Alliance
BEHAVIORAL HEALTHCARE

Cultural Competency Plan

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Cultural and Linguistic Competency Overview

What is Cultural Competency?

According to the United States Department of Health and Human Services (DHHS), Office of Minority Health (OMH), *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." The OMH website states that, *"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."

Child welfare advocate and social worker, Terry L. Cross, and his fellow researchers who studied the system of care for minority children with severe emotional issues defined cultural competency as "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" (Cross, Bazron, Dennis & Isaacs, 1989).

Linguistic Competence: Definition

Linguistic competence is defined as the capacity of an organization and its personnel to communicate effectively and to convey information in a manner that is easily understood by diverse groups including: 1) persons of limited English proficiency; 2) those who have low literacy skills or are not literate; 3) individuals with disabilities; and 4) those who are Deaf and/or Hard of Hearing; and 5) those with blindness or visual impairment. Linguistic competence enables organizations and providers to respond effectively to the health and mental health literacy needs of the populations they serve. Policies, structures, practices, procedures and dedicated resources support this capacity.

Principles for Language Access

- Services and supports delivered in the preferred languages and/or modes of delivery of the populations served.
- Written materials that are translated, adapted, and/or provided in alternative formats based on the needs and preferences of the populations served.
- Interpretation and translation services that comply with all relevant Federal, state, and local mandates governing language access.
- Engaged consumers who evaluate language access and other communication services to ensure quality and satisfaction.

In addition to the best practices aforementioned, the US Department of Health and Human Services Centers for Medicare & Medicaid Services has produced a *Toolkit for Making Written Material Clear and Effective* which can be utilized as a reference when producing written

materials. This information is available at http://www.cms.gov/Outreach-and-Education/Outreach/WrittenMaterialsToolkit/index.html?redirect=/WrittenMaterialsToolkit/.

Alliance Behavioral Healthcare's Mission, Vision and Values

Our Mission: To improve the health and well-being of the people we serve by ensuring highly effective, community-based support and care.

Our Vision: To be a leader in transforming the delivery of whole person care in the public sector.

Alliance Behavioral Healthcare Values

- Accountability and Integrity: We keep the commitments we make to our stakeholders and to each other. We ensure high-quality services at a sustainable cost.
- Collaboration: We actively seek meaningful and diverse partnerships to improve services and systems for the people we serve. We value communication and cooperation between team members and departments to ensure that people receive needed services and supports.
- Compassion: Our work is driven by dedication to the people we serve and an understanding of the importance of community in each of our lives.
- Dignity and Respect: We value differences and seek diverse input. We strive to be inclusive and honor the culture and history of our communities and the people we serve.
- Innovation: We challenge the way it's always been done. We learn from experience to shape a better future.

Background and the Agency's Perspective

Alliance Behavioral Healthcare (Alliance) is a public local management entity/ managed care organization (LME/MCO) responsible for overseeing the delivery of publicly-funded mental health, intellectual/developmental disabilities and substance abuse services (MH/DD/SAS) in Durham, Wake, Cumberland and Johnston Counties. Alliance works closely with community partners, advocates and its Closed Provider Network to address the MH/DD/SAS needs of the people and communities in these areas.

Equitable access to quality MH/DD/SA services for people of all cultures has been an ongoing goal of North Carolina. In 2011, the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS) and the Division of Medical Assistance (DMA), under the authority of the North Carolina Department of Health and Human Services, approved Alliance's application to become a MCO. On February 1, 2013, the Alliance MCO began the local operation of a 1915 (b)/(c) Medicaid Waiver site for Durham, Wake, Cumberland, and Johnston Counties. Cultural competency is a requirement of the Waiver.

In 2013, Alliance established a Cultural Competency Committee to oversee the development of a Cultural Competency Plan. The purpose of the **Alliance Cultural Competency Plan** is two-fold: first, to foster cultural competency within the Alliance organization and second, to nurture and guide cultural competency in the Alliance Closed Provider Network. Alliance strives to be an organization that respects all people as individuals, recognizes and values cultural diversity, rejects negative stereotypes and discriminatory behaviors, models accepted cultural competency standards and commits to an ongoing process of organizational self-assessment and improvement. Alliance works to create a Provider Network that is knowledgeable of best practices related to cultural competency, follows Alliance's Cultural Competency Plan or a similarly adequate plan, and accepts the continued responsibility of improving cultural competency.

Alliance recognizes that cultural competency is a developmental process that continuously evolves. To facilitate this growth, Alliance will partner with its providers to build upon this plan and to expand its cultural competency efforts through ongoing assessments and annual reviews to the plan.

Best Practices for Developing a Plan

In developing its Cultural Competency Plan Alliance incorporated many of these guidelines from the National Center for Cultural Competence.

Cultural Competency: Conceptual Framework

Cultural competency requires that organizations:

- Have a defined set of values and principles.
- Demonstrate behaviors, attitudes, policies and structures that enable them to work effectively cross-culturally.
- Have the capacity to (1) value diversity, (2) conduct self-assessment, (3) manage the dynamics of difference, (4) acquire and institutionalize cultural knowledge, and (5) adapt to diversity and the cultural contexts of the communities they serve.
- Incorporate the above in all aspects of policy making, administration, practice and service.
- Involve systematically consumers, key stakeholders and communities.

Guiding Principles

Organizational

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

Practice and Service Design

- Identifies and understands the needs and help-seeking behaviors of individuals and families.
- Designs and implements services that are tailored or matched to the unique needs of individuals, children, families, organizations and communities served.
- Is client driven and culturally sensitive.

Community Engagement

- Extends the concept of self-determination to the community.
- Involves working in conjunction with natural, informal support and helping networks within culturally diverse communities (e.g. neighborhood, civic and advocacy associations; local/neighborhood merchants and alliance groups; ethnic, social, and religious organizations; and spiritual leaders and healers).
- Allows communities input to determine their own needs.

- Treats community members as full partners in decision making.
- Offers potential economic benefits to the communities from collaboration.
- Should result in the reciprocal transfer of knowledge and skills among all collaborators and partners.

Family and Consumers

- Definition of "family" varies by culture.
- Family is usually the primary system of support and preferred intervention.

Family/consumers are the ultimate decision makers for services and supports for their children and/or themselves.

Cultural Competency Work Plan

A Goal-Oriented Approach

Alliance's Cultural Competency Work Plan is intended as a goal-oriented map to guide the LME/MCO in promoting cultural competency within the organization and throughout the provider network. The work plan establishes goals from key focus areas, identifies related activities, defines timelines and determines indicators for the fiscal period beginning July 1, 2015 and ending June 30, 2018. Throughout this period, Alliance will monitor its performance in meeting cultural competency goals and may utilize the information in developing future work plans. Alliance will also evaluate compliance of provider service organizations in assessing their agencies' cultural competency and in developing their own work plans. These processes will be ongoing with the objective of continuous improvement in cultural competency.

Alliance recognizes that collaboration with internal and external partners is critical to creating and nurturing a culturally competent mental health care system. The LME/MCO will be guided by its executive team, Cultural Competency Committee, internal staff, and organizational committees as it develops future revisions to the Cultural Competency Plan and subsequent work plans.

Three-Year Plan for Promoting Cultural Linguistic Competency

The following goals have been identified for Fiscal Years 2016 through 2018. Specific strategies, including responsible parties and projected completion dates, shall be developed for each goal by the individual or group assigned to complete each task. Progress toward achieving each goal shall be reviewed by the Cultural and Linguistic Competency Committee, the Alliance Provider Advisory Council and the Quality Management Department at least annually. Status reports will be shared with Alliance's Continuous Quality Improvement Team, the Executive Leadership Team and the Alliance Board as necessary.

Goals for Year 1 (2016)

Alliance Internal

- Annual update training on Cultural and Linguistic Competence (CLC) for all Alliance staff
- Develop a process for sharing Consumer and Family Advisory Council (CFAC) monthly feedback with appropriate committees within Alliance Behavioral Healthcare
    - Determine who will benefit from the CFAC information
    - Work with Director of Consumer Affairs to implement a process
- Identify all Alliance documentation that needs translation
    - Develop implementation plan for document translation
    - Develop process for future documentation translation

- Review Alliance staff
    - Executive leadership cultural composition
    - Current data on staff cultural composition
- Review Alliance community events and incorporate CLC principles
- Identify and recruit other cultural groups to give input regarding Alliance and it's provider network include (i.e. – Refugees, Veterans, Lesbian, Gay, Bisexual, Transgender, Questioning (LGBTQ), Religious, Native Americans, various age, rural, urban and socio-economic groups)
- Develop a survey for providers to monitor their capacity to provide services to various cultural groups and languages.

Alliance Closed Provider Network

- Design training for providers on elements of CLC Plan
- Begin implementation of training

Goals for Year 2 (2017)

Alliance Internal

- Discuss with Network Development a process to include consumer/cultural group CLC feedback in the development and evaluation of services
- Determine the most needed/appropriate audiences for targeted marketing and public relations campaigns
- Identify strategies to maintain/support a culturally representative staff
    - Executive Leadership
    - Other staff
- Review and standardize hiring practices to ensure a culturally representative workforce
- Develop a systematic process to ensure that culturally relevant information is included in Alliance community events
- Continue to identify and recruit other cultural groups to give input regarding Alliance and it's provider network (suggested – Refugees, Veterans, LGBTQ, Religious, Native Americans, various age groups, rural and urban, and socio-economic groups)
- Monitor network capacity to provide services to various cultural groups.

Alliance Closed Provider Network

- Design evaluation plan of provider CLC plans
- Begin implementation of CLC plan reviews

Goals for Year 3 (2018)

Alliance Internal

- Conduct a system-wide cultural self-assessment that includes:
    - Demographic data regarding Alliance employment practices including hiring, promotions and staffing positions reflecting relevant cultural/demographic indicators.
    - Alliance functioning regarding diverse consumers.
- Monitor network capacity to provide services to various cultural groups.

Alliance Closed Provider Network

- Ongoing monitoring of provider CLC plans
    - Technical assistance provided as needed on plans

Legal Considerations

Title VI of the Civil Rights Act of 1964

Title VI declares that no person shall be subject to discrimination on the basis of race, color or national origin under any program or activity that receives federal financial assistance.

What is the penalty for non-compliance with Title VI?

- Loss of federal funds
- Loss of future federal and state funding
- Subject to legal actions from NC DHHS, legal services organizations and private individuals.
- Possible "Informed Consent" issues which could lead to medical malpractice charges for both the public and private sector.

Americans with Disabilities Act (ADA)

The landmark Americans with Disabilities Act (ADA) enacted on July 26, 1990, provides comprehensive civil rights protections to individuals with disabilities in the following areas:

- **(Title I) Employment**

  Business must provide reasonable accommodations to protect the rights of individuals with disabilities in all aspects of employment. Possible changes may include restructuring jobs, altering the layout of workstations, or modifying equipment. Employment aspects may include the application process, hiring, wages, benefits, and all other aspects of employment. Medical examinations are highly regulated.

- **(Title II) Public Services**

  Public services, which include state and local government instrumentalities, the National Railroad Passenger Corporation, and other commuter authorities, cannot deny services to people with disabilities participation in programs or activities which are available to people without disabilities. In addition, public transportation systems, such as public transit buses, must be accessible to individuals with disabilities.

- **(Title III) Public Accommodations**

  All new construction and modifications must be accessible to individuals with disabilities. For existing facilities, barriers to services must be removed if readily achievable. Public accommodations include facilities such as restaurants, hotels, grocery stores, retail stores, etc., as well as privately owned transportation systems.

- **(Title IV) Telecommunications**

  Telecommunications companies offering telephone service to the general public must have telephone relay service to individuals who use telecommunication devices for the deaf (TTYs) or similar devices.

- **(Title V) Miscellaneous**
  Includes a provision prohibiting either (a) coercing or threatening or (b) retaliating against the disabled or those attempting to aid people with disabilities in asserting their rights under the ADA.

References and Helpful Resources

Cross, T. L., Bazron, B. J., Dennis, K. W., & Issacs, M. R. (1989). Towards a culturally competent system of care: A monograph on effective services for minority children who are severely emotionally disturbed. Washington, DC: National Technical Assistance Center for Children's Mental Health, Georgetown University Child Development Center.
http://www.mhsoac.ca.gov/meetings/docs/Meetings/2010/June/CLCC_Tab_4_Towards_Culturally_Competent_System.pdf

Cultural and Linguistic Competency Action Plan Recommendations for the North Carolina Department of Health and Human Services Division of Mental Health, Developmental Disabilities and Substance Abuse Services (2006)
http://www.ncdhhs.gov/mhddsas/statspublications/Publications/culturalcompplan10-23-06.pdf

Defining Cultural Competence: A Practical Framework for Address Racial/Ethnic Disparities in Health and Health Care (2003)
http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1497553/pdf/12815076.pdf

Issue Brief: The Massachusetts Health Policy Forum (1999**)**
http://masshealthpolicyforum.brandeis.edu/publications/pdfs/05-Jul99/IB%20CultCompetnc%205.pdf

National Center for Cultural Competence. www.nccc.georgetown.edu

National Standards for Culturally and Linguistically Appropriate Services (CLAS). http://minorityhealth.hhs.gov/omh/browse.aspx?lvl=2&lvlid=53

The Lewin Group, Inc. HRSA's Office of Minority Health and Office of Planning and Evaluation
http://www.hrsa.gov/culturalcompetence/healthdlvr.pdf

US DHHS CMS: Toolkit for Making Written Material Clear and Effective,
http://www.cms.gov/Outreach-and-Education/Outreach/WrittenMaterialsToolkit/index.html?redirect=/WrittenMaterialsToolkit/