H. CULTURAL COMPETENCE

Cultural Competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among consumer providers, family member providers, and professionals that enables that system, agency or those professionals, consumer, and family member providers to work effectively in cross-cultural situations.

History and Background

Cultural norms, values, beliefs, customs and behaviors may influence the manifestation of mental health problems, the use of appropriate levels of care/services, the course of treatment and the successful attainment of positive outcomes. The County's dynamic demographics combined with the recognition that culture is a key factor in service delivery pose an ongoing challenge for the MHP and its contracted mental health care providers. The 2010 United States Census reports a 10% population increase in San Diego County, with no single racial/ethnic group comprising a majority. Whites make up 48% of the population, Hispanics – 32%, Asians – 11%, Blacks – 5% and Native Americans/American Indians – 1%.

As the diversity of the population continues to increase, the FY 2015-16 Progress Towards Reducing Disparities Report noted an increase in the number of Medi-Cal mental health clients from various minority populations. Efforts to reduce barriers to behavioral health care across clients in different age groups and racial/ethnic minorities have been a priority for BHS. However, the demographic breakdown of individuals eligible for BHS services differs markedly from the demographic make-up of the county as a whole. For example, although individuals of Hispanic origin make up 30% of the adults in the San Diego County population, this segment accounts for 60% of the eligible client population. A disparity was also found between the number of minority clients participating in the Medi-Cal program and the number of clinicians available with self-assessed proficiency in needed ethnic, racial and cultural specialties.

The Cultural Competence Plan reports that in addition to changing demographics related to ethnicity and race, age demographics are changing in the county and will affect service demands. The number of older adults living in San Diego is one of the most rapidly increasing populations, with an estimated 23.5% being 55 years of age or older.

Cultural Competence Plan

To address these issues in the 2017 Cultural Competence Plan and the Three-Year Strategic Plan, the MHP set the following objectives to improve cultural competence in the provision of mental health services:

1) Continue to conduct an ongoing evaluation of the level of cultural competence of the mental health system, based on an analysis of gaps in services that are identified by

comparing the target population receiving mental health services to the target population receiving the Medi-Cal and the target population in the County as a whole.
2) Continue to compare the percentage of each target population with provider staffing levels.
3) Investigate possible methods to mitigate identified service gaps.
4) Enhance cultural competence training system wide.
5) Evaluate the need for linguistically competent services through monitoring usage interpreter services.
6) Evaluate system capability for providing linguistically competent services through monitoring organizational providers and FFS capacities, compared to both threshold and non-threshold language needs.
7) Study and address access to care issues for underserved populations.

Current Standards and Requirements

To meet State and County requirements, providers are required to maintain and reflect linguistic and cultural competence through all levels of their organization and in their policies, procedures, and practices. Providers must ensure that program staff is representative of, and knowledgeable about, the clients' culturally diverse backgrounds and that programs are reflective of the specific cultural patterns of the service region.

***National Culturally and Linguistically Appropriate Services (CLAS) Standards**:*

The National Culturally and Linguistically Appropriate Services (CLAS) Standards have replaced the Culturally Competent Clinical Practice Standards. The CLAS Standards are a series of guidelines that are intended to inform and facilitate the efforts towards becoming culturally and linguistically competent across all levels of a health care continuum. The CLAS Standards were originally developed by the Health and Human Services Office of Minority Health and are comprised of 15 Standards. All Statements of Work include the language on the requirement of the programs to implement the CLAS Standards.

The Standards are as follows:

Principal Standard:

1. Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

Governance, Leadership, and Workforce:

2. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.

3. Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.
4. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

Communication and Language Assistance:

5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.
6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.
7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.
8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

Engagement, Continuous Improvement, and Accountability:

9. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.
10. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.
11. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.
12. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.
13. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.
14. Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.
15. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.

Cultural Competence Training Opportunities through the MHP

- Cultural Competence Trainings are available through the County Knowledge Center (TKC) for County operated program staff at no cost and for a small number of providers on a fee basis.

- Cultural Competence Trainings are available through some of SDCBHS's larger contractors. Community Research Foundation, New Alternatives, and Mental Health Systems, Inc. offer such trainings to their own program staff, but other providers may send staff on a fee basis.
- SDCBHS Contracted Trainings are available through the Responsive Integrated Health Solutions (RHIS). Limited classroom training and on-line trainings are available at no cost to staff of County contracted and County operated programs. RHIS also offers a one-hour eLearning on the implementation of CLAS Standards.

Cultural Competence Monitoring and Evaluation:

The MHP QI Unit and the CORs are responsible for monitoring and evaluating compliance with cultural competence standards as outlined in the County's Cultural Competence Plan and with State and Federal requirements. The QM Unit and the CORs utilize both the medical record review and the annual Contract Review to monitor providers regarding cultural competence. In addition, provision of/usage of the tools listed below is now cultural competence requirement:

Program Level Requirements:

1. Cultural Competence Plan (CC Plan). CC Plans are required for all legal entities. If your organization does not have a CC Plan, the CC Plan Component Guidelines outlined below may be used to assist you in developing a CC Plan. They are available in the Cultural Competence Handbook (pages 12-13) on the Technical Resource Library (TRL) website at: http://www.sandiegocounty.gov/hhsa/programs/bhs/technical_resource_library.html The CC Plan Component Guidelines are as follows:

   - Current Status of Program
     - Document how the mission statements, guiding principles, and policies and procedures support trauma-informed cultural competence.
     - Identify how program administration prioritizes cultural competence in the delivery of services.
     - Agency training, supervision, and coaching incorporate trauma-informed systems and service components.
     - Goals accomplished regarding reducing health care disparities.
     - Identify barriers to quality improvement.
   - Service Assessment Update and Data Analysis
     - Assessment of ethnic, racial, linguistic, and cultural strengths and needs of the community.
     - Comparison of staff to diversity in community.
     - A universal awareness of trauma is held within Agency. Trauma is discussed and assessed when needed and relevant to client/target population needs.

- Use of interpreter services.
- Service utilization by ethnicity, race, language usage, and cultural groups.
- Client outcomes are meaningful to client's social ecological needs.

➢ Objectives
- Goals for improvements.
- Develop processes to assure cultural competence (language, culture, training, and surveys) is developed in systems and practiced in service delivery.
  - Trauma-informed principles and concepts integrated
  - Faith-based services

New contractors need to submit a CC Plan, as specified in their Statement of Work, unless their legal entity has already provided one. As new programs are added, legal entities are expected to address their unique needs in the CC Plan.

Plans should be sent via email to BHS-HPA.HHSA@sdcounty.ca.gov.

2. Annual Program Evaluation – every year, program managers are required to complete a cultural competence assessment of each program, using the tool which will be provided by SDCBHS electronically to each program manager. Every program manager is provided three weeks to complete the survey. The survey can be completed in approximately one hour or less. The tool is available in the CC Handbook on TRL for reference.

3. In order to present a welcoming appearance to unique communities, providers are required to ensure that their facility is comfortable and inviting to the area's special cultural and linguistic populations. Program hours of operation must be convenient to accommodate the special needs of the service's diverse populations.

Staffing Level Requirements

Biennial Staff Evaluation – every two years, staff members of the County-contracted and County-operated behavioral health programs are required to self-assess their cultural competence in providing behavioral health services. The staff are provided two weeks to complete the survey. The tool is available in the CC Handbook on TRL for reference.

A Minimum of 4 hours of Cultural Competence Training Annually. Contractors shall require that, at a minimum, all provider staff, including consultants and support staff interacting with clients or anyone who provides interpreter services must participate in at least four (4) hours of cultural competence training per year. Training may include attending lectures, written coursework, a review of published articles, web training, viewed videos, or attending a conference can count the amount of time devoted to cultural competence enhancement. A record of annual minimum four

hours of training shall be maintained on the Monthly Status Report. The following conditions also apply:

a. All new staff have one year to complete the 4 hours of cultural comp training.
b. Staff hired after May 15 are exempt from the requirement for that fiscal year but must meet requirement "a".
c. Volunteers who have served or are expected to serve 100 or more hours at the program must meet the requirement.

***Consumer Preference – Cultural/Ethnic Requirements**:*
Consumers must be given an initial choice of the person who will provide specialty mental health services, including the right to use culturally specific providers. Providers are also reminded that whenever feasible and at the request of the beneficiary, clients have the right to request a change of providers. Requests for transfers are to be tracked on the Suggestion and Transfer section attached to the Quarterly Status Report.

***Consumer Preference – Language Requirements**:*
Services should be provided in the client's preferred language. Providers are required to inform individuals with limited English proficiency in a language they understand that they have a right to free interpreter services. There shall not be the expectation that family members provide interpreter services, including the use of minor children. A consumer may still choose to use a family member or friend as an interpreter, only after first being informed of the availability of free interpreter services. The offer of interpreter services and the client's response must be documented.

Progress notes shall indicate when services are provided in a language other than English. Providers are also reminded that, whenever feasible and at the request of the beneficiary, consumers must be given an initial choice of or the ability to change the person who will provide specialty mental health services, including the right to use linguistically specific providers.

Some county and contracted programs are Mandated Key Points of Contact. As a Mandated Key Point of Contact, the program must have staff or interpretation available to clients during regular operating hours that are linguistically proficient in the mandated threshold languages. The Access and Crisis Line, the EPU, and the ESU are Mandated Key Points of Entry for all threshold languages. In addition, the following clinics are also designated as Mandated Key Points of Entry for the languages listed:

- Spanish
  - EPU
  - All Outpatient and Case Management programs
- Vietnamese
  - UPAC
- Tagalog
  - UPAC

- Arabic
    - East County Mental Health

All other County and Contracted providers must at a minimum be able to link clients with appropriate services that meet the client's language needs whether the language is a threshold language or not.

Additional Recommended Program Practices

Programs will also be encouraged to do the following:

- If there is no process currently in place, develop a process to evaluate the linguistic competency of staff that is providing service or interpretation during services, in a language other than English. This may be accomplished through a test, supervision or some other reliable method. The process should be documented. A suggested process for certification of language competence can be found on page 51 of the CC Handbook on TRL.

- Conduct a survey or client focus group every couple of years and include clients who are bi-lingual and monolingual to assess program and staff cultural competence, community needs and the success of efforts the program is making to meet those needs. Suggestions surveys and discussion questions are available on pages 53, 57, and 59 of the CC Handbook on TRL.