

# **A Guide for Advancing Family-Centered and Culturally and Linguistically Competent Care**



**National Center for Cultural Competence**  
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## Introduction

The movements to advance family-centered care and cultural and linguistic competence have often evolved along parallel tracks. This fact is well documented in the early definitions of family-centered care in the literature (Bishop, Woll, & Arango, n.d.). Although these definitions reference “honoring cultures, cultural diversity, and family traditions,” little emphasis was placed on policies and structures necessary to translate this philosophy into family-centered practice. A pervading perception within the movement was that if an organization was family-centered, then by default it must be culturally competent. Moreover, much of this literature did not tend to draw upon and integrate the rich body of knowledge related to cultural and linguistic competence. A recent literature review commissioned by the Maternal and Child Health Bureau (MCHB), Health Resources and Services Administration (HRSA), U.S. Department of Health and Human Services (DHHS), draws this conclusion. Bishop, Woll, and Arango (2003) conducted a broad review of the literature and other sources of information on family-centered care. This review encompassed the period of 1993-2003 and included 250 journal and other articles, books, chapters, videos, monographs, Web sites, training manuals, resource catalogs and guides, block grants, and display posters. The authors found that “little mention of cultural competence was made in family-centered care materials” (Arango & McPherson, 2005).

Family-centered care and cultural and linguistic competence are essential approaches to address the multiple strengths, needs, and preferences of this nation’s families who have children and youth with special health care needs. MCHB convened a meeting to explore ways in which family-centered care and cultural and linguistic competence could be integrated in a more effective manner to support and sustain a community-based system of services that are comprehensive, coordinated, and accessible and that provide the highest quality of care.

The meeting brought together a cadre of 18 individuals representing a wide variety of organizations vested in providing services and supports that are family-centered and culturally and linguistically competent.

**Health Resource and Services Administration  
Maternal and Child Health Bureau  
Definition of Special Health Care Needs**

Children with special health care needs includes all children, who have or are at increased risk for, chronic physical, developmental, behavioral and emotional conditions who also require health and related services of a type or amount beyond that required by children generally.

## DEFINITIONS

The following definitions are offered to provide a context for using this guide.

### Definition of Family

Family is an enduring relationship, whether biological or non-biological, chosen or circumstantial, connecting a child/youth and parent/caregiver through culture, tradition, shared experiences, emotional commitment and mutual support.

Source: United Advocates for Children of California (2005). <http://www.uacc4families.org/aboutus/mission.cfm>

### NCCC's Definition of Cultural Competence

Cultural competence requires that organizations:

- have a congruent, defined set of values and principles, and demonstrate behaviors, attitudes, policies, and structures that enable them to work effectively cross-culturally;
- have the capacity to (1) value diversity, (2) conduct self-assessment, (3) manage the dynamics of difference, (4) acquire and institutionalize cultural knowledge, and (5) adapt to the diversity and cultural contexts of communities they serve; and
- incorporate the above into all aspects of policymaking, administration, practice, and service delivery and systematically involve consumers, key stakeholders and communities.

Cultural competence is a developmental process that evolves over an extended period of time. Individuals, organizations, and systems are at various levels of awareness, knowledge and skills along the cultural competence continuum.

Modified from Cross, T., Bazron, B., Dennis, K., & Isaacs, M. (1989). *Towards a culturally competent system of care. Vol. 1*. Washington, DC: The National Technical Assistance Center for Children's Mental Health, Georgetown University Child Development Center.

### NCCC's Definition of Linguistic Competence

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

- bilingual/bicultural or multilingual/multicultural staff;
- cross-cultural communication approaches;
- cultural brokers;
- foreign language interpretation services including distance technologies;
- sign language interpretation services;
- multilingual telecommunication systems;
- videoconferencing and telehealth technologies;
- TTY and other assistive technology devices;

### **Definitions Continued**

- computer assisted real time translation (CART) or viable real time transcriptions (VRT);
- print materials in easy to read, low literacy, picture and symbol formats;
- materials in alternative formats (e.g., audiotape, Braille, enlarged print);
- varied approaches to share information with individuals who experience cognitive disabilities;
- materials developed and tested for specific cultural, ethnic and linguistic groups;
- translation services including those of:
  - legally binding documents (e.g., consent forms, confidentiality and patient rights statements, release of information, applications)
  - signage
  - health education materials
  - public awareness materials and campaigns; and
- ethnic media in languages other than English (e.g., television, radio, Internet, newspapers, periodicals).

(Goode, T.D., and Jones, W., 2000, Revised 2006)

## **GUIDING VALUES AND PRINCIPLES**

### **Culturally and Linguistically Competent Guiding Values & Principles**

The following guiding values and principles are offered as a context for using the guide.

#### **Organizational**

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

#### **Practice & Service Design**

- Cultural competence is achieved by identifying and understanding the needs and help-seeking behaviors of individuals and families.\*
- Culturally competent organizations design and implement services that are tailored or matched to the unique needs of individuals, children, families, organizations and communities served.\*
- Practice is driven in service delivery systems by client preferred choices, not by culturally blind or culturally free interventions.\*
- Culturally competent organizations have a service delivery model that recognizes mental health as an integral and inseparable aspect of primary health care.

#### **Language Access**

- Services and supports are delivered in the preferred language and/or mode of delivery of the populations served.
- Written materials are translated, adapted, and/or provided in alternative formats based on the needs and preferences of the populations served.

### **Guiding Values and Principles Continued**

- Interpretation and translation services comply with all relevant Federal, state, and local mandates governing language access.
- Consumers are engaged in evaluation of language access and other communication services to ensure quality and satisfaction.

### **Community Engagement**

Cultural competence extends the concept of self-determination to the community.\*

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

### **Family & Consumers**

- Family is defined differently by different cultures.\*\*\*
- Family as defined by each culture is usually the primary system of support and preferred intervention.\*\*\*
- Family/consumers are the ultimate decision makers for services and supports for their children and/or themselves.\*\*\*

\*Adapted from Cross, T. et al., 1989

\*\* “Other Guiding Values and Principles for Community Engagement” and “Family & Consumers” are excerpts from the work of Taylor, T., & Brown, M., 1997, Georgetown University Child Development Center (GUCDC), University Affiliated Program, and

\*\*\* “Promoting Cultural Diversity and Cultural Competency-Self Assessment Checklist for Personnel Providing Services and Supports to Children with Disabilities & Special Health Care Needs,” Goode, T., 2002, NCCC, GUCDC

## **Family-Centered Care**

The following guiding values and principles are offered as a context for using the guide.

### **Definition of Family-Centered Care**

Family-Centered Care assures the health and well-being of children and their families through a respectful family-professional partnership. It honors the strengths, cultures, traditions and expertise that everyone brings to this relationship. Family-Centered Care is the standard of practice which results in high quality services.

### **Principles of Family-Centered Care for Children**

The foundation of family-centered care is the partnership between families and professionals. Key to this partnership are the following principles:

- Families and professionals work together in the best interest of the child and the family. As the child grows, s/he assumes a partnership role.

***Guiding Values and Principles Continued***

- Everyone respects the skills and expertise brought to the relationship.
- Trust is acknowledged as fundamental.
- Communication and information sharing are open and objective.
- Participants make decisions together.
- There is a willingness to negotiate.

**Based on this partnership, family-centered care:**

1. Acknowledges the family as the constant in the child's life.
2. Builds on family strengths.
3. Supports the child in learning about and participating in his/her care and decision-making.
4. Honors cultural diversity and family traditions.
5. Recognizes the importance of community-based services.
6. Promotes an individual and developmental approach.
7. Encourages family-to-family and peer support.
8. Supports youth as they transition to adulthood.
9. Develops policies, practices, and systems that are family-friendly and family-centered in all settings.
10. Celebrates successes.

Sources: National Center for Family-Centered Care. (1989). Family-centered care for children with special health care needs. Bethesda, MD: Association for the Care of Children's Health.

Bishop, K., Woll, J., & Arango, P. (1993). Family/professional collaboration for children with special health care needs and their families. Burlington, VT: University of Vermont, Department of Social Work.

Bishop, K., Woll, J., & Arango, P. (n.d.). Family-centered care projects 1 and 2 (2002-2004). Algodones, NM: Algodones Associates.

## RATIONALE FOR CARE THAT IS FAMILY-CENTERED AND CULTURALLY AND LINGUISTICALLY COMPETENT

### Demographic Profile of Children & Youth With Special Health Care Needs

According to the National Survey of Children with Special Health Care Needs (NS-CSHCN), conducted in 2001, the estimated prevalence of children (birth-17 years of age) with special health care needs was **10.3 million**, or 12.8%, nationally, with 20% of households having one or more children with special health care needs. Analyses of these data indicate that prevalence varies significantly according to race and ethnicity. Native American/Alaskan Natives have the highest prevalence at 16.6%, closely followed by 15.1% of families who self-identify as Multi-Racial (non-Hispanic). An estimated 14.2% of White, 13% of Black, 9.6% of Native Hawaiian/Pacific Islander, 8.5% of Hispanic, and 4.4% of Asian children have special health care needs. The prevalence of special health care needs for Hispanic children is lower than that of all other ethnic groups, except Asian children. The parents of Hispanic children were also more likely than others to respond to the survey in a language other than English. The NS-CSHCN prevalence results are consistent with other survey studies finding lower rates of chronic conditions or disabilities in the Hispanic child population, but much remains to be learned about cultural and linguistic effects of parental response to national surveys. Although this survey has limitations due to methodology (relied solely on telephone interviews and excluded young adults from ages 18 to 21), it was the first attempt to document the status of families of children with special health care needs nationally. Currently, MCHB estimates that 18 million children and youth (birth-21 years of age) in the United States have special health care needs (<http://ftp.hrsa.gov/mchb/factsheets/dscshcn.pdf>).

### Disparities in Care

According to the National Survey of Children with Special Health Care Needs, 2001, there are significant disparities related to race and ethnicity in how families perceived the services and supports they receive for their children (U.S. Department of Health and Human Services, 2004). When compared to White children with special health care needs, Black and Hispanic children with special health care needs are more likely to have families who report disparate experiences in the health care delivery systems. Salient findings related to cultural and linguistic competence and the six core components of an integrated system of services for children and youth with special health care needs are as follows.

- *Component 1: Families partner in decision making and will be satisfied with the services they receive*—almost half of Hispanic and Black children with special health care needs have families who reported that the services they receive are not family-centered.
- *Component 2: Children and youth with special health care needs receive coordinated, ongoing comprehensive care within a medical home*—more than half of Hispanic (55.9%) and Black (51.6%) families of children with special health care needs have families who report that they do not receive services for their children in a medical home.

The Maternal and Child Health Bureau has identified six components of a comprehensive system of services for children and youth with special health care needs (CSHCN) including:

- 1) Families of CSHCN will participate in decision making and will be satisfied with the services they receive
- 2) All CSHCN will receive coordinated comprehensive care in a medical home
- 3) All CSHCN will be adequately insured for the services they need
- 4) All children will be screened early and continuously for special health care needs
- 5) Services for CSHCN will be organized so families can use them easily
- 6) All youth with special needs will receive the services needed to support the transition to adulthood.

Maternal and Child Health Bureau

### **Rationale for Care Continued**

- *Component 3: Families of children and youth with special health care needs have adequate private and/or public insurance to pay for the services they need*—more than half of Hispanic and Black children with special health care needs have families who report that they do not have adequate insurance for their children. NS-CSHCN findings include these categories: “multi-racial,” described as any non-Hispanic child/youth reporting two or more race categories, and “other,” described as any non-Hispanic child/youth reporting only the Asian, Native American/Native Alaskan, or Native Hawaii/Pacific Islander category. Similar findings were reported for these demographic groups as those cited above. Although the findings are still emerging, data broken down (disaggregated) by race and ethnicity to date clearly reflect the need for care that is family-centered and culturally and linguistically competent as essential approaches for achieving each of the six core outcomes.

### **A Word About the Evidence**

#### ***Culturally and Linguistically Competent Care***

An emerging body of evidence documents the role and efficacy of cultural and linguistic competence in (1) increasing access to, and the acceptability of, care; (2) improving quality and safety in the provision of care; and (3) reducing disparities in the delivery of health and mental health care services and outcomes for racially and ethnically diverse populations. It also documents the consequences to patients and their families when these approaches to care are not provided. This research explores the link between cultural and linguistic competence and improved health outcomes in clinical care and interventions for specific diseases, health and mental health promotion and screening, and patient-provider concordance, to name a few. These studies largely focus on adults, although a number of them address children and youth with special health care needs. Several examples follow:

- Lieu et al. (2004) found that cultural competence policies were an independent predictor of quality in the care of children with asthma regarding underuse of preventive medications (associated with more severe episodes and higher hospitalization rates) and parents’ rating of care.
- La Roche et al. (2006) examined the efficacy of Multifamily Asthma Group Treatment (MFA GT) in 24 African American and Hispanic families who have children with asthma. This randomized controlled pilot study found that the MFA GT was effective in asthma management and reduced emergency department visits. The study also found that the return on investment was more than 50% compared to resources spent on the intervention.
- Cohen et al. (2005) found that “Spanish-speaking patients and families who requested an interpreter seemed to have a significantly increased risk for serious medical events during pediatric hospitalization compared with patients whose families do not have a language barrier” (p. 577). This case-control study was conducted at a large, academic, regional children’s hospital located in the Pacific Northwest area of the country.

### *Rationale for Care Continued*

#### *Family-Centered Care*

There is also a body of evidence that documents the role and efficacy of family-centered care by 1) having positive impact on the mental health of families of children and youth with special health care needs, including their capacity to cope; 2) increasing family satisfaction with care; and 3) improving the quality of care.

- Ireys et al. (2001) examined the maternal outcomes of a support intervention for families of children with selected chronic illness. This randomized control clinical trial found that family support can have beneficial effects on the mental health status of mothers of children with chronic illness, specifically reducing anxiety and symptoms of maternal depression.
- Singer et al. (1999) conducted a qualitative study that used consumer satisfaction interviews with parents of children with disabilities to evaluate Parent to Parent mentoring programs in five states. Eighty-nine percent of parents in the study rated Parent to Parent as helpful. Specifically, they found that Parent to Parent programs (1) are a valuable source of assistance for many families of children with disabilities, (2) offer a unique form of assistance not typically met by formal service systems, (3) help parents make cognitive adaptations to disability in the family, and (4) help parents to become more effective at coping with the demands of parenting a child with a disability while maintaining a desirable family life.
- Fina et al. (1997) described 14 years of experience in parent participation in the post-anesthesia care unit (PACU) of a major children's hospital. They studied (1) quality improvement monitors of the level of comfort of patients admitted to the PACU—specifically involving parents in the care of their children, and (2) parents' satisfaction as active participants in the care of their children. They found that parental presence had a calming and anxiety-reducing effect on the patient and that parental visitation contributes to quality care and increases family satisfaction.

## Purpose of the Guide

One product of the meeting was a template developed by participants that offered concrete examples of strategies and approaches to integrate family-centered care and cultural and linguistic competence. Participants grouped the template of strategies and approaches into 10 categories. For the purposes of this guide, the authors collapsed these categories into five primary areas of focus that include (1) Research and Dissemination; (2) Training, Education, and Professional Development; (3) Information Exchange and Social Marketing; (4) Innovative Practices; and (5) Accountability and Outcomes. Additionally, the authors developed a framework for advancing care that is family-centered and culturally and linguistically competent that describes a set of strategies and activities, and lists responsible entities/individuals, potential partners, and resources.

The guide is designed to:

- provide the strategies suggested by meeting participants and offer new ones to integrate and advance care that is family-centered and culturally and linguistically competent; and
- assist organizations and systems in meeting the MCHB performance measures for family-professional partnerships and cultural competence.

The guide is intended for use by a diverse array of stakeholders and constituencies in the integrated system of services for children and youth with special health care needs and their families. This supportive group includes, but is not limited to, state and local health and mental health programs, family organizations, hospitals, clinics, universities and research and training centers, professional associations, and HRSA/MCHB grantees.

The guide provides a template of strategies and activities, responsible entities and individuals, potential partners, and resources for five areas of focus that were identified by meeting participants as essential to family-centered and culturally and linguistically competent care. The template consists of:

- **Strategies and activities** consist of suggested approaches to advance family-centered and culturally and linguistically competent policies, structures, and practices within programs, organizations, and systems.
- **Responsible entities and individuals** are a list of those that should assume a major leadership role in promoting care that is family-centered and culturally and linguistically competent and integrated into a comprehensive system of services.
- **Potential partners** are an expansive list of organizations and programs that can be engaged in collaborative activities and partnerships.
- **Resources** consist of suggested organizations and businesses, within both the public and private sector, that may contribute or invest in efforts to advance and sustain care that is family-centered and culturally and linguistically competent. Resources may include revenue, personnel, incentives, in-kind contribution, facilities, and other goods and services.

## Areas of Focus

### **Research and Dissemination**

There is an emerging body of research that examines the efficacy of health and mental health outcomes associated with family-centered care, cultural competence, and linguistic competence, respectively. However, little within this literature examines the correlation between these three approaches and their impact on health care equity, disparities, and quality. This area of focus provides strategies to integrate and advance this much-needed research agenda.

### **Training, Education, and Professional Development**

Nationally, health and mental health care organizations and systems are struggling to respond effectively to the needs and preferences of individuals and families from culturally and linguistically diverse groups. Academic institutions and other health and mental health care training programs have an essential role in preparing personnel to have the values, knowledge, and skill sets to provide care that is family-centered and culturally and linguistically competent. Families and youth with special health care needs should also be seen as partners integrally involved in these educational activities. This area of focus provides strategies to incorporate principles and practices of family-centered care and cultural and linguistic competence into training, education, and professional development activities.

### **Information Exchange and Social Marketing**

The concepts and practices of family-centered care and cultural and linguistic competence are not well understood by most families. This lack of understanding also extends to many providers of health and mental health care and their respective practices and organizations. Concerted attention must be devoted to increasing awareness of the benefits of these practices, such as improved quality of care, better health outcomes, increased satisfaction with care, enhanced relations between the patient-provider, reduced risk of medical errors attributed to language/cultural barriers, and reduced racial, ethnic, and geographic disparities. This area of focus suggests strategies for exchanging information and conducting social marketing initiatives that integrate these practices and increase awareness among families, youth, and providers.

### **Innovative Practices**

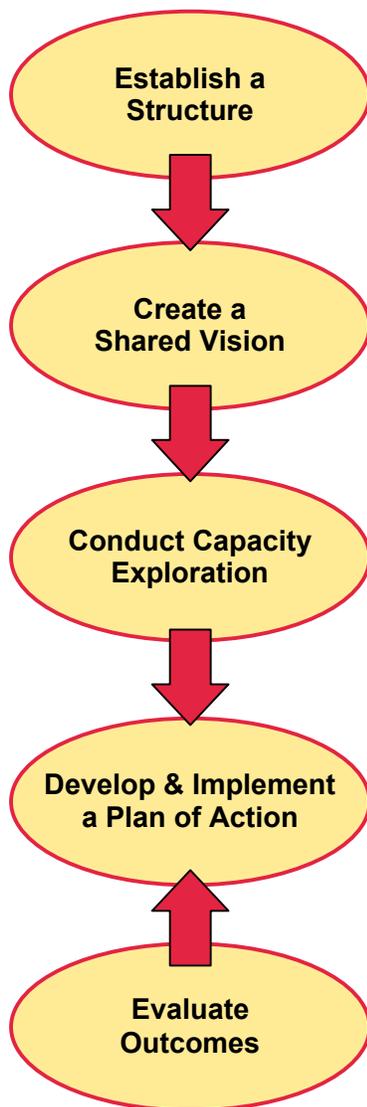
Some programs serving children and youth with special health care needs and their families are using an array of innovative practices that integrate family-centered care and cultural and linguistic competence. However, many of these programs neither have the personnel nor the resources to (1) conduct research efforts on the efficacy of their interventions and practices, (2) determine whether such interventions and practices are replicable for different cultural groups and in different settings, or (3) publish and disseminate their work. This area of focus provides concrete strategies for documenting innovative practices, including isolating and defining the specific elements of family-centered care and cultural and linguistic competent care that are effective. It also recommends broad distribution of such practices in multiple formats and venues.

### **Accountability and Outcomes**

There are Federal requirements, mandates, standards, and guidelines for both cultural competence and linguistic competence (e.g., Title VI, Section 601, Civil Rights Act of 1964, Culturally and

Linguistically Appropriate Standards in Health Care (CLAS), Executive Order 13166, and MCHB Strategic Plan Goals and Performance Measures for States and Special Projects of Regional and National Significance). Additionally, there are performance measure goals that specifically address aspects of family-centered care in MCHB-funded programs and related systems of care. For the purposes of this guide, accountability and outcomes in family-centered care and cultural and linguistic competence are limited to those as specified by these requirements. This area of focus provides strategies to assess the extent to which values, policies, structures, and practices of family-centered care and cultural and linguistic competence are integrated within organizations and the six core components of a comprehensive system of care.

## Suggested Steps for Using this Guide



- **Establish a structure to guide the work**

Convene a work group, committee, or task force with the responsibility of exploring the integration of family-centered care and cultural and linguistic competence. This group can serve as the primary entity to plan, implement, and provide oversight in this process of exploration. The group should include representation from all levels of the organization, families, and other constituency groups.

- **Create a shared vision**

Convene a forum to explore and define the concepts of family-centered care and cultural and linguistic competence and their value and relevance for the organization and the families and communities served. Forum participants should comprise key stakeholders including, but not limited to, staff, families, youth, community organizations in the service area, and other invested constituency groups.

- **Conduct capacity exploration**

The work group should conduct a comprehensive review of the five areas of focus of the guide to determine the feasibility and the organization's capacity to implement the strategies and activities delineated in the guide. Ascertain the level of effort, resources, and partnerships needed for each strategy. Reach consensus, and submit recommendations to policy makers and/or governing boards on priority areas of focus and specific strategies and activities.

- **Develop and implement a plan of action**

Create a plan of action for identified areas of focus. Determine the specific strategies/activities, partners, resources, timetables, and responsible parties, and establish benchmarks to monitor and assess progress.

- **Evaluate outcomes**

Develop measures to assess the extent to which the processes delineated in the plan achieved the desired outcomes.

## AREA OF FOCUS Research and Dissemination

Strategies and Activities	Responsible Entities and Individuals	Potential Partners	Resources
<p>Require research initiatives to use culturally and linguistically competent and participatory action research methodologies that include the active involvement of consumers/key stakeholders in all aspects of research (e.g., choice of topic and questions, design, sampling, instrumentation, data collection and analysis, and dissemination).</p> <p>Conduct public awareness campaigns to provide information to consumers and communities about the benefits of participating or collaborating in research initiatives examining family-centered care, cultural and linguistic competence, and quality of care.</p> <p>Conduct research, and disseminate findings, on the benefits and outcomes of family-centered care that is culturally and linguistically competent.</p>	<ul style="list-style-type: none"> <li>▪ Universities and colleges</li> <li>▪ Researchers</li> <li>▪ HRSA/MCHB grantees</li> <li>▪ Centers of Excellence</li> <li>▪ Research institutes</li> <li>▪ Family organizations</li> </ul>	<ul style="list-style-type: none"> <li>▪ Professional health, mental health, and medical associations</li> <li>▪ American Academy of Pediatrics</li> <li>▪ National Medical Association</li> <li>▪ National Hispanic Medical Association</li> <li>▪ Family organizations</li> <li>▪ Youth organizations</li> <li>▪ Community-based organizations and programs</li> <li>▪ Ethnic-based advocacy organizations</li> <li>▪ State Title V programs</li> <li>▪ Civic and social associations</li> <li>▪ Quality improvement organizations/initiatives concerned with health, mental health, and education</li> </ul>	<ul style="list-style-type: none"> <li>▪ Federal, state, and local governments</li> <li>▪ Foundations</li> <li>▪ Ethnic media</li> <li>▪ Professional health, mental health, and medical organizations</li> <li>▪ Faith-based organizations</li> <li>▪ Quality improvement organizations/initiatives</li> </ul>

**AREA OF FOCUS**  
**Training, Education, and Professional Development**

Strategies and Activities	Responsible Entities and Individuals	Potential Partners	Resources
<p>Consult with and include families in curricula development for pre-service, in-service, and continuing education activities and courses.</p>	<ul style="list-style-type: none"> <li>▪ Universities and colleges</li> <li>▪ Research and training centers</li> <li>▪ MCHB and other Federal agencies</li> <li>▪ Family and youth organizations</li> <li>▪ MCHB grantees including national centers</li> <li>▪ Public and private hospitals</li> </ul>	<ul style="list-style-type: none"> <li>▪ Family organizations</li> <li>▪ Youth organizations</li> <li>▪ Community-based organizations and programs</li> <li>▪ American Academy of Pediatrics</li> <li>▪ Quality improvement organizations/initiatives concerned with health, mental health, and education</li> <li>▪ Ethnic-specific organizations</li> <li>▪ State Title V programs</li> <li>▪ Professional health, mental health, and medical associations</li> <li>▪ Public school systems</li> <li>▪ Civic and social associations</li> <li>▪ National social organizations (e.g., sororities and fraternities)</li> <li>▪ Health equity and social justice organizations</li> </ul>	<ul style="list-style-type: none"> <li>▪ Federal, state, and local governments</li> <li>▪ Foundations</li> <li>▪ Ethnic media</li> <li>▪ Professional health, mental health, and medical organizations</li> <li>▪ Health plans</li> <li>▪ Quality improvement organizations/initiatives</li> </ul>
<p>Identify and include families and youth as faculty, trainers, and facilitators in educational activities such as grand rounds, workshops, seminars, and conferences.</p>			
<p>Provide in-service training and continuing education to providers, interdisciplinary teams, and organizations on instituting policies, structures, and practices that are family-centered and culturally and linguistically competent.</p>			
<p>Conduct professional development and in-service training within family organizations on the values, principles, policies, and practices of care that are family-centered and culturally and linguistically competent.</p>			
<p>Provide orientation training, mentoring, and other supports for all volunteers to ensure an understanding and acceptance of values, principles, and practices governing cultural and linguistic competence and family-centered care.</p>			

**AREA OF FOCUS**  
**Information Exchange and Social Marketing**

Strategies and Activities	Responsible Entities and Individuals	Potential Partners	Resources
<p>Provide information about family-centered care and cultural and linguistic competence to families and youth that will enable them to advocate on their own behalf for services that they need and prefer (e.g., innovative and promising practices, evidenced-based practices, Title VI language access provisions, and CLAS Standards).</p> <p>Convene forums that link family-centered care and cultural and linguistic competence to such outcomes as improved quality of care and reductions in health disparities to facilitate the exchange of information among and between families.</p> <p>Develop materials and resources for social marketing that inform providers and families about the benefits of care that are both family-centered and culturally and linguistically competent (e.g., Bright Futures, Medical Home Index, toolkits, consumer checklists/brochures, multimedia resources, and Public Service Announcements).</p> <p>Tailor social marketing campaigns to the cultural and linguistic context of families, consumers, and communities. These campaigns should:</p> <ul style="list-style-type: none"> <li>- Engage community members in identifying the need, purpose, and design of the approach;</li> <li>- Provide information in multiple formats (e.g., videos, CDs, and advertisements);</li> <li>- Use credible voices to deliver health and mental health messages (e.g., cultural brokers, promotoras, and community leaders); and</li> <li>- Deliver information in a variety of settings (e.g., health fairs, pediatric practices, school-based clinics, local merchants, and faith or spiritual gatherings).</li> </ul>	<ul style="list-style-type: none"> <li>▪ MCHB and other Federal agencies</li> <li>▪ Family and youth organizations</li> <li>▪ State Title V programs</li> <li>▪ MCHB grantees including national centers</li> <li>▪ Universities and colleges</li> <li>▪ Professional health, mental health, and medical associations</li> <li>▪ Health plans</li> </ul>	<ul style="list-style-type: none"> <li>▪ Ethnic-based advocacy organizations</li> <li>▪ Faith-based organizations</li> <li>▪ Family organizations</li> <li>▪ Community-based organizations and programs</li> <li>▪ Quality improvement organizations/initiatives</li> <li>▪ Youth organizations</li> <li>▪ American Academy of Pediatrics</li> <li>▪ State Title V programs</li> <li>▪ Professional health, mental health, and medical associations</li> <li>▪ Civic and social associations</li> <li>▪ Informal support and helping networks</li> <li>▪ National social organizations (e.g., sororities and fraternities)</li> <li>▪ Health equity and social justice organizations</li> <li>▪ Public school systems</li> </ul>	<ul style="list-style-type: none"> <li>▪ Foundations</li> <li>▪ Ethnic media</li> <li>▪ Professional health, mental health, and medical organizations</li> <li>▪ Quality improvement organizations/initiatives</li> <li>▪ Faith-based organizations</li> <li>▪ Merchant and business associations</li> <li>▪ Federal, state, and local governments</li> <li>▪ Cable public access television stations</li> </ul>

**AREA OF FOCUS**  
**Innovative Practices**

Strategies and Activities	Responsible Entities and Individuals	Potential Partners	Resources
<p>Identify:</p> <p>(a) information on systems development and integration initiatives and programs that have policies that promote, implement, and sustain care that is family-centered and culturally and linguistically competent and to track their impact on quality of care.</p> <p>(b) specific elements related to family-centered care and cultural and linguistic competence that are effective in addressing disparities in health and mental health care based on social, economic, cultural, linguistic, and geographic barriers.</p> <p>(c) organizational policies that support the employment of families and youth or compensate them for their participation in program activities.</p> <p>(d) strategies that adhere to the values and practices of care that are family-centered and culturally and linguistically competent, as an intervention strategy for specific diseases and conditions (e.g., diabetes, asthma, sickle cell disease, and physical, emotional, and other disabilities) and that use community-based coalitions.</p> <p><b>The above strategies and activities should be broadly disseminated in multiple formats and venues.</b></p>	<ul style="list-style-type: none"> <li>▪ Research institutes</li> <li>▪ HRSA/MCHB grantees</li> <li>▪ Centers of Excellence</li> <li>▪ Family organizations</li> <li>▪ Universities and colleges</li> <li>▪ MCHB and other Federal agencies</li> </ul>	<ul style="list-style-type: none"> <li>▪ Community-based organizations and programs</li> <li>▪ Community systems development and integration collaborative/governance bodies</li> <li>▪ State Title V programs</li> <li>▪ Family organizations</li> <li>▪ Youth organizations</li> <li>▪ Pediatric practices</li> <li>▪ Public and private hospitals</li> <li>▪ Professional health, mental health, and medical associations</li> <li>▪ Public school systems</li> <li>▪ Community health centers</li> <li>▪ Quality improvement organizations/initiatives</li> </ul>	<ul style="list-style-type: none"> <li>▪ Foundations</li> <li>▪ Community-based and civic organizations</li> <li>▪ Quality improvement organizations/initiatives</li> <li>▪ Federal, state, and local governments</li> <li>▪ State Title V programs</li> </ul>

## AREA OF FOCUS Accountability and Outcomes

Strategies and Activities	Responsible Entities and Individuals	Potential Partners	Resources
<p>Conduct a self-assessment to determine the extent to which the organization or program complies with Title VI of the Civil Rights Act of 1964 (that requires programs and agencies receiving Federal financial assistance to take reasonable steps to ensure that individuals with limited English proficiency are not discriminated against because of national origin) and other mandates.</p> <p>Review organizational policies, structures, practices, and dedicated resources to implement the CLAS Standards effectively.</p> <p>Establish organizational procedures for tracking, monitoring, and measuring the extent to which family-centered care and cultural and linguistic competence are integrated into <i>and</i> impact the six components of a comprehensive system of care:</p> <ol style="list-style-type: none"> <li>1) Medical home</li> <li>2) Adequate insurance</li> <li>3) Early and continuous screening</li> <li>4) Organization of services</li> <li>5) Partner in decision making and satisfaction with services</li> <li>6) Transition to adult health care, work, and independence</li> </ol> <p>Develop policy and practice standards that integrate family-centered care, cultural and linguistic competence, and quality indicators.</p>	<ul style="list-style-type: none"> <li>▪ Licensing and accreditation bodies for health and mental health care and social service professionals and organizations</li> <li>▪ MCHB/Division of Services for Children with Special Health Needs (DSCSHN)</li> <li>▪ HRSA/MCHB grantees</li> <li>▪ State and local MCH programs</li> <li>▪ Public and private hospitals</li> <li>▪ Family organizations</li> <li>▪ Health, mental health, and social service programs</li> </ul>	<ul style="list-style-type: none"> <li>▪ Regional and state Offices of Minority Health</li> <li>▪ DHHS/Office for Civil Rights</li> <li>▪ Family organizations</li> <li>▪ Youth organizations</li> <li>▪ Community-based organizations and programs</li> <li>▪ American Academy of Pediatrics</li> <li>▪ Quality improvement organizations and initiatives</li> <li>▪ Ethnic-based advocacy organizations</li> <li>▪ State Title V programs</li> <li>▪ Professional health, mental health, and medical associations</li> <li>▪ National social organizations (e.g., sororities and fraternities)</li> <li>▪ Health equity and social justice organizations</li> </ul>	<ul style="list-style-type: none"> <li>▪ Federal, state, and local governments</li> <li>▪ Professional health, mental health, and medical organizations</li> <li>▪ Quality improvement organizations and initiatives</li> </ul>

<b>AREA OF FOCUS</b>	<b>Strategies and Activities</b>	<b>Responsible Entities and Individuals</b>	<b>Potential Partners</b>	<b>Resources</b>

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The NCCC provides national leadership and contributes to the body of knowledge on cultural and linguistic competency within systems and organizations. Major emphasis is placed on translating evidence into policy and practice for programs and personnel concerned with health and mental health care delivery, administration, education, and advocacy.

The NCCC uses four major approaches to fulfill its mission including (1) Web-based technical assistance, (2) knowledge development and dissemination, (3) supporting a “community of learners,” and (4) collaboration and partnerships with diverse constituency groups. These approaches entail the provision of training, technical assistance, and consultation and are intended to facilitate networking, linkages, and information exchange. The NCCC has particular expertise in developing instruments and conducting organizational self-assessment processes to advance cultural and linguistic competency.

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