



Cultural Competence in Action: An Analysis of Cultural Competency Outcome Assessment in the Behavioral Health Field

Prepared for the Virginia Department of Behavioral Health and Developmental
Services' Office of Cultural and Linguistic Competence

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Report Summary

As the United States changes from a country of one majority to a country of multiple minorities, cultural competence in the delivery of healthcare services is a necessary phenomenon. This report examines the Virginia Department of Behavioral Health and Developmental Services' (DBHDS) Office of Cultural and Linguistic Competence (OCLC) in terms of measuring the success of OCLC's efforts to promote cultural competence throughout the organization. This report reviews the traits and characteristics of a culturally competent organization; it also reviews general evaluation methodology as well as the performances and characteristics of the cultural competence programs in other states. The Office's structure and processes have been evaluated in relation to the information provided from the literature. Based on the information found, nine recommendations have been suggested to help OCLC measure the outcomes of its efforts. One of these recommendations includes involving other organizations with the steering committee to inform the Virginia General Assembly of the importance of providing cultural competent behavioral health services. This information has then been used to develop a template that OCLC can use in the future to further evaluate its progress.

Statement of Problem & Purpose of Report

Mental Health Service and Cultural Competency in the United States

According to the United States Census Bureau as stated in DBHDS' 2009-2010 annual report, between 2000 and 2007, Virginia experienced a record growth of foreign born citizens exceeding 794,000 foreign births (2009). This increase in foreign born individuals is a small example of the cultural shifts in society which has created an environment in which organizations must become culturally competent and provide services in a culturally relevant manner in order to reduce recidivism and increase benefits. With this increase of minorities, arises a concern for the healthcare treatment of these individuals. The purpose of this report is to identify current benchmark standards being used within the behavioral health field to measure outcomes of cultural competence programs and to use this data to develop a template to be used specifically by OCLC to measure their outcomes.

Historically, minorities have fared worse than whites in terms of receiving culturally appropriate healthcare. Specifically in the area of mental health, minorities have been disadvantaged due to access to treatment and quality of care (Joint Commission on Healthcare, 2008). "Because of disparities in mental health services, a disproportionate number of minorities with mental illnesses do not fully benefit from...the opportunities and prosperity of our society. This preventable disability from mental illness exacts a high societal toll and affects all Americans" (2008, p. 3). Unfortunately, "mental health services, even when accessed, may not meet the individual's needs because individual circumstances,

gender, race, culture, and other characteristics that shape a person's image and identity, and affect response to stress and problems are not considered in making diagnoses and in treatment. In other words, within the mental health care setting, culture impacts how people label and communicate distress, explain the causes of mental health problems, perceive mental health providers, and utilize/respond to mental health treatment. Cultural competence is the integration...of knowledge about individuals and groups of people into specific standards, policies, practices and attitudes used in appropriate cultural settings to increase the quality of services; thereby producing better outcomes" (p.10).

The Office of Cultural and Linguistic Competence in Virginia's Department of Behavioral Health and Developmental Services

In the State of Virginia, the Office of Cultural and Linguistic Competence within the Department of Behavioral Health and Developmental Services is within the Human Resources Department. An organizational chart is available in Appendix A. It is responsible for implementing cultural and linguistic competence into the services administered. "Established in 2008...the office represents DBHDS's strong commitment to the elimination of disparities in mental health and developmental services and its efforts to implement a comprehensive and systematic approach to addressing these issues. The Office of Cultural and Linguistic Competence, along with a dedicated steering committee, leads efforts to provide improved services to multicultural consumers and works toward eliminating the disparities within the state's mental health and developmental services system" (DBHDS, 2009, p. 4).

The Department of Behavioral Health and Developmental Services system is composed of "sixteen state operated facilities, forty community services boards and over one thousand private providers of services" (2009). The Office of Cultural and Linguistic Competence was developed with the purpose of providing the following measures to the DBHDS system:

- Identifying critical data elements for measuring the agency's cultural and linguistic competence;
- Developing an agency cultural competence plan and coordinating its integration into agency policies, systems, program requirements and regulations;
- Providing resources and support for the implementation of cultural competence requirements of providers; and
- Supporting development guidelines for linguistic standards and a needs assessment for linguistic services. (2009).

To help OCLC meet its goal of eliminating disparities within the State's mental health, intellectual disability and substance-use disorder system, the Office is supported by the Cultural and Linguistic Competence Steering Committee (CLCSC). The steering committee is comprised of members from the various Community Service Boards, numerous community organizations such as Community Alternatives, Inc., Virginia Asian Foundation and Commonwealth Catholic Charities as well as public organizations such as the Piedmont Geriatric Hospital and Central Virginia Health Services (2009). The Cultural and Linguistic Competence Steering Committee is guided by the Charter for the Cultural and Linguistic Competence Steering Committee. This Charter outlines the Committee's mission, aims and goals, members and meetings and responsibilities.

Since its inception in 2008, OCLC has implemented plans and behaviors for promoting cultural competence within Virginia's behavioral health services, but there has been no procedure for measuring how successful the organization has been in its efforts. The organization needs to be able to identify the

specific procedures and behaviors that are or are not improving the quality of care and access to culturally related services so that the organization can progress and grow by making whatever changes necessary to further the development of culturally related services.

Methodology

In order to determine benchmark standards within the behavioral health community, the research team began by reviewing the literature on what the characteristics of a culturally competent organization are and identifying what one can expect to find within a culturally competent organization. The team contacted the National Center for Cultural Competence. The center advised that most states were still in the phase of developing their Cultural Competence programs and were not yet measuring their success or identifying areas to measure. However, a list of sources and states were provided to use as a starting point.

The team also conducted a literature review on program evaluation; scholarly literature was the main source of information for this section. Focusing on general program development as well as program development specifically within the health field, the group identified best practices used to create tools for evaluating programs in general.

Using the states provided by the center, the team identified a list of states that had completed a significant amount of work in the behavioral health field and used the work of these states to compare to OCLC. The literature reviewed showed that there were numerous areas of focus of the different cultural competence programs within the various states. To narrow down the search and to make the information more comparable, the team focused on the following three areas: communications, organizational infrastructure and staff development. These areas will be further explained throughout the next section of the report.

Upon completion of the literature review, the team compared and contrasted OCLC with the characteristics of a culturally competent organization and with the programs and performances of other states. Using the data obtained from the program evaluation literature, the group developed nine recommendations for OCLC and created a template to be used by OCLC in the future to measure its outcomes in the areas of communication, organizational infrastructure and staff development. The template can be found in Appendix B.

Report of Findings

From the review of the literature, the research team found information that is valuable to the development of culturally competent organizations and to the evaluation of those organizations. First, the team examined culturally competent organizations. Although there is no clear definition of cultural competence, culturally competent organizations must work to develop cultural competence as it is extremely valuable, especially in the field of behavioral health. The team also examined evaluation models. There is no standardized method of evaluating cultural competence in health care, but utilizing the Centers for Disease Control's framework and applying other evaluation principles will be valuable as the evaluative process is begun. Finally, the team reviewed other prominent states' cultural and linguistic assessment programs. Each state was evaluated based on three categories: communication, organizational infrastructure, and staff development. Culturally competent organizations can analyze and utilize these best practices as they improve their organization's cultural competence.

Culturally Competent Organizations

There is no clear consensus on the definition of cultural competence.

The healthcare industry has been a leader in the cultural competence movement providing research, best practices, guidelines, and standards of care aimed at offering equitable services (Borrego & Johnson 2011). One of the most prominent definitions of cultural competence can be found in Cross et al.'s (1989) work, *Towards a Culturally Competent System of Care*. The U.S. Department of Health and Human Services' Office of Minority Health used Cross et al.'s work to create their definition of cultural competence when developing Culturally and Linguistically Appropriate Standards (CLAS) of Health Care. The definition is as follows:

Cultural and linguistic competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations. "Culture" refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. "Competence" implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities (2001, ix).

In healthcare, the concept of culture is complex, as organizations must have the ability to manage cultural diversity internally by respecting employee characteristics (Borrego & Johnson, 2011) while dealing with layers of external diversity as employees gain skills to relate to consumers and stakeholders from various backgrounds (Betancourt, 2005). The Virginia Office of Cultural and Linguistic Competence embraces an even broader sense of culture including factors such as sexual orientation, education, and life experiences in addition to race, language, and ethnicity. The Office of Cultural and Linguistic Competence contends that by understanding a client's background and sense of identity, practitioners discover an important component in the provision of culturally competent care ("About the Office," n.d.).

Definitions of cultural competence are often abstract in nature (Borrego & Johnson 2011; Engebretson, Mahoney, & Carlson, 2008). While the field of cultural competency is gaining momentum (Betancourt 2005), there is no clear consensus on how cultural competency is defined, operationalized, and assessed (Engebretson, Mahoney, & Carlson, 2008). There is a lack of empirical evidence supporting cultural competence (Betancourt, et al. 2003; Betancourt et al., 2005; Hernandez et al., 2009; Rice, 2007). Research by Betancourt et al. (2003) discovered that some providers view cultural competence as a "soft science" suggesting that for provider "buy-in" to occur there is a need for evidence-based research. Sue (2006) suggests that the cultural competency movement has thus far operated from a philosophical definition of cultural competence, and this is inadequate to further progress. In order to shift from a philosophical to an operational definition based on practice and empirical data, the following questions should be considered:

- 1) What characteristics constitute cultural competency?
- 2) Do different competencies exist for different groups or does cultural competency reside in individuals independent of groups?
- 3) Are different cultural competencies required at different times in the process?
- 4) Is cultural competency a uni-dimensional versus multi-dimensional phenomenon; if it is multi-dimensional, are certain dimensions more important than others? (Sue, 2006)

Equally important is the fact that many national, state, and local legislators, while acknowledging the importance of cultural competence in providing equitable care, are provided no clear definition, and are thus unable to measure and enforce standards through regulations (“National Standards for Culturally” 2001). Uniformity among all health care providers about what a culturally competent health system looks like would provide policymakers with an easier task of weighing in on the issues of cultural competence and including cultural competence in future legislation (“National Standards for Culturally,” 2001). While this could be a difficult consensus to achieve, the process of developing a common understanding and vision for cultural competence could be an experience of great value.

Despite the ambiguity of its definition, cultural competence has received favorable attention as a potential factor in improving the quality of services delivered to all patients (Betancourt et al., 2003), and as a way of changing the “one size fits all” approach to health care (Betancourt et al., 2005).

Cross et al. (1989)’s definition of cultural competence is the most prominent found in the literature related to behavioral health.

Cross et al. (1989) introduces the concept that cultural competence is necessary in light of inevitable cultural changes of society. Cultural competence is conceptualized as a continuum with six defined points ranging from cultural destructiveness to cultural proficiency. Cultural destructiveness is characterized as an intentional act of destroying a culture, and is at the most negative end of the continuum. The second step along the continuum is called cultural incapacitation, characterized by unintentional actions, yet no less contributing to instances of bias such as racism. Next on Cross et al.’s continuum is cultural blindness. Cultural blindness is the belief that all people are the same, and therefore, all people will benefit from the exact same services being delivered. This approach fails to recognize that people are unique individuals with unique experiences, beliefs and values, and attempts to approach work with a “one size fits all” strategy.

On the positive side of the continuum is pre-competence. An organization at the pre-competence level acknowledges the need for cultural competence, and may undertake activities that demonstrate their commitment to the movement; however, an organization is not said to be culturally competent until there is a respect and acceptance of diversity, a recognized need and follow-through regarding self-assessment of cultural competence, a continual commitment to expanding cultural knowledge and resources, and an effort to better adapt services for the clients served. At the most positive end of the continuum is an organization which has achieved cultural proficiency. This flagship organization holds culture in high regard and attempts to conduct research, develops ground-breaking therapeutic approaches, and shares best practices and findings with other agencies. A culturally proficient organization is a leader in the cultural competence movement, continually seeking ways to better the services provided and hiring staff who are dedicated to advancing cultural competence.

Cross et al. (1989) suggests that the degree to which cultural competence is achieved is affected by three factors.

Attitudes, policies, practices are major areas in which development can, and must occur, for an agency to move toward cultural competence. Attitudes must change to become less ethnocentric and less biased. Policies must change in order to become more flexible and culturally impartial. Practices must become more congruent with the culture of the client from the initial contact through termination of services. [...] Every level of an agency (board members, policymakers, administrators, practitioners, and consumers) must participate in the process. At each level the principles of valuing difference, self-assessment, understanding dynamics,

building cultural knowledge, and practice and adaptations can be applied. When, at each level, progress is made in implementing the principles and as attitudes, policies, and practices change in the desired direction, an agency becomes more culturally competent (17-18).

Each organization has a different starting point from which to launch their cultural competence initiatives and is found at various stages along Cross et al.'s continuum (Goode & Jackson 2003). According to the National Center for Cultural Competence, culturally competent organizations have the capacity to 1) respect and value diversity, 2) conduct self-assessment, 3) manage the dynamics of difference, and 4) adapt to the various cultures represented within the communities being served (Goode & Jackson 2003). The Virginia Office of Cultural and Linguistic Competence is currently in the planning phase of self-assessment, a process which should shed new light on where the organization currently falls along the cultural competence continuum.

Cultural competence is important in the field of mental health services.

Despite the ambiguity around the definition of cultural competence and lack of empirically based research, cultural competence has received attention as a way of increasing equity and impacting the cost and quality of health care (Betancourt et al., 2005). Legislative mandates, accreditation standards, service quality improvement, and increases in workforce diversity, are among the reasons discussed in literature as reasons for embracing cultural competence. These pressures are only likely to grow as the American workforce expands and diversifies over the coming years.

Federal mandates such as CLAS will guide the work of agencies such as Virginia's Office of Cultural and Linguistic Competence, as in order to receive federal funds these must be administered in service delivery ("National Standards for Culturally," 2001). The federal government is playing a critical role in the promotion of cultural competence as it requires more culturally competent practices from agencies through laws such as the Disadvantaged Minority Improvement Act of 1990, the Developmental Disabilities Assistance and Bill of Rights Act of 1994, the Emergency Medical Treatment Act of 1996 (Rice 2007), Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, and the Americans with Disabilities Act. As will be discussed later in this report, several States are following suit in the quest for mandating culturally competent practice.

In addition to legislative mandates, organizations must meet the criteria of the Joint Commission. The Joint Commission develops accreditation standards for hospital and health care agencies and periodically evaluates the facilities' effectiveness. In 2009, the Joint Commission developed accreditation standards around the topic of patient-centered care and cultural competence. *Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care: A Roadmap for Hospitals* gives an overview of the new standards. The Joint Commission will gather data and give feedback to each institution starting in 2011. While accreditation will not yet be dependent on compliance with these new standards, the organization is telegraphing its intention to begin making cultural competence a formal part of accreditation as early as 2012.

While no formal data yet exists to prove the positive impact of cultural competence with regards to quality of service (Betancourt et al., 2005), it is widely believed that cultural competence will help agencies respond to the issues of health disparities among minorities and underserved populations (Engbretson, Mahoney, & Carlson, 2008). Cultural competence may help serve as a "bridge" and a method of creating common ground for providing culturally relevant patient care for immigrant and minority communities (Borrego & Johnson, 2011). It seems logical to support cultural competence for if a patient feels respected and understood, one would expect a better clinical and social outcome for the

patient (Siegel et al., 2000). Rice (2007) notes that there are four reasons for promoting and integrating cultural competence in public service delivery. They are as follows:

- 1) Culture provides a context and insight into human behavior during service delivery (Applewhite 1998).
- 2) Cultural competence provides an opportunity to correct and address inadequacies within programs serving minorities and other underserved populations (Geron, 2002).
- 3) Boyle and Springer suggest that cultural competence increases the relevance of a public agency's work to its target populations (as cited in Rice, 2007, p.44).
- 4) Developing a deeper awareness, gaining knowledge, and honing cultural competency skills better prepares service workers to do their job (Suzuki et al., 2001).

In "An Older and More Diverse Nation by Midcentury," the U.S. Census Bureau has projected that there will be no ethnic majority in the United States by 2050. Managers will be faced with supervising a diverse workforce, and Borrego and Johnson believe cultural competence will help managers recognize the need for inclusion of all employees (2011). Cultural competence will transform a public organization from one that "says" it believes in valuing diversity to one where practice truly reflects a commitment to high-performance and effectiveness (Borrego & Johnson 2011).

Believing the above reasons to be true, federal, state, and local agencies are including culturally competent principles in their mental health systems, monitoring how well their systems are complying with principles of cultural competence, and setting performance measures for evaluating their organizational cultural competence (Siegel et al., 2000).

Program Evaluation

Evaluation is an important part of assessing the impact and outcomes of a program. Evaluation is defined as the "systematic investigation of the merit, worth or significance of an object" (Centers for Disease Control and Prevention, 1999, p. 2). During the past three decades, the practice of evaluation has evolved as a discipline with new definitions, methods, approaches, and applications to diverse subjects and settings.

Effective program evaluation utilizes systematic evaluation to improve and account for public health actions by involving procedures that are useful, feasible, ethical, and accurate (Centers for Disease Control and Prevention, 1999). Effective program evaluation also helps to guide public health activities which lead to:

- a) "Using science as a basis for decision-making and public health action;
- b) Expanding the quest for social equity through public health action;
- c) Performing effectively as a service agency;
- d) Making efforts outcome oriented; and
- e) Being accountable" (Centers for Disease Control and Prevention, 1999; p. 1).

Emphasis is then placed on practical, ongoing evaluation strategies that involve all program stakeholders, not just evaluation experts.

In regards to cultural competence, according to The Lewin Group (2002) "commentators generally agreed that the assessment of cultural competence should not be considered an isolated event, but rather a continuous process that is emphasized and integrated in an organization's overall assessment activities. Cultural competence assessment, like other significant management activities, should be clearly identifiable and targeted to garner the leadership and resources required, while being an integral

part of an organization’s regular performance and quality assessment activities” (p. 16). Thus, the evaluation becomes part of the daily activities of an organization and it guides daily actions.

Evaluating outcomes is just as important as examining outputs.

As discussed above, effective program evaluation shifts the focus of efforts to become more outcome oriented, rather than outputs. To understand how to shift efforts to an outcomes focus, it is important to understand the difference between outputs and outcomes. An output measures what an organization does whereas an outcome measures the difference that an organization has made. Chart 1, below, shows differences between outputs and outcomes in terms of program evaluation.

Chart 1: Outputs versus Outcomes

Outputs	Outcomes
Services are made available without allowing geography, developmental issues, mental health, or culture to be barriers.	Proportionate utilization of services and proportionate improvement in targeted service outcomes.
HR plan/policy to ensure that diversity is represented at all stages of the hiring process and among evaluators.	Organization has the capacity to serve clients from all ethnic/cultural and special demographics in the community. Documentation that staff composition is reflective of the diversity within the community.
Organization has incorporated cultural competency development into the organization overall staff development/training plan.	Percentage of providers, staff, and volunteers received cultural competency and gender specific services training.
Evidence of data collection and tracking.	Program evaluation(s) assessing the performance of programs and services and monitoring their progress in achieving stated goals and objectives.

Source: Oregon Partners for Children and Families, 2010

From these definitions, it is evident that outcomes based measurements are key to assessing the impact and return on investment of a program. An effective program evaluation will measure both outputs and outcomes to assess impact.

There is a need for a standardized evaluation method of cultural competence in behavioral health.

There are many different methods of program evaluation. However, there is not one standardized method available for organizations seeking to identify the outcomes of their cultural competence efforts in their organizations. A review of the literature for cultural competence in health care, mental health, and public health was conducted and identified some key needs and factors to be considered in an evaluation of cultural competence.

Castillo et al. (2011) established a framework for cultural competence in health care organizations. This article emphasizes the need for establishing specific culturally competent strategies and how to implement best practices. However, no evaluation tool was identified. The article also stated “...additional research studies are necessary to develop and analyze cultural competence assessment

tools that are specific for various types of health care organizations” (p. 213). An assessment tool and standards will establish consistency in service delivery and ensure that best practices and strategies are implemented into everyday practice (2011).

Whealin et al. (2008) examined program evaluation and established cultural competence in private mental health practices. This article outlined 10 useful steps that are important in creating competent mental health practices. The final step of the process outlined, is “evaluate findings, identify goals, and disseminate recommendations” (p. 321). Culturally competent organizations evaluate their practices, seek to improve their practices, and then share their information with other organizations reaching towards similar goals. Within evaluating findings it is important that certain critical indicators are established, with both long and short term results. Goals and priorities must also be established. This article also emphasized the need for continual evaluation and follow up. A culturally competent organization must include that in their day-today practice (2008).

Critical indicators of a culturally competent organization were established by the Lewin Group. These indicators are grouped into structure indicators, process indicators, and output indicators (2002). Structure indicators assess an organization’s capability to support cultural competence through adequate and appropriate settings and infrastructure, including staffing, facilities, and financial means. Process indicators assess the content and quality of activities, procedures, methods, and interventions in the practice of culturally competent care and in support of such care. Output indicators are used to assess immediate results of culturally competent policies, procedures, and services that can lead to achieving positive outcomes. The Lewin Group also identifies that these indicators lead to intermediate outcome indicators that lead to more intermediate objectives that relate to the provision of, the response to, and the results of care and service delivery (2002).

Bhui et al. reviewed model evaluations of cultural competence in mental health care. This article emphasized the role of training methods and how the method of evaluation is determined by the method of training (2007). It was also discussed that many critical indicators for cultural competence have not been established or standardized. This is largely why researchers have been unable to develop a standardized way to evaluate cultural competence training programs. Each organization is different and has a unique set of traits which inevitably make it difficult to standardize certain aspects. However, more standardized training methods will ultimately lead to more standardized evaluation models and vice versa.

McDougle et al. and Thom et al. also examined the need for a standardized evaluation model. McDougle et al. (2010) stated, “Comparative studies evaluating the effectiveness of different methods of training and combinations of those methods need to be conducted” (p. 760). Thom et al. also examines a specific study where cultural competency training curriculums were evaluated based on patient satisfaction from patients (2006). The study did not find any impact from a brief training program; however, the effects of more long-term training programs were not evaluated. Ultimately, the article concluded that more research on outcomes-based evaluation is necessary.

Effective program evaluation uses a systematic process to evaluate outcomes of a program.

The CDC has outlined a framework for program evaluation in public health. This framework outlines six steps that are necessary in providing effective program evaluation and relevant outcomes based data.

The first step is engaging stakeholders. This means identifying any persons involved in or affected by the program and any primary users of the evaluation. After these individuals are identified, they must be

involved in the evaluation process in some way. If all stakeholders are included, especially the most relevant ones, they can help guide the process and provide effective feedback. The second step is to describe the program. This means examining the need for the program, the expected effects of the program, the activities the program is engaged in, the resources available, the context and logic of the program, and the model the program is based on.

The third step is to focus the evaluation design. This identifies the purpose, the users, the uses, the relevant questions to be answered, the methods, and agreements of the evaluation. Evaluations can gain insight into a program, change the practices of a program, assess the effects of the program, and/or affect the participants of the program. A program that assesses cultural competence is seeking to assess effects of the program. As such, this will involve, “assessing skills development by program participants, comparing changes in provider behavior over time, comparing costs with benefits, finding out which participants do well in the program, deciding where to allocate new resources, documenting the level of success in accomplishing objectives, demonstrating that accountability requirements are fulfilled, aggregating information from several evaluations to estimate outcome effects for similar kinds of programs, and gathering success stories” (Centers for Disease Control and Prevention, 1999, 12).

The fourth step is to gather credible evidence. This involves collecting data and evaluating critical indicators. This also includes utilizing trusted sources and ensuring that you have both the quantity and quality of data to make your evaluation valid (Centers for Disease Control and Prevention, 1999). Next, conclusions should be justified through evaluating standards, synthesizing, analyzing, and interpreting data (Centers for Disease Control and Prevention, 1999). This is the step where outputs can be converted into outcomes. From here, recommendations are also provided. Finally, the final step is to ensure use and share lessons learned (Centers for Disease Control and Prevention, 1999). This involves sharing the data with any relevant organization or individual, especially those key stakeholders identified in step 1.

Along with these six steps of program evaluation, the CDC also identifies four key standards for consideration in the evaluation process. The first principle is utility. The principle of utility applies to ensure that information serves the needs of its intended users. The second principle is feasibility – is the data realistic, prudent, diplomatic, and frugal? The third principle is propriety. This principle includes the responsibility to behave legally, ethically, and with the regard for the welfare of those involved and affected. Accuracy is the fourth and final principle. This principle applies to the ability of the data to reveal and convey technically accurate information (Centers for Disease Control and Prevention, 1999).

Table 1 below, adapted from the CDC report, also outlines additional standards for judging program performance. If these standards are considered and included in the process of program evaluation, the evaluation will be more successful.

Table 1: Standards of Program Performance

- Needs of participants;
- Community values, expectations, norms;
- Degree of participation;
- Program objectives;
- Program protocols and procedures;
- Expected performance, forecasts, estimates;
- Feasibility;
- Sustainability;
- Absence of harms;
- Targets or fixed criteria of performance;
- Change in performance over time;
- Performance by previous or similar programs;
- Performance by a control or comparison group;
- Resource efficiency;
- Professional standards;
- Mandates, policies, statutes, regulations, laws;
- Judgments by reference groups (e.g., participants, staff, experts, and funding officials);
- Institutional goals;
- Political ideology;
- Social equity;
- Political will; and
- Human rights.

The California Endowment identifies characteristics of a multicultural evaluation that incorporates all stakeholders.

The California Endowment also identified what a multicultural evaluation must include.

A multicultural evaluation is most useful when there are questions about program implementation difficulties, questions regarding a program's potential effects on beneficiaries, more information is desired from a specific stakeholder's knowledge or views, and/or a program's applicability and effectiveness needs to become more known and validated (2003). These are all important issues that need to be addressed in program evaluation.

A multicultural evaluation involves the following aspects:

1. Community residents, project staff, and other stakeholders drive the evaluation process in addition to the funders, program managers, and researchers (The California Endowment 2003).
2. Members of community groups, project staff, and the evaluator drive indicators of program progress rather than professional evaluators and outside experts (The California Endowment 2003).
3. Evaluator and participating stakeholders are responsible for data collection, analysis, and preparing final reports (The California Endowment 2003).
4. The local evaluator serves the role of coach, facilitator, negotiator, and "critical friend" rather than as just an expert or leader (The California Endowment 2003).
5. Rather than just consultant and expert fees, time, energy, and commitment from local residents, project staff, and other stakeholders are necessary. It requires the coordination of many players and they must be trained to develop skills to adequately evaluate (The California Endowment 2003).
6. This approach, utilizing local leaders and stakeholders will result in more local, relevant knowledge, as well of verification of information of key players, will build knowledge, skills, and

relationships from community residents and stakeholders and increases the relevance of the findings for each community (The California Endowment 2003).

Stakeholders are a key component of a multicultural evaluation. As discussed by the CDC above, a stakeholder analysis is the first step of the program evaluation process. This is especially true when considering a multicultural evaluation; the more stakeholders are involved, the more relevant the data, outcomes, and subsequent changes will be.

Summary of Other States' Cultural and Linguistic Assessment Programs

The literature reflects that the development and evaluation of cultural competency programs have taken place within a number of domains. The Lewin Group (2002) provides seven domains that provide a framework for organizing and reviewing a culturally competent organization. The seven domains are organizational values, governance, planning and monitoring/evaluation, communication, staff development, organizational infrastructure and services/intervention. This work will focus on four primary domains; they are governance, communication, staff development and organizational infrastructure. The aspects of the organization covered in each domain are described below:

Governance: The goal-setting, policy-making, and other oversight vehicles an organization uses to help ensure the delivery of culturally competent care.

Communication: The exchange of information between the organization/providers and the clients/population, and internally among staff, in ways that promote cultural competence.

Staff Development: An organization's efforts to ensure staff and other service providers have the requisite attitudes, knowledge and skills for delivering culturally competent services.

Organizational Infrastructure: An organization's delivery or facilitation of clinical, public health, and health related services in a culturally competent manner. (2002, p 5-6)

According to Beamon et al. (2006), states have generally taken one of two approaches to address the issue of cultural competency. They are either taking action through the use of policy or they are implementing programs and initiatives in conjunction with policy implementation. The states below have implemented policies and have programs that are assessing cultural competence in one aspect or another. Each state varies structurally, politically, and systematically. Thus, we have provided a summary of each state's main findings within each section.

California

In the state of California, the Office of Multicultural Services (OMS) under the California Department of Mental Health is responsible for implementing cultural competency into the Department's areas of expertise. Within OMS is the Cultural Competency Advisory Committee (CCAC). The committee is comprised of persons from "the California Mental Health Directors Association, mental health consumers and family members, cultural competency consultants, ethnic-specific programs, and university affiliates" (State of California, 2011). OMS is guided in its effort to promote cultural competency by such Federal authorities as Title VI of the Civil Rights Act of 1964, Executive Order 13166, August 2000, and CLAS. At the state level, the Office is guided by the Dymally-Alatore Bilingual Services Act of 1973, California Welfare and Institutions Code, Sections 14684 (h) and the DMH Information Notice No. 02-03, Addendum for Implementation Plan for Phase II Consolidation of Medi-Cal Specialty Mental Health Services – Cultural Competence Plan Requirements ("Fact sheet: language," 2009).

In their Cultural Competence Plan, the CCAC developed a list of eight criteria to be implemented by the counties' mental health systems. They are: 1) commitment to cultural competence; 2) updated

assessment of service needs; 3) strategies and efforts for reducing racial, ethnic, cultural, and linguistic mental health disparities; 4) client/family member/community committee: integration of the committee within the mental health system; 5) culturally competent training activities; 6) county's commitment to growing a multicultural workforce: hiring and retaining culturally and linguistically competent staff; 7) language capacity; and 8) adaptation of services ("California department of," 2011). The criteria relevant to the domains being discussed are addressed below.

Communication: California emphasizes linguistic competence.

As it relates to communication, California CCAC has focused on developing language capacity. CCAC asks the county to identify the number of bilingual staff members, show proof of evidence of procedures readily available for limited English proficiency (LEP) individuals, provide evidence that clients have been made aware of their right to have access to services in their language and documents, including all clinical findings and reports must be in the clients' preferred language (2011).

Organizational infrastructure: California emphasizes documented proof of a multicultural workforce.

CCAC promotes the Counties' commitment to growing a multicultural workforce by calling for the hiring and retention of culturally and linguistically competent staff (2011). The Department requires the counties to review the Public Mental Health Workforce Needs Assessment completed by John Shea, PhD in 2009. This document reviewed the workforce retained by the counties in comparison to the target population of the Department of Mental Health (Shea, 2009). Counties are asked to summarize whether they have obtained a multicultural workforce and whether they have reached the target audiences identified in the Needs Assessment ("California department of," 2011).

Staff development: California requires training for all staff.

OMS provides culturally competent training activities. The Department dictates that counties shall require cultural competence training every year for all employees and shall extend this invitation to shareholders. The Department requires the county to complete an assessment in which they provide the projected number of employees requiring training, an explanation of the topics of the training, pre and post test results for training completed and a protocol for ensuring the staff is utilizing the information and skills learned through the training sessions (2011).

Oregon

In 1999, the Oregon Legislature passed the SB 555 which required local communities to "incorporate diversity in the development of their local coordinated comprehensive plans for children and families. As the lead agency for guiding and coordinating comprehensive planning for children and families, the Oregon Commission on Children and Families (OCCF) and local commissions in each county play an important role in ensuring these principles are implemented" (Carley, 2010). Within this committee is the subcommittee called the Cultural Competency and Gender Specific Services Committee (CC&GSS). CC&GSS is responsible for developing "cultural competency requirements within the comprehensive planning guidelines, and providing technical assistance to communities while encouraging collaborations amongst the participants" (Sekino, n.d.); the participants are the Department of Human Services, Department of Education, Oregon Youth Authority, Department of Justice, Juvenile Departments,

County Commissions on Children and Families, and other government agencies and community based organizations.

The CC&GSS Committee developed a guideline of outputs and outcome measures to be used to analyze the success or lack thereof of the different partners. They identified specific outputs which encompassed those behaviors of the organization to promote cultural and linguistic competency and they identified outcome measures which would measure the success of the outputs (Partners for Children and Families, n.d.)

Another important initiative of Oregon worth mentioning is that the state underwent cultural competency training of their trainers. This training was designed to prepare a group of qualified culturally competent trainers to provide training to agencies, committees and departments. Training topics varied from culture definitions to such topics as the farm workers/migrant issues, bi-racial issues to lesbian, gay, transgender-sexual minority's issues (n.d).

Communication: Oregon emphasizes documented use of interpreters and translators.

CC&GSS requires the documented use of qualified interpreters and translators for LEP and non-English speakers. They also require documented culturally competent referrals for treatment and resources to match the client's needs.

Organizational infrastructure: Oregon promotes community engagement in all aspects of cultural competence development.

CC&GSS requires "organizations to develop participatory, collaborative partnerships with communities and tribes, and to utilize a variety of formal and informal mechanisms to facilitate community and client/consumer involvement in designing, implementing, and planning a service delivery system and cultural competency standards" (Partners for Children and Families, n.d.). CC&GSS also requires partners from all cultural and special populations of the community to be actively involved in the design and implementation, delivery and evaluation of programs and services, the development of the organization's cultural competency policy and plan and in the organization's advisory committees and workgroups (n.d.).

Staff development: Oregon ensures workforce diversity through interview questions and techniques.

Oregon's CC&GSS has worked within the domain of staff development in terms of workforce diversity by calling for the implementation of strategies to recruit, retain and promote a diverse staff at all levels and that leadership is representative of the population being served (n.d). They have also required a copy of all HR plans/policies in an effort to ensure that diversity is represented at all stages of the hiring process; CC&GSS look for plans that show evidence of interview questions that will assess a candidate's cultural competency, ability to work in a culturally diverse environment and ability to serve a culturally diverse population (n.d.). CC&GSS has also focused on the training of staff by requiring eight hours of annual training for all staff members.

New York

In the state of New York, the Bureau of Cultural Competence which is a subdivision of the Office of Mental Health (OMH) is responsible for integrating cultural competence within the policy, procedures and practices of the New York State's Mental Health System. The Bureau of Cultural Competency is

governed by Title VII of the Civil Rights Act of 1964, the National Standards on Culturally and Linguistically Appropriate Services (CLAS) and the Office of Mental Health Section of Mental Hygiene Regulation 527.4 which forbids discrimination against non-English-speaking and deaf or hard-of-hearing and requires that the services, communications and accommodations for these individuals reflect their culture (Bureau of Cultural Competence, 2010).

The Bureau of Cultural Competence provides a summary of their activities/accomplishments in regards to whether they have accomplished the goals they set out to achieve. Within this document, the Bureau discusses each plan and identifies the measures taken to successfully achieve those plans and the outcomes of these measures. The Bureau looked at goals within the following categories: Capacity/needs assessment, services, information exchange, human resources and outcomes (2010). The following section reviews their analysis in terms of the domains of communication, organizational infrastructure and staff development.

Communication: New York encourages the use of a website to facilitate communication.

The state required the “information exchange to facilitate the dissemination of information relevant to cultural competence to OMH facilities as well as licensed providers in order to improve their cultural competence; and to be the conduit of community based information that improves OMH policies and procedures for diverse cultural groups” (Bureau, 2011). The output for this domain was the dissemination and upkeep of the website for cultural competence information and tools.

Organizational infrastructure: New York participates in minority events to recruit a diverse workforce.

OMH uses “Human Resources to promote and sustain recruitment of culturally diverse staff reflective of NYS behavioral health system” (2011). The Bureau also participated in the Black and Latino Caucus and the Somos El Futuro (Hispanic Legislative Day) in an effort to recruit employees from these minority populations. Training was provided to staff regarding cross-cultural situations and the Bureau added 15 additional questions to test future applicants in their knowledge of cultural competence (2011).

Staff development: New York requires translation of services and documents into six different languages.

OMH developed “services to improve the quality of services for diverse cultural groups with respect to language accommodations, modifications to existing services and/or introduction of new services” (2011). This resulted in the development and presentation of training on language accommodations and the translation of legal documents requiring signatures into six languages.

Virginia Office of Cultural and Linguistic Competence and the Virginia General Assembly

The Virginia Office of Cultural and Linguistic Competency is governed by federal legislation and documents such as the Civil Rights Act of 1964, Executive Order 13166 and the Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons. The Office of Cultural and Linguistic Competence is also guided by Departmental guidelines such as the Departmental Instruction 209 (RTS) 95 Language Access Services for Individuals with Limited English Proficiency or Other Communication or Language Barriers, Department of Behavioral Health and Developmental Services Position Statement on Culturally and Linguistically Appropriate Services including DBHDS State Board Policy 1023 08-02. Dissimilar to a number of the other states evaluated, Virginia OCLC is not guided by any state legislation requiring the implementation of cultural competence into DBHDS’ services.

A review of the bills passed by the Virginia General Assembly indicates that there have been several bills and resolutions that have been passed requiring the implementation of cultural competence in other professions. There have been a number of bills passed in reference to cultural competency in the school system. In the 2000 session, House Joint (HJ) Resolution 234 was passed requiring cultural diversity competence training for all school personnel identifying and placing students in special education programs. In the 2001 Session, House Bill (HB) 2353 Cultural Diversity competency training of school personnel, passed with 23 yeas and zero nays. HB 2353 “Requires all persons subject to the Virginia Licensure Regulations for School Personnel to complete cultural diversity training as a condition of licensure and license renewal, effective July 1, 2003” (2001). As late as 2004, the General Assembly passed Senate Bill (SB) 222 Cultural diversity policies; establishment for local school boards & institutions of higher education which Requires the Board of Education to establish guidelines to assist school boards in developing cultural diversity policies that promote the knowledge of racial and ethnic cultures, and language minority populations represented in the public schools of the Commonwealth (2004). Also during the 2001 Session, the General Assembly passed HB 2502 Cultural diversity competency training for law enforcement officers which:

Clarifies that the Department of Criminal Justice Services must establish compulsory training standards in cultural diversity competency for basic training and the recertification of law-enforcement officers. Also provides that law-enforcement officers must have cultural diversity sensitivity, in addition to basic training in previous capacities as a law-enforcement officer, as a condition of exemption from certain mandatory training requirements (2001).

This is not to say that cultural competence within the Mental Health Department has not been considered or brought up in any of the sessions. In 2004, Senate Joint (SJ) Resolution 25 directed the Joint Commission on Health Care (JCHC) to complete a two-year study regarding the mental health needs and treatment of young minority adults in the Commonwealth (Joint Commission on Health Care, 2008). JCHC completed its study in 2007 and provided three policy options for the General Assembly to take:

Option 1: Take no action

Option 2: Request by letter from JCHC Chairman for the Virginia Department of Health Professions (or Board of Medicine/Psychology) to examine the issue of requiring cultural competence training for licensure of health practitioners. (Similar to New Jersey Senate Bill 1444 passed in 2005 and California Assembly Bill 1195 passed in 2006)

Option 3: Request by letter from JCHC Chairman for the State Council of Higher Education for Virginia (SCHEV) to examine the issue of requiring cultural competence training as part of college curriculum for health profession majors (2008). (Taking note of the Washington Senate Bill 6194) (JCHC, 2008).

In response to the study completed by JCHC, SJ 46 mental health needs and treatment of minority young adults, the Joint Commission on Health Care Studying was passed.

SJ 46 directs the Joint Commission on Health Care to continue its study of the mental health needs and treatment of young minority adults in the Commonwealth. In conducting the study, the Joint Commission on Health Care shall continue, among other things, to (i) estimate the number of mentally disabled young adults by gender, age, and racial and ethnic classification, in

the geographical regions of the Commonwealth; (ii) identify the prevailing mental health and emotional disorders and their etiology among minority young adults; (iii) identify the mental health needs of minority citizens, particularly minority young adults in Virginia; (iv) determine whether mental health care providers are trained to provide culturally competent mental health treatment; (v) assess the need for culturally competent mental health treatment in Virginia; and (vi) review federal and state laws and regulations governing the confidentiality of health care, mental health treatment, and medical records. The Commission must submit its findings and recommendations to the 2009 Regular Session of the General Assembly (2008).

As can be seen both in the report completed by JCHC and from the State's governance literature above, in comparison to other states, the Virginia General Assembly is behind the curve in enacting legislation mandating cultural competence into the mental health field in the state of Virginia.

The following is a review of the Virginia OCLC in terms of the domains:

Communication: Virginia seeks to eradicate language access barriers.

"Since the DBHDS system is legally required to comply with Title VI of the Civil Rights Act of 1964 and the provisions that prohibit discriminating on the basis of national origin, the OCLC focuses much of its time and resources on helping the system develop efficient and effective language services and policies" (DBHDS, 2009). Specifically, OCLC has promoted language access services in the following types: language access planning consultation, translation authorization forms in facilities and translation and interpretation grant proposals (2009).

Organizational infrastructure: Virginia focuses on hiring a bilingual staff.

The Office of Cultural and Linguistic Competence has promoted workforce diversity by focusing on hiring a bilingual staff. OCLC has also used its data collection as a method to measure and develop "targeted interventions to improve the quality of care delivered to specific organizations" (2009). These data collection methods include surveying on the perceived importance of cultural and linguistic competence, surveying on perceptions of mental health disparities, conducting a system survey on cultural and linguistic competence and the addition of CLC questions to the annual consumer survey (2009).

Staff development: Virginia provides cultural competence training across the system.

The Office of Cultural and Linguistic Competence promotes staff development by providing training in a number of areas, including CLAS Standards and how to use them to promote cultural competence within the workforce environment, cultural awareness and having a video series on race and class (2009). The office also conducts training for personnel providing the cultural and linguistic training.

Recommendations

Based on the information learned through the literature, nine recommendations have been developed for implementation by the OCLC. They are as follows:

1. *Incorporate cultural competence questions in prospective employee interviews.* By employing individuals who are from the cultures being serviced, the Department will be better able to relate to and provide services consistent with the client's natural systems. A culturally proficient organization seeks out culturally competent prospective employees (Cross et al. 1989).

2. *Conduct an organizational-wide assessment.* An organizational-wide assessment provides a baseline for determining where DBHDS falls on the cultural competence continuum. By undergoing an assessment, an organization makes a public statement about their commitment to cultural competence and the principles it espouses (Olavarria et al. 2009). It also allows time for an agency to measure and reflect on the extent to which they are meeting the needs of its unique clients. Short- and long-term strategic planning processes are strengthened when assessment results are used to inform the process (Olavarria et al. 2005). Strengths and areas of need, both at the individual and systemic levels, can be determined during an organizational cultural competence assessment (Olavarria et al. 2005).
3. *Develop ways to utilize captured data from the management information system.* The management information system could serve as a bridge between stakeholders and as a tool for sharing knowledge with peers. Captured data is useless unless it is used to guide decision-making and planning. Performance measures can be valued if a management information system is used to capture data (Siegel et al. 2000). Etsy & Rushing (2007) suggest that data driven decision-making will lead to a more responsive government that makes decisions based on an empirically based process rather than on experience, instinct, dogma, or beliefs. The use of information dashboards, a visual representation of data, began in the corporate world, but is being utilized by public agencies (Gorcester & Reinke 2007). By using a dashboard, an agency can take data, “consider it, debate it, and heed it in making decisions” (Gorcester & Reinke 2007, 53). Collected data is meaningless until it is analyzed. Attached in Appendix 2 is an example of a data dashboard.
4. *Evaluate data collection methodology to identify additional needs.* Each CSB, hospital, and private provider has its own unique set of needs. Therefore, each entity will benefit from its own cultural competence assessment. While the evaluation is locally based, the OCLC should ensure that data is collected and analyzed in a consistent manner.
5. *Translate all legal documents and correspondences into the languages of the 2nd and 3rd largest groups served by DBHDS.* This allows the conduction of services to go further than just providing an interpreter to explain the documentation being provided. It allows the client to read and understand the documents for him/herself.
6. *Conduct a client perspective assessment.* Introducing cultural competence attitudes, beliefs, and practices across the system will result in increased patient satisfaction and better health and social outcomes for the patient.
7. *Create a more diverse staff within the system.* There should be an intricate web of diverse stakeholders across mental health consumers, private consultants, university staff, and government agencies. One method of ensuring diversity is through the use of a board matrix. Nonprofits use board matrices to ensure board diversification. The matrix attached as Appendix 3 can be used to diversify the staff and the board.
8. *Join forces with the Joint Commission to inform the Virginia General Assembly.* By mandating the monitoring of cultural competence programs, legislators can ensure accountability for public funding, provide a mechanism for increasing equity, and potentially decrease health care costs.

9. *Incorporate evaluation into day-to-day program operations.* The assessment or measurement of cultural competence is an important aspect of organizational behavior and should be a regular management function. Assessment is not an isolated event; it is an integral part of an organization's regular performance and quality assessment activities.

Conclusion: Cultural Competence is not an Endpoint – It is a Journey

The field of cultural competence is still emerging (Betancourt et al., 2005) with a need for definitional clarity and empirically-based research to secure future funding for the effort. Making the connection between culturally competent care and improved health outcomes will make it easier to argue the relevance of cultural competent care. The emergence provides the Virginia OCLC with the opportunity to emerge as a leader in cultural competence.

A clear picture of the cause of disparities is difficult due to external factors outside of the health care delivery system (Betancourt et al. 2003). According to Siegel et al. (2000):

Ongoing cultural competency activities are expected to result in favorable consumer outcomes. However, since outcomes are influenced by multiple factors other than cultural competency activities of the care organization, outcomes of persons in multicultural groups need to be compared with those of other groups in the same environments. It is inconsistencies in these outcomes that can provide an indication of whether cultural competency principles are in effect (99).

Despite the cultural competence definition ambiguity and a multitude of external factors to consider, cultural competence continues to be seen as a way to increase equity for underserved populations (Betancourt et al. 2003).

The movement of an organization from mismanagement, be it intentional or unintentional, to one that focuses all efforts on providing respectful care for all consumers is a complex process (Cross et al. 1989). By joining forces with the Joint Commission and the Virginia General Assembly, the Virginia OCLC can realize their role as an agent of change in the Department of Behavioral and Developmental Services system of care. Legislative mandates requiring cultural competency will influence the work of all stakeholders in the fight to provide quality care.

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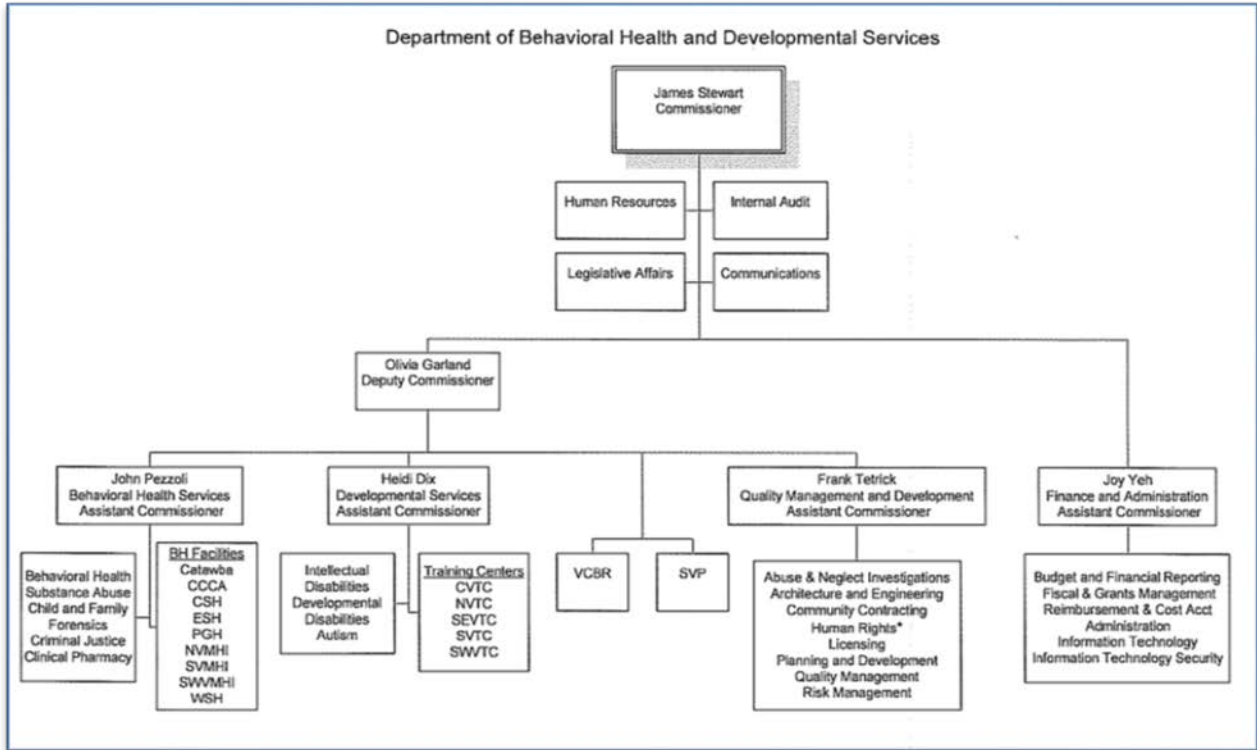
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Appendix A: Organizational Chart



Appendix B: Organizational Template

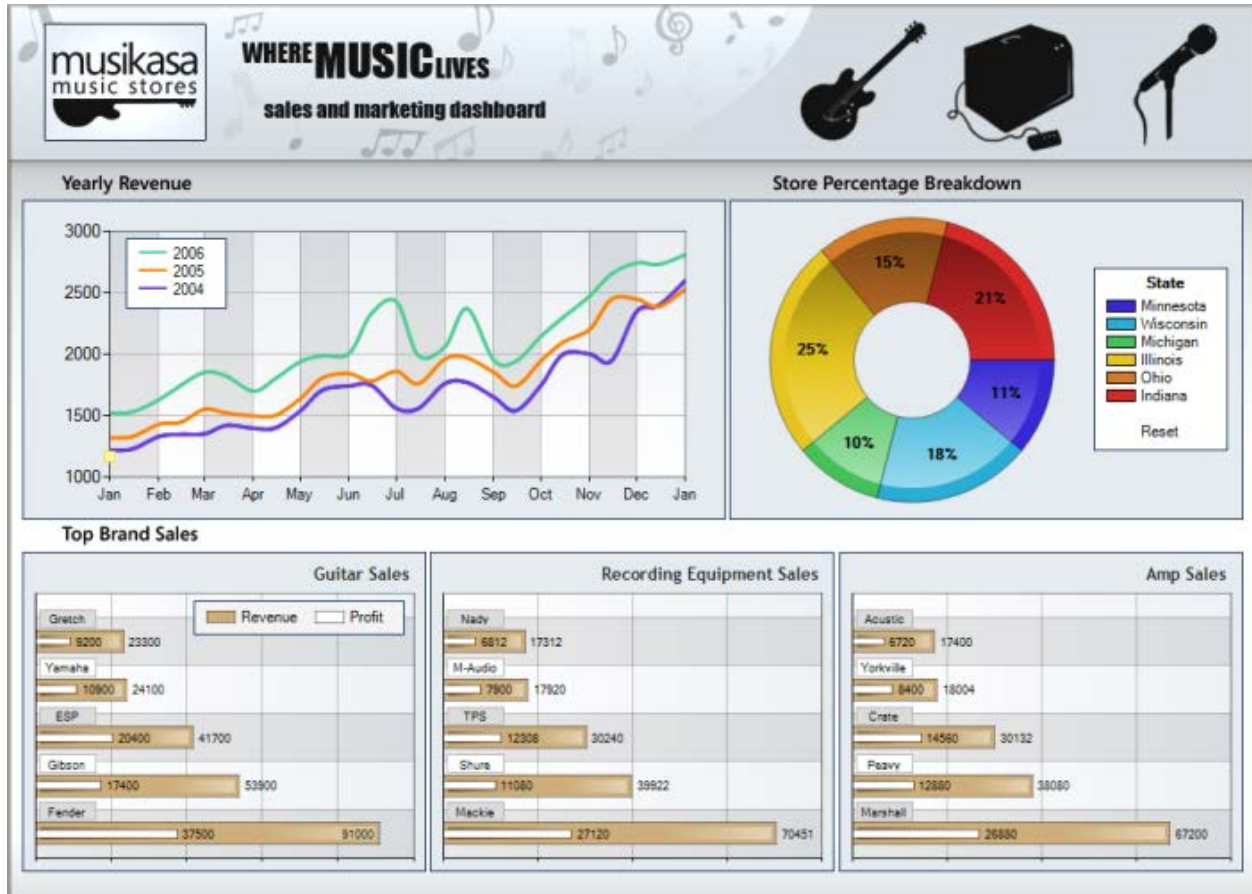
Communication		Fully Implemented	Partially Implemented	Not Implemented; Planning to Implement	Not Implemented; Not Planning to Implement
The exchange of information between the organization/providers and the clients/population, and internally among staff, in ways that promote cultural competence.					
Criterion 1:	Cultural Competency Supportive Content				
	Development/distribution of cultural behavioral health materials				
	Through presentations, talks, etc.				
	By print media				
	By workshops				
	By internet				
	Through intra-departmental memos				
	Other, specify (not scored)				
Criterion 2:	Provision of Language Assistance Services				
	Translation of materials to the 2nd and 3rd largest groups served				
	Bilingual Staff				
	Interpreter Services				
Criterion 3:	Community Involvement in Culturally Competent Activities				
	Material reviewed by local experts				
	Family education and support groups				

Staff Development		Fully Implemented	Partially Implemented	Not Implemented; Planning to Implement	Not Implemented; Not Planning to Implement
An organization's efforts to ensure staff and other service providers have the requisite attitudes, knowledge and skills for delivering culturally competent services.					
Criterion 1:	Culturally Competent Training Activities				
	Training plan				
	Funds are allocated for training and continuing education related to cultural competence				
	Evidence of training				
	Training for all staff				
	Report of training				
Criterion 2:	Commitment to Growing a Multicultural Workforce				
	Staff composition reflects the demographics of the service area				
	Complete a workforce needs assessment				
	Interview questions that reflect knowledge of cultural competence of the interviewee				
Criterion 3:	Performance Review				
	Cultural Competence as part of personnel performance reviews				
	Incentives for continued culturally competent practices				

Organizational Infrastructure		Fully Implemented	Partially Implemented	Not Implemented; Planning to Implement	Not Implemented; Not Planning to Implement
An organization’s delivery or facilitation of clinical, public health, and health related services in a culturally competent manner.					
Criterion 1:	Documents and policies are reviewed annually to ensure compliance with culturally competent principles				
	Mission statement				
	Vision statement				
	Strategic plans				
	OCLC cultural and linguistic plan				
	Policy and procedure manuals				
	HR employee handbook/orientation materials				
	OCLC training manual/toolkits				
	Contracts with stakeholders				
	Other key documents as identified by OCLC				
Criterion 2:	Community members within the service area are given the opportunity to provide feedback on the level of cultural competence in the services provided.				
	Clients are asked to complete satisfaction surveys				
	Local council meetings and advisory meetings serve as a forum for consumers, family members of consumers, and key community leaders dedicated to improving behavioral health services				
	Provider town-hall meetings allow stakeholders to develop transparent channels for information sharing an anecdotal evaluation.				

Criterion 3:	Proof of Evidence				
	Documentation of languages available at point of first contact and trained translators/interpreters available and in-language clinicians/staff.				
	Leadership accountability and oversight mechanisms				

Appendix C – Data Dashboard Example

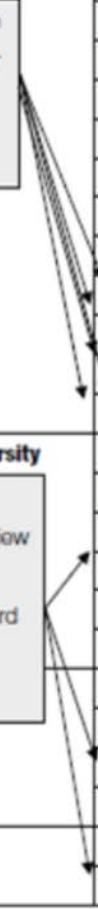


Appendix D – Sample Board Matrix

	Board Member Name										
	Years on Board										
Relationships	Access: Community leaders and groups										
	Access: Grassroots leaders and groups										
	Access: People with money										
Area of Expertise	Public Relations										
	Financial Management										
	Fundraising										
	Human Resources										
	Legal										
	Planning										
	Business										
	Faith-Based										
	Public Sector										
	Education										
Sector	Philanthropic										
	Neighborhood/geographic location										
	Ethnic Diversity	Caucasian									
		Native American									
		African American									
		Latino / Latina									
Asian or Pacific Islander											
Age	Other										
	Over 65										
	51-65										
	36-50										
Sex	20-35										
	Female										
	Male										

Identify areas of expertise needed to provide proper oversight for the type of work you do

Diversity is important to bring various points of view and insights. It is also important to have a board representative of your constituents.



Appendix E – States’ Domain Comparison Chart

Communication

- California - identifies bilingual staff, shows proof of evidence of procedures for LEP clients and proof that clients are made aware of their rights to have access to services in their languages.
- Oregon - documented use of qualified interpreters and translators when necessary and documented culturally appropriate referrals to treatment services and resources that match the client's needs.
- New York - cultural competency tools and information disseminated on the website.
- Texas - developed collaborative partnership between researchers, practitioners, policy makers and community.
- Arizona - once it is known that a language is spoken by 3,000 individuals or 10% of the population (whichever is less) then all materials are translated into that language; within 10 days of their first service , clients are provided a list of all providers in the network that speak their language.
- Virginia - language access planning including translation of documents.

Staff Development

- California - annual cultural competence training for all staff, pre and post test training evaluations, development of protocol to ensure that staff is utilizing the learned skills.
- Oregon - cultural competence included in overall staff development/training plan, all employees/volunteers engage in eight hours of annual cultural competence training.
- New York - developed & presented training on language accommodations, translated legal documents requiring signatures into six languages.
- Texas - focuses efforts on identifying and placing culturally competent staff in areas of benefit.
- Arizona - training to increase awareness of cultures .
- Virginia - training of trainers; including training on the implementation of language services, CLAS standards training and general cultural competence care training.

Organizational Infrastructure

- California - hiring & retention of diverse staff, review of the target population's needs in light of workforce diversity, requires counties to report on the workforce composition and population demographics.
- Oregon - includes the community to identify and address issues with cultural competence implementation and development.
- New York - participates in cultural events such as the Black and Latino Caucus for recruitment, cross cultural training sessions and prospective applicants are tested for cultural competence.
- Texas - systems approach that focuses on organizational components that impact cultural proficiency by promoting ongoing assessments and staging of recommendations for actions
- Arizona - development of alternative training mechanisms.
- Virginia - hiring of qualified bilingual staff training program initiated.