Oregon Health Authority
Office for
Oregon Health Policy and Research

Oregon Health Care Workforce Committee

Recommendations for the
Oregon Health Policy Board

December 2010

based practice.[11] Recognizing the importance of addressing health care inequities, the Committee adds cultural competency as a sixth, distinct core skill. Cultural competency is vital not only to improve the quality of care delivered to racially and ethnically diverse patients but also to strength health care professionals' abilities to communicate and collaborate with each other.

Efforts to formalize new competencies in professional practice are already occurring at the national and state levels. For example, the American Board of Medical Specialties has included new requirements regarding interpersonal and communications skills in Maintenance of Certification testing for physicians. The Oregon State Board of Nursing revised the Oregon Nurse Practice Act to include competencies in nursing informatics. Building on current efforts, the OHA should convene representatives from the Oregon's health care industry, academic programs, licensing boards, professional associations, and culturally diverse communities to guide the development of desired competencies and related curricular standards for Oregon's health professions' education programs. As with the previous recommendation, this work would support the Committee's first priority of preparing the workforce for new models of care delivery.

3. **Adopt a payment system that encourages the most efficient use of the health care workforce.**

   A payment environment that restricts who can be reimbursed for service provision encourages practices to use higher-level practitioners to perform functions that could be done just as well—and less expensively—by other qualified providers. This leads to underutilization of existing workforce capacity, with negative consequences for access, quality, and cost. The Committee strongly supports shifting away from this type of payment system to a more comprehensive and/or accountable payment system, as proposed by the Incentives and Outcomes Committee. This recommendation supports the Committee's first and second priorities.

   The methods of transitioning to a more integrated payment system should allow practices to build teams that use the best provider for a given function. In primary care, this might mean a base payment sufficient to hire a clinical pharmacist to educate patients about managing their prescriptions or community health workers to serve as bridges between clinical care and population-level prevention. Payment for certified health care interpreter services and the use of telemedicine to make health care more available in rural and remote settings are also strategies that should be considered as components of a comprehensive system.

4. **Identify barriers that prevent health care professionals from practicing to the full scope of their licenses.**

   As new models of care delivery develop, the Committee, OHA and the state's health professional licensing boards should examine payment policies, credentialing standards, organizational structures, and other relevant factors to ensure that there are no barriers to

utilizing the full potential of each professional's license. This recommendation supports the Committee's first and second priorities.

5. **Stimulate local creativity and resource sharing for health care workforce development.**

   In the context of increasing interest in regionalization of health care and local accountability, statewide recruitment programs such as the primary care loan repayment program can only be part of the solution. Some communities may need a professional who is not included in the program's scope; others may find that loan repayment is not the right incentive to attract health professionals to their area. At the same time, thousands of dollars are expended by individual employers in health professional recruitment efforts, particularly for rural and underserved areas. The OHA should help increase the efficiency of existing health care workforce development efforts by exploring structures in which health care employers, private industry, government representatives and community leaders can come together (similar to a community health collaborative model) to: identify local health care workforce needs; pool financial resources to recruit professionals; and devise appropriate community recruitment and retention incentives.

   As a first step, in 2011 the OHA should convene stakeholders and conduct a feasibility study of mechanisms for and identify barriers (e.g. antitrust laws) to cooperative health care professional recruitment and retention across employers and communities. This work would support the Committee's priority of improving the capacity and distribution of the health care workforce.

6. **Enhance resources for health professions education programs.**

   This proposal is the long-term version of short-term recommendation #4. Assuming a more robust state economy in future years, the Committee urges increased investment in heath care professions education to help create the estimated 58,000 health care professionals that Oregon needs by 2018. This recommendation relates to the Committee's third priority of expanding the health care workforce through education and training.

7. **Maintain and enhance resources for K-12 math, science, and health career exposure.**

   In order to build Oregon's health care workforce of the future, we must invest in the K-12 education pipeline to introduce students, particularly those from Oregon's rural and racial and ethnic minority populations, to and prepare them for health profession careers. Unfortunately, cumulative cuts over several years to Oregon's school districts and Area Health Education Centers budgets have reduced funding for math and science education and exposure to health careers, particularly in rural Oregon. The result has produced students who do not meet minimum qualification standards for admissions to post-secondary health profession education programs. Even though the state's budget challenges make it difficult, the Committee urges the Health Policy Board and the state to maintain now and enhance when possible funding for math, science and health career

experience in Oregon's primary and secondary schools to prepare Oregon's future health care workforce. As above, this recommendation relates to the Committee's third priority of expanding the health care workforce through education and training.

IV. Vision, Context, and Constraints

The short- and longer-term recommendations in this report are proposed as strategies to create an Oregon health care workforce that is:

- **Diverse and culturally competent**. Oregon's population is becoming increasingly diverse and health care providers in the state should reflect this diversity. Providers should be able to offer services in the patient's preferred language and to provide care in a manner that is appropriate and acceptable for the patient's culture. Improving the diversity and cultural competence of Oregon's health care workforce would produce a range of benefits including increased access to care for vulnerable populations[12], improved patient-provider communication and quality of care, and expanded availability of living wage careers for racial and ethnic minorities.

- **Comfortable working in inter-professional teams**. Multidisciplinary teams (health care professionals from different fields working together to provide patient-centered care) are a key feature of many models of future primary care and have the potential to increase care coordination, improve quality and efficiency, and enhance job satisfaction and retention for care providers. To work effectively in such teams, health care providers will need a clear understanding of the breadth of knowledge and skills possessed by professionals outside their own disciplines. They will also need training in operational and managerial functions such as team oversight, negotiation, and performance improvement.

- **Practicing in the locations and specialties areas where it is most needed**. All Oregonians should have access to the care they need within a reasonable distance of their own communities. To make this possible, the current trend of decreasing enrollment in primary care disciplines must be reversed and disincentives for practicing in rural and underserved locations must be removed. Recruitment and admissions strategies for health education programs, reimbursement structures, support mechanisms for isolated practitioners, and community incentives should all be examined for their potential to improve the geographic and specialty distribution of the primary care workforce.

The recommendations in this report are strategies proposed by the Oregon Health Care Committee as the most feasible first steps toward creating a workforce that reflects the vision above. However, it is important to note that many of the policies and system changes that would make this workforce vision possible fall outside the traditional arena of workforce development. The Committee recognizes and supports the following elements of broad-based health care reform as necessary context for its more targeted recommendations:

- **Rapid migration away from fee-for-service payment systems**. Paying for units of service or procedures rewards volume and expensive treatments rather than improved health outcomes and superior quality and efficiency. For example, under fee-for-service systems, providers are often not compensated for valuable and time-consuming functions like care coordination, discharge planning, medication management, and other activities that are critical to keeping people healthy. Moreover, restrictions on who can be reimbursed under certain fee-for-service payment systems lead to under-utilization of existing workforce capacity by discouraging mid-level providers and paraprofessionals from providing care within their scopes of practice. Shifting to more integrated or comprehensive payment structures will enable the workforce reconfiguration that is necessary to help Oregon meet its triple aim objectives.

- **Greater emphasis on prevention and population health**. The increasing burden of chronic diseases and poor health at the population level contribute significantly to the demand for health care professionals. In the long-term, investing in public health strategies that prevent or reduce disease and implementing health care reforms that encourage prevention and patient self-management will alleviate some of need to produce additional health care professionals. In the short-term, however, a greater emphasis on prevention and population health would require expanding the capacity of the public health and primary care segments of the workforce.

- **Improved data collection**. Better data and more meaningful measurement of costs and outcomes will be critical to the success of health care reform as a whole. For workforce development, more detailed and accurate information about the characteristics of the current health care practitioners, the projected supply of new professionals, and the future demand for care are obviously key resources for strategic planning. However, reliable data on cost, accessibility, utilization, quality, equity, and efficiency will also be necessary to track and evaluate the impact of workforce development efforts and to adjust those and other reform strategies as needed. Better data on race, ethnicity, language, and other demographic characteristics are critical to assess whether reform efforts are benefitting everyone equally.

Finally, it is important to recognize the limits of state's role and influence in developing, Oregon's health care workforce. Education standards, policy decisions and regulatory structures at the national and federal levels affect Oregon's health care workforce development efforts. These include:

- National health profession education accreditation standards that dictate curriculum and clinical training requirements and limit curricular innovation;
- Higher degree requirements for entry-level clinical occupations, also known as "degree creep," which exacerbate shortages and impede career pathways;
- Reimbursement policies that incent students, particularly those with significant student loan debt, to enter specialty practices over primary care and health promotion practices; and

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and environmental changes. Key among these is the relationship between educational attainment and health. Poor health in childhood negatively affects educational attainment, which in turn reduces future income and decreases the practice of good health behaviors. Better student health, particularly for diverse populations, will help to increase high school graduation rates and improve health outcomes.

» Maximizing electronic health record adoption and connectivity and ensuring collection and reporting of race and ethnicity data to effectively track health disparities. This effort will include partnerships with the Oregon Health Information Technology Extension Center and with statewide health information exchange efforts under the Health Information Technology Oversight Council.

For more information

Please see: Oregon Health Improvement Plan Committee report and appendices at www.oregon.gov/OHA/action-plan/

Health Information Exchange Strategic and Operational Plans for Oregon at www.oregon.gov/OHA/action-plan/

Improve health equity.

Better health and lower costs for everyone

STRATEGY 3

Health inequities are unnecessary, unjust and avoidable. They are the result of health, economic and social policies that have disadvantaged communities of color, immigrants and refugees, and other diverse groups over generations. These disadvantages result in tragic health consequences for Oregon's diverse populations and increased health care costs for everyone.

In state comparisons, Oregon's African American diabetes mortality rate is surpassed only by West Virginia's. Only seven states have higher rates of African American stroke mortality than Oregon. African American Oregonians have a diabetes mortality rate that is 2.6 times the rate for white Oregonians, and a stroke mortality rate that is 1.7 times higher.

Also, Oregon is:

» 26th in the percentage of African American and Latino live births by cesarean delivery; both are slightly better than U.S. averages

» 25th in the percentage of African American and 30th for Latina mothers beginning prenatal care in the first trimester, both below U.S. averages.

As Oregon's population becomes increasingly diverse, we must develop a public health and health care system that effectively meets the needs of Oregon's diverse and geographically disparate populations:

» The Latino population has almost doubled in the past 10 years, and is now the largest minority population with well over 400,000 people.

» Asian Americans number more than 130,000 in the state.

» American Indian and Alaska Native and African American populations number 67,000 and 63,000 respectively; both experience disproportionate health burdens that result in unacceptable costs for individuals, families, communities and health systems.

» International migration is adding to the cultural and language diversity of the state, with the Russian community continuing to grow, along with Somali and Iraqi populations. Oregon is expected to add 197,000 through international immigration over a 30-year period ending in 2025.

These demographics create significant opportunities for improvement and challenge Oregon's health system to provide care in culturally appropriate ways, including developing a provider workforce that reflects our state's growing diversity. Recruiting and retaining a racially and ethnically diverse workforce is essential to ensuring effective health practices, access to care, and health outcomes for populations experiencing significant health burdens. Unfortunately, few of Oregon's medical school graduates represent minority communities. In 2009, only eight of 121 graduates were Latino, African American, Native American, or Pacific Islander. As these groups and other minority populations continue to grow, it is important to have health care providers who understand each minority population's cultural norms and expectations (including patients' values, beliefs, religion, and communication styles), and who speak the language or have high-quality translation and interpretation services available.

What we need to achieve

Reach the highest possible level of health for all people.
In implementing health care reform, the Oregon Health Policy Board and the Oregon Health Authority will strive to avoid creating or maintaining health policies that perpetuate or increase these avoidable and unjust health inequities. OHA and

its Board are committed to promoting health equity for all people in all regions of the state, inclusive of race, ethnicity, socioeconomic status, occupation, ability and sexual orientation. Tackling health inequities also requires looking at the ways in which jobs, working conditions, education, housing, social inclusion, media and even political power affect individual and community health. When health and societal resources are distributed equally, population health will be equitable as well.

Next steps to realizing health equity

Despite these challenges, many opportunities exist to create equitable health outcomes for all of Oregon's diverse populations. These are directly connected to the Board's other key foundational strategies.

> **Using community health workers as team members for the delivery of primary care, behavioral health care, and community prevention improves health outcomes** because they are trained and trusted members of the communities in which they work and share culture, language, and experience with patients. This is especially important in communities of color or other underserved communities. Community health workers are already successfully providing culturally specific patient-centered preventive health care in some of Oregon's most underserved areas. Creating incentives that encourage the use of community health workers is a priority in OHPB's strategies for a healthy Oregon.

> **Ensuring that health care providers receive ongoing training in cultural competence.** With Oregon's increasingly diverse population and strong evidence of racial and ethnic disparities in health care, it is imperative that health care professionals are educated to work effectively with diverse groups. Ongoing training in cultural competence will improve provider-patient communications, public health efforts and health outcomes.

> **Doing more to collect and analyze data at the most granular levels of race, ethnicity, national origin, language, ability, sexual orientation, education and literacy level, and occupation** will help health systems, community groups, and consumers better understand quality and health outcomes. This helps to ensure that our efforts are improving the health and lives of diverse communities within Oregon.

For more information

Please see: Health Equity Policy Review Committee at
www.oregon.gov/OHA/omhs/health_equity.shtml

For more information

Please see: Health Insurance Exchange Report and appendices at www.oregon.gov/OHA/action-plan/

STRATEGY 5

Reduce barriers to health care.

Adequate insurance, providers with the right training for the right places, and easy access to care

Today, 17 percent of Oregonians are uninsured. We project that, by 2014, 93 percent of all Oregonians will have access to health care coverage as a result of insurance market reforms, expansions of Medicaid, creation of state health insurance exchanges, and federal tax credits that help make coverage offered through exchanges more affordable. The Kaiser Family Foundation estimates that Oregon's Medicaid enrollment will increase by 60 percent.

We have a responsibility to ensure that the newly covered can find health care providers and a moral obligation to make certain that the remaining uninsured still have access to care. Decisive action must be taken now to ensure that Oregon has a health care workforce capable of meeting the demand for quality services in 2014 and beyond.

What we need to achieve

All Oregonians should be able to get safe and effective care that is coordinated locally, using statewide resources when necessary, from a team of appropriately trained health care providers.

While health insurance expansions will provide unprecedented levels of coverage, they will also put unprecedented pressure on the delivery system. We also know that having health insurance is not the same thing as having access to care. To ensure that Oregonians can get the health care they need, when and where they need it, we must:

- Foster the development of local and regional solutions for health care access that include Oregon's traditional safety-net providers;
- Improve the capacity and distribution of the primary care workforce;

» Expand education and training opportunities;

» Train, recruit and retain a workforce that is diverse, culturally competent, and prepared to change the way health care is delivered; and

» Successfully implement insurance expansions.

Next steps

The strategies below address both our current health care workforce needs and the needs Oregon might have in the future, when health care delivery looks different than it does today.

> **Promote local and regional accountability for health and health care.** Communities and regions, accessing statewide resources when necessary, are uniquely qualified to develop locally relevant strategies to improve health outcomes and address the health disparities that exist within their populations. Oregon's traditional safety net providers' expertise would benefit any regional frameworks because they have significant experience providing health care services to diverse populations with fixed resources. Development and implementation of frameworks such as regional accountable health organizations will reduce fragmentation and improve access by locally integrating physical, behavioral, and oral health, and long-term care.

> **Revitalize the state's primary care practitioner loan repayment program** to help meet the demand for care and to support a renewed emphasis on preventive and primary care across the health system. Loan repayment effectively encourages providers to choose primary care and to practice in rural and underserved communities. Oregon's Primary Care Services Program, which provides partial loan repayment to primary care providers in return for service time in rural or underserved areas, should be financed as soon as possible at a level that would bring at least 30 additional primary care professionals to rural and underserved areas each year.

» The Legislature and the Office of Rural Health should investigate sustainable financing mechanisms.

> **Align student requirements for clinical training.** To streamline and increase capacity in the final stages of training for health professionals, OHA will work with relevant stakeholders to:

» Standardize administrative requirements for student clinical placement (drug testing, criminal background check, HIPAA training, etc.) via a student "passport" (2011).

» Establish uniform standards for student clinical liability to reduce the time and expense of contract negotiations between educational institutions and training sites; also explore ways to encourage more community-based and outpatient practices to serve as clinical training sites (2012).

> **Revise policies that prevent public educational institutions from responding quickly to health care workforce training needs.** Current interpretation of a law designed to ensure that public investment does not adversely affect private business means that private entities can block development of new public training programs or program locations even if they do not intend to offer the training themselves. The result is that training programs for high-demand health care occupations may not be equally available to rural and urban students or to rural or underserved communities. OHA will convene stakeholders in 2011 to draft revisions to the policy.

> Use a range of methods to **recruit and retain a workforce that is racially and ethnically diverse and culturally competent.** Improving the diversity and cultural competence of Oregon's health care workforce will produce a range of benefits including increased access to care for vulnerable populations, improved patient-provider communication and quality of care, and expanded availability of living-wage careers for racial and ethnic minorities.

» OHA will collaborate with health care professional regulatory boards and professional societies to identify the best methods of ensuring that licensed health care professionals receive ongoing training in cultural competency.

» OHA will incorporate incentives for using community health workers into primary care payment reform and implementation of patient-centered primary care home standards.

> **Adopt payment systems that encourage use of the best provider (or provider team) for a given care need.** Payment structures such as fee-for-service tend to encourage higher-level practitioners to see patients even when the same care could be provided as well or better — and less expensively — by other qualified providers. This means we are not using our health care workforce optimally, which reduces access and increases the overall cost of care. Rapid transition to more comprehensive and accountable payment systems, particularly in primary care, will enable practices to build teams that use the best combination of providers to efficiently meet patient needs.

- **Expand health care workforce data collection.** Complete and accurate information about all licensed providers is essential for design and evaluation of strategies to improve access, including efforts to increase workforce diversity. This will require:
  - Legislative action in 2011 to extend the requirement to participate in Oregon's health care workforce database to all health professional licensing boards. Reporting would begin with the boards governing licensed mental and behavioral health care professionals.
- **Successful implementation of insurance expansions.** In order for the expansion of coverage via Medicaid and a new health insurance exchange to be successful, Oregonians must know what their insurance options are and how to access them. This will entail:
  - Developing outreach and marketing plans that effectively enlist community partners;
  - Implementing application assistance strategies;
  - Implementing efficient electronic eligibility and enrollment systems that will increase current system capacity;
  - Developing a strategy to clearly communicate information about eligibility and coverage for public and private insurance options; and
  - Assessing eligibility and enrollment requirements to ensure that current policies do not create inequities or unnecessary burdens.

For more information

Please see: Health Care Workforce Committee Report and appendices at www.oregon.gov/OHA/action-plan/

STRATEGY 6

Set standards for safe and effective care.

Primary care homes, electronic health information, evidence-based care, and addressing medical liability

The health care each individual receives varies for a number of reasons. This leads to less-than-optimal health outcomes in some instances and overuse of care in others. We need to create the standards and other tools that will ensure

Actions	2011	2012	2013	2014	2015
Promote local and regional accountability for health and health care	OHA explores and develops regional frameworks with stakeholders				
Build the health care workforce					
• Use loan repayment to attract and retain primary care providers in rural and underserved areas	Legislature and Office of Rural Health develop financing plan	Implement and expand loan repayment; revise eligibility in line with workforce needs			
• Standardize prerequisites for clinical training via a student "passport"	OHA partners develop consensus requirement	Introduce passport Explore standardizing students' clinical liability			
• Revise "adverse impact" policy to enable public educational institutions to respond to workforce training needs	OHA partners revise policy				
• Improve diversity and cultural competency of health care workforce	OHA and partners identify best methods to ensure ongoing cultural competency	OHA incents use of Community Health Workers in primary care homes			
• Extend participation in Oregon's Healthcare Workforce Database to all health professional licensing boards.	Legislature authorizes database expansion	Incorporate reporting from new health care professional licensing boards as data needs dictate and board readiness allows			
Move to patient-centered primary care, first for OHA lives (Medicaid recipients, state employees, educators) and then statewide	OHA implements Patient-Centered Primary Care Homes (PCPCHs) where it has significant purchasing power	Implementation expands			75% of all Oregonians have access to PCPCH
Introduce value-based benefit designs that remove barriers to preventive care	OHA does additional design and modeling work OHA develops roll-out plans include. education and outreach	OHA and partners offer value-based benefit package (VBBP) in OHA coverage	VBBP offered in Oregon Exchange		

Expand the use of health information technology (HIT) and exchange (HIE)	OHA consolidates HIE planning in new Office of Health Information Technology (OHIT) Legislature establishes a public-private state-designated entity for HIE	Transition HIE services and operation to the state-designated entity	Widespread adoption and use of electronic health records Leverage HIE to support quality of care, including care coordination		
Develop Oregon guidelines for clinical best practices	OHA and partners create 10 sets of Oregon-based best practice guidelines and standards of care	OHA and partners use standards to increase appropriateness of care and reduce costs			
Strengthen medical liability system performance					
• Remove insurance concerns as barriers to full disclosure of adverse events by providers and facilities	Legislature enacts law removing barriers to disclosure	OHA and partners use standards to increase appropriateness of care and reduce costs			
• Clarify that statements of regret or apology may not be used to prove liability in negligence cases	Legislature amends Oregon's "apology" law				
• Explore alternative systems	OHA pursues funding or team to study alternative compensation system for medical errors				
Performance measurement	OHPB finalizes Scorecard with Oregon standard quality measures OHA sets common standards for diversity data in its systems	Ongoing: OHPB reviews, revises, and holds reforms accountable to Scorecard 2012-14: OHA rolls out diversity data standards in its systems and works to extend them to private sector			

The Board's agenda and ongoing action items are continuing to be developed.

Oregon Health Authority
Cultural Competence Continuing Education Committee

I. Authority

The Cultural Competence Continuing Education (CCCE) Committee is established by the Oregon Health Authority to explore opportunities to promote cultural competence continuing education for health care professionals. During and since the 2011 legislative session, discussions with stakeholders have reinforced that cultural competence in health care is an important issue that should be taken up during the interim.

This charter defines the objectives, responsibilities and scope of activities of the Cultural Competence Continuing Education Committee based on the objectives and activities outlined in SB 97, which was introduced in the 2011 legislative session.

II. Deliverables

1. Identify committee co-chairs
2. Develop and recommend a definition of 'Cultural Competency' and 'Linguistic Competency'.
3. Evaluate other states' and national entities' Cultural Competence continuing education options for licensed health care providers
    a. Identify options that are relevant to provider type, provider specialty and geographic location.
4. Identify existing continuing education standards relative to cultural competence currently used by other organizations, states, or national bodies.
5. Identify a proposed list of Cultural Competence Continuing Education Standards for Oregon health care providers.
6. Develop a list of continuing education opportunities relating to Cultural Competence that meet the proposed standards and make the list available to each of the health professions licensing boards. Continuing education opportunities may include, but need not be limited to:
    a. Courses delivered either in person or electronically;
    b. Experiential learning options such as cultural or linguistic immersion;
    c. Service learning; or
    d. Specially designed cultural experiences.
7. Explore implementation costs and logistical issues for the health professions licensing boards related to establishing Cultural Competence continuing education tracking for licensed health care providers.
8. Examine operational issues, including but not limited to the feasibility of developing a communication plan for Cultural Competence continuing education for health care providers and maintaining a central listing of continuing education options.
9. Identify opportunities to pursue gifts, grants or contributions from any public or private source for the purpose of developing and implementing continuing education opportunities for health care providers in Oregon

III. Time Line

- Convene CCCE Committee (April, 2012)

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- Exploration of definitions, standards, and options for Cultural Competence Continuing Education (April 2012 – June 2012)
- Develop a definition of 'Cultural Competency' and 'Linguistic Competency' to be recommended to OHA Leadership (June 2012)
- Evaluate other states' and national entities' cultural competence continuing education options for licensed health care providers. (June – October 2012)
- Identify a proposed list of cultural competence continuing education standards for Oregon health care providers. (December 2012)
- Develop a list of continuing education opportunities relating to Cultural Competence that meet the proposed standards and make the list available to each of the health professions licensing boards. (December 2012)
- Explore implementation costs and logistical issues for the health professions licensing boards related to establishing cultural competence continuing education tracking for licensed health care providers. (October – December 2012)
- Examine operational issues, including but not limited to the feasibility of developing a communication plan for cultural competence continuing education for health care providers and maintaining a central listing of continuing education options. (October – December 2012)
- Identify opportunities to pursue gifts, grants or contributions from any public or private source for the purpose of developing and implementing continuing education opportunities for health care providers in Oregon. (October-December 2012)

IV. Dependencies

The CCCEC will seek information from and collaborate with a wide range of state and national partners including:

a. The Oregon Healthcare Workforce Institute
b. Health care employers and providers
c. The Oregon Health Policy Board and its Workforce Committee
d. Health care professional licensure and certification boards, in Oregon and nationally
e. Community based Organizations
f. Health care professional educators
g. Joint Commission and other national health care accreditation bodies

V. Staff Resources

The Office of Equity and Inclusion will provide staff support to Committee leadership.

Committee Lead: Tricia Tillman
Committee Staff: Rachel Gilmer, Emily Wang

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Committee Co-Chairs:
Randy Everitt, Oregon Health Licensing Agency
Fabiana Wallis, Oregon Psychological Association

Committee Members:
Patricia Ahlen, Oregon Medical Association
Jean Donovan, Oregon Nurses Association
Kristi Emerson, Northeast Oregon Network
Liz Fouther-Branch, Go To Help, LLC
Michelle Gaines, Oregon Mortuary & Cemetery Board
Felicia Holgate, Oregon Occupational Therapy Licensing Board
Mary Rita Hurley, Oregon Center for Nursing
Christine Lau, Asian Health and Service Center
Ernest Meshack-Hart, Oregon Dentists Association
Netia Miles, Oregon Medical Board
Dayna Morrison, LGBTQ Health Coalition of the Columbia-Willamette
Sheila Murty Job, Legacy Health
Maura Roche National Association of Social Workers , Planning Parenthood, Basic Rights Oregon
Nancy Sellers, Oregon Board of Optometry
Danielle Sobel, Oregon Medical Association
Isabelle Soule, Oregon Health and Sciences University
Huma Qureshi-Pierce, Oregon Board of Chiropractors
Malinda Trujillo, Veterans Association
Ron Williams, Oregon Action
Judith Woodruff, Northwest Health Foundation
Jason Young, Chiropractor

Committee Staff:
Committee Lead: Tricia Tillman, Oregon Health Authority Office of Equity and Inclusion
Committee Assistants: Rachel Gilmer, Oregon Health Authority Office of Equity and Inclusion
Emily Wang, Oregon Health Authority Office of Equity and Inclusion

Evidence-Based Research in Support of Cultural Competence Continuing Education

Cultural Competence Education and Provider-Patient Relationship
Cultural Competence and Self-Reported Provider Improvement Accuracy of Self-Reporting

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Cultural Competence Education and Provider-Patient Relationship

Title: Effective Physician-Patient Communication and Health Outcomes: A Review
Author: Stewart, MA
Date: 1995, 2000
Source: Journal of Canadian Medical Association
Although many studies largely rely on self-perceptions that could prove to be inaccurate, this article explores the plethora of literature available that suggests that training in general can be successful in changing physician behavior.

Since communication skills and other aspects of physician behavior have been linked to patient adherence, outcomes, and satisfaction, training could yield improvements in these areas. Relying on this chain of reasoning, interest and activity in cultural competency training have been heightened.

Title: Physician Cultural Competence and Patient Ratings of the Patient-Physician Relationship
Author: Kathryn A. Paez, et al.
Date: February 5, 2009
Source: Society of General Internal Medicine

Objective:
To determine the association of patients' ratings of the patient-physician relationship with physicians' self-reported cultural competence (CC).

Method:
Physicians completed a survey assessing their CC in three domains:

1. motivation to learn about other cultures (motivation attitudes),
2. awareness of white privilege and acceptance of a racial group's choice to retain distinct customs and values (power assimilation attitudes),
3. and clinical behaviors reflective of CC.

Their African-American and white patients completed interviews assessing satisfaction with the medical visit, trust in their physician, perceptions of their physician's respect for them and their participation in care. Authors conducted regression analyses to explore the associations between CC and patient ratings of the relationship.

Results:

- Patients of physicians reporting more frequent CC behaviors were more satisfied and reported seeking and sharing more information
- Patients of physicians reporting more motivation to learn about other cultures were more satisfied, perceived their physicians were more facilitative and reported seeking and sharing more information during the medical visit
- Physicians' power assimilation attitudes were associated with patients' ratings of physician facilitation

Conclusions:
Attitudinal and behavioral components of CC are important to developing higher quality, participative relationships between patients and their physicians.

Cultural Competence and Self-Reported Provider Improvement

Title: Cultural Competence: A Systematic Review of Health Care Provider Educational Interventions
Author: Beach, Mary Catherine, MD, MPH
Date: April, 2005
Source: Medical Care, Volume 43, Number 4

Objective:
This literature review sought to synthesize the findings of studies evaluating interventions to improve the cultural competence of health professionals.

Methods:
Authors performed electronic and hand searches from 1980 through June 2003 to identify studies that evaluated interventions designed to improve the cultural competence of health professionals. They abstracted and synthesized data from studies that had both a before- and an after-intervention evaluation or had a control group for comparison and graded the strength of the evidence as excellent, good, fair, or poor using predetermined criteria.

Main Outcome Measures:
Authors sought evidence of the effectiveness and costs of cultural competence training of health professionals.

Results
Thirty-four studies were included in our review. There is excellent evidence that cultural competence training:

1. improves the knowledge of health professionals (17 of 19 studies demonstrated a beneficial effect),
2. improves the attitudes and skills of health professionals (21 of 25 studies evaluating attitudes demonstrated a beneficial effect and 14 of 14 studies evaluating skills demonstrated a beneficial effect).
3. impacts patient satisfaction (3 of 3 studies demonstrated a beneficial effect)

Authors were unable to identify studies that have evaluated patient health status outcomes or determined the costs of cultural competence trainings.

Conclusions:
Cultural competence training shows promise as a strategy for improving the knowledge, attitudes, and skills of health professionals. Future research should focus on patient outcomes and should determine which teaching methods and content are most effective.

Title: A Curriculum for Multicultural Education in Family Medicine
Author: Culhane-Pera, K.A, et al.
Date: 1991
Source: Family Medicine

Authors evaluating a multicultural curriculum for family practice residents found that trainees reported self-assessed increases in knowledge, cross-cultural communication skills, and cultural competency. Students' Self-evaluations were confirmed by faculty assessments.

Title: Evaluating the Impact of Multicultural Counseling Training
Author: D'Andrea, M.J Daniels and R. Heck
Date: 1991
Source: Journal of Counseling and Development 70 (September/October)

Authors found that participants in multicultural counseling training perceived themselves as being more aware, knowledgeable, and skillful compared to both pretraining reports and controls

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Title: Cultural competence of certified nurse practitioners
Author: V. Koempel
Date: 2003
Source: Minnesota State University, Mankato.

In this study, respondents indicated that it was continuing education and training that contributed to their cultural competence.

Title: Integrating Family and Culture into Medicine; A Family Systems Block Rotation
Author: Marvel, Grow, and Morphew
Date: 1993
Source: Family Medicine

Report evaluated a method for educating residents that involved a block rotation that integrates family systems theory, family-oriented skills, and sociocultural awareness. Residents completing evaluations 1 year after graduation indicated that these skills proved useful to them in practice.

Title: Perspectives of Registered Nurse Cultural Competence in a Rural State
Author: Seright, Teresa MSN, RN
Date: Spring 2007
Link: http://www.rno.org/journal/index.php/online-journal/article/viewFile/9/181

History:
The purpose of this study was to determine the relationship between cultural competence and educational preparation in North Dakota, a majority white state that is growing increasingly diverse with a large American Indian, and refugee population. It was hypothesized that the North Dakota nurses who reported participation in cultural competency educational programs would rank themselves higher on the IAPCC-R (Inventory for Assessing the Process of Cultural Competence) than those who had not reported participation in such programs. A voluntary sample of registered nurses from urban and rural hospitals in the state of North Dakota were surveyed. The majority of respondents were white and female.

Method – the IAPCC-R
The IAPCC-R was a 25 item self-administered tool that was designed for use by health professionals to measure cultural competence. Reliability of the IAPCC-R had been established in prior research studies which produced Cronbach's Alpha coefficients ranging from .77-.90 Content validity was established by reviews of national experts in the field of transcultural health care (Campinha-Bacote, 2003). The IAPCC-R measured the five constructs of cultural competence:

- cultural knowledge;
- cultural skill;
- cultural encounters;
- cultural awareness;
- and cultural desire.

Results
Ongoing education, or cultural diversity training, at the workplace, positively impacted IAPCC-R scores more than any other variable. It was hypothesized that study participants who participated in cultural diversity training at their work places would score higher on the IAPCCR than those who had little or no training at their work places. Higher scores did correlate to more frequent training.

Title: Culturally Competent Nursing Modules Two-Year Evaluation Report
Authors: Office of Minority Health, U.S. Department of Health and Human Services
Date: March 16, 2007 to March 16, 2009
Link: https://www.thinkculturalhealth.hhs.gov/Documents/CCNMEvalReportFINAL.pdf

History:
In 2004, the Office of Minority Health (OMH) at the U.S. Department of Health and Human Services initiated the development of the Culturally Competent Nursing Modules (CCNMs) in order to help nurses develop cultural and linguistic competencies required to improve the quality of care for ethnically diverse communities. The CCNMs are grounded in the National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS) and the most recent research in the field of cultural competence education. The curriculum underwent a rigorous development process which included: a needs-assessment phase comprised of focus groups and development of an Environmental Scan; ongoing input from a National Project Advisory Committee; a Consensus-Building process; and pilot and field testing of draft curricula throughout the country with practicing nurses as well as nurses in academic settings. The CCNMs were released to the nursing community on the World Wide Web on March 16, 2007.

Collaborative Process for Curriculum Development:
A National Project Advisory Committee (NPAC) was convened to serve in an advisory capacity during the curriculum development process. A Consensus Building meeting was held to establish priorities for the Culturally Competent Nursing Modules. It was important for the credibility and comprehensiveness of the curriculum that the perspectives, concerns, and knowledge of various stakeholders groups were reflected in how the modules were developed, presented, and written. Concept papers focusing on the three themes of the CLAS Standards facilitated discussion at the Consensus Building meeting and helped to identify potential focus areas for the design of the modules.
During their development, the Culturally Competent Nursing Modules underwent three phases of focus group testing by nurses across the United States.

Curriculum Content:
The curriculum is grounded in the principles of the CLAS Standards and is structured around their three themes.

- **Curriculum Course 1, Delivering Culturally Competent Nursing Care**, provides nurses with the principles of cultural competency, a self-assessment tool to address potential gaps in cultural competency learning, and tools and strategies for increasing cultural awareness during a clinical encounter, as well as skills for delivering patient-centered care.
- **Curriculum Course 2, Language Access Services**, offers an overview of language access services, provides tools and strategies for effective communication between a nurse and a patient, and demonstrates the rationale for health literacy.
- **Curriculum Course 3, Supporting and Advocating for Culturally Competent Health Care Organizations**, articulates the need for nurses to play the role of advocates for cultural competency within their organizations and provides tools and strategies for integrating this education into their environment.

This Two-Year Evaluation Report organizes data and methodologies into the analysis of four themes which focus on the following research questions:

- Does completion of the curriculum result in a nurse's:
    - Satisfaction with the type of training provided within the CCNM?
    - Increase in knowledge regarding cultural competency?
    - Change in behavior as a result of the training?
    - Working towards changing their practices and health care organizations to reflect the knowledge gained with the CCNM training?

Web-Based:

The CCNMs were revised following field testing, and were submitted for accreditation and award of continuing education credits. The CCNM e-learning program was launched on the www.thinkculturalhealth.org Web site on March 16, 2007.

The CCNMs are a web-based curriculum organized by the three themes of the CLAS Standards. Each theme represents a single course, which is then further divided into six distinct modules. Each course begins with a pretest intended to measure nurses' existing knowledge of relevant concepts, identify knowledge gaps, and focus their attention on specific concepts discussed in this module.

Each course is organized around video-enabled case studies that illustrate the concepts covered in the course materials and allows for participant feedback and self-assessment. The use of video enhances the instructional message and boosts the learner's attention on the concepts covered in the module, as well as the non-verbal communication cues necessary for effective communication.

Module case studies are based on interactions between nurses and a diverse group of patients, including an elderly African-American woman, a Native American youth, a Hispanic American male, individuals of Asian descent, and a Muslim couple. Each of the scenarios presented reflect real-life situations that nurses encounter daily, such as language barriers and the need for appropriate interpretation services, or cultural issues of gender concordance in patient care.

After viewing each case study, nurses answer self-exploration questions designed to stimulate in-depth reflection of their feelings related to the learning content. The questions also encourage relating the case study to their own experiences involving cultural competency concepts.

After completing self-exploration questions, participants review instructional content and have an opportunity to transfer their knowledge to solving problems related to their own clinical experiences. They can also compare their own insights to those submitted by their peers. A posttest consisting of ten multiple choice questions concludes each course.

Results:

In general, participation in the entire CCNM curriculum is consistent with meaningful and significant score increases on the pre- and posttests.

Results indicated that participation in the curriculum had a positive impact on the behavior of nurses in their interactions with patients. Nurses stated that as a result of taking the curriculum, they were more sensitive to and understanding of cultural differences, and focused more on a patient-centered approach. Additionally, they added that they learned new methods for increasing organizational awareness of cultural competency, and potential ways of incorporating that into their practice.

There was also evidence suggesting that the curriculum helps stimulate greater understanding and empathy for differing patient types who experience barriers to care as a result of a lack of understanding of cultural norms or behaviors. The extent to which that understanding leads to behavioral and organizational modifications could potentially lead to an increase in more effective and higher quality care.

There was substantial evidence that participation in the entire curriculum results in increased self-awareness of culturally competency concepts. This is significant in its ultimate impact on patient care and the potential to transform health care organizations and produce positive and high-quality health outcomes.

Title: Cultural Competency in Health Care: Evaluating the Outcomes of a Cultural Competency Training Among Health Care Professionals (Oregon State University Study)
Author: Khanna, Sunil, et al, Oregon State University
Date: September, 2009
Source: Journal of the National Medical Association
Link: http://findarticles.com/p/articles/mi_7640/is_200909/ai_n39231235/

Background
Despite the lack of research funneled towards studies that link a provider's cultural knowledge and awareness to improved health outcomes for communities of color, largely due to lack of funding and methodological difficulties, Oregon State University Professor, Sunil Khanna, and his colleagues have conducted research and are continuing to develop studies that effectively evaluate cultural competence training. His 2009 study links cultural competence training to improved patient-provider communication and to increased provider knowledge and skill sets, which we know ultimately leads to improved patient satisfaction and compliance.

In 2009, they conducted an evaluation study among 43 health care professionals (health care providers and health administrators) who attended a 4-hour cultural competency workshop. Using a post-then-pre method of self-reported evaluation, which the researchers found decreased self-reporting bias as participants become more aware of the knowledge base and more willing to admit previous lack of knowledge after the training, they attempted to answer a key question: Does cultural competency training produce a measurable change in knowledge and skills relating to the care of patients from diverse cultural and ethnic backgrounds?

Results:
The study findings suggested that there are statistically significant changes in participants' self-report of knowledge and skills related to cultural competency. Their study shows that a cultural competency training program that integrates key topics as recommended by the Institute of Medicine and includes Culturally and Linguistically Appropriate Services in Health Care standards improves the knowledge and skills of health care providers and administrators. Following the training, the participants self-reported not only an enhanced understanding of the health care experiences of patients with diverse backgrounds, but also an improvement in their skills to effectively work in cross-cultural situations.

Next Steps:
Professor Khanna and his colleagues would like to conduct a study that tracks providers and patients for one-year following the cultural competence training. This would include tracking patient outcomes and satisfaction, including patient's perceptions and understanding of provider biases.

Accuracy of Self-Reporting

Title: Social learning theory
Author: Bandura, A.
Date: 1977

This study examined self-efficacy in job performance and found that there is a significant association between one's perception of ability and actual level of performance of skills and level of job knowledge

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Title: Implementation and evaluation of cultural competency training for pharmacy students
Authors: Assemi M, Cullander C, Hudmon, K.
Date: 2004
Source: University of California, San Francisco

In this study, the authors, pharmacology faculty members, studied pharmacy students' perception of self-efficacy when prescribing for and/or educating culturally diverse patients regarding medications prior to and following an educational intervention. The intervention consisted of an 8-hour course teaching methods of incorporating cultural sensitivity into medication therapy.

The 12-item instrument developed to measure pharmacy students' self-efficacy for cultural competence incorporated measures of participant bias, as well as confidence in skills necessary to provide culturally competent care to diverse populations. This measure showed a relatively high level of internal consistency between staff and students.

Cultural Competence Continuing Education Committee:Definitions and Standards

SurveyMonkey

1. Please indicate the professional sector in which you work:

	ResponsePercent	ResponseCount
Health Systems Organization	4.3%	7
Health Care Provider	**50.6%**	**83**
Social Worker	0.6%	1
Provider Professional Association	4.9%	8
Health Licensing Board	11.6%	19
Community Based Organization	3.7%	6
Government	4.3%	7
Academic Institution	13.4%	22
Other (please specify)	6.7%	11
	AnsweredQuestion	**164**
	SkippedQuestion	**2**

2. Are you a member of the Oregon Health Authority's Cultural Competence Continuing Education Committee?

	ResponsePercent	ResponseCount
Yes	7.4%	12
No	**92.6%**	**151**
Other (please specify)	0.0%	0
	AnsweredQuestion	**163**
	SkippedQuestion	**3**

3. Do you agree with this definition for cultural competence: A life long process of examining values and beliefs, of developing and applying an inclusive approach to health care practice in a manner that recognizes the dynamics of power and privilege while also preserving the dignity of individuals, families and communities This process is applicable to all patients ; assumptions will not be made on the basis of a person's expressed or perceived race, color, spiritual beliefs, creed, age, tribal affiliation, national origin, immigration or refugee status, marital status, socio-economic status, veteran's status, sexual orientation, gender identity, gender expression, and gender transition, level of formal education, physical or mental disability, medical condition or any other consideration under federal, state and local law. The term "cultural" is used here in its broadest sense as "the totality of a person's or a group's accumulated experience", and the term "competency" is defined as the "ability to do something well." Based on this document's definition of cultural competency, it would mean to adequately engage in the lifelong process or self-examination, inclusivity, awareness and respect in health care practice in accordance to the principles and standards below.

	ResponsePercent	ResponseCount
Strongly Disagree	13.9%	20
Disagree	4.9%	7
Neutral	17.4%	25
Agree	**41.7%**	**60**
Strongly Agree	22.2%	32
	AnsweredQuestion	**144**
	SkippedQuestion	**22**

4. Please provide feedback below, particularly if you selected disagree for the definition above:

	ResponseCount
	37
AnsweredQuestion	**37**
SkippedQuestion	**129**

5. Prevention-Intervention Continuum: Culturally competent practice is part of primary, secondary and tertiary prevention by promoting optimal health experiences in the context of differences, and is not limited to reactive responses to specific incidents.

	ResponsePercent	ResponseCount
Strongly Disagree	3.4%	4
Disagree	3.4%	4
Neutral	20.7%	24
Agree	**51.7%**	**60**
Strongly Agree	20.7%	24
	AnsweredQuestion	**116**
	SkippedQuestion	**50**

6. Systemic-Individual Continuum: Culturally competent practice requires systemic support, organizational implementation and integration of culturally competent practice with corresponding strategic goals in conjunction with individual provider education in order to maximize patient outcomes and ultimately reduce health disparities.

	ResponsePercent	ResponseCount
Strongly Disagree	7.8%	9
Disagree	6.0%	7
Neutral	22.4%	26
Agree	**44.0%**	**51**
Strongly Agree	19.8%	23
	AnsweredQuestion	**116**
	SkippedQuestion	**50**

7. Evidence-Assumption Continuum: Culturally competent practice emphasizes integration of best available empirical knowledge, emerging best practices, local outcome data, community involvement, and clinical expertise in the context of client characteristics, culture, and preferences while avoiding uninformed assumptions about patients.

	ResponsePercent	ResponseCount
Strongly Disagree	4.3%	5
Disagree	3.5%	4
Neutral	12.2%	14
Agree	**57.4%**	**66**
Strongly Agree	22.6%	26
	AnsweredQuestion	**115**
	SkippedQuestion	**51**

8. Strength-Deficit Continuum: Culturally competent practice promotes a cultural identity centered approach that identifies and respects the strengths and resources that patients bring to the health encounter.

	ResponsePercent	ResponseCount
Strongly Disagree	5.3%	6
Disagree	2.6%	3
Neutral	21.1%	24
Agree	**44.7%**	**51**
Strongly Agree	26.3%	30
	AnsweredQuestion	**114**
	SkippedQuestion	**52**

9. Collaboration-Unilateral Continuum: Culturally competent practice creates an environment where providers, patients, and community members work collaboratively as equal partners in the decision making process to promote lifelong health and well being.

	ResponsePercent	ResponseCount
Strongly Disagree	6.0%	7
Disagree	6.0%	7
Neutral	15.5%	18
Agree	**42.2%**	**49**
Strongly Agree	30.2%	35
	AnsweredQuestion	**116**
	SkippedQuestion	**50**

10. Please provide feedback below, particularly if you selected disagree for any of the five principles above:

	ResponseCount
	32
AnsweredQuestion	**32**
SkippedQuestion	**134**

11. Culturally Competent practice requires self-awareness and self-assessment of beliefs, attitudes, emotions and values.

	N/A (not applicable/ not needed – or less than minimum)	Minimum	Gold Standard (more than minimum)	RatingCount
Provider is mindful of cultural factors that may influence own and patient's behaviors	5.7% (6)	**51.4% (54)**	42.9% (45)	105
Explore concepts of power, privilege and oppression across personal identities	30.8% (32)	**38.5% (40)**	30.8% (32)	104
Foster a non-judgmental and respectful environment during the health encounter	3.8% (4)	41.3% (43)	**54.8% (57)**	104
Provider understands relationship between cultural competence and ethics	14.3% (15)	**51.4% (54)**	34.3% (36)	105
Provider demonstrates commitment to equal quality of care	4.8% (5)	39.4% (41)	**55.8% (58)**	104
Provider is proactive in eliminating barriers	10.6% (11)	43.3% (45)	**46.2% (48)**	104
			AnsweredQuestion	**105**
			SkippedQuestion	**61**

12. If needed, please provide feedback on any of the aforementioned standards below:

	ResponseCount
	15
AnsweredQuestion	**15**
SkippedQuestion	**151**

13. Culturally Competent practice requires the acquisition of knowledge:

	N/A (not applicable/ not needed – or less than minimum)	Minimum	Gold Standard (more than minimum)	RatingCount
Understanding of cultural competence as a developmental process and not an endpoint and includes lifespan perspective from pre-natal to end of life	9.0% (9)	**56.0% (56)**	35.0% (35)	100
Knowledge of ethnocentrism, micro-aggressions, identity, privilege, power, oppression, assumptions and bias as it applies to vulnerable populations	25.5% (26)	**43.1% (44)**	31.4% (32)	102
Knowledge of legal, regulatory and accreditation issues of diversity and linguistic issues and your own professional standards regarding cultural competence	12.7% (13)	**61.8% (63)**	25.5% (26)	102
Knowledge of health disparities and social determinants of health	11.8% (12)	**57.8% (59)**	30.4% (31)	102
Knowledge of the limits of cross-language communication and cross-cultural variation in verbal and non-verbal communication	8.8% (9)	**54.9% (56)**	36.3% (37)	102
Knowledge of medical pluralism or integration of traditional and biomedical	22.4% (22)	**48.0% (47)**	29.6% (29)	98
Knowledge of local and national demographics, including local and state history of minority communities	21.8% (22)	**51.5% (52)**	26.7% (27)	101
Knowledge of meaning of culture, and culture of health care	8.9% (9)	**59.4% (60)**	31.7% (32)	101
Knowledge of trauma-informed care principles	24.2% (24)	**51.5% (51)**	24.2% (24)	99
Knowledge of a wellness model of health	14.3% (14)	**42.9% (42)**	**42.9% (42)**	98

Knowledge of epidemiology and within-group variance, including population specific diseases	11.0% (11)	**46.0% (46)**	43.0% (43)	100
Knowledge of genome research and ethnopharmacology	31.3% (31)	**46.5% (46)**	22.2% (22)	99
			AnsweredQuestion	**102**
			SkippedQuestion	**64**

14. If needed, please provide feedback on any of the aforementioned standards below:

	ResponseCount
	12
AnsweredQuestion	**12**
SkippedQuestion	**154**

15. Culturally Competent practice requires specific educational approaches for knowledge acquisition.

	N/A (not applicable/ not needed – or less than minimum)	Minimum	Gold Standard (more than minimum)	RatingCount
Trainers obtain informed consent from participants (e.g. strong emotions that may be elicited, plan to respond to adverse outcomes, offer follow-up)	21.0% (21)	**53.0% (53)**	26.0% (26)	100
Trainings should be offered in a wide range of options utilizing multiple education modalities, including case studies	6.9% (7)	**51.5% (52)**	41.6% (42)	101
Trainings are best accomplished by an interdisciplinary, multi-cultural team	19.6% (20)	**45.1% (46)**	35.3% (36)	102
Trainers elicit information from target audience to assess provider's existing knowledge and strengths and tailor trainings to meet provider needs	16.0% (16)	**58.0% (58)**	26.0% (26)	100
Trainings incorporate process-oriented tools	18.0% (18)	**63.0% (63)**	19.0% (19)	100
Training style and methodology reflect the principles of privilege, power, oppression and bias, and the guiding principles of cultural competency outlined in this document	29.0% (29)	**47.0% (47)**	24.0% (24)	100
Trainer skills are not degree dependent, but attitude, knowledge and skill dependent	21.0% (21)	**54.0% (54)**	25.0% (25)	100
Trainings create a spirit of collaboration and interaction	7.9% (8)	**57.4% (58)**	34.7% (35)	101
Trainings must provide a broad and inclusive definition of diversity, even if it will focus on a specific population	7.1% (7)	**58.6% (58)**	34.3% (34)	99

Trainings offer follow-up through coaching, supervision, mentorship and/or consultation	20.0% (20)	**45.0% (45)**	35.0% (35)	100
Trainings are evaluated to assess impact on participants and efficacy of trainers	8.9% (9)	**53.5% (54)**	37.6% (38)	101
			AnsweredQuestion	**103**
			SkippedQuestion	**63**

16. If needed, please provide feedback on any of the aforementioned standards below:

	ResponseCount
	5
AnsweredQuestion	**5**
SkippedQuestion	**161**

17. Culturally competent practice requires the acquisition of skills:

	N/A (not applicable/ not needed – or less than minimum)	Minimum	Gold Standard (more than minimum)	RatingCount
How to assess own biases or preconceptions	6.1% (6)	**54.5% (54)**	39.4% (39)	99
How to collaborate with patients in making health care decisions	3.0% (3)	**49.5% (49)**	47.5% (47)	99
How to be fluent in communication tools and assessment strategies, e.g. patient- and family-centered communication	7.1% (7)	**55.1% (54)**	37.8% (37)	98
How to assess receptivity to knowledge and literacy level of patients	9.2% (9)	**59.2% (58)**	31.6% (31)	98
How to collect and utilize data to inform clinical practice related to health equity	15.5% (15)	**56.7% (55)**	27.8% (27)	97
How to collaborate effectively with community, providers and non-traditional healers	20.4% (20)	**52.0% (51)**	27.6% (27)	98
How to assess own empathic attunement	22.4% (22)	**46.9% (46)**	30.6% (30)	98
How to effectively advocate for cultural competence within own professional setting	13.3% (13)	**55.1% (54)**	31.6% (31)	98
How to access self-assessment tools	10.2% (10)	**67.3% (66)**	22.4% (22)	98
How to adequately intervene if witnessing culturally-insensitive or oppressive behavior	12.1% (12)	**51.5% (51)**	36.4% (36)	99
How to access and interact with diverse local communities	13.1% (13)	**60.6% (60)**	26.3% (26)	99
How to assess own language skills and proficiency	20.2% (20)	**56.6% (56)**	23.2% (23)	99

How to adequately use interpreter services	7.1% (7)	**61.6% (61)**	31.3% (31)	99
How to access translated materials if not available at own professional setting	7.1% (7)	**66.7% (66)**	26.3% (26)	99
			AnsweredQuestion	**99**
			SkippedQuestion	**67**

18. If needed, please provide feedback on any of the aforementioned standards below:

	ResponseCount
	6
AnsweredQuestion	**6**
SkippedQuestion	**160**

19. Please indicate your self-identified gender by selecting one of the following:

	ResponsePercent	**ResponseCount**
Female	**63.0%**	**63**
Male	37.0%	37
Transgender	0.0%	0
Other (please specify)		0
AnsweredQuestion		**100**
SkippedQuestion		**66**

20. Please indicate how you identify ethnically (check all that apply):

	ResponsePercent	ResponseCount
Latino/Hispanic	12.5%	9
Non Latino Hispanic	**66.7%**	**48**
Decline to Answer	18.1%	13
Unknown	2.8%	2
	Other (please specify)	26
	AnsweredQuestion	**72**
	SkippedQuestion	**94**

21. Please indicate how you identify racially

	ResponsePercent	ResponseCount
American Indian or Alaskan Native	0.0%	0
Asian	4.3%	4
Black, African, Caribbean or African American	6.4%	6
Native Hawaiian or Pacific Islander	0.0%	0
White	**78.7%**	**74**
Decline to Answer	11.7%	11
Unkown	0.0%	0
	Other (please specify)	6
	AnsweredQuestion	**94**
	SkippedQuestion	**72**

22. Please indicate your preferred spoken language

	ResponseCount
	90
AnsweredQuestion	**90**
SkippedQuestion	**76**

23. Do you identify as Lesbian, Bisexual, Gay or Queer?

	ResponsePercent	ResponseCount
Yes	4.1%	4
No	**90.8%**	**89**
Decline to Answer	5.1%	5
	Other (please specify)	1
AnsweredQuestion		**98**
SkippedQuestion		**68**

24. Please indicate the type of geographic region of Oregon you reside in:

	ResponsePercent	ResponseCount
Urban	**50.5%**	**49**
Suburban	26.8%	26
Rural	21.6%	21
Frontier	1.0%	1
Indian Reservation	0.0%	0
Ranchero	0.0%	0
	Other (please specify)	3
	AnsweredQuestion	**97**
	SkippedQuestion	**69**

25. Please share with us any other part of your identity that you would like us to know:

	ResponseCount
	16
AnsweredQuestion	**16**
SkippedQuestion	**150**

Page 2, Q1. Please indicate the professional sector in which you work:		
1	long term care consultant	Dec 2, 2012 12:40 PM
2	Optometric Student	Dec 2, 2012 1:16 AM
3	Salon Owner/Stylist	Nov 30, 2012 7:25 PM
4	Retired Health Care Provider	Nov 30, 2012 6:33 PM
5	Nursing Home Administrator	Nov 30, 2012 4:53 PM
6	Research organization	Nov 30, 2012 12:36 PM
7	dietitian	Nov 30, 2012 10:48 AM
8	Licensed dietitian	Nov 30, 2012 10:37 AM
9	On call in the ER and full-time in the Academic Institution	Nov 28, 2012 6:44 PM
10	non profit organization	Nov 28, 2012 3:14 PM
11	Health Care Provider & Health Licensing Board	Nov 15, 2012 1:57 PM

Page 3, Q4. Please provide feedback below, particularly if you selected disagree for the definition above:		
1	I agree with the paragraph explanation. The terminology re; recognizing dynamics of power is somewhat confusing	Dec 6, 2012 10:41 PM
2	When it comes ot transcultural nursing, I think that the nurse and patient must have trust, mutual respect, and a willingness to compromise, in order to make effective inter-cultural exchange possible. Both parties must be involved.	Dec 4, 2012 9:48 AM
3	This definition would only apply if the term were 'cultural competence for health care practice.' It is not inclusive of cultural competence overall.	Dec 3, 2012 4:14 PM
4	Not sure that if we are defining competence and hope to measure it somehow that we can have a life long process - never reached? Issue of needing to update continually vs. are we now competent.	Dec 3, 2012 1:38 PM
5	I would like to see some data where this has been shown to be a problem, and not just another area that is someone's special interest (ie. pain management cme requirements). I would like some data showing that this training improves patient care. At a time when physicians and nurses are overburdened with paperwork with less time to spend with their patients, I do not see the wisdom in diverting much needed medical dollars to something like this. Many hospitals already provide such training, and professionals who feel they need additional training in this area should be able to avail themselves to it voluntarily. It seems to me that teachers and politicians would benefit more from this sort of education.	Dec 3, 2012 10:53 AM
6	define what is meant by dynamics of power and privilege; finanical power and priviledge, race power and priviledge?	Dec 3, 2012 8:01 AM
7	Plain language?	Dec 3, 2012 7:22 AM
8	Those of us who train for many years to care for patients develop these skills along the way. If not, they are weeded out. It is unfair to single out the medical profession for this training when we are the profession most likely to possess these skills. Politicians are much more in need of this training than medical professionals.	Dec 2, 2012 10:41 PM
9	It seems awfully wordy. Defintions are useful if they define a clear path when faced with a fork in the road. This does not.	Dec 2, 2012 9:52 PM
10	I disagree because of the sentence ending in: "or any other consideration under federal, state and local law." This is vague & open ended.	Dec 2, 2012 2:26 PM
11	Wtih greater detail comes a higher likelihood of exceptions or internal conflicts. For instance, if I know someone's religion forbids a woman to shake my hand, I won't offer it out of respect...but that is an "assumption" on my part that they follow their religion to the letter. Be cautious with the wording; imagine the clinical circumstances where exceptions could/should/would arise.	Dec 2, 2012 11:39 AM
12	The idea of " power and privilege" has no place in delivering health care as it is just code words for pushing the concept of "equality", which is the antithesis of Liberty	Dec 1, 2012 6:56 PM
13	The definition doesn't mention culture- I firmly believe, after 20 years of working	Dec 1, 2012 6:07 PM

Page 3, Q4. Please provide feedback below, particularly if you selected disagree for the definition above:		
	with Native American populations that Campinha-Bacote's (2002) definition is the most accurate and inclusive. I also don't see why the "power and privilege" part is necessary. Here is the Campinha-Bacote definition- "The Process of Cultural Competence in the Delivery of Healthcare Services," is a culturally consciously model of care that defines cultural competence as "the process in which the healthcare professional continually strives to achieve the ability and availability to effectively work within the cultural context of a client" (family, individual or community).	
14	The general idea is good. I'm not clear why the definition is limited to just health care practice. I am also bothered by the phrasing in that it seems to put power and privilege in opposition to dignity of individuals. I think including words like power and privilege without using terminology that expresses a need for balance or respect is lacking somehow. The word "inclusive" is excellent but then to me using terms of power/privilege (without recognizing a range or lack thereof) seems divisive. The term "life long" is also misleading to me as that is unrealistic; if someone had a worldview with significant bias in their past, but evolves their thought processes to be more inclusive (which I think is generally, on some scale, what occurs with everyone) then "lifelong" would not apply to the period prior to their recognition of their bias. I would suggest "ongoing" or "continuing" as a more accurate reflection of what people are capable of.	Nov 30, 2012 7:34 PM
15	It's a really long and wordy definition, don't you think?	Nov 30, 2012 7:26 PM
16	Your definition does not recognize that there are some things that are just plain wrong, despite the culture of the patient saying it's right (ex: clitoral excision). Your definition is too concerned about white power and privilege overwhelming others' culture, and in your attempt to bend over backwards to be politically correct, you create hostility to all and any "value judgments" based on the observer's culture. We cannot throw out the baby with the bathwater: when we elevate others' cultural preferences over common sense and best medical practices in the name of "inclusive approach" and political correctness, we are at risk of creating harm to the patient. Your definition makes no room for my value judgment and would assign me to Hades for having a value judgment, any value judgment, that comes from my position of "power and privilege", when really my value judgment is sound medical practice. Political correctness within medicine is asking for trouble.	Nov 30, 2012 6:01 PM
17	"...the dynamics of power and privilege..." is, from this opinion, poorly worded; it has no specificity as to the recognition that is mentioned. In addition, it alludes to only one aspect of culture - that of financial or political status (without mentioning other aspects, such as race, religion, etc..). ABSOLUTELY REMOVE IT.	Nov 30, 2012 4:13 PM
18	I think the part of the line in italics recognizing the dynamics of power and privilege, throws in an unnecessary and confusing and in its own right a judgement	Nov 30, 2012 3:52 PM
19	I do have a concern over the slant towards the perception of "power" and privilege, as if Healthcare providers are instrinsically, even intentionally, rather than oftentimes unknowingly, overbearing or inappropriate due to cultural ignorance. Perhaps adding the dynamics of "vulnerability", (power, privilege and vulnerability) would help address the duality of the dynamic. This means that the	Nov 30, 2012 2:32 PM

Page 3, Q4. Please provide feedback below, particularly if you selected disagree for the definition above:		
	provider may not be perceived by some populations as exercising or abusing power, but would be for more vulnerable populations or situations, where the vulnerabilty is a result of suffering from poverty, oppression, bigotry from others, limited healthcare literacy and language/cultural barriers. The vulnerability dynamic also applies to the providers themselves. The providers who lack cultural sensitivity are also vulnerable to making errors in communication, doctor-patient rapport, understanding the whole patient, and thereby providing less optimal care, and risk losing their patients, or at best, resulting in poor adherence/compliance from their patients . Providers I have worked with, as a whole, want to do what's best for their patients. Perhaps "vulnerability" is not the best word, but I hope I have communicated the sentiment of my thoughts.	
20	Power and privilege comment does not fit with the second paragrah explaination.	Nov 30, 2012 12:20 PM
21	I would recomend the following definition: A life-long process of examining values and beliefs, of developing and applying an inclusive approach to health care practice in a manner that recognizes the dynamics of various cultures and preserves the dignity of individuals, families and communities.	Nov 30, 2012 11:43 AM
22	I think that the phrase "dynamics of power and privilege" is open for very broad interpretations. I do not really understand what it means of what it is trying to convey.	Nov 30, 2012 11:40 AM
23	I prefer either of the following two definitions to the one above...the one above is too vague and broad. The Office of Minority Health, U.S. Dept of HHS Cultural and linguistic competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations. 'Culture' refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. 'Competence' implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities. (Adapted from Cross, 1989). Cultural Competence http://medical-dictionary.thefreedictionary.com/Cultural+Competence The ability to understand, appreciate, and interact with persons from cultures and/or belief systems other than one’s own, based on various factors	Nov 30, 2012 10:42 AM
24	What in the world does this say? So vague that it is entirely meaningless as a tool.	Nov 30, 2012 8:00 AM
25	it is unclear what is meant by power and privilege.	Nov 29, 2012 9:24 PM
26	Definition seems far too long. A list such as found in the first sentence of the second paragraph is hard to manage over time. Someone will find another category than must be included. General, inclusive language would be preferred. Is cultural competence the most currently accepted term in the industry? Cultural awareness, cultural intelligence, etc?	Nov 29, 2012 2:47 PM
27	I find the wording regarding the dynamics of power and privilege to be insulting.	Nov 29, 2012 2:30 PM
28	This is a very "white male" centric definition. Cultural competence is needed mostly because our society is ignorant of one another, not just because of power	Nov 29, 2012 8:57 AM

Page 3, Q4. Please provide feedback below, particularly if you selected disagree for the definition above:		
	and privilege dynamics. Most health practitioners and the general population want to do the "right thing" (and have sworn to devote their professional career to do so); however, some are unaware (i.e. ignorant) of how to do so. Minority and depressed populations are also ignorant of one another. For instance, An Asian person may not fully understand the cultural needs of Arabic peoples and vice versa. Or perhaps an African American woman does not understand the cultural needs of an Islamic woman wearing a Niqab and Khimar. If we are to be culturally competent, it is important to not isolate the "white male" dynamic and influence as the only one that needs correcting. We ALL need to do a better job of understanding one another, regardless of the dynamics any one individual brings. This definition is in itself in need of some cultural competence. It invalidates the entire effort.	
29	How is this measured? Is there a necessity that it be measured? Or is simply agreeing to the principal sufficient?	Nov 19, 2012 4:28 PM
30	Cultural competence implies something that is attained, whereas the definition describes a process. I do agree that it is a process and would prefer something other than cultural competence. for example: cultural humility, the practice of cultural understanding or integration, diversity in health care.	Nov 19, 2012 11:40 AM
31	Don't understand the emphasis on ' power and priveledge'.	Nov 16, 2012 10:29 PM
32	We feel that our membership will not fully understand or respond well to the terms "power and privilege". We are not opposed to including the terms as part of cultural competency training to allow our members to explore this dynamic however, in a state definition, feel strongly that this could isolate and/or alienate participants in a training.	Nov 16, 2012 9:22 AM
33	It is different from all other definitions from many resources. 1 hour discussion with Riikka Salonen (Manager workforce Equity and Inclusion OHSU--see Google/LinkedIn) and then Webinar on Culturally Competent Healthcare: strategies and tools---She gave her own definition in the Webinar (she invited me to webinar). After the competency piece, she believes in cultural humility. She would not/does not use Power&Priviledge except in much more advanced groups (atty group who have PhDs). Topic should be approached carefully/cautiously. European/American folks would just become defensive--without benefit. She trains/trains trainers--18 yrs in CC Ed	Nov 15, 2012 9:47 PM
34	From a medical/health care perspective cultural competence should be limited to epidemiology and socio-cultural areas that directly relate to disease processes in specific ethnic groups.	Nov 15, 2012 2:03 PM
35	“competency” should be replaced with "competence" for consistency?	Nov 14, 2012 1:54 PM
36	The phrase "the dynamics of power and privilege" is offensive and implies that only those who are in positions of power are culturally insensitive. Health care providers will be put off by this definition, and it is highly likely it will reduce enthusiasm to embrace the rest of the definition. Much better to remove "...that recognized the dynamics of power and privilege while also preserving" and replace it with "preserves." I ran this definition by my Board and the response was unanimous that they would not be inclined to adopt the definition as presented.	Nov 14, 2012 8:56 AM

Page 3, Q4. Please provide feedback below, particularly if you selected disagree for the definition above:		
37	Cultural comptetence (for me) is a state of respectful acceptance for those things I know and those things that I do not know.	Nov 14, 2012 8:29 AM

Page 4, Q10. Please provide feedback below, particularly if you selected disagree for any of the five principles above:		
1	These terms do not make any sense. The definitions are irrelevant because the terms are confusing and don't reflect the definition.	Dec 3, 2012 4:16 PM
2	Question of "culturally competent" practices might lead to stereotyping and not respecting an individual of any particular cultural group that deviates from that "norm"	Dec 3, 2012 1:40 PM
3	needs to include funders, insurance, billing that rewards, pays for culturally competent care. include those creating policies for practice. consider collaborative as equal; however does this also infer equal power in decision making? What are the minimum standards of each continuum?	Dec 3, 2012 8:08 AM
4	plain language?	Dec 3, 2012 7:26 AM
5	these definitions are all wordy, absolutely not memorable and so vague that they could mean almost anything	Dec 2, 2012 9:53 PM
6	#9 is written as if a person can have lifelong health. This is not possible for many people. Plus many patients are not interested in promoting health even if you offer health promotion information. The way #9 is written it assumes patients will collaborate in the decision. They may collaborate to continue to do poor self care. I think this question needs to be re-written or eliminated.	Dec 2, 2012 2:38 PM
7	#5, agree until "and"...I really didn't understand the intent after "and"...distracted from the point. #6. disagree with"requires" strongly. The rest sounds low-yield for the cost, time, etc. This is important, but the implications of this statement sounds like someone's getting carried away; the goal can be achieved simply; the resources savings should be redirected in a way to actually yield more/better care. 8. replace "respects" with 'understands" or "bases counseling with awareness of" and I'd be more supportive. sometimes the cultural support runs contrary to the patient's and provider's goal..."respect" might imply not recommending anything that would run contrary to group beliefs, etc.	Dec 2, 2012 11:52 AM
8	since when does the answer from an eye examination change depending on the "cultural" background of an individual. 20/20 is 20/20 except in the world where the preceding definitions can mean anything	Dec 1, 2012 6:59 PM
9	#6: I do not have a frame of reference for what "systemic support" or "organizational implementation" means, so until that time, I cannot agree with this statement because it doesn't make sense to me.	Nov 30, 2012 7:37 PM
10	Most especially the best practices part!	Nov 30, 2012 7:36 PM
11	A doctor's education is not equivalent to community members or patients. Evidence-based medicine shows us what works and what doesn't. If a patient comes to me, they are paying for the value of my education and experience: if they don't like what my medical experience has to say, they have the freedom to find another doctor with a different approach. To force all doctors to become "culturally competent" as defined by a committee composed of mostly non-doctors, is an insult to the practice of medicine. Yes I know I sound like a privileged elitist, but the reality is that blood tests and labwork don't care what colour the patients' skin is: the numbers are the numbers and we need to treat or	Nov 30, 2012 6:14 PM

Page 4, Q10. Please provide feedback below, particularly if you selected disagree for any of the five principles above:		
	not. It doesn't matter the culture of the patient: they need treatment or they don't and they will accept treatment or they won't. My job as a doctor is to diagnose and offer treatment; together as doctor-patient we can discuss different avenues of treatment and together decide, but if someone rejects treatment when I know it's best for them, I won't be able to continue the relationship b/c they are rejecting medical advice and embarking on a harmful path. For me to act otherwise is to invite malpractice lawsuits when the disease invariably spreads due to patient refusal to comply. This is not about power & privilege but the reality of medical treatment and spread of disease. The uneducated patient is simply not equipped to be a true equal partner in the doctor-patient relationship, despite cultural competency committee's desire to make it equal.	
12	All of these reflect a goal for each of us, recognizing that none of us will ever be 100% effective in reaching that goal 100% of the time. We will all show our biases and prejudices from time to time.	Nov 30, 2012 4:58 PM
13	"systemic support, organizational implementation and integration" implies a possible institutionalized program that requires outcomes assessments, which may be a potentially bureaucratic nightmare for health care providers. This concerns me, as there are enough items to comply with Health Care reform regulations already than to add another 'compliance' element to the picture. This may ultimately sacrifice optimal one-on-one patient and practice care for elements that usually play only a small part in the overall care of the patient.	Nov 30, 2012 4:20 PM
14	Insight may need to be taught even if it challenges a cultural norm	Nov 30, 2012 3:55 PM
15	I don't disagree with any of the above principles, but find that they are the same as patient-centered principles in general.	Nov 30, 2012 2:29 PM
16	A collossal waste of time money and words.	Nov 30, 2012 2:20 PM
17	I agree there needs to be culturally competency practices that will help reduce health care disparities, but there also needs to be some systems in place to ensure the individual receiving that care is being responsible and respectful to those providers. Success of cultural competency can only happen if all parties involved are working together toward the same goal.	Nov 30, 2012 1:15 PM
18	Equal partners in decision making does not make sense here. A provider may have to make a decision based on education and background that a community member may not have...	Nov 30, 2012 12:51 PM
19	Not sure I truly understand Numbers 5 or 8 and Number 9 doesn't make sense to me...collaboration-unilateral continuum??? I don't understand or get it. Collaboration is working together or cooperatively while unilateral is working alone - onesided decision-making.	Nov 30, 2012 10:52 AM
20	The continuum "titles" are not all easily understood (prevention-intervention, and collaboration-unilateral). Without the following statement, these would not have made sense on their own. Number 9 would use a word other than "create" such as promotes.	Nov 29, 2012 2:53 PM
21	What happened to the premise that all information available to the public should	Nov 29, 2012 2:27 PM

Page 4, Q10. Please provide feedback below, particularly if you selected disagree for any of the five principles above:		
	be written at an 8th grade level. The way these definitions are written it will be difficult to bring them down to a practitioner level.	
22	#9. Would like collaboration to include on macro level such as state, law enforcement, policies and so on.	Nov 29, 2012 1:20 PM
23	Strength-Deficit -- Cultural identity should be a factor, but it should not be the CENTRAL. I believe practitioners should strive to treat each patient as an individual rather than putting him/her into a box labeled by their culture and then interpreting all data through that lens. Would you propose that providers ASK the patient what culture they identify with? For myself and many others, we identify with multiple cultures -- no one culture encapsulates me. Or would you propose that the provider ASSESS the patient for their culture? This seems equally fraught with problems.	Nov 29, 2012 9:06 AM
24	#8 ? strengths and resources - what does the term resources mean? I would suggest consistent terminology "strengths" and "deficits"	Nov 28, 2012 5:40 PM
25	No of the principles above will mean anything to the individuals attending your trainings. Break it down! Does it have to be complex before it can be simplified?	Nov 28, 2012 3:18 PM
26	I would like to add "....Culturally competent practice creates and MAINTAINS an evnironment where providers, patients, and community members work collaboratively as equal partners in the decision making process to promote lifelong health and well being.	Nov 19, 2012 4:28 PM
27	No mention of workplace satisfaction and collaboration and no mention of resource limitations	Nov 16, 2012 10:33 PM
28	An area which may need to be explored is the 'cultural' perception of the nature of death and dying vs the extension of life	Nov 16, 2012 4:33 PM
29	#5-care should shift to the patient centered medical home and management of chronic diseases and preventive medicine interventions. #6--addition of patient satisfactions/do not assume this will solve health inequities #7-Cost effective evidence based medicine with acknowledged level of evidence (could be an "I"--insufficient)--#8--adds nothing. Definitions should say respect.--or add it to #9--shared decision making between the Healthcare provider and patient and/or family-to the extent of involvement desired by the patient. This is in the context and support of the medical home and neighborhood/community. The community does not get an equal say. Stop after the word process. #10--CC goal is to help reduce health inequities (by reducing healthcare inequities)	Nov 15, 2012 10:15 PM
30	Most of these are "loaded" questions. We all need to take care of patients in an unbiased way, provide equal care to everyone irrespective of ethnic, cultural or socio-economic status. However, patients need to hear the truth about their specific conditions. Examples; stop smoking, stop drinking in excess, stop high risk lifestyle behavior like homosexuality or illicit drug use etc.	Nov 15, 2012 2:10 PM
31	#5. change "specific events" to s"specific health events" #6. Wording is complex and confusing	Nov 14, 2012 2:00 PM

Page 4, Q10. Please provide feedback below, particularly if you selected disagree for any of the five principles above:		
32	Most providers are going to want to have this information in plain English. All of state government remains under the Governor's Executive Order to write in plain English. This is being over-written.	Nov 14, 2012 8:59 AM

Page 5, Q12. If needed, please provide feedback on any of the aforementioned standards below:		
1	Unsure that equal quality of care demonstration is cultural vs. what we strive to do with every patient encounter. Proactive might mean "solely" up to and this is more than provider should have to do - many interests including pay and insurance demands enter her not under provider control.	Dec 3, 2012 1:52 PM
2	how will you measure each? this may help to determine how impactful each standard could be, to help prioritize behavior and knowledge as min vs gold.	Dec 3, 2012 8:15 AM
3	Again, very wordy and really not clear what they mean	Dec 2, 2012 9:56 PM
4	Power and privilege is an important concept but just doesn't work here.	Dec 1, 2012 6:15 PM
5	I have no idea how the first item could be implemented as things can be so different in different cultures and I don't see a way a training could cover all the possibilities a health care provider is likely to encounter	Nov 30, 2012 7:48 PM
6	I'm not sure what it means to explore concepts of power, privilege and oppression. Sounds like too much naval-gazing	Nov 30, 2012 4:58 PM
7	Treat everyone equally well. Period.	Nov 30, 2012 4:30 PM
8	What a waste of time	Nov 30, 2012 2:43 PM
9	In my mind there is a big difference between the choices of minimum and gold standard.	Nov 30, 2012 11:47 AM
10	again, power and privilege needs definition	Nov 29, 2012 9:37 PM
11	Many of these will be difficult to evaluate at the completion of a training session or class	Nov 29, 2012 3:01 PM
12	Explore concepts of ignorance, not just power, privilege and oppression. Again, this is a white-centric assumption that this is the only dynamic that needs correcting.	Nov 29, 2012 9:18 AM
13	I don't know how you would assess commitment to equal quality of care, hence designated this question as NA. Actually you can't determine whether provider understands relationship between cultural competence and ethics or other concepts unless you provide an exam...	Nov 19, 2012 5:06 PM
14	Assuming a provider in a rural/frontier area would have access to values/social determinants which are culturally specific might be difficult/ How would the state/CCOs provide adequate training for all providers?	Nov 16, 2012 4:44 PM
15	After discussing with Riikka and discussions with other teachers, I don`t feel that the above add to the teaching process and other professional standards.	Nov 15, 2012 10:31 PM

Page 5, Q14. If needed, please provide feedback on any of the aforementioned standards below:		
1	I don't know what you mean by trauma-informed care (does it relate to survivors of violence?)	Dec 5, 2012 6:50 PM
2	unsure what trauma-informed care principles are so must need this. Assuming that we understand genome research and ethnopharmacology well enough to have proven clinical outcomes is a stretch I think.	Dec 3, 2012 1:52 PM
3	I think there are min and gold standards in each of these.	Dec 3, 2012 8:15 AM
4	Again, all of these are wordy, academic and more appropariate for a graduate seminar	Dec 2, 2012 9:56 PM
5	Some of these are good things to know, but have no application for certain health care professions. To apply all of them to all health care professions is not reasonable as some of these concepts are so far beyond the training of those health care practitioners.	Nov 30, 2012 7:48 PM
6	Demographics and population-specific conditions are useful in patient management. Likewise, familiarity with genetic research and ethnopharmacology may also be useful. The other points...not so much.	Nov 30, 2012 4:30 PM
7	Many of the items listed above relate to conditions that would be better discussed in continuing education and are not appropriate in a "cultural competence" course.	Nov 30, 2012 11:56 AM
8	unclear what trauma-informed care principles are	Nov 29, 2012 9:37 PM
9	Some aspects are setting-specific: trauma-informed care principles, etc.	Nov 19, 2012 5:06 PM
10	Some of the questions have many 'and' choices responses could have been different. eg knowledge of meaning of culture and culture of health care could have been two questions?	Nov 16, 2012 4:44 PM
11	do not see why accupunturist would need much of this--or mortician--or perhaps pharmacist.	Nov 15, 2012 10:31 PM
12	Some of these statements are so overwritten that they will cause even doctors' eyes to glaze over..	Nov 14, 2012 9:12 AM

Page 5, Q16. If needed, please provide feedback on any of the aforementioned standards below:		
1	Training is one thing but follow up would be much more burdensome, money intensive and paid by whom? I feel trainers need to devise own efficacy tools for their work, not the providers.	Dec 3, 2012 1:52 PM
2	There is no "document" that I've seen (and I don't consider this survey a document) to reference as it is asking for opinions, not stating information other than the initial definition, which I already commented on.	Nov 30, 2012 7:48 PM
3	Who are these trainers? What is their desired goal? Need specificity here.	Nov 30, 2012 4:30 PM
4	Providers respond better to other providers who understand the profession better than someone who has never done the work before.	Nov 30, 2012 12:55 PM
5	Feel it would be best to have the goals and methods suggested by folks that have actually done quite a bit of training. Riikka did not feel that one could/should do specific impact assessment.	Nov 15, 2012 10:31 PM

Page 5, Q18. If needed, please provide feedback on any of the aforementioned standards below:		
1	Again, I'm not sure all of these apply to all health professions equally. The key points to me are effective communication and compassion and the provider's ability/willingness to self-assess to ensure ongoing improvement.	Nov 30, 2012 7:48 PM
2	Many of the items above are rudimentary, taught in basic health care education and is a daily part of health care encounters. I would suggest these things be reinforced in health care education programs, not through continuing education.	Nov 30, 2012 11:56 AM
3	The one standard identified as N/A appears to be repetitive and too similar to 6th standard in this section	Nov 19, 2012 9:51 AM
4	trainings for provider may also need to presented in ways the providers would understand. The expectation are for providers to learn new information and the information should be provided in a cultrually(provider culture) sensitive method as well	Nov 16, 2012 4:44 PM
5	Get feedback from experienced trainers and teachers--VIA putting on the webinar, Georgetown, Riikka. Riikka did not feel that one could use and off the shelf program--one must be developed by/for the organization. She did not feel that a 3 doctor office could pull all of this off on their own. Possibly the state/CCO. See her Webinar and joint commission roadmap, etc.	Nov 15, 2012 10:31 PM
6	Again, statements are overwritten. Putting "non-traditional healers" in with "community" and "providers" foin the question regarding effective collaboration broadens the question too far. Doctors are busy and already have high responsibility for medically-based continuing education. Cultural competency training approved by the Board will need to be focused on medical outcomes, with clear explanations of relevancy to achieving those outcomes.	Nov 14, 2012 9:12 AM

Page 6, Q20. Please indicate how you identify ethnically (check all that apply):		
1	northern european	Dec 5, 2012 6:48 PM
2	British & Eastern European	Dec 4, 2012 6:40 AM
3	anglo american	Dec 3, 2012 2:02 PM
4	Roma	Nov 30, 2012 8:34 PM
5	White	Nov 30, 2012 5:01 PM
6	irish-american	Nov 30, 2012 4:59 PM
7	Mixed region - Carribean/European	Nov 30, 2012 4:33 PM
8	english	Nov 30, 2012 4:03 PM
9	Italian-American	Nov 30, 2012 2:32 PM
10	Caucation	Nov 30, 2012 1:52 PM
11	1/4 latina	Nov 30, 2012 12:55 PM
12	Caucasian	Nov 30, 2012 12:19 PM
13	american	Nov 30, 2012 12:05 PM
14	white	Nov 29, 2012 9:38 PM
15	Asian (Filipino)....bicultural.	Nov 29, 2012 1:30 PM
16	American	Nov 29, 2012 10:14 AM
17	multiple; there is not an option for this	Nov 29, 2012 9:22 AM
18	NA	Nov 19, 2012 4:49 PM
19	Japanese American	Nov 19, 2012 12:25 PM
20	italian, irish	Nov 19, 2012 11:50 AM
21	Malay	Nov 19, 2012 10:33 AM
22	Caucasian	Nov 16, 2012 10:41 PM
23	Japanese	Nov 16, 2012 4:45 PM
24	Why are there only 2 ethnics?-Hispanic and all others?	Nov 15, 2012 10:39 PM
25	white	Nov 14, 2012 2:12 PM
26	Black Man	Nov 14, 2012 8:30 AM

Page 6, Q21. Please indicate how you identify racially		
1	Roma	Nov 30, 2012 8:34 PM
2	mexican american	Nov 30, 2012 2:12 PM
3	Bi-cultural	Nov 29, 2012 1:30 PM
4	multiple; there is not an option for this	Nov 29, 2012 9:22 AM
5	Hispanic/Latino	Nov 19, 2012 11:49 AM
6	Latino	Nov 14, 2012 7:14 PM

Page 6, Q22. Please indicate your preferred spoken language		
1	English	Dec 6, 2012 11:03 PM
2	English	Dec 6, 2012 11:53 AM
3	English	Dec 5, 2012 6:52 PM
4	English	Dec 5, 2012 6:48 PM
5	english	Dec 4, 2012 6:40 AM
6	English	Dec 3, 2012 2:06 PM
7	english	Dec 3, 2012 2:04 PM
8	english	Dec 3, 2012 2:02 PM
9	English	Dec 3, 2012 10:59 AM
10	American English	Dec 3, 2012 8:24 AM
11	English	Dec 3, 2012 7:57 AM
12	English	Dec 3, 2012 7:29 AM
13	Don't you think that woul dhave been nice to ask before one started the survey	Dec 2, 2012 9:57 PM
14	English	Dec 2, 2012 3:09 PM
15	English	Dec 2, 2012 12:47 PM
16	English	Dec 1, 2012 7:04 PM
17	English	Dec 1, 2012 6:18 PM
18	English	Dec 1, 2012 12:38 PM
19	Spanglish	Nov 30, 2012 8:34 PM
20	American English	Nov 30, 2012 7:57 PM
21	English	Nov 30, 2012 7:57 PM
22	English	Nov 30, 2012 6:24 PM
23	Inglais	Nov 30, 2012 5:11 PM
24	English	Nov 30, 2012 5:01 PM
25	English	Nov 30, 2012 4:59 PM
26	English	Nov 30, 2012 4:33 PM
27	english	Nov 30, 2012 4:03 PM

Page 6, Q22. Please indicate your preferred spoken language		
28	English	Nov 30, 2012 3:28 PM
29	english	Nov 30, 2012 3:10 PM
30	English	Nov 30, 2012 2:44 PM
31	English	Nov 30, 2012 2:33 PM
32	English	Nov 30, 2012 2:32 PM
33	english	Nov 30, 2012 2:12 PM
34	English	Nov 30, 2012 1:51 PM
35	english	Nov 30, 2012 1:44 PM
36	English	Nov 30, 2012 1:40 PM
37	English	Nov 30, 2012 1:08 PM
38	English	Nov 30, 2012 12:55 PM
39	english	Nov 30, 2012 12:22 PM
40	English	Nov 30, 2012 12:19 PM
41	English	Nov 30, 2012 12:09 PM
42	american english	Nov 30, 2012 12:05 PM
43	english	Nov 30, 2012 12:04 PM
44	decline	Nov 30, 2012 11:56 AM
45	English	Nov 30, 2012 11:56 AM
46	English	Nov 30, 2012 11:51 AM
47	English	Nov 30, 2012 11:48 AM
48	English	Nov 30, 2012 11:20 AM
49	English	Nov 30, 2012 10:05 AM
50	English	Nov 30, 2012 10:00 AM
51	American English	Nov 30, 2012 9:45 AM
52	English	Nov 30, 2012 9:01 AM
53	english	Nov 29, 2012 9:38 PM
54	English	Nov 29, 2012 3:01 PM

Page 6, Q22. Please indicate your preferred spoken language		
55	English	Nov 29, 2012 2:39 PM
56	English	Nov 29, 2012 2:30 PM
57	English	Nov 29, 2012 1:30 PM
58	English	Nov 29, 2012 10:14 AM
59	English	Nov 29, 2012 9:22 AM
60	English	Nov 28, 2012 9:51 PM
61	English	Nov 28, 2012 6:53 PM
62	english	Nov 28, 2012 4:09 PM
63	English	Nov 28, 2012 3:36 PM
64	English	Nov 28, 2012 3:24 PM
65	English	Nov 19, 2012 5:33 PM
66	English	Nov 19, 2012 5:06 PM
67	English	Nov 19, 2012 4:49 PM
68	English	Nov 19, 2012 12:25 PM
69	english	Nov 19, 2012 11:50 AM
70	English	Nov 19, 2012 11:49 AM
71	English	Nov 19, 2012 11:34 AM
72	english	Nov 19, 2012 11:09 AM
73	english	Nov 19, 2012 10:33 AM
74	English or Spanish equally	Nov 19, 2012 9:52 AM
75	Ingles	Nov 18, 2012 10:04 PM
76	English	Nov 16, 2012 10:41 PM
77	English	Nov 16, 2012 4:45 PM
78	English	Nov 16, 2012 2:25 PM
79	English	Nov 16, 2012 9:35 AM
80	English	Nov 15, 2012 10:39 PM
81	English	Nov 15, 2012 2:17 PM

Page 6, Q22. Please indicate your preferred spoken language		
82	English	Nov 14, 2012 10:38 PM
83	Englis	Nov 14, 2012 7:14 PM
84	English	Nov 14, 2012 2:12 PM
85	english	Nov 14, 2012 11:48 AM
86	English	Nov 14, 2012 10:37 AM
87	English	Nov 14, 2012 9:14 AM
88	English	Nov 14, 2012 8:45 AM
89	spanglish	Nov 14, 2012 8:38 AM
90	Hood/English	Nov 14, 2012 8:30 AM

Page 6, Q23. Do you identify as Lesbian, Bisexual, Gay or Queer?		
1	why do u ask this???	Dec 4, 2012 6:40 AM

Page 6, Q24. Please indicate the type of geographic region of Oregon you reside in:		
1	Urban outside the Portland metro area--is a big deal	Nov 15, 2012 10:39 PM
2	currently live suburban but maintain rural upbringing values	Nov 14, 2012 8:38 AM
3	Global Citzen	Nov 14, 2012 8:30 AM

Page 6, Q25. Please share with us any other part of your identity that you would like us to know:		
1	My children are biracial.	Dec 5, 2012 6:52 PM
2	Why must I choose Latino?	Nov 30, 2012 8:34 PM
3	I fall into two categories from the first question: I am both a Board Member and a Practicing Professional for Massage Therapy. I think the concept of cultural competency is excellent. I have some concerns as to the extent of the requirements for continuing education in this field specifically, especially in regards to quantity and cost at the professionals' expense. Based on data from the Federation of State Massage Therapy boards, the average annual income for a massage therapist is $21,063 and 1.2% of that is spent on mandatory continuing education. When compared to physicians, only 6% (half) of their annual income is spent on continuing education. When looking at cultural competence especially, I think the different "cultures" of different health professions should be taken into consideration as far as the level of requirement for each as well. Since I don't know what considerations are on the table at this time (at any level), I can't speak to specifics. However, I would be happy to discuss any of my comments further if someone is interested. Heather Bennouri (971) 570-5404 or heather@bennouri.net	Nov 30, 2012 7:57 PM
4	I come from a disadvantaged background and I fought to get where I am today. I made it to be a doctor and I'm resentful of the notion that I'm not culturally sensitive and require a committee to tell me how to do my job, just because of the colour of my skin or the professional position that I hold.	Nov 30, 2012 6:24 PM
5	I have a history of working with indigenous Central Americans.	Nov 30, 2012 5:11 PM
6	Provider in very racially-diverse (Asian, Latino, Black, Russian, other) clinical settings using interpreters regularly for over a decade. Continue to see diverse populations in several clinic settings for last 15 years.	Nov 30, 2012 4:33 PM
7	1st generation American	Nov 30, 2012 1:40 PM
8	Over 65 yrs of age	Nov 30, 2012 1:08 PM
9	This survey was in itself offensive based on the clear focus that only the power and privilege dynamic needs to be fixed. If this is to be a truly effective initiative, it needs to address all types of ignorance.	Nov 29, 2012 9:22 AM
10	Aware of ethnic/racial origins of grandparents as multi-racial of Irish/Native American/African but identify myself only as African American	Nov 19, 2012 4:49 PM
11	Bi-racial family, father and maternal grandparents are immigrated to US from Sri Lanka and Norway/Finland, respectively.	Nov 19, 2012 10:33 AM
12	David Komeiji	Nov 16, 2012 4:45 PM
13	over 65--non-disabled--not active military or veteran--not actively mentally ill/disabled--not in poverty---Insured---not teen/early 20`s--mainline Protestant (other questions had mentioned faith)	Nov 15, 2012 10:39 PM
14	A believer in the saving grace of Jesus Christ and his finished work on the cross! John 3:16	Nov 15, 2012 2:17 PM

Page 6, Q25. Please share with us any other part of your identity that you would like us to know:		
15	Community of Faith	Nov 14, 2012 8:45 AM
16	Immigrant/1st generation	Nov 14, 2012 8:44 AM

Cultural Competency Continuing Education Options

Training Name And Contact	Overview
Culturally Competent Healthcare: Strategies and Tools for Making a Difference http://viadelivers.com/webinar_culturally_competent_healthcare.php	The surge of immigrants into the United States and the expanding domestic diversity has increased the demand for culturally and linguistically flexible healthcare services. People with disabilities constitute the largest minority group in the United States. Lesbian, gay, bisexual and transgender individuals often face bias when seeking healthcare services. All of these communities have a variety of healthcare needs that service providers should address. Attendees will walk away with: • Definitions of cultural competence and cultural humility in the healthcare context. • A business case for diversity, inclusion and cultural competence for healthcare organizations. • Systemic approaches for diversifying the healthcare workforce. • Tools for creating healthcare organization with more inclusive policies, practices and climate. • Training approaches that increase intercultural awareness of a diverse, interdisciplinary staff.
Cultural Competence Resources for Health Care Providers http://www.hrsa.gov/culturalcompetence/	
Diversity RX http://www.diversityrx.org/topic-areas/cultural-competence-training	The purpose of DiversityRx is to improve the accessibility and quality of health care for minority, immigrant, and indigenous communities. We support those who develop and provide health services that are responsive to the cultural and linguistic differences presented by diverse populations. DiversityRx informs, educates, and supports health care providers, policymakers, researchers, and advocates who share our goals. We facilitate the exchange of knowledge and information among professional colleagues. We provide professional development opportunities and offer technical assistance on key practice and policy issues. We also spearhead research and policy development, and advocate for culturally responsive care.

Cultural Competency Continuing Education Options

Culture and Health Care: *An E-Learning Course (based on Cultural Sensitivity: A Guidebook* *for Physicians and Healthcare)* *Created by Doctors in Touch (a for profit organization). Accrediting sponsor: Southwest Memorial Hospital in Cortez, Colorado.* *http://www.doctorsintouch.com/courses_for_CME_credit.htm*	This course uses a case-based, interactive approach that offers core cultural information about nine different major ethnic groups in the U.S.
CultureVision Web Seminars *Launched by Cook Ross, a diversity training and consulting company.* *http://www.crculturevision.com/*	More than 20 cultural competency-focused web seminars--Topics range from general survey classes to exploration of cultural considerations with specific racial/ethnic groups, and examination of cultural diversity issues within specialty areas or on specialized health issues.
Delivering Culturally Effective Care Available through Virtual Lecture Hall *An online CME provider owned by Medical Directions, Inc., an education publishing and research company.* *http://www.vlh.com/*	Program designed to teach general concepts that help practitioners treat patients from diverse cultures. It also addresses issues in managing diabetes for particular racial/ethnic groups.

Cultural Competency Continuing Education Options

A Family Physician's Practical Guide to Culturally Competent Care Jointly sponsored by the Professional Education Services Group (PESG), Science Applications International Corporation (SAIC), and Astute Technology, PESG, a full service medical education company, is the accreditation sponsor. *The CCCMs were commissioned by the Department of Health and Human Services (DHHS) Office of Minority Health (OMH).* *https://cccm.thinkculturalhealth.hhs.gov/GUIs/GUI_AboutthisSite.asp*	Cultural Competency Curriculum Modules (CCCM)-includes self-assessments, case studies, video segments, and CME post-tests. Users have the opportunity to provide evaluative feedback that is vetted through an ongoing quality control process.
Quality Interactions: A Patient-Based Approach to Cross-Cultural Care Developed by Alexander Green, Group, in conjunction with Critical Measures, LLC, one of the first consulting companies in the U.S. to integrate programs and services that address the issues of cultural competence, organizational change, diversity and legal compliance. *http://www.qualityinteractions.org/prod_overview/index.html*	The training takes a patient-based approach to cross-cultural care, providing users with skills and tools to analyze how patient cultural perspectives can have an impact on their health and health care. The training provides general orientation to cultural competency concepts, three patient case studies (i.e. patients presenting with clinical issues where culture plays a role), and a conceptual framework to help users strengthen their capacity to analyze cross-cultural issues.

Cultural Competency Continuing Education Options

Cultural Competency Challenge CD *Developed by the American Academy of Orthopaedic Surgeons Diversity Committee and funded in part with an educational grant from orthopaedics manufacturer, Zimmer.* *http://www.aaos.org/news/aaosnow/jan10/youraaos10.asp*	Teaching tool designed to help practitioners gauge their "cultural care IQ" through a review of patient case studies.
PsychCME *Developed byThe Duke University Medical Center; offered by CME Outfitters, an accredited health care communications agency* *PsychCME TV, satellite broadcasts on cultural competency, have received commercial support from companies (i.e. Wyeth Pharmaceuticals.)* *http://www.prweb.com/releases/20051090/2/prweb204840.htm*	A psychiatric continuing education effort. Topics have included: "A Surgeon General's Perspective on Cultural Competency: What Is It and How Does It Affect Diagnosis and Treatment of Major Depressive Disorder?"
Foundations in Cross-Cultural Medicine *Provided by The Harvard Pilgrim Health Care Institute for Linguistic and Cultural Skills* *https://www.harvardpilgrim.org/portal/page?_pageid=848,169186&_dad=portal&_schema=PORTAL*	Designed to help clinical practitioners "to develop and refine skills for a more patient-centered service approach"

Cultural Competency Continuing Education Options

Kaiser Permanente *http://info.kaiserpermanente.org/communitybenefit/assets/pdf/our_work/global/Centers_of_Excellece_Brochure.pdf*	A range of efforts from the creation of education monographs and population targeted Centers of Excellence in Cultural Competence, to externally contracted and in-house cultural competency training. Various physician education trainings provided with cultural and linguistic competency components.
The Kaiser Permanente/California Endowment Clinical Cultural Competency Video Series	Includes 20 videos with accompanying materials created as tools for training cultural competence to healthcare providers.The videos are designed as modules that can be used singly or combined with others.
L.A. Care Health Plan's cultural competency presentations http://www.lacare.org/providers/classes http://www.lacare.org/sites/default/files/files/Provider-Toolkit-FINAL(1).pdf	Its health care interpreter training program, which bilingual physicians may take to advance their cultural and linguistic competency skills, includes cultural competency curricular content.
University of California-San Francisco (UCSF)-The Center for the Health Professions *http://futurehealth.ucsf.edu/Public/About-The-Center/Mission.aspx*	Provides education and training in cultural competency.
The Center for Healthy Families and Cultural Diversity, University of Medicine & Dentistry New Jersey(UMDHJ) *http://rwjms.umdnj.edu/departments_institutes/family_medicine/chfcd/index.html*	Provides training and consultation to a variety of CME cultural competency programs

Center for Immigrant Health, New York University School of Medicine	Facilitates the delivery of linguistically, culturally, and epidemiologically sensitive healthcare services to newcomer populations. As part of it efforts, it provides cultural competency training to health provider organizations (e.g., major hospitals) in the New York area. The Center also provides interpreter training to bilingual individuals, some of whom are doctors interested in honing their cultural and linguistic skills.
Intercultural Communications Institute , a private nonprofit foundation, formally accredited by the counseling association. http://www.intercultural.org/	Offers general and health care cultural competency training workshops
National Center for Cultural Competence Sample Program: Infusing Cultural and Linguistic Competence into Health Promotion Training http://nccc.georgetown.edu/	Assists various health-related governmental agencies with cultural competency curriculum development, training, and technical assistance efforts; has designed general assessment and training tools-including self-assessment tools.
Aetna	Over 95% of its physicians and nurses complete *Quality Interactions* , the online cultural competency training CME. (See above, for more information on Quality Interactions).
Blue Cross Blue Shield of Florida	Has a 3 year training contract with *Quality Interactions, where providers will take the online course during year 1, and then participate in refresher courses in years 2 and 3. (See above, for more information on Quality Interactions)*
The Bon Secours Health System , a Catholic health ministry with hospitals, nursing care facilities, assisted living facilities, and home care and hospice programs located in 12 communities in 9 states	Utilizes *CultureVision* as its education and training program. (See above, for more information on *CultureVision.*)

Cultural Competency Continuing Education Options

The Centers for Medicare and Medicaid Services (CMS) *http://www.cms.gov/*	CMS' Quality Improvement Organizations (QIOs) have focused on disparities reduction, specifically increasing understanding of cultural competency and compliance with Office of Minority Health (OMH) culturally and linguistically appropriate services (CLAS) standards among physicians and their staff. The Underserved Quality Improvement Support Center helped QIOs prepare this Scope of Work (SOW)by conducting research, developing cultural competency strategies, and providing free learning sessions to the QIOs. QIO's (i.e. Lumetra in California), will be outreaching to physicians, seeking to engage 100 physicians each year in *A Family Physician's Practical Guide to Culturally Competent Care* , as well as working with about 50 practices annually to help providers implement the CLAS Standards (e.g., working with office managers to develop more linguistically competent signage, strategies to work better with interpreters, etc.) Lumetra is also planning to conduct a series of events focused on clinical topics (e.g., diabetes) that have a cultural competency focus.
The Commission to End Health Care Disparities , a Task Force chaired by the AMA in conjunction with the National Medical Association, with representation from over 35 state and specialty medical societies and other health care organizations http://www.ama-assn.org/ama/pub/physician-resources/public-health/eliminating-health-disparities/commission-end-health-care-disparities.page	Will come out with CME-based cultural competency training in the near future.
Tool for Assessing Cultural Competency Training (TACCT) *Developed by The Association of American Medical Colleges with partnership support of The California Endowment (TCE)* *www.aamc.org/meded/tacct/start.htm*	Strengthening cultural competency education and training opportunities in California medical schools and nationally

Cultural Competency Continuing Education Options

The Providers Guide to Quality and Culture Joint venture of Management Sciences for Health, the U.S. Department of Health and Human Services Health Resources and Services Administration (HRSA) Bureau of Primary Health Care. http://erc.msh.org/mainpage.cfm?file=1.0.htm &module=provider&language=English	This online learning tool is designed to help providers strengthen their capacity to provide high quality, culturally competent services to multi-ethnic populations.It offers an interactive tutorial that helps providers assess their skills and learn techniques to better serve multi-ethnic groups.
California community clinics *- Asian Health Services/AHS (Oakland)* *-Family HealthCare Network (Tulare County)* *- Golden Valley Health Centers (Central Valley)*	Cultural competency training programs for their employees
Alameda Alliance for Health , nonprofit health plan serving Alameda County in California; Supported by TCE funds http://www.alamedaalliance.org/	Provides assessment of cultural competency skills and provider trainings.It is one of the first managed care organizations to undertake a systemic approach incorporating scientific methodology and an organizational analysis model to analyze its provision of culturally and linguistically appropriate health care services. Its efforts have helpedposition cultural competency as a strategy to improve organizational management and patient outcomes.
*Molina Healthcare'*s Cultural and Linguistics Services Program http://www.molinahealthcare.com/medicaid/providers/nm/pdf/nm_mhc_cc_programs_and_training_for_providers_flyer.pdf?E=true	Every employee goes through a six-hour cultural training "to learn about the populations the health plan serves and become more adept at dealing with cultural differences. The health plan has an internal *cultural and linguistics advisory commission* , composed of representatives across departments.The health plan also consults with a *cultural advisory committee* comprised of community representatives.
The Center for Cross-Cultural Health , a nonprofit training, research, and consulting group http://www.crosshealth.com	Provides cultural competency consulting services to health and human services providers nationally

Cultural Competency Continuing Education Options

The Cross Cultural Health Care Program(CCHCP) *http://www.xculture.org/*	Program serves as a bridge between communities and health care institutions to ensure full access to quality health care that is culturally and linguistically appropriate. It provides cultural competency training, interpreter training, and working more effectively with interpreter trainings. Its trainings and seminars, including train the trainer sessions, can be customized for particular individuals or organizations.
Be Safe: National Minority Aids Education and Training Center Cultural Competency Model *http://aidsinfo.nih.gov/hiv-aids-health-topics/110/cultural-competency*	Training tool developed to address the issue of cultural competency within the context of working with special treatment populations (i.e. African Americans; American Indians, Alaska Natives, Native Hawaiians; Asians and Pacific Islanders; Latinos; etc.) This curricular tool help's strengthen the professional cultural competence of those who treat minority patients with HIV/AIDS.
The Cross-Cultural Education Primer Developed by the Culturally Competent Care Education Committee at Harvard Medical School *http://www.hms.harvard.edu/cccec/teaching/primer/index.htm*	Program focuses on the practical application of basic concepts of cross-cultural care in a clinical setting. It is intended to show the importance of sociocultural factors and their impact on health beliefs, behaviors, and medical care, and to help providers learn concepts and skills that enhance their ability to communicate with, diagnose, and treat patients from diverse sociocultural backgrounds.
The National Centers of Excellence in Women's Health Cultural Competence Curriculum Created by Harvard Medical School's Center of Excellence in Women's Health, in conjunction with: Centers of Excellence in Women's Health at Boston University, University of Puerto Rico, University of Washington and Tulane/Xavier Universities. *Developed for the U.S. Department of Health and Human Services' Office on Women's Health.*	This model curriculum is designed to train health care providers about the unique needs of minority and other underserved women.The curriculum can be adopted for use in multiple educational settings within academic medical institutions, as well as in other health care arenas.

Physician Toolkit and Curriculum: Resources to Implement Cross-Cultural Curriculum Guidelines for Medicaid Practitioners Created by the University of Massachusetts Medical School and the Executive Office of Health and Human Services, Massachusetts Office of Medicaid Program, Clinical Affairs Department.	This toolkit introduces the fundamentals of cross-cultural practice and offers processes and steps for serving culturally diverse populations. It is accompanied by a modular provider curriculum supplement that could be used to design CME trainings.
Toward Culturally Competent Care: A Toolbox for Teaching Communication Strategies Created by the UCSF Center for the Health Professions. http://futurehealth.ucsf.edu/LinkClick.aspx?fileticket=d5X%2FOqyqeuY%3D&tabid=185	Provides curricular materials intended to teach the culturally competent skills needed for practical day-to-day encounters between clinicians and patients, including how to work more effectively with interpreters.The materials are adaptable for sequential one-hour sessions or for daylong seminars. They have been used in designing course curricula for student elective courses, including Cultural Competency in Pharmaceutical Care Delivery, a one-day training template to teach 1stand 3rdyear Doctor of Pharmacy degree program students.
The American Academy of Family Physicians Quality Care for Diverse Populations Produced by AAFP with partial funding from Health Resources and Services Administration and the Bureau of Primary Health Care. http://www.aafp.org/online/en/home/clinical/publichealth/culturalprof.html	Includes 5 videos, CD-ROM materials, and a facilitator's guide.
The Angry Heart:The Impact of Racism on Heart Disease Among African Americans Created by Jay Fedigan. http://www.fanlight.com/catalog/films/331_ah.php	Series spotlights the heart disease epidemic among African Americans as told through the story of one African American male's experience.

Community Voices: Exploring Cross-Cultural Care Through Cancer *Created by Jennie Gree and Kim Newell.* *http://fanlight.com/catalog/films/329_cv.php*	Provides a video and facilitator's guide.
Worlds Apart. A Four-Part Series on Cross-Cultural Healthcare Created by Maren Grainger-Monsen and Julia Haslett of the Stanford University Center for Biomedical Ethics. *http://www.fanlight.com/catalog/films/912_wa.php*	A trigger series to raise awareness on how cultural barriers impact care, particularly patient-provider communication.
Think Cultural Health *https://www.thinkculturalhealth.hhs.gov/Content/ContinuingEd.asp* *Developed by US Dept of HHS, Office of Minority Health*	The goal of Think Cultural Health is to Advance Health Equity at Every Point of Contact through the development and promotion of culturally and linguistically appropriate services. Our continuing education programs are designed to help individuals at all levels and in all disciplines promote health and health equity. Developed by US Dept of HHS, Office of Minority Health. Linguistic and cultural competency education
TRAIN National https://www.train.org/DesktopShell.aspx?tabid=1	Free online training resource
National Center for Cultural Competence (Georgetown) http://www11.georgetown.edu/research/gucchd/nccc/	NCCC helps provide capacity to mental and physical health care programs to design, implement, evaluate cultural/linguistically competency.

Cultural Competency Continuing Education Options

"Let's Talk" Diversity Training #1-Annette Chastain Annette@ChastianAndAssociates.com (Jefferson County/Confederated Tribes of Warm Springs, OR)	Participants will participate in an experiential activity called The Cultural Exchange (Created by Education and Training Consultants) that creates a framework for discussing topics like assumptions, stereotyping, power/dominance, racism, and intent versus impact in a safe environment. The goal is to gain awareness for diversity, create a sense of belonging with the group, and see diversity from other perspectives. Participants will explore unearned and earned advantages and disadvantages.
"Let's Talk" Diversity Training #2-Annette Chastain Annette@ChastianAndAssociates.com (Jefferson County/Confederated Tribes of Warm Springs, OR)	The Participants will participate in an experiential activity called BARNGA with an original processing framework to discuss how we personally experience diversity, how we feel/think about situations, brain development related to self-regulation, and the self-defense coping skills we use during cross-cultural conflict with others. Participants will experience an activity to create acknowledgement of the environments of the agency, and whether it is welcoming for diverse people.
"Let's Talk" Diversity Training #3-Annette Chastain Annette@ChastianAndAssociates.com (Jefferson County/Confederated Tribes of Warm Springs, OR)	Participants will discuss poverty. Participants will engage in activities designed to create environments where we re-think how we have stereotyped poverty and how this impacts our agencies. Participants will began to integrate lessons learned so the new norms are becoming automatic, or the right thing to do. Participants will gain empathy skills to look at people, not through people, and to be inclusive of the entire community served by your agency.
"Let's Talk" Diversity Training #4-Annette Chastain Annette@ChastianAndAssociates.com (Jefferson County/Confederated Tribes of Warm Springs, OR)	Participants will discuss different cultural groups like Hispanic and Native American. Gain an understanding of how history, oppression, and racism effects health.
Morrison Child & Family Services Diversity & Inclusion http://www.morrisonkids.org/contact+us_program+contacts.aspx	Goal: Achieve greater diversity and inclusion at Morrison Child and Family Services by institutionalizing development and support of an informed and diverse staff to better serve children and families Purpose: Increase representation, increase awareness, increase education, increase accountability, increase engagement

Cultural Competency Continuing Education Options

Moving Toward Cultural Agility for Healthcare Providers - Anastasia Sofranac, Oregon Center for Nursing http://www.oregoncenterfornursing.org/index.php?mode=cms&pageId=diversity	Learn and explore the business case for diveristy and your own agility by examining unconscious bias, cultural/emotional intellegence, assessment tools, Intercultural Development Continuum, and a developing personal & professional action plans.
Caring for The People of Oregon: Developing Cultural Competence - Anastasia Sofranac, OCN http://www.oregoncenterfornursing.org/index.php?mode=cms&pageId=currproj	Provide training in culturally and linguistically appropriate service delivery. Increase participant knowledge of cultural beliefs and practices that may impact their clients' health beliefs, decisions, and practices
Oregon Center for Nursing: Exploring Cultural Competence - The Emerging Picture Isabelle Soule, PhD, RN, Assistant Professor, OHSU http://www.oregoncenterfornursing.org/index.php?mode=cms&pageId=diversity	Cultural competence is a fluid, dynamic process progressing from awareness to engagement and application and spiraling back again at ever-deepening levels across four domains Outline: I. Two concepts · Culture · Cultural competence II. Research findings and cultural competence model (Soulé, 2010) III. Intercultural roadmap exercise
Oregon Center for Nursing: Caring For the People of Oregon: Developing Cultural Competence Joanne Noone, PhD, RN, CNE, Assistant Professor, OHSU - Ashland Campus http://www.oregoncenterfornursing.org/index.php?mode=cms&pageId=diversity	**Module one** – Overview of Cultural Assessment -Discuss general aspects of cultural beliefs and practices to incorporate into an assessment to determine their impact on health beliefs, decisions, and practices. -Describe best practices before, during, and after an interview r to facilitate communication when using an interpreter **Module two** – Caring for the Hispanic Client -Describe the changing ethnic demographics in Oregon. - Discuss cultural beliefs and practices of Hispanic Americans that may impact their health beliefs, decisions, and practices. **Module three** – Caring for the Native American Client - Describe the various Native American tribes in Oregon. - Discuss cultural beliefs and practices of Native Americans that may impact their health beliefs, decisions, and practice

Cultural Competency Continuing Education Options

Oregon Center for Nursing: Moving Towards Culturally Competent Care of the Somali/Somali Bantu Population Multnomah County Health Department Training Unit http://www.oregoncenterfornursing.org/index.php?mode=cms&pageId=diversity	**Section 1**: 30 minutes -Describe brief overview of the history of Somali/Somali Bantu Population -Brief Epidemiology profile **Section 2** : 30 minutes -Identify common beliefs and cultural practices of the Somali/Somali Bantu Population **Section 3** : 30 minutes -Discuss additional insights and information from community members **Section 4** : -List of additional resources & References
Oregon Center for Nursing: Moving Towards Culturally Competent Care of the Burmese Population Multnomah County Health Department Training Unit http://www.oregoncenterfornursing.org/index.php?mode=cms&pageId=diversity	**Section 1:** -Describe brief overview of the history of refugees from Myanmar (Burma) population -Brief Epidemiology profile **Section 2:** -Identify common beliefs and cultural practices of the Burmese Muslim, Zomi and Karen Population **Section 3:** -Discuss additional insights and information from community members **Section 4:** -List of additional resources & References
Oregon Center for Nursing: Cultural Competency Learning Activities for Nursing Students Jesika Gavilanes, MA, Instructor & Statewide Simulation Manager and Glenise McKenzie PhD, RN, Assistant Professor, Oregon Health & Science University http://www.oregoncenterfornursing.org/index.php?mode=cms&pageId=diversity	• Understand national nursing education recommendations for education on cultural competency. • Gain awareness of specific tools and activities used to present basic cultural competence training to students in didactic, clinical and simulation settings. • Identify a strategy for integration of diversity and cultural competency into the curriculum via these shared cultural learning activities.

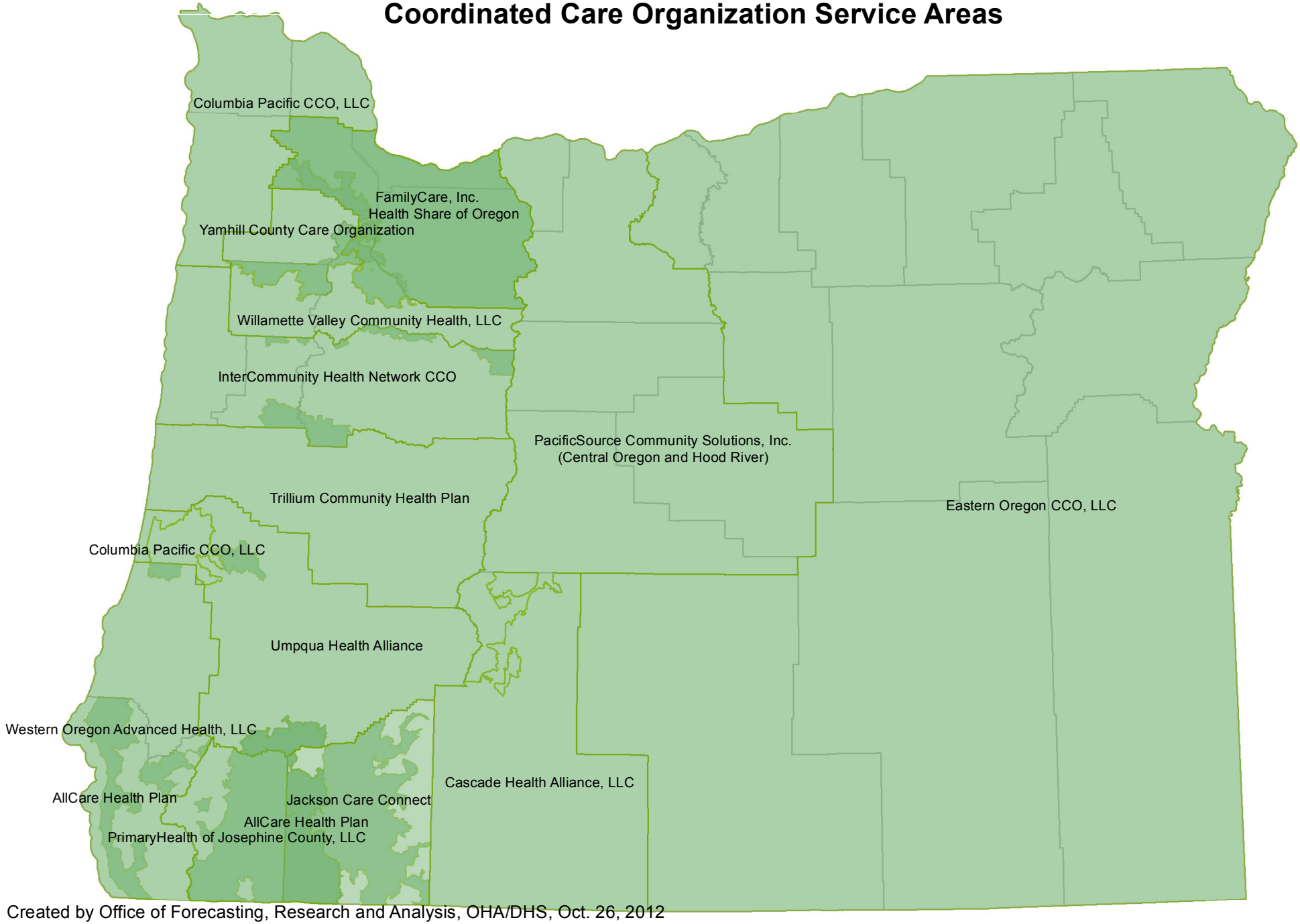
Community Action Poverty Simulation www.communityaction.org	Complex lived experience of poverty (50-100+ participants)
Cultural Detective www.culturaldetective.com	Perspective shifting: Contains critical incidents with people from many cultures in diverse settings (Few to 100+ participants)
Visuals Speak www.visualsspeak.com	Novel way to approach culture via image –increased awareness of positionality (Few to many participants)
BARNGA Source: Nicholas Brealey Publishing http://nicholasbrealey.com/london/barnga.html	Intercultural awareness - positionality (20-100+ participants); This cross-cultural simulation game illustrates that although people from other cultures may appear similar, they may be significantly different. Participants are divided into groups, and separate cultures are developed through the use of different sets of game rules. The groups then interact nonverbally, ending with a discussion of the experience. Vividly demonstrates how assumptions of similarity can provoke misunderstandings and conflict.
BaféBafé Source: Simulation http://www.stsintl.com/business/bafa.html	Diversity cross- cultural simulation (20-100+ participants); Training Systems Participants are divided into two cultures, Alpha and Beta, and are taught one culture's distinctive characteristics and behaviors. Players then attempt to understand the other culture through a series of controlled visits. Designed to demonstrate how easy it is to develop counter-productive attitudes, misperceive events, and communicate poorly in a cross-cultural situation. Rafa-Rafa is a version of this game designed for elementary age children.
“I would rather be_____ than _____”	Values clarification (Few to many participants)
Awareness Wheel http://www.primarygoals	Acknowledges many ways of knowing – facilitates self- awareness of positionality – compares and contrasts with other perspectives (Few to many participants)
Power Walk or Power Shuffle www.trainingforchange.org	Insight into rank, privilege, oppression (Few to many participants)
The Thaigi Group – www.thaigi.com	

University of Minnesota Center for Advanced Research on language acquisition (CARLA) http://www.carla.umn.edu/index.html	
An Alien Among Us Source: Intercultural Press	Six candidates are selected to go on a mission based on attributes that fall into nine categories: gender, age, religion, profession, health, nationality, reason for going, positive attributes, and negative attributes. Participants come to understand that differences and diversity are not synonymous with problems and difficulties but rather can enrich human experience. They discover that they have overlooked the benefits of the differences they were inclined to devalue.
The Albatross Source: Beyond Experience, 2nd edition O/P	Visitors to an imaginary culture (Albatross) are greeted with an elaborate ceremony. Allows participants to observe the culture, interpret the behavior that is observed, and discuss their perceptions. Demonstrates how easy it is to interpret incorrectly what is observed.
The New Commons Game Source: Richard Powers, P.O. Box 276, Oceanside, OR 97134. (503) 842-7247, rpowers@oregoncoast.com	Authored by Richard Powers, this exercise explores alternative responses to the “tragedy of the commons.”
Conducting Planning Exercises Source: Simulation Systems	Paul Twelker’s simulation is designed to facilitate the examination and proposal of alternative solutions to a given problem. “Frame” game format.
Death of a Dissident Source: American Forum for Global Education	This simulation concerns economic development, including foreign investment, civil unrest, social justice, and human rights in a Caribbean dictatorship. After one of their number has been murdered, activists refuse to leave the U.S. Embassy. All parties negotiate.
Diversafari Source: Executive Diversity Services or Intercultural Communication Institute	Diversafari combines global cultural awareness with proven adult learning methods in a scalable, reusable, and extremely practical learning program of tools designed to maximize understanding of intercultural communication styles, values and behaviors.

Diversophy: Understanding the Human Race Source: George Simons International	A game which develops the wisdom and skill needed to understand and collaborate with people who are different. Board game with question cards and facilitator guidebook. Average playing time is 75-90 min., 4-6 players. Conference version available for large groups.
Ecotonos Source: Intercultural Communication Institute	Ecotonos is an excellent tool for engaging in problem solving and decision making in multicultural groups. Methods and processes of decision making in these groups are analyzed, diagrammed, and compared, and guidelines for effectiveness generated. Participants enhance their understanding of the impact of culture on decision-making and problem solving and develop their skills in participating effectively in a multicultural decision-making process.
Fire in the Forest Source: American Forum for Global Education	This is set in the Amazon Rain Forest, with conflicting claims to the land and its use by environmentalists, settlers, and native tribes. Violence erupts, which local government officials have difficulty containing. Negotiations become critical. Learning objectives include environmental protection, and respect for indigenous cultures, social justice, economic development, and poverty
It's Not My Problem Source: Simulation Technologies	This simulation asks participants to increase their understanding of the issues surrounding AIDS.
Looking Glass, Inc.: A Management Simulation of a Day In the Life of Top Management Source: Center for Creative Leadership	This highly active exercise deals with issues of effective managerial styles and team building. Skill building in feedback, organizational values awareness, and leadership.
The Owl Source: Beyond Experience, 2nd edition O/P	An interview situation between two members of U.S. culture and three members of another culture—Country X—that demonstrates the difficulties of communicating and getting what one wants and needs in a cross-cultural situation. Also deals with male/female roles and relationships
Randömia Balloon Factory Source: Nicholas Brealey Publishing	Simulates a realistic business-related problem that many Western managers and trainers experience when they interact with people who have different value-driven behaviors. Designed for 15 to 35 participants and takes about three hours.

Redundancia: A Second Language Simulation Source: Nipporica Associates or Intercultural Communication Institute	Requires 10 minutes to conduct and about 30 to debrief. Participants experience speaking a second language nonfluently; how it affects one's ability to stay focused and connected with the listener, and one's feelings of competence and confidence. Participants also experience listening to second language speakers: their own tendencies to help or to become distracted. Observers note the speaker's nonverbal communication. Extremely powerful. ″
Rockets and Sparklers Source: Nicholas Brealey Publishing	Requires 90 minutes to set-up, play and debrief. This is a cultural encounter simulation designed to identify different aspects of culture--values and behaviors—and explore the influence of culture on our behavior and our interpretation of the behavior of others. In 52 Activities for Exploring Values Differences by Donna M. Stringer and Patricia A. Cassiday.
Star Power Source: Simulation Training Systems	Participants have a chance to progress from one level of society to another by acquiring wealth through trading with the other participants. Groups are formed based on economic status and develop their own cultural characteristics. When the most "successful" are allowed to change the rules of the game, conflict usually results. Demonstrates how groups develop a "culture," but most importantly, enables many participants to deal with their assumptions about the uses and abuses of power.
Where Do You Draw the Line? Source: Simulation Training Systems	Designed by R. Garry Shirts, this ethics game examines what "should be" without excluding consideration of "what is." (Works well as "frame" game.)
Simulation Games by Thiagi Source: Diversity Simulation Games by Thiagi Sivasalilam Thiagarajan "Thiagi"	This collection includes seven simulation game booklets: Cash Games; Diversity *Simulation Games* ; *More Cash Games* ; *Seven More Simulations* ; *Sh! Sexual Harassment Simulation* ; *Teamwork Games* ; *and Triangles: Exploring Organizational Relationships.*

Teatro Milagro Cultural Competency "Reality Theatre" Workshops [Teatro Milagro is a division of the Miracle Theatre Group-525 SE Stark St., Portland, OR 97214] www.milagro.org	Teatro Milagro's Cultural Competency Workshops use a combination of popular education and role-playing techniques to engage participants as "actors" in "Reality Theatre." A program that creates dialog that provokes self-reflection and the need for improvement. The process of using theatre as a medium in this program allows us to address sensitive issues and discover new solutions to interpersonal concerns while maintaining a fun and relaxed atmosphere throughout the group. Another component of the CDS program is to reflect upon actual experiences or impressions regarding cultural interactions. The goal of these programs is to improve the level of understanding between the staff and the clients they serve, so that cultural competency can be improved. These programs can be made available in either English or Spanish languages. **Small Group Sample Outline:** "Reality Theatre" Demo Workshop: 1 hour Intro Icebreaker -image theatre 5 min. Intro Milagro 5 min. Anonymous impressions exercise 5 min. Share out culturally awkward situations 10 min. Create skits: Form small groups to create skits that dramatize some form of change. 15 min. Share skits/Discuss/rework one scene of most concern 15 min. Wrap up – Share what you learned/liked/would take back to your community. 5 min.


Coordinated Care Organization Service Areas
Columbia Pacific CCO, LLC
FamilyCare, Inc.
Health Share of Oregon
Yamhill County Care Organization
Willamette Valley Community Health, LLC
InterCommunity Health Network CCO
PacificSource Community Solutions, Inc.
(Central Oregon and Hood River)
Trillium Community Health Plan
Eastern Oregon CCO, LLC
Columbia Pacific CCO, LLC
Umpqua Health Alliance
Western Oregon Advanced Health, LLC
Cascade Health Alliance, LLC
AllCare Health Plan
Jackson Care Connect
AllCare Health Plan
PrimaryHealth of Josephine County, LLC
Created by Office of Forecasting, Research and Analysis, OHA/DHS, Oct. 26, 2012

Oregon Association of Hospitals and Health Systems

Cedar Hills Hospital
Providence St. Vincent Medical Center (WA County)
Oregon Health & Science University
Shriners Hospital for Children
Legacy Good Samaritan Medical Center
Legacy Emanuel Medical Center
Providence Portland Medical Center
Adventist Medical Center
Legacy Mount Hood Medical Center
Providence Hood River Memorial Hospital
Columbia Memorial Hospital
Providence Seaside Hospital
Tuality Healthcare
Tillamook County General Hospital
Providence Newberg Medical Center
Kaiser Sunnyside Hospital
Providence Milwaukie Medical Center
Providence Willamette Falls Medical Center
Legacy Meridian Park Medical Center
Willamette Valley Medical Center
Silverton Hospital
Santiam Memorial Hospital
Salem Hospital
Samaritan North Lincoln Hospital
West Valley Hospital
Samaritan Pacific Communities Hospital
Samaritan Albany General Hospital
Samaritan Lebanon Community Hospital
Good Samaritan Regional Medical Center
Peace Harbor Hospital
Sacred Heart Medical Center, University Place
Sacred Heart Medical Center at Riverbend
McKenzie-Willamette Medical Center
Lower Umpqua Hospital
Cottage Grove Community Hospital
Bay Area Hospital
Coquille Valley Hospital
Southern Coos Hospital & Health Center
Mercy Medical Center
Three Rivers Community Hospital
Providence Medford Medical Center
Rogue Valley Medical Center
Curry General Hospital
Ashland Community Hospital
Sky Lakes Medical Center
Mid Columbia Medical Center
Mountain View Hospital
St. Charles Medical Center Redmond
St. Charles Medical Center Bend
Pioneer Memorial Hospital (P)
Good Shepherd Medical Center
St. Anthony Hospital
Pioneer Memorial Hospital (H)
Grande Ronde Hospital
Wallowa Memorial Hospital
St. Alphonsus Medical Center Baker City
Blue Mountain Hospital
St. Alphonsus Medical Center Ontario
Harney District Hospital
Lake District Hospital

Clatsop
Columbia
Tillamook
Washington
Multnomah
Hood River
Yamhill
Clackamas
Polk
Marion
Lincoln
Benton
Linn
Jefferson
Wasco
Sherman
Gilliam
Morrow
Umatilla
Union
Wallowa
Baker
Wheeler
Grant
Crook
Deschutes
Lane
Douglas
Coos
Curry
Josephine
Jackson
Klamath
Lake
Harney
Malheur

84
5

Legend:

Critical Access Hospitals (CAH): a rural community hospital that is certified to receive cost-based reimbursement from Medicare.

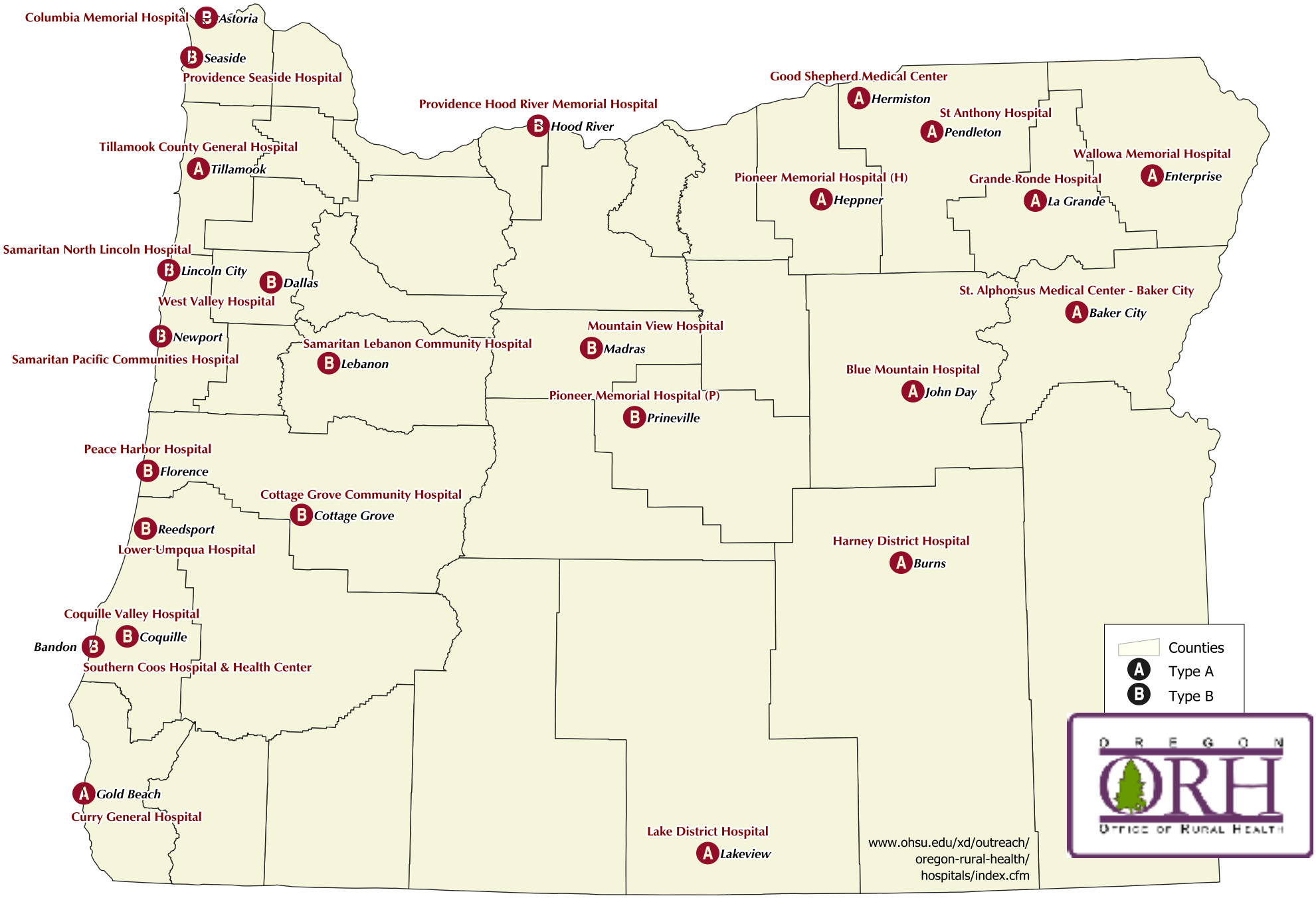
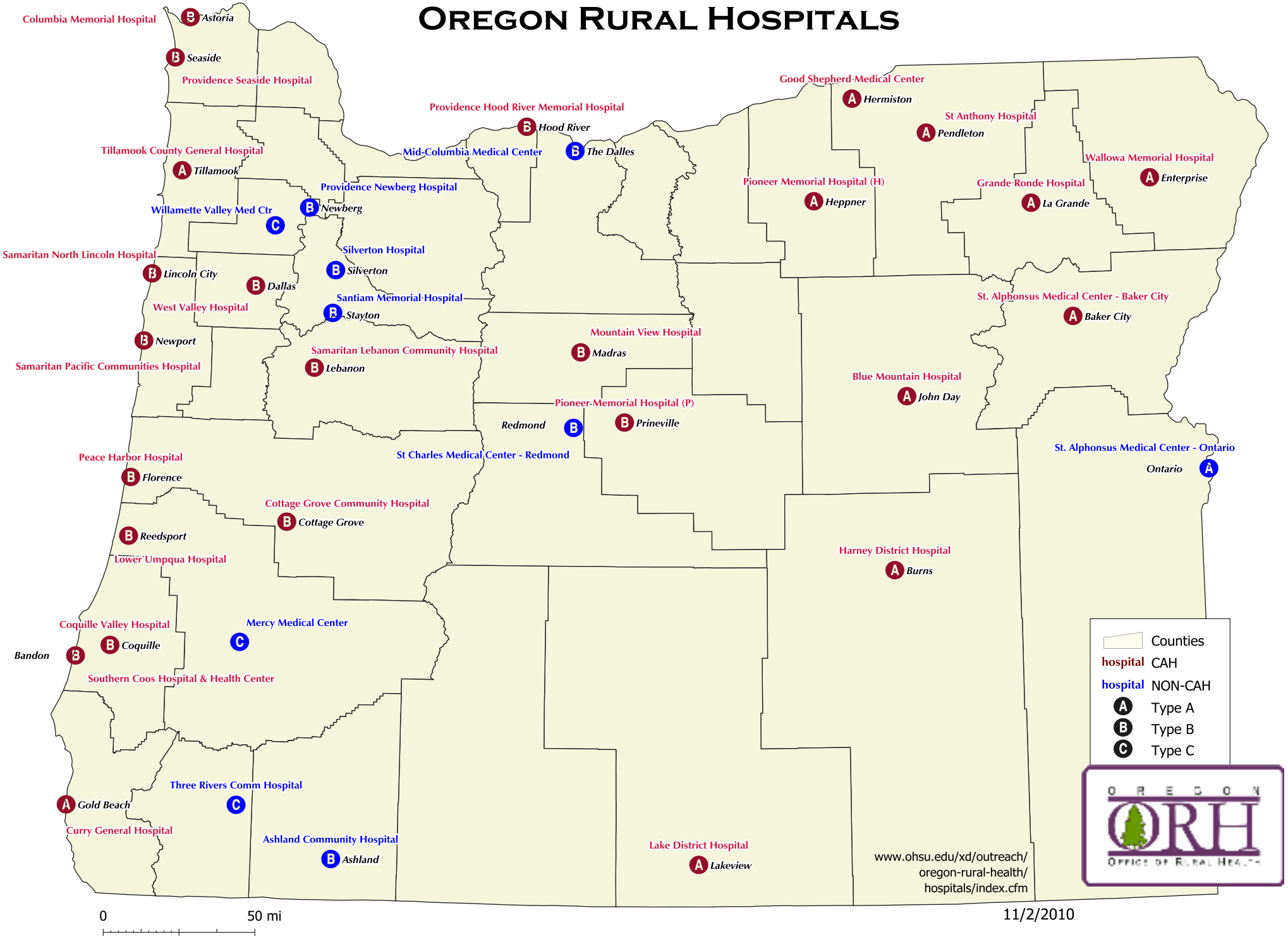
Diagnosis-Related Group (DRG): is a system to classify hospital cases into one of approximately 500 groups, also referred to as DRGs, expected to have similar hospital resource use, developed for Medicare as part of the prospective payment system. These hospitals participate in the Oregon Hospital Tax program to fund the Oregon Health Plan (OHP).

▲ **Type A** hospitals are small and remote and have 50 or fewer beds. Type A hospitals are located more than 30 miles from another acute care, inpatient facility.

● **Type B** hospitals are small and rural and have 50 or fewer beds. Type B hospitals are located 30 miles or less from another acute care facility.

Revised: July 28, 2011
Cultural Competence Continuing Education Committee

Oregon Critical Access Hospitals



Oregon Rural Hospitals