on their ability to communicate effectively in their language of origin.</td>
</tr>
<tr>
<td></td>
<td>* they may or may not be literate in their language of origin or English.</td>
</tr>
<tr>
<td>12.</td>
<td>When possible, I ensure that all notices and communiqués to parents are written in their language of origin.</td>
</tr>
<tr>
<td>13.</td>
<td>I understand that it may be necessary to use alternatives to written communications for some families, as word of mouth may be a preferred method of receiving information.</td>
</tr>
<tr>
<td>14.</td>
<td>I understand the principles and practices of linguistic competency and:</td>
</tr>
<tr>
<td></td>
<td>* apply them within my program or agency.</td>
</tr>
<tr>
<td></td>
<td>* advocate for them within my program or agency.</td>
</tr>
<tr>
<td>15.</td>
<td>I understand the implications of health literacy within the context of my roles and responsibilities.</td>
</tr>
<tr>
<td>16.</td>
<td>I use alternative formats and varied approaches to communicate and share information with children and/or their family members who experience disability.</td>
</tr>
</tbody>
</table>

**VALUES AND ATTITUDES**

|   | I avoid imposing values that may conflict or be inconsistent with those of cultures or ethnic groups other than my own. |
| 17. | In group therapy or treatment situations, I discourage children from using racial and ethnic slurs by helping them understand that certain words can hurt others. |
| 18. | I screen books, movies, and other media resources for negative cultural, ethnic, or racial stereotypes before sharing them with children and their parents served by my program or agency. |
| 19. | I intervene in an appropriate manner when I observe other staff or parents within my program or agency engaging in behaviors that show cultural insensitivity, bias or prejudice. |
| 20. | I understand and accept that family is defined differently by different cultures (e.g. extended family members, fictive kin, godparents). |
| 21. | I recognize and accept that individuals from culturally diverse backgrounds may desire varying degrees of acculturation into the dominant culture. |
| 23. | I accept and respect that male-female roles in families may vary significantly among different cultures (e.g. who makes major decisions for the family, play and social interactions expected of male and female children). |
| 24. | I understand that age and life cycle factors must be considered in interactions with individuals and families (e.g. high value placed on the decisions of elders or the role of the eldest male in families). |
| 25. | Even though my professional or moral viewpoints may differ, I accept the family/parents as the ultimate decision makers for services and supports for their children. |
| 26. | I recognize that the meaning or value of medical treatment, health and mental health care, and special education may vary greatly among cultures. |
| 27. | I recognize and understand that beliefs and concepts of emotional well-being vary significantly from culture to culture. |
| 28. | I understand that beliefs about mental illness and emotional disability are culturally-based. I accept that responses to these conditions and related treatment/interventions are heavily influenced by culture. |
| 29. | I accept that religion and other beliefs may influence how families respond to illnesses, disease, disability and death. |
| 30. | I recognize and accept that folk and religious beliefs may influence a family's reaction and approach to a child born with a disability or later diagnosed with a physical/emotional disability or special health care needs. |
| 31. | I understand that traditional approaches to disciplining children are influenced by culture. |
| 32. | I understand that families from different cultures will have different expectations of their children for acquiring toileting, dressing, feeding, and other self-help skills. |
| 33. | I accept and respect that customs and beliefs about food, its value, preparation, and use are different from culture to culture. |
| 34. | Before visiting or providing services in the home setting, I seek information on acceptable behaviors, courtesies, customs and expectations that are unique to families of specific cultures and ethnic groups served by my program or agency. |
| 35. | I seek information from family members or other key community informants that will assist in service adaptation to respond to the needs and preferences of culturally and ethnically diverse children and families served by my program or agency. |
| 36. | I advocate for the review of my program’s or agency’s mission statement, goals, policies, and procedures to ensure that they incorporate principles and practices that promote cultural diversity and cultural competence. |
How to use this checklist

This checklist is intended to heighten the awareness and sensitivity of personnel to the importance of cultural diversity and cultural competence in human service settings. It provides concrete examples of the kinds of values and practices that foster such an environment. There is no answer key with correct responses. However, if you frequently responded "C", you may not necessarily demonstrate values and engage in practices that promote a culturally diverse and culturally competent service delivery system for children with disabilities or special health care needs and their families.