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Nassau Partnership for Healthy Communities
Cultural Competency Self-Assessment

Summary Report of
Findings and Recommendations

V. Elaine Gross, President
Veronica L. Todaro, Senior Program Consultant

6800 Jericho Turnpike, Suite 109W
Syosset, NY 11791-4401
516-921-4863 (phone) 516 921-4866 (fax)
www.eraseracismny.org

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I. Acknowledgements

ERASE Racism would like to acknowledge those organizations and individuals that were essential to the design, creation, and implementation of the Nassau Partnership for Healthy Communities (NPHC) Cultural Competency Self-Assessment project. First, we wish to recognize the North Shore Long Island Jewish Health System (NS-LIJ) for their leadership in obtaining and administering the federally-funded Healthy Communities Access Program (HCAP) grant that, through the NPHC initiative, supported the work of Cultural Competency Self-Assessment project

We would also like to thank the NPHC Cultural Competency Sub-Committee* for providing direction on the overall goals and objectives of the Cultural Competency Self-Assessment project as well as offering feedback in the development of the survey tool that was administered to participating health care providers. The Sub-Committee met monthly and played an essential role in shaping this project.

This project was dependent on the expertise, commitment, and initiative of staff from both ERASE Racism and NPHC. Lori Andrade, former Project Manager with ERASE Racism, and Jill Williams, former NPHC Cultural Competency Coordinator, did an excellent job researching and developing the assessment tool and we are grateful for their collaborative work. Ronnie Todaro, Senior Program Consultant with ERASE Racism, subsequently conducted the analysis of the survey results and produced this insightful and sensitively written report.

Most importantly, we would like to thank the six health care providers who volunteered to participate in the Cultural Competency Self-Assessment project by completing the survey tool. Please note: In the interest of confidentially, the names of the participating health care institutions are not listed in this version of the report. The contribution of their time and resources, and willingness to share information about their organizational cultural competency policies and practices not only provided tremendous insight and food for thought, but laid the groundwork for moving forward in promoting culturally competent health care service delivery in Nassau County.

**NPHC Cultural Competency Sub-Committee members in 2004 are as follows: V. Elaine Gross, Co-Chair; Emanuel Andinam, Ph.D., Co-Chair; Lori Andrade; Rose Guercia, MD; Faroque Kahn, MD; Donna Kass; Sandra Mahoney; Marion Terry; Jill Johnson Williams; and Vicky White.*

Cultural competency: "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."[1]

II. Introduction

In 2004, the Nassau Partnership for Healthy Communities (NPHC) initiative, contracted with ERASE Racism to lead the process of designing and testing a cultural competency self-assessment tool for primary and specialty ambulatory care providers participating in the NPHC consortium project.

ERASE Racism is a non-profit organization dedicated to identifying and addressing the policies and practices that perpetuate institutional and structural racism with a focus in health care, housing, and public school education. The organization has a strong track record in working with foundations and organizations to identify and address organizational practices and policies that may inadvertently create barriers that inhibit institutions from becoming more culturally responsive.

ERASE Racism is also one of the few organizations in the country with an explicit mission that focuses on institutional and structural racism as a means to: decrease racial inequity; stem disparities in opportunities; services, and resources; combat disparate social, health, education, and economic outcomes; and help organizations become more culturally responsive. Institutional racism usually goes unnoticed and unchallenged, which is why it can be perpetuated by seemingly benign policies, practices, behaviors, traditions, and structures. Attaining cultural competency can pose a significant institutional challenge as it intersects with numerous areas within an organization.

In addition to ERASE Racism's work in assessing organizational cultural competency, the group provides direct assistance in implementing institutional change. Just recently, ERASE Racism designed and implemented a seminar as part of the curriculum for Stony Brook Medical School students in Stony Brook, New York, on the importance of cultural competency in health care.

The federal Healthy Communities Access Program (HCAP) grant provides funding for the NPHC project that is administered by the North-Shore-Long Island Jewish Health System (NS-LIJ). The NPHC collaborative includes healthcare providers, social service agencies, and community-based organizations. Through NPHC, these groups and individuals collectively seek to reduce health care disparities and increase both access to services and improved health outcomes in underserved communities within Nassau County.

The target population for this program is the uninsured and underinsured of Nassau County, with special emphasis on eight high-risk zip codes where rates of diabetes, HIV, hypertension, and substance abuse disproportionately impact residents. These zip codes include Inwood, Hempstead, Freeport, Roosevelt, Uniondale, Westbury, Long Beach and Elmont. The eight communities represent a majority of Nassau's Black and Hispanic residents (56% of the total of 276,267 reported in the 2000 Census) as well as undocumented immigrants who may not be adequately represented in the Census count.

[1] U.S. Department of Health and Human Services, OPHS Office of Minority Health National Standards for Culturally and Linguistically Appropriate Services in Health Care, see Appendix A.

The Need for Cultural Competency
The National Center for Cultural Competence at the Georgetown University Center for Child and Human Development articulates six salient reasons for review of cultural competence within health care organizations:

- To respond to current and projected demographic changes;
- 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 health outcomes;
- To meet legislative, regulatory, and accreditation mandates;
- To gain a competitive edge in the market place; and
- To decrease the likelihood of liability/malpractice claims. [2]

NPHC collaborative recognized cultural competency as a critical component in the provision of quality health care services to Nassau County's underinsured and underserved particularly given the changing demographics of the County. The NPHC Cultural Competency Self-Assessment project provides the collaborative with a framework by which to consider these changing racial and ethnic demographics and its impact on the delivery of health care.

The Purpose of the NPHC Self-Assessment
The purpose of the NPHC Cultural Competency Self-Assessment was to offer providers a framework for determining their organization's capacity to deliver culturally competent health care services as a means of improving access to care, quality of care, and health outcomes for patients. The tool allowed for the assessment of structures, policies, and practices within the organization, such as:

- Availability and use of patient demographic data in planning, service delivery, and evaluation;
- Monitoring and use of health outcomes in planning, service delivery, and evaluation;
- Level of cultural and ethnic diversity among leadership and staff;
- Existence and effectiveness of formal policies and practices for the recruitment, hiring, retention, promotion, and management of grievances/complaints;
- Staff education and training policies, practices, and effectiveness;
- Extent of verbal and written language assistance;
- Inclusion of patients and community members in planning and service delivery;
- Outreach and education programs and services; and
- Facility location and environment.

[2] National Center for Cultural Competency, *"Why is There a Compelling Need for Cultural Competence?"* http://gucchd.georgetown.edu/nccc/cultural5.html, (accessed April 8, 2005).

These areas were identified for their value in creating an overarching snapshot of the capacity of the health care service provider in meeting the needs of patients, as well as serving as discreet organizational areas for cultural competence development. In addition, the categories are aligned with the U.S. Department of Health and Human Services OPHS Office of Minority Health National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS).

It is important to note that the NPHC Cultural Competency Self-Assessment was not developed as a mechanism for comparing one provider with another, but as a tool for individual organizational use in the creation of a cultural competency roadmap. One organization may use the self-assessment as a baseline for the creation of a number of new initiatives, systems, and structures, while another may use it as an annual checklist for review of practices and policies that are currently in place.

It is also important to recognize that there are a number of regulatory and professional standards that health care providers are compelled to adhere to, such as the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), Equal Employment Opportunity (EEO) laws, Office of Civil Rights Limited English Proficient (OCR LEP) guidelines, etc., many of which influence health care provider policies and procedures. A logical next step for health care providers would be to take this dynamic into account through a more detailed analysis of the ways in which regulatory and professional standards negatively and positively influence and direct cultural competency within the health care delivery setting.

The NPHC Cultural Competency Self-Assessment Process

ERASE Racism worked in partnership with NPHC staff and the Cultural Competency Sub-Committee, comprised of health care providers and community members, to develop a survey that drew upon the U.S. Department of Health and Human Services National Standards for Culturally and Linguistically Appropriate Services in Health Care (please see Attachment A), the work of Dennis Andrulis, a research professor at Downstate Medical Center Brooklyn and a recognized expert on cultural competence in health care, and literature review conducted by ERASE Racism staff.

In developing the Self-Assessment tool with NPHC and the Cultural Competency Sub-Committee, it was decided that the focus of the project would be on ethnic, linguistic, and racial competency. It is acknowledged that there are other areas of cultural competency that are well worth examining and not considered within this project, such as religion and sexual orientation.

A group of six health care providers volunteered to participate in the cultural competency self-assessment project.[3] These providers completed the self-assessment tool with the understanding that information provided would be treated in a confidential manner.

ERASE Racism compiled and analyzed the Cultural Competency Self-Assessment responses and provided a detailed blinded summary report to NPHC leadership. This report included tabulations of each question response in chart format and specific findings and recommendations for each of the forty-six questions contained within the Self-Assessment. The detailed report of tabulations, findings, and recommendations was also sent to each of the six participating providers for review and commentary. Feedback from NPHC leadership and

[3] One of the self-assessment survey respondents is not an ambulatory care provider. While the purpose of this project was to focus on outpatient care, we felt that it was important to include this provider's information in the findings and recommendations.

participating health care providers was incorporated into a draft summary report of findings and recommendations. This summary report was distributed to NPHC leadership, the six participating providers, and the NPHC Cultural Competency Sub-Committee for review and commentary.

The Cultural Competency Self-Assessment project is a critical first step in developing a cultural competency framework for the NPHC collaborative as a whole as well as for individual health care providers in fostering a process, programs, policies, and services that ultimately result in better quality of care and health outcomes for Nassau County residents.

III. Provider Feedback on the Cultural Competency Self-Assessment

The health care provider feedback on the NPHC Cultural Competency Self-Assessment was positive. Specifically, providers reported the following:

- Three providers who completed the evaluation form reported that the survey took 5 to 6 hours to complete. Another provider stated that the survey was done over a four week period and another said that it took "a long time."
- Four providers did not find the questions to be confusing or requiring an inordinate amount of time to answer. However, one provider found the scoring of "effectiveness" to be subjective, adding that, "this suggests that the tool is an important part of a larger dialogue which requires each "member" to hear the perspective of the other." A similar comment was offered by another provider who stated, "There were questions where our leadership did not agree on the answer. Those took more time to think through."
- Three providers did not find that there were any specific questions that they were unable to answer due to lack of available data. One of the two providers unable to answer some of the questions does not provide outpatient care.
- Four providers found the tool easy to complete. One provider stated that, "each question is presented clearly and succinctly." Another stated that it was "time consuming but not difficult."
- All providers found that the process gave their organization a fair and accurate portrait of the cultural competence of their organization. One provider noted that, "the tool can be an effective component of a larger discussion, but cannot stand alone as a definitive portrait," while another provider commented that, "the survey does not really assess the experience of clients and whether they find our organization to be welcoming and meeting their needs." This provider also stated that they do attempt to get this information through patient satisfaction surveys.

IV. Cultural Competency Self-Assessment Findings and Recommendations

Providers are doing good work in attempting to meet the racial, ethnic, and linguistic needs of their patient population within a health care environment. Services and programs are reflective of this. At the same time and as anticipated, there is room for growth and improvement. This is completely expected given the complexity of health care institutions and multiple aspects of cultural competency.

As mentioned earlier, the intention of the self-assessment is not to compare one provider with another or to pass judgment, but to offer insight and information useful in continuously improving the cultural competency policies and practices of Nassau County health care institutions that serve a diverse patient population. It became apparent through the analysis of the Cultural Competency Self-Assessment results that responses to survey questions almost always brought to light additional questions that could be asked to further develop a snapshot of each organization's cultural competency capacity.

Overall, those providers participating in the NPHC Cultural Competency Self-Assessment have incorporated specific policies and practices to meet the cultural and ethnic needs of their patient population.

Key Findings

The following are the key findings of the Cultural Competency Self-Assessment as it relates to overall provider response, again with the caveat that these findings are presented not to compare providers or mark some providers as doing a "better" job than others, but to offer insight into the general status of cultural competency among those providers who voluntarily participated in the self-assessment process**.**

- **Use of Patient Demographic, Health, and Community Information**: Overall, those providers participating in the self-assessment use some combination of demographic, health care outcome, and community data for planning and program development.
- **Board and Staff Diversity:** There is diversity within certain staffing areas in each organization, with a particular concentration among those positions that are considered "frontline" such as nursing and administrative staff. Lack of diversity was the most apparent among board members.
- **Staff Education and Training:** Across the board, providers use training, orientation, and reading materials as methods to improve cultural competency. Education is provided to clinical staff on the special needs of racial and ethnic patients. In almost all instances, cultural competency is required of staff at least once per year. Providers rate their cultural competency training as effective.
- **Language Assistance:** All providers inform patients of their rights and the availability of language assistance services. They universally use in-house staff, bilingual staff, and telephone language lines for interpretation and translation services. Providers offer a majority of materials in a language other than English, however most do not offer translation of information in areas such as medical discharge instructions and directions to the medical facility. Less than half of the providers conduct quality assessments of their interpretation services.

- **Community Partnerships and Collaboration:** All providers have a community advisory board and half have some form of a diversity committee/cultural competency advisory board with community representation. All providers, to varying degrees, conduct outreach in places of worship, community meetings and schools and offer special health care programs for racially diverse communities. Almost all providers utilize ethnically and racially diverse media sources, again, to varying degrees.

Findings and Recommendations by Cultural Competency Area

The following are specific findings and recommendations for each of the five cultural competency areas assessed through the project:

A. Use of Patient Demographic, Health Outcome, and Community Data

Finding

Overall, those providers participating in the self-assessment use some combination of demographic, health outcome, and community data for planning and program development. Information on health outcomes is attained from sources such as the Nassau County Health Assessment, the Partnership for Healthy Moms and Babies, and adverse discharge rates for Ambulatory Care Sensitive Conditions. Systematic collection, analysis, and use of data are critical to shaping cultural competency policies and practices.

Recommendations

- **Assessing data collection types and needs:** A critical indicator of an organization's commitment to cultural competence is cultural competency-related data collection.[4] A level of analysis that may prove helpful would be to assess whether there is additional demographic information that may offer a deeper and broader perspective when examining the direction and focus of cultural competency policies and programs.
- **Aligning demographics, health care needs, and programs and services:** It would be useful to do an analysis of cultural competency needs through an evaluation of the alignment among: demographic profile information on ambulatory patients by zip code/town; defined service area by zip code/town; and current programs and services. The next level of analysis would be to do a detailed mapping of these components. There was a slight discrepancy in how demographic information was provided, with some respondents offering data by zip code and/or town and while another provided a visual map documenting patient volume by zip codes.
- **Identifying needs for improvement in data type and collection systems:** An additional level of analysis would be useful to determine what formal responsibilities and systems are in place for obtaining, reviewing, using, and modifying categories of patient demographic information.

[4] The Lewin Group, *Indicators of Cultural Competence in Health Care Delivery Organizations: An Organizational Cultural Competence Assessment Profile*. Prepared for The Health Resources and Services Administration, U.S. Department of Health and Human Services, (April 2002) p. 17.

- **Patient demographics and inclusion of "multi-racial":** All providers collect demographic information pertaining to race, while, based on responds to the survey, few providers use the category of "multi-racial." A logical follow-up question to providers is whether there are plans to include a multi-racial category in the future (U.S. Census Bureau is now including the multi-racial categorization in their data collection and reporting).
- **Services to those with hearing, visual, and limited English proficiency:** On average, approximately half of the providers collect information on those with special hearing, visual, and limited English proficiency needs. How hearing and visual needs are met in relation to education, training, materials, etc. was not specifically determined through the self-assessment and would be a logical point of follow-up.
- **Use of health outcomes to define programs and services:** Almost all providers use health outcomes to define new community health initiatives. There seems to be varying levels of access to and use of types of data. It would be advantageous for providers to collaborate on health outcome review and program development as appropriate so that there is uniformity in how needs are assessed and services are targeted and developed.

Provider Focus: *All five of those providers using health outcomes to define programs and services offered examples, such as using indicators to create programs to address higher rates of death by breast cancer and cervical cancer, blood pressure screening, pre-natal care, chronic diseases, and kid's health. More specifically, one provider created operating metrics to monitor the distribution and allocation of community health resources, with preference given to the allocation of resources to high need areas, defined as communities in the top quartile county-wide of adverse discharges rates for Ambulatory Care Sensitive Conditions (ACS)(inpatient admissions that could have been avoided if adequate primary care was available). This provider is expanding on this strategy throughout 2005 by reaching out to the community to explore opportunities for the creation of a shared "Community-Based Participatory Research" (CBPR) program that will target high-need communities. Another provider cited the use of the Nassau County Health Assessment as well as other sources of community health data for defining new initiatives.*

B. Board and Staff Diversity

Finding

There is diversity within certain staffing areas in each organization, with a particular concentration among those positions that are considered "frontline" such as nursing and administrative staff. Lack of diversity was the most apparent among board members. It is recognized that attaining staff and board diversity is a function of many complex factors that are not unique to health care institutions, such as workforce demographics.

There is low representation of people of color among board/trustees and senior management. This is a critical issue given that most successful cultural competency initiatives are dependent on support from the top. (It is recognized that diversity does not necessarily guarantee embracing cultural competency policies and practices, however it is an indicator of organizational behavior and practices.)[5]

Recommendations

- **Increasing board diversity:** Board diversity is a continual challenge faced by many organizations and is an area where thoughtful dialog would be useful on obstacles and successes to shaping a board that is more representative of the community served.
- **Role of board leadership**: Providers may wish to examine the role of board leadership in developing the cultural competence of the organization through such means as the creation of a board diversity initiative and/or cultural competency committee.
- **Comparison of patient profile and board/staff profile:** The assessment found that there were significant differences among board demographics and patient demographics. While it is acknowledged that there are a number of factors that influence board and staff composition, providers may wish to examine the relationship between patient demographics and volunteer leaders and staff as an additional means of gauging diversity and cultural competency policies and practices.
- **Human resources policies and practices:** Most providers responded that they do not have written policies and practices for the recruitment, hiring, retention, promotion, and management of grievances/complaints as it relates to various race and ethnic groups. However one provider responded "yes" and stated that "all ethnic and racial demographic groups have been impacted by these policies." This leads to the conclusion that some follow-up questions and further analysis would be helpful in determining the extent to which providers are utilizing human resources opportunities to expand cultural competency.

[5] The Lewin Group, p. 17.

- **Complaints, retention, and promotion:** In general, providers have found that complaints, retention, and promotions are the same for staff of color when compared to white staff. Differences, where found, were positive, for example, a decrease in complaints or an increase in retention and promotions among staff of color. It may be helpful to examine how this information is collected and give some thought to whether there would be increased complaints, retention, and promotions across the board if written policies where adopted and promoted.

C. Staff Education and Training

Finding

Across the board, providers use training, orientation, and reading materials as methods to improve cultural competency. Education is provided to clinical staff on the special needs of racial and ethnic patients. In almost all instances, cultural competency is required of staff at least once per year. Providers rate their cultural competency training as effective.

Recommendations

- **Special needs education:** Providers educate all or some clinical staff on the special needs of racial and ethnic patients, such as cultural beliefs and practices, adherence to treatment regimens, perception of illness and treatment, and death and dying rituals. It would be of value to examine the type of education that is provided and how effectiveness is measured.

> ***Provider Focus****: One provider stated, "Low health literacy occurs across all socioeconomic and racial/ethnic groups in society. As such, clinical staff is encouraged to be cognizant of this issue. Through the use of the nursing education form, nurses are trained to pick-up problems related to health literacy. This would include confirming that the patient understands any physician orders that were provided during their visit including how/when to use their medication." Another provider noted that they employ a "cultural initiatives assistant" who conducts training of staff.*

- **Training, orientation, and materials:** All providers use training, orientation, and reading materials as methods to improve cultural competency and in almost all cases rate their methods as 4 on a scale of 1 to 5. It would be useful to identify the types of materials utilized, the source of the materials, and who provides the trainings as well as how ratings are determined. For example, is the rating based on management, staff, and/or patient input.

  Cultural competency training is required for staff with the exception, in some instances, of physicians. Board/trustee training is voluntary. Providers may wish to require training for physicians as well as board/trustees.

  All providers require cultural competency training at least once per year and overall, rate their trainings as effective in the areas of patient care, medical error, and workplace relationship effectiveness. As with other education and training, it would be useful to have a greater understanding of the source and type of materials, who provides the training, and how effectiveness is measured.

Provider Focus: *One provider noted that, "cultural competence training is incorporated into all aspects of the organization, through a specific organizational program. In addition staff may receive continual cultural competence training through service trainings and staff enrichment day." The provider also cited existence of an organizational diversity initiative." Another provider reported the implementation of "departmental diversity focus groups in nursing."*

- **Interpreter and clinical staff training:** The majority of providers offer training to clinical staff on communications with non-English speaking patients and on low health literacy. None offer clinical staff training on the inability to read/write in one's native language. Fewer providers offer interpretation for patients in relation to cross-cultural terminology and racial/ethnic cultural traditions.

  It would be helpful for providers to determine patient needs in the areas of interpretation of cross-cultural terminology and racial/ethnic cultural traditions as well as clinical staff training on low health literacy and inability to read/write in one's native language. As with other aspects of this assessment, there may be opportunities for sharing information and collaboration among providers.

Provider Focus*: One provider noted that they offer medical interpretation services for staff that are taught by the NYU School of Immigrant Health, with department managers actively recruiting staff within their departments to maximize utilization of these services. The classes are not limited to Spanish/English bi-lingual staff – they are open to any staff member that also speaks a non-English language.*

One provider mentioned the provision of in-house training for clinical staff in communicating with patients with low health literacy via educational curriculum and reinforced by mentors.

- **Rewards for exceptional work contributing to cultural competence**: Providers may wish to consider offering a formal rewards system for staff work contributing to cultural competence. One provider offered such a program – in the form of honoring staff that participate in three events held in diverse community areas per year at an annual employee recognition awards breakfast.

D. Language Assistance

Finding

All providers inform patients of their rights and the availability of language assistance services. They universally use in-house staff, bilingual staff, and telephone language lines for interpretation and translation services. Providers offer a majority of materials in a language other than English, however some do not offer translation of information in areas such as medical discharge instructions and directions to the medical facility. Less than half of the providers conduct quality assessments of their interpretation services.

Recommendations

- **Patient rights and language assistance information:** All providers stated that they inform patients of their rights and the availability of language assistance services. Two of the providers stated that they provide a written Patient Bill of Rights to patients when they register.

  It is useful for providers to use a variety of venues for the provision of information on patient rights and the availability of assistance services. For example, if not already employed, it may be helpful to use a combined approach of posting a sign in the waiting room with information about patient rights in multiple languages, accompanied with written materials and a systematic approach for communicating this information via clinical staff.

- **Translation services:** Providers universally use in-house staff, bilingual staff, and telephone language lines for interpretation/translation services, with a small number incorporating community volunteers and contracted interpreters. Providers may wish to compare language assistance tools with the needs of their patient population to ensure alignment between the two.

  There are a number of areas, such as the translation and availability of health care information that offer opportunities for coordination and collaboration via the NPHC partnership.

- **Methods for identifying interpretation needs:** Providers use multiple methods for identifying interpretation needs of individual patients, all using the admission process. It would be of value to know if identification is formally the responsibility of a specific staff member and what management systems are in place.

  In addition to assessing how the interpretation needs of patients are met, it may be useful to assess how providers identify materials in need of translation and new materials that would be of use to patients.

- **Information translated and source of materials:** Providers offer a majority of materials in a language other than English. Most providers do not offer translation of medical discharge instructions and directions, which raises the issue of access to and quality of care. As with other areas, it may be useful for providers to collaborate on the creation and use of materials, as appropriate.

  All providers use translated materials from other organizations. In some instances, materials are translated by staff or services are purchased from a professional translator. In addition to assessing how materials are translated, it may be of value to identify whether and how materials are reviewed for accuracy and appropriateness.

- **Assessment of interpretation services:** Two of the six providers conduct a quality assessment of their interpretation services. These two providers have recently created a formal system that will include ongoing patient satisfaction surveys, on-site risk assessment, quality outcomes and the use of secret shoppers. A system for evaluating the quality of interpretation services would add value to quality of care. This may be an area in which providers within NPHC could collaborate on a shared assessment tool.

Provider Focus: *One provider noted the use of patient satisfaction surveys specifically addressing communication issues. The provider has convened a multidisciplinary workgroup to create a Limited English Proficiency (LEP) implementation plan based on industry best practices and state/federal regulations. An integral component of the LEP plan design and implementation will be ongoing assessments via patient satisfaction surveys, risk assessment "walk-through," quality outcomes and the use of secret shoppers.*

E. Community Partnerships and Collaboration

Finding

All providers have a community advisory board and half have some form of a diversity committee/cultural competency advisory board with community representation. All providers, to varying degrees, conduct outreach in places of worship, community meetings and schools and offer special health care programs for racially diverse communities. Almost all providers utilize ethnically and racially diverse media sources, again, to varying degrees.

Recommendations

- **Inclusion of patients and community members in planning and service delivery**: All providers have a community advisory board with three providers having some form of diversity committee/cultural competency advisory board with community representation. A suggested additional level of analysis is to assess the perspective of patients and communities of the inclusiveness and responsiveness of providers. In addition, it would be useful to examine the extent to which patients and community members are apprised of outcomes based on their input.

Provider Focus: *One provider stated that they develop their strategic plan, "using feedback and data from populations served obtained through varied communications channels including community service boards, focus groups, public forums and task forces, community education and outreach activities, and patient satisfaction surveys – is working on expansion of this efforts." Another said that, "[the] diversity committee is comprised of staff and community representation including professionals who provide services to the population served by the organization." While a third provider mentioned the creation of a cultural initiatives committee comprised of all internal departments as well as individuals and organizations from the community."*

One provider uses a patient satisfaction survey that is "mailed to patients after they are discharged." The survey is available in English and Spanish and results are incorporated in the planning and delivery of services." This provider also reported the creation of a Cultural Competency Community Board comprised of "community members as well as representatives from community faith based organizations and businesses."

- **Outreach and education programs and services:** All providers do outreach in places of worship, community meetings, and schools and do so to varying degrees. Four of the six providers offer educational programs that address health beliefs/needs of racially and ethnically diverse populations. These programs include breast and cervical cancer, HIV, STDs, chronic disease, safe kids, pre-natal care, and screening for prostrate cancer. These programs are aligned with information provided on health outcomes.

  All six providers develop special health programs for racially diverse communities. These health programs include the provision of blood pressure testing among the African American community, mobile health units, and facilitating enrollment in Child Health Plus as well as programs focused on a specific demographic group, such as African-American women.

- **Aligning needs with programs and services:** As with any community outreach, education, and off-site services it is useful to have specific measurable outcomes that loop back to organizational goals. It may be helpful for providers to examine the existing outreach, education, and service initiatives to determine if amount, type, and location of outreach is aligned with service delivery goals and appropriately incorporates cultural competency.

- **Media outreach:** Five of the six providers utilize ethnically and racially diverse media sources. It may be helpful to examine if the use of ethnically and racially diverse media sources reached beyond the promotion of services and events. Providers may wish to investigate opportunities for leveraging media buys by group purchasing, shared ads, and coordinated earned (free) media.

- **Facility location and environment:** Five of the six providers attempt to attract racially and ethnically diverse patients by providing an attractive setting in location and appearance. It may be helpful to further examine how a culturally competent health care setting is defined in terms of best practices. There is a difference between placing multi-lingual health materials in the waiting area or examination rooms and incorporating racial, cultural, and ethnic diversity into the physical health care service delivery environment by including culturally relevant non-health related reading materials (magazines, newspapers), information on community event announcements (concerts, fairs), other media (TV/VCR tapes), and office art/wall hangings.

F. Organizational Development Considerations

Finding

It is apparent that health care providers are making a serious effort in the area of cultural competency from the standpoint of services, programs, and the provision of materials. What was not fully assessed as a specific category is the extent to which providers are creating an organizational framework for cultural competence. This framework would "develop, implement, and promote a written strategic plan that outlines clear goals, policies, operational plans, and management accountability and/or oversight mechanisms to provide culturally and linguistically appropriate services." (CLAS Standard 8, see Appendix A for more details.)

In addition, providers, if they do not do so already, may wish to conduct ongoing self-assessments and determine the extent to which cultural competency measures are integrated into "internal audits, performance improvement programs, patient satisfaction assessments, and outcomes-based evaluations." (CLAS Standard 9, see Appendix A for more details.)

Recommendations

Key strategic recommendations that relate to fostering an environment of continual improvement and systems development among health care providers that offer services to a culturally and ethnically diverse patient population are to:

- **Establish Formal Systems for Inter-Organizational Collaboration:** Create a formal collaborative within the structure of NPHC that allows for the sharing of cultural competency information, ideas, best practices, and the pooling of resources.
- **Develop a NPHC Cultural Competency Strategic Plan and Guidelines:** Develop an overarching NPHC cultural competency strategic plan that is reflective of community needs, best practices, and provider goals and objectives.
- **Offer Providers Strategic Planning Tools and Resources:** Equip providers with the tools to create systems and plans to integrate cultural competency policies and practices throughout all levels of the organization.

***Provider Focus**: One provider stated that they "engaged a competence consultant to perform a Diversity Assessment of the management and staffing structure. The goal of the study is to find out how much "know how" is available with the organization for embracing and managing diversity, including the ability to foster an organizational culture that is capable to taking advantage of the benefits of a heterogeneous workforce, as well as be able to respond to the challenges that diversity represents. Interviews were conducted with a representative sample of staff and were designed to solicit employee views on how the organization can better reflect the diverse cultural base of patients. The information compiled through this process was compared to best practices that have been developed by US Corporations. Using the findings, staff will work with the consultant to design programs and infrastructure to address gaps in the existing organizational framework."*

V. Conclusion

One of the primary purposes of the NPHC Cultural Competency Self-Assessment was to offer health care providers a framework for determining their organization's capacity to deliver culturally competent health services as a means of improving access to care, quality of care, and health outcomes for patients. While there may be varying points on the continuum in the provision of culturally competent health care, each of the providers participating in the self-assessment recognizes the importance of offering services that take into account ethnic, linguistic, and racial characteristics of their patients. The challenge at hand is for providers to plot their own course for moving their organization to the next level of cultural competence, be it programmatic, such as expanding language assistance services or implementing a formal feedback mechanism for patient satisfaction assessment, or organizational, such as the development of a cultural competency strategic plan.

When this project began, the hope was that providers would use the self-assessment tool and the experience of completing the survey as a resource in the continuous review, creation, and implementation of new and innovative cultural competency programs and policies designed to meet the needs of an increasingly diverse patient population. Based on the thoughtfulness and thoroughness of provider responses, and their evaluative feedback on the tool and the process, we are optimistic that we have succeeded in meeting the objective.

In addition to offering health care providers an internal organizational tool and process for cultural competency assessment, this project offered a unique opportunity to examine and consider the collective provider responses and as such, offer a broader view of cultural competency policies and practices across Nassau County. As mentioned in the beginning of this report, the primary focus in this regard was not comparative, but a means for examining the ways in which the provider community is striving toward the same goals and facing similar challenges. This information is important because it offers insight and commentary on potential avenues for sharing information and resources as well as exploring opportunities for formal collaboration.

Cultural competency is a critical component to the delivery of quality health care to those residents within Nassau County that are ethnically, linguistically, and racially diverse. ERASE Racism is encouraged by the work that has been done to date by providers and looks forward to both observing and collaborating in the continued growth of culturally competent institutions throughout Nassau County.

Appendix A

U.S. Department of Health and Human Services, OPHS Office of Minority Health National Standards for Culturally and Linguistically Appropriate Services in Health Care

STANDARD 1
CULTURALLY COMPETENT HEALTH CARE (GUIDELINE)
Standard and Commentary
1. Health care organizations should ensure that patients/consumers receive from all staff members effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.

STANDARD 2
STAFF DIVERSITY (GUIDELINE)
Standard and Commentary
2. Health care organizations should implement strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area.

STANDARD 3
STAFF EDUCATION AND TRAINING (GUIDELINE)
Standard and Commentary
3. Health care organizations should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery.

STANDARD 4
QUALFIED LANGUAGE ASSISTANCE SERVICES (MANDATE)
Standard and Commentary
4. Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.

STANDARD 5
NOTICES TO PATIENTS/CONSUMERS OF THE RIGHT TO LANGUAGE ASSISTANCE SERVICES (MANDATE)
Standard and Commentary
5. Health care organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.

STANDARD 6
QUALIFICATIONS FOR BILINGUAL AND INTERPRETER SERVICES (MANDATE)
Standard and Commentary
6. Health care organizations must assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family and

friends should not be used to provide interpretation services (except on request by the patient/consumer).

STANDARD 7
TRANSLATED MATERIALS (MANDATE)
Standard and Commentary
7. Health care organizations must make available easily understood patient related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.

STANDARD 8
ORGANIZATIONAL FRAMEWORK FOR CULTURAL COMPETENCE (GUIDELINE)
Standard and Commentary
8. Health care organizations should develop, implement, and promote a written strategic plan that outlines clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services.

STANDARD 9
ORGANIZATIONAL SELF-ASSESSMENT (GUIDELINE AND RECOMMENDATION)
Standard and Commentary
9. Health care organizations should conduct initial and ongoing organizational self-assessments of CLAS-related activities and are encouraged to integrate cultural and linguistic competence-related measures into their internal audits, performance improvement programs, patient satisfaction assessments, and outcomes-based evaluations.

STANDARD 10
COLLECTION OF DATA ON INDIVIDUAL PATIENTS/CONSUMERS (GUIDELINE)
Standard and Commentary
10. Health care organizations should ensure that data on the individual patient's/consumer's race, ethnicity, and spoken and written language are collected in health records, integrated into the organization's management information systems, and periodically updated.

STANDARD 11
COLLECTION OF DATA ON COMMUNITIES (GUIDELINE)
Standard and Commentary
11. Health care organizations should maintain a current demographic, cultural, and epidemiological profile of the community as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.

STANDARD 12
COMMUNITY PARTNERSHIPS FOR CLAS (GUIDELINE)
Standard and Commentary
12. Health care organizations should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and patient/consumer involvement in designing and implementing CLAS-related activities.

STANDARD 13
COMPLAINT AND GRIEVANCE RESOLUTION (GUIDELINE)
Standard and Commentary
13. Health care organizations should ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by patients/consumers.

STANDARD 14
INFORMATION FOR THE PUBLIC (RECOMMENDATION)
Standard and Commentary
14. Health care organizations are encouraged to regularly make available to the public information about their progress and successful innovations in implementing the CLAS standards and to provide public notice in their communities about the availability of this information.

Nassau Partnership for Healthy Communities
Healthy Communities Access Program (HCAP)
Cultural Competency Self-Assessment

Nassau Partnership for Healthy Communities
Healthy Communities Access Program (HCAP)
Cultural Competency Self-Assessment

As part of the NPHC grant, ERASE Racism was selected to develop this cultural competency assessment questionnaire. ERASE Racism is a nationally recognized racial equity initiative working on Long Island to address institutional racism and decrease disparities based on race. The assessment process draws from the U.S. Department of Health and Human Services' National Standards for Culturally and Linguistically Appropriate Services in Health Care (see attached Standards), the work of Dennis Andrulis, a research professor at Downstate Medical Center Brooklyn and a recognized expert on cultural competence in health care and from members of the Cultural Competency Subcommittee convened under the auspices of the NPHC grant. The cultural competency self-assessment questionnaire is designed for primary and specialty ambulatory care settings in organizations participating in the Nassau Partnership for Healthy Communities (HCAP) grant.

The assessment process is comprised of the following *Self-Assessment Questionnaire*. While we anticipate that this questionnaire will require input from various associates in your facility, only one questionnaire needs to be completed by each organization. The questionnaire is divided into five sections:

1. **Patient Demographics**
2. **Staff Demographics**
3. **Staff Training and Education**
4. **Language Assistance Services**
5. **Community Partnerships and Services**

In completing the self-assessment questionnaire, some institutions have found it helpful to:

- Create a task force of stakeholders: 8-12 people who represent certain key functions or departments. Taskforce members may come from finance, admitting, patient registration, human resources, information systems, administration, translators/interpreters, social workers, community relations and employee relations specialists, or clinical staff.
- Select a task force leader: This person serves as a leader in making important decisions and has access to people at all levels and information from all sources.

It is not necessary to create a task force or select a leader; these are merely suggestions on how to go about completing the questionnaire.

If there are questions while completing the questionnaire please contact ERASE Racism at 516-921-4863 or elaine@eraseracismny.org. After the *Self-Assessment Questionnaire* is completed, **mail it back to ERASE Racism at 6800 Jericho Turnpike, Suite 112W, Syosset, NY 11791**. A member of the ERASE Racism staff may contact the individual(s) who completed the questionnaire for further clarification and follow-up.

Self- Assessment Questionnaire:
Relevant Terms

The following words are used in the self-assessment questionnaire. We provide the following definitions to assist you in completing the questionnaire.

Cultural Competency: A set of congruent behaviors, attitudes, and polices that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations" (CLAS Standards, 2001:4.)

Ethnicity: Belonging to a common group — often linked by race, nationality and language — with a common cultural heritage and/or derivation.

Healthy Communities Access Program (HCAP): A Federal program administered through Health Resources and Services Administration (HRSA) to address healthcare disparities and access to care. Funds for the NPHC grant come from HCAP.

Institutional Racism: Racial prejudice plus the institutional and systemic power to dominate, exclude, abuse, and discriminate against groups of people based on a socially-constructed designation of "race."

Nassau Partnership for Healthy Communities (NPHC): A group of healthcare providers, social service agencies and community-based organizations working together to help individuals and communities in Nassau County obtain good health care, even if they do not have or can not access health insurance.

People of color: People that are not European-American, White or Caucasian. This includes African Americans, Blacks, Afro-Caribbeans, Asians, Pacific Islanders, South Asians, Hispanics, Latinos, Native Americans, Indigenous people, Eskimos, Native Alaskans and multiracial people.

Race: A socially defined population that is derived from distinguishable physical characteristics.

Section 1
Patient Demographics:

1. Do you collect patient demographic information for		
• All of your programs?	Yes	No
• Some of your programs? If yes, please specify	Yes	No

If you answered no to both parts of question #1, skip to question #6.

2. What is the current utilization of your Ambulatory Care Services by the following groups?

Patient Demographics/Ambulatory Care Services

	Primary Care	**Specialty Care**
African American, Black, Afro-Caribbean		
Asian, Pacific Islander, South Asian		
Hispanic, Latino		
Native American, Indigenous, Eskimo, Native Alaskan		
Multiracial		
European-American, White, Caucasian		
Total		

3. Does your organization collect and maintain patient demographic data on the following populations?		
• Hearing impaired	Yes	No
• Visual impaired	Yes	No
• Limited English Proficiency	Yes	No
• Other. Please specify		

4. How does your organization identify patient demographic characteristics? (i.e. racial and ethnic origin)		
• Self identification by the patient	Yes	No
• Identified by staff during General Registration and/or Admitting Department's assessment	Yes	No
• Other. Please specify		

5. Please describe any initiatives, policies and practices that have been developed based on racial and ethnic characteristics over the past three years? (For example, is signage available in ambulatory care settings for Spanish speaking patients?) Please provide any supplemental materials describing such policy.

Communities Served

6. What is the demographic profile of your ambulatory care patient population (primary and secondary) by zip code **or** town?

Please provide percentages.

Zip Code	Town	Percentage

Section 2
Management and Staff Demographics:

7. Please provide the demographic profile of the management and staff of your organization's outpatient care setting.

	Board members, Trustees	Upper/senior management	Middle management	Non-management administrative staff	Environmental services, support staff (transportation food services, housekeeping)	Clinical department heads, chief of staff	Attending physicians	Nurses	Non-physician providers (PA, NP, PT, OT, MSW)	Other clinical staff (lab tech, nursing assistant)
African American, Black, Afro-Caribbean										
Asian, Pacific Islander, South Asian										
Hispanic, Latino										
European-American, White, Caucasian										
Native American, Indigenous, Eskimo, Native Alaskan										
Multiracial										
Total										

The following questions are related to human resources polices that address diversity issues.		
8. Does your organization have a written policy for the recruitment of people from various racial and ethnic groups?	Yes	No
9. Does your organization have a written policy for hiring people from various racial and ethnic groups?	Yes	No
10. Does your organization have a written policy for the retention of people from various racial and ethnic groups?	Yes	No
11. Does your organization have a written policy for the promotion of people from various racial and ethnic groups?	Yes	No
12. Does your organization have a written policy to address grievances and complaints that relate to race and ethnicity?	Yes	No

13. If you answered yes to any of questions 8-12, for each please attach the written policies and specify which ethnic and racial demographic groups have been impacted by this policy.

14. With regard to staff of various racial and ethnic groups at your organization, rate the following statements by circling increasing, decreasing or the same			
• EEOC complaints are	Increasing	Decreasing	The same
• Retention of staff of color compared to retention of White staff is	Increasing	Decreasing	The same
• Promotions of staff of color compared to promotions of White staff are	Increasing	Decreasing	The same

Section 3
Staff Education & Training:

15. Are clinical staff members educated regarding the following special needs of racial and ethnic patients?			
• Cultural beliefs and practices	All	Some	None
• Adherence to treatment regimens (e.g. dietary requirements)	All	Some	None
• Integration with patient preference for alternative therapies	All	Some	None
• Familial involvement in care	All	Some	None
• Perception of illness and treatment	All	Some	None
• Institutional racism and the resulting inequalities	All	Some	None
• Death and dying rituals of diverse cultures	All	Some	None

If you answered none to all parts of question #15, skip to question #21.

16. Does your organization conduct cultural competence training (educating staff members about racial and ethnic diversity)? If no, skip to #21	Yes	No

17. Does your organization use any of the following methods to improve cultural competence within your institution? If so, rate how effective they have been.

			Highly effective	Effective	Neutral	Somewhat effective	Not effective
• Training	Yes	No	5	4	3	2	1
• Orientation	Yes	No	5	4	3	2	1
• Reading materials	Yes	No	5	4	3	2	1

If you rated any of the above highly effective, please describe what makes the method highly effective.

18. Is cultural competence training mandatory or voluntary for the following (circle the best answer):			
• Board members or Trustees	Mandatory	Voluntary but expected	Voluntary
• Upper/senior management	Mandatory	Voluntary but expected	Voluntary
• Middle management	Mandatory	Voluntary but expected	Voluntary
• Non-management administrative staff	Mandatory	Voluntary but expected	Voluntary
• Environmental services (transportation, food services, housekeeping)	Mandatory	Voluntary but expected	Voluntary
• Clinical department heads, chief of staff	Mandatory	Voluntary but expected	Voluntary
• Attending physicians	Mandatory	Voluntary but expected	Voluntary
• Nurses	Mandatory	Voluntary but expected	Voluntary
• Non-physicians providers (PA, NP, PT, OT, MSW)	Mandatory	Voluntary but expected	Voluntary
• Other clinical staff (lab tech, nursing assistant, orderly)	Mandatory	Voluntary but expected	Voluntary

19. How often is cultural competency training provided?	More than once a year		Once a year		Less than once a year
20. Rate the effectiveness of cultural competence training initiatives provided by your organization in addressing:	Highly effective	Effective	Neutral	Somewhat effective	Not effective
• Patient care	5	4	3	2	1
• Medical errors	5	4	3	2	1
• Workforce relationships	5	4	3	2	1
If you rated any of the above highly effective, please describe what makes the initiative highly effective.					

21. Are staff interpreters provided training in cross-cultural medical terminology? If yes, please describe	Yes	No
22. Are interpreters provided training to respond to racial and ethnic cultural traditions (e.g. death/dying rituals, involvement of family, etc)? If yes, please describe.	Yes	No
23. Is clinical staff provided training in communicating with patients who speak languages other than English? If yes, please describe	Yes	No
24. Is clinical staff provided training in communicating with patients with low health literacy? If yes, please describe.	Yes	No

25. Is clinical staff provided any training in communicating with patients who are unable to read and write in their native language? If yes, please describe.	Yes	No

Section 4
Language Assistance Services to People with Limited English Proficiency

26. What types of interpreter/translation services are provided?		
• Community volunteers (CV)	Yes	No
• In-house staff (S)	Yes	No
• Contracted interpreters (CI)	Yes	No
• Bilingual staff (B)	Yes	No
• Telephone language lines, ATT, CyraCon services (TLL)	Yes	No
• Other. Please specify.	Yes	No

27. In the last 3 years, what language interpreter/translation services have been provided? Use the abbreviations provided in question #25 to describe the service provided.

Language	**Service Provided (CV, S, CI, B, TLL)**	**Number of patients using service (if data is not available indicate if service is predominately used)**

28. How does your organization identify patients needing interpretation and translation services? Circle yes for all that apply		
• Identification by admissions assessment	Yes	No
• Identification by nursing assessment	Yes	No
• Identification by physician	Yes	No
• Medical support staff assessment	Yes	No
• Self-identification	Yes	No
• Other. Please specify.	Yes	No

29. Who translates patient information (written materials) into languages other than English?		
• Translated by hospital staff or person hired by contract	Yes	No
• Translated by volunteers	Yes	No
• Translations purchased from professional translator	Yes	No
• Translated material secured from other agency or organization	Yes	No
• Other. Please specify.	Yes	No

30. What patient materials are translated into languages other than English?			**Languages**
• Patient education materials	Yes	No	
• Patient satisfaction survey	Yes	No	
• Marketing/Advertisements	Yes	No	
• Billing information	Yes	No	
• Directions to site/services	Yes	No	
• Patient Bill of Rights	Yes	No	
• Medication/discharge instructions	Yes	No	
• Signage	Yes	No	
• Other, please specify			

31. Are patients informed of their rights and the availability of language assistance services? If yes, please describe.	Yes	No
32. Does your organization assess the quality of interpretation services? If yes, please describe.	Yes	No

Section 5
Community Partnerships and Services

33. Please list the communities that are within your primary and secondary service area by zip code/town?

Zip Code	Town

Seeking Community Input

34. Does your organization have a community advisory board?	Yes	No
35. Does your organization incorporate the input of racially and ethnically diverse **patients** in the planning and delivery of services? If yes, please describe.	Yes	No
36. Does your organization incorporate the input of racially and ethnically diverse **communities** in the planning and delivery of services? If yes, please describe.	Yes	No
37. Are health outcomes used to define new community health initiatives? If yes, please describe and give an example.	Yes	No

Community Involvement/Education

38. Does your organization outreach (provide patient education and or medical screening) in diverse **places of worship**? If yes, please describe and give examples.	Yes	No
39. Does your organization encourage staff to participate in community meetings? If yes, please describe and give the name of community meeting.	Yes	No
40. Does your organization outreach (provide patient education or medical screening) to **schools** in racially and ethnically diverse communities? If yes, please describe and give the name of one or more schools.	Yes	
41. Does your organization offer communities educational programs that address health beliefs/needs of racially and ethnically diverse populations? If yes, please describe.	Yes	No
42. Does your organization develop special health programs for ethnically or racially diverse communities (such as hypertension education in African American communities)? If yes, please describe.	Yes	No

43. Does your organization monitor health outcomes regarding ethnically and racially diverse groups? If yes, please describe.	Yes	No

Outreach and Marketing

44. Does your organization utilize ethnically and racially diverse media sources (i.e., diverse newspapers, community flyers, churches, etc.) for promotion of health related services? If yes, please describe and list some examples.	Yes	No
45. Does your organization attempt to attract racially and ethnically diverse patients by providing a setting that is attractive in location and appearance (e.g., does the décor, artwork, reading materials in waiting areas, etc. affirm that a racially diverse patient population is welcome?) If yes, please describe.	Yes	No

Closing Comments

46. Does your organization offer a rewards system or incentive program for exceptional work contributing to cultural competence? If yes, please describe.	Yes	No
47. Please use the space below to provide any additional information concerning cultural competence at your organization that was not covered in this survey tool.		
Contact Information: Please provide the following contact information. Organization: Contact person: Email: Telephone number:		