Alliance Behavioral Healthcare
Cultural Competency Plan
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Cultural Competency Overview

What is Cultural Competency?

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).

According to the United States Department of Health and Human Services, 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.”

Alliance Behavioral Healthcare’s Mission, Vision and Values

Our Mission: We pursue a community effort dedicated to supporting the lives of citizens affected by mental illness, developmental disabilities, and substance abuse by assuring a collaborative, accessible, responsive and efficient system of services and supports.

Our Vision: We are a community with energy and momentum that embraces people with disabilities as equal partners and valued citizens. When citizens with disabilities reach their full potential, the entire community benefits.

Alliance Behavioral Healthcare values:

- Discovering ways to nurture community strengths in order to accomplish what none of us can do alone

- Involving stakeholders for the advancement of all citizens in our diverse community

- Partnerships with community agencies that assure that best practices are applied through person-centered planning

- Community resources that offer enduring ways to support people with disabilities

- Community partners that leverage dollars and develop in-kind partnerships to respond to the mental health, developmental disabilities and substance abuse services needs of all citizens
• Advocacy efforts that challenge the MH/DD/SAS delivery system to improve continuously
• Accountability of all parties in the system
• Exemplary practices that lead to meaningful outcomes and are cost effective
• High consumer and family satisfaction
• Collaboration with our community partners and stakeholders
• Building community capacity that includes the identification of existing community resources and gaps
• Services and supports that are consumer and family friendly, age appropriate and culturally competent
• The flexibility of the MH/DD/SAS system to provide programs and supports when needed, at the level needed and in the amount necessary, so people may enter and exit components of the system as their needs change and without fear of re-entry complications
• Ongoing community education that assists in the elimination of stigma and discrimination

Background and the Agency’s Perspective

Alliance Behavioral Healthcare (Alliance) is the state-mandated, local management entity (LME) responsible for overseeing the delivery of publicly-funded mental health, intellectual/developmental disabilities and substance abuse services (MH/DD/SAS) in Durham and Wake Counties. Alliance works closely with community partners, advocates and the provider network to address the service 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 mental health reform. 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 managed care organization (MCO). On February 1, 2013, the Alliance MCO will begin 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.

The agency 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: 1) to foster cultural competency within the Alliance organization; and 2) to nurture and guide cultural competency in the provider network. Internally, 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
COMMITMENTS TO CULTURAL COMPETENCY

Alliance commits to an ongoing process of organizational self-assessment and improvement. Externally, 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 updates to the Plan.

**Best Practices for Developing a Plan**

In developing the *MCO 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 & 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 driven in service delivery systems by client preferred choices, not by culturally blind or culturally free interventions
• Utilizes a service delivery model that recognizes mental health as an integral and inseparable aspect of primary health care

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 to determine their own needs
• Treats community members as full partners in decision making
• Should offer economic benefits to the communities from collaboration
• Should result in the reciprocal transfer of knowledge and skills among all collaborators and partners

Family & 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

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 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

**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, 2012 and ending June 30, 2015. Throughout this period, Alliance will monitor its performance in meeting cultural competency goals and will utilize the information in developing a new 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.

Alliance’s Cultural Competency Work Plan focuses on the following key areas:

**Three Year Plan for Promoting Cultural Linguistic Competency**

The following goals have been identified for Fiscal Years 2013 through 2015. 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 monitored by the Quality Management Department with status reports provided to the MCO Continuous Quality Improvement Team and the Area Board.

**Goals for Year 1 (2013):**

- Conduct a system-wide cultural self-assessment that includes:
  - Demographic data regarding LME employment practices including hiring, promotions and staffing positions by ethnic/racial and gender groups.
  - LME functioning regarding diverse consumers.
Goals for Year 2 (2014):

- Develop a plan and process to:
  - Identify culturally appropriate diagnostic tools and the training of employees to utilize these tools.
  - Conduct community needs assessment of target ethnic/racial groups.
  - Plan community forums to educate community on behavioral healthcare issues.

- Develop a community engagement plan that includes community education forums and involvement of culturally diverse grassroots consumers in decision-making, implementation and evaluation of programs.

- Develop short-term and long-range plans to increase ethnic/racial representation through the recruitment of a culturally diverse workforce.

Goals for Year 3 (2015):

- Create an accountability process that includes grassroots groups and consumers as full participants.

- Increase capacity to provide customer friendly services to all ethnic/racial groups, particularly those in need of translation and interpretation services.

- Engage in culturally specific marketing and public relations engagement strategies.
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


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

