REVISED ADDENDUM 4/2002
REQUIRED COMPONENTS FOR IMPLEMENTATION PLAN
Consolidation of Specialty Mental Health Services (Phase II)

PLAN FOR CULTURALLY COMPETENT SPECIALTY MENTAL HEALTH SERVICES

INTRODUCTION

Purpose

The purpose of this addendum is to establish standards and plan requirements for Mental Health Plans (MHP) in achieving cultural and linguistic competency under consolidation of specialty mental health services (Phase II). Each MHP is required to develop a Cultural Competence Plan (CCP) consistent with these standards and requirements. The intent in issuing these standards and requirements is to assist MHPs in creating a more responsive and accessible system for Medi-Cal beneficiaries for the delivery of quality and cost-effective specialty mental health services.

Background

In a state where the demographics have changed significantly over the last decade, meeting the demand for cultural and linguistic services is important. The Department of Mental Health (DMH) focused efforts to meet the specialty mental health needs of culturally, ethnically and linguistically diverse communities through the establishment of a Cultural Competence Task Force (CCTF) in November 1996. The CCTF was asked to provide ongoing advice on issues of cultural and linguistic competence in the delivery of specialty mental health services. To begin, the CCTF was asked to provide advice on the development of plan requirements and the adoption of related regulations for the consolidation of Medi-Cal specialty mental health services. The standards and plan requirements reflected in this document are the result of that effort.

The CCP requirements are being issued as an addendum to the Required Components for Implementation Plans for Consolidation of Specialty Mental Health Services (Phase II).

Cultural Competence Plans were due July 1998 and reviewed September 1998. Feedback was provided to MHPs and in 1998 the Cultural Competence Plan Requirements (CCPR) were incorporated into the annual review protocol.

In September 1999 the CCTF was renamed the Cultural Competence Advisory Committee (CCAC) (Attachment B) to reflect the ongoing importance of this work. It is an advisory body to the State Department of Mental Health.

Statement of Philosophy and Future Direction

There is recognition by the DMH, the California Mental Health Directors Association (CMHDA), and the CCAC that cultural competence is a goal toward which professionals, agencies and systems should strive. Becoming culturally competent is a developmental process and incorporates – at all levels – the importance of culture, the assessment of cross-cultural relations, vigilance towards the dynamics that result from cultural differences, the expansion of cultural knowledge, and the adaptation of services to meet culturally-unique needs. The provision of medically necessary specialty mental health services in a culturally competent manner is fundamental in any effort to ensure access and delivery of appropriate services to Medi-Cal beneficiaries. It is also essential to the provision of high quality and cost-effective specialty mental health services. Providing services in a manner that fails to achieve its intended result due to cultural and linguistic barriers is not cost effective.

Future CCP requirements will evolve as more experience through plan development and implementation progresses. While efforts are being made on an ongoing basis to achieve cultural competence, as our competence improves, our standards will need to improve. Therefore, it is expected that the next steps will include: ensuring that the newly developed standards are clearly defined and applied consistently statewide; providing technical assistance in the development of strategic plans to achieve standards; and developing related systems oversight and monitoring processes. It is also expected that these basic standards will be modified in the future as we gain experience with consolidated specialty mental health services and competence advances.

Definitions

There are many definitions of cultural competence and related terminology. The DMH has adopted, and offers the following definitions for the purpose of establishing a framework for the CCP requirements:

Access – availability of medically necessary managed care specialty mental health services to Medi-Cal beneficiaries who need them in a manner that promotes, provides the opportunity for, and facilitates their use. This access, by treatment setting is indicated by penetration rates by age, gender, ethnicity and diagnostic category that are reflective of the Medi-Cal beneficiary population.

Client Culture – Mental health clients bring a set of values, beliefs and lifestyles that are molded, in part, by their personal experiences with a mental illness, the mental health system and their own ethnic culture. When these personal experiences are shared, mental health clients can be better understood and be empowered to effect positive system change.

Competence – acquisition of knowledge, skills, and experience necessary for the development and implementation of mental health interventions adaptive to the different groups served (Cross et al, 1989. Towards a Culturally Competent System of Care: A Monograph on Effective Services for Minority Children who are Severely Emotionally Disturbed Volume I).

Culture – the integrated pattern of human behavior that includes thought communication, actions, customs, beliefs, values and institutions of a racial, ethnic, religious or social group. Culture defines the preferred ways for meeting needs (Cross et al, 1989). A particular individual's cultural identity may involve the following parameters among others: ethnicity, race, language, age, country of origin, acculturation, gender, socioeconomic class, disabilities, religious/spiritual beliefs and sexual orientation.

Cultural Competence – a set of congruent practice skills, knowledge, behaviors, attitudes, and policies that come together in a system, agency, or among consumer providers and professionals that enables that system, agency, or those professionals and consumer providers to work effectively in cross-cultural situations. (Adapted from Cross et al, 1989).

Culturally Competent Mental Health Agency – an agency that acknowledges and incorporates at all levels the importance of culture, the assessment of cross-cultural relations,

vigilance towards the dynamics that result from cultural differences, the expansion of cultural knowledge, and the adaptation of services to meet culturally-unique needs.

Culture-Specific Community Providers – agencies, individuals within agencies, or individuals that demonstrate experience providing culturally competent specialty mental health services to Medi-Cal beneficiaries with specific cultural and linguistic needs.

Key Points of Contact – (Mandate/Non-mandated) – common points of access to specialty mental health services from the MHP, including, but not limited to, the MHP's beneficiary problem resolution process, county owned or operated or contract hospitals, and any other central access locations established by the MHP."

Linguistically Proficient – persons who meet the level of proficiency in the threshold languages as determined by the MHP.

Mandated Key Points of Contact – common points of entry into the mental health system, including 24-hour toll free line, beneficiary problem resolution system, inpatient hospital or other central access or contact locations where there is face-to-face encounters with consumers as designated by MHPs, that are located in regions or areas that meet threshold language population concentrations.

Medi-Cal Beneficiaries – any person certified as eligible under the Medi-Cal program according to Title 22, Section 51001.

Medi-Cal Mental Health Client – a Medi-Cal beneficiary who has received a Medi-Cal specialty mental health service within a specified time period (one-year).

Non-Mandated Key Points of Contact – common points of entry into the mental health system, including 24-hour toll free line, beneficiary problem resolution system, inpatient hospital or other central access or contact locations designated by MHPs, that are located in regions or areas that do not meet threshold language population concentrations.

Penetration Rate – the total number of persons served divided by the number of persons eligible.

Primary Language – that language, including sign language, which must be used by the beneficiary to communicate effectively and which is so identified by the beneficiary.

Retention Rate – the percent of new clients who receive 2,3,4, etc. follow-up day or outpatient services following an initial non-crisis contact with the mental health system. This measures the rate at which new clients in general are retained in the system for treatment.

Specialty Mental Health Services – includes the following: rehabilitative mental health services, psychiatric inpatient hospital services, targeted case management, psychiatrist services, psychologist services, and Early and Periodic Screening, Diagnosis and Treatment (EPSDT) supplemental services.

Threshold Language – the annual numeric identification on a countywide basis, of 3,000 beneficiaries or five (5) percent of the Medi-Cal beneficiary population, whichever is lower, whose primary language is other than English, for whom information and services shall be provided in their primary language.

Current State Statutory Provisions Related to Cultural and Linguistic Competence

There are several provisions within current federal and state statutes, regulations and DMH policy letters related to cultural competence in the delivery of specialty mental health services that are referenced in Attachment A. These provisions are separate and supplemental to other federal or state laws that prohibit discrimination based on race, color or national origin and disabilities.

The DMH specific provisions that guided the development of these cultural competence plan requirements are as follows:

State Statute

Welfare and Institutions Code (WIC) 14684 (h) – "Each plan shall provide for culturally competent and age-appropriate services, to the extent feasible. The plan shall assess the cultural competence needs of the program. The plan shall include, as part of the quality assurance program required by Section 4070, a process to accommodate the significant needs with reasonable timelines. The department shall provide demographic data and technical assistance. Performance outcome measures shall include a reliable method of measuring and reporting the extent to which services are culturally competent and age-appropriate."

Federal Statute Executive Orders

Title VI of the Civil Rights Act of 1964, U.S. Code 2000-d (Code of Federal Regulations, Part 21: the Std. Title VI).

Sec. 2000 d. – "No person in the United States shall on the ground of race, color, or national origin be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance."

As pertains to language access: Title VI of the Civil Rights Act prohibits recipients of federal funds from providing services to limited English proficient (LEP) persons that are limited in scope or lower in quality than those provided to others. An individual's participation in a federally funded program or activity may not be limited on the basis of LEP. Since Medi-Cal is partially funded by federal funds, **all** MHPs must ensure that all Medi-Cal LEP members have equal access to all mental health care.

Executive Order 13160 of June 23, 2000. Nondiscrimination on the Basis of Race, Sex, Color, National Origin, Disability, Religion, Age, Sexual Orientation, and Status as a Parent in Federally Conducted Education and Training Programs. To ensure that persons with limited English skills can effectively access critical health and social services, the Office of Civil Rights (OCR) published policy guidance which outlines the responsibilities under federal law of health and social services providers who receive Federal financial assistance from HHS to assist people with limited English skills.

As pertains to language assistance to persons with limited English proficiency (LEP). The guidance explains the basic legal requirements of Title VI of the Civil Rights Act of 1964 (Title VI) and explains what recipients of Federal financial assistance can do to comply with the law. The guidance contains information about best practices and explains how OCR handles complaints and enforces the law.

PLAN REQUIREMENTS

By June 30th of each year: Title 9, CA Code of Regulations, Chapter 11, Medi-Cal Specialty MHS, Article 4., 1810.410 (c); each Mental Health Plan (MHP) shall submit an annual CCP update consistent with the requirements of this revised CCP document, consistent with the plan reporting requirements, including the population assessment and organizational and service provider assessments.

OVERVIEW

The intent of the CCP requirements is to establish a statewide process and common framework for the developmental process of achieving cultural competence in the provision of services under the consolidation of Medi-Cal specialty mental health services. The plan requirements that follow relate to the completion of a population assessment and an organizational and service provider assessment. This includes contract agencies and individual providers. These are considered the first steps in determining delivery system needs and form the basis for the next step of developing a strategic plan to achieve cultural competence. A successful response to these plan requirements will include the completion of the needs assessments (Part I and II),

identification of measurable objectives to move toward cultural competency, and compliance with those indicators or measures within the timeframes specified in the next section titled Standards.

PART I - POPULATION ASSESSMENT

An important element in developing an effective delivery system under the consolidation of specialty mental health services is to understand the demographic composition of the population to be served. MHPs shall assess the demographic make-up and population trends of their service area, as well as the demographic characteristics of the Medi-Cal beneficiary population and the current users of mental health services. A population assessment to identify the cultural and linguistic needs of the eligible beneficiary population is critical to designing and planning for the provision of appropriate and effective specialty mental health services. The CCP shall include a population assessment that addresses at least the following components.

(Note: The regions for reporting are the regions or areas that are used by the MHP to subdivide the county for planning and service delivery.)

A. County Geographic and Socio-Economic Profile

Requirement: An annual description of the county geographic and socioeconomic profile. Specifically, the profile shall include the following:

1. Geographical location and attributes of the county and by region, including:

    a) main urban and rural centers;
    b) terrain and distances; and
    c) main transportation routes and availability of public transportation.

2. Socioeconomic characteristics of the county and by region, including

   a) primary economic support;
   b) average income levels;
   c) welfare caseload; and
   d) employment data.

3. Other relevant county or regional characteristics of interest.

Data Sources: The County Planning Office should be able to provide this general description. In addition, the State Department of Finance sends population data from the United States Census to County Planning Offices.

B. Demographics (by ethnicity, age and gender, and primary language spoken)

Requirement: An annual comparative description of the demographic characteristics of both the general population and the Medi-Cal beneficiary population for the county, including appropriate displays of data. Specifically, the demographic profile shall include at least data on ethnicity, age and gender, and primary language spoken, by the following population groupings:

1. General population in county;

2. General population in county by region;

3. Most recent available number of Medi-Cal beneficiaries in county;

4. Most recent available number of Medi-Cal beneficiaries in county by region; and

5. Seasonal migrants who are Medi-Cal beneficiaries in the county by region (estimate number if available and appropriate.)

Data Sources (listed by number corresponding to the above): (1) DMH will provide age and gender data annually, and data on primary language spoken from the most current Decennial Census. Annual ethnicity data will be provided. More detailed ethnicity data may be available from County Planning Offices; (2) if the regions used by the MHP are unique to mental health, special reports may need to be developed by the County Planning Office or the MHP; and (3) DMH has provided the number of Medi-Cal beneficiaries based on the annual MEDS file data.

C. Utilization of Medi-Cal Specialty Mental Health Services (by ethnicity, age and gender, diagnosis and primary language spoken):

Requirement: An annual description of the demographic characteristics of the Medi-Cal mental health consumer population (defined as persons using Medi-Cal specialty mental health services in both the Inpatient Consolidation (IPC) and Short-Doyle/Medi-Cal (SD/MC) systems) using the most recent available data, including appropriate displays of data. The utilization profile shall include at least data on ethnicity, age and gender, diagnosis, and primary language spoken, by the following service category groupings:

1. Most recent available number of Medi-Cal beneficiaries using medically necessary specialty mental health services in the county (FFS and SD/MC) arrayed by one of the following service category groupings:

    a) Medi-Cal Beneficiaries
    b) All Services (clients)
        1) Inpatient
        2) Crisis
        3) Outpatient
        4) Day Treatment/Residential

2. Most recent available number of Medi-Cal beneficiaries using medically necessary specialty mental health services by county region (FFS and SD/MC) arrayed by one of the following service category groupings:

    a) Medi-Cal Beneficiaries
    b) All Services (clients)
        1) Inpatient
        2) Crisis
        3) Outpatient
        4) Day Treatment/Residential

Data Sources: DMH will provide summary data for each MHP to complete their annual Cultural Competency Plan Requirement Population Assessment Updates. This data will be provided by county of beneficiaries. In addition, MHP's may use data from the MEDS file, Inpatient Consolidation data, Claims File and Short/Doyle Medi-Cal (SD/MC) approved Claims files.

Please Contact Terry MacRae, Research Analyst, Statistics and Data Analysis, at (916) 653-5826 with any questions about the summary data.

D. Analysis

Requirement: An annual analysis of the population assessment data and conclusions drawn by the MHP in terms of designing and planning for the provision of appropriate and effective specialty mental health services. The analysis can include:

- access for specific groups by mode of service and age group
- comparison of disparities by ethnic group along service types
- discrepancies and utilization by mode of service

Specifically, identify any objectives related to the need for, and the provision of, culturally and linguistically competent services based on the population assessment, the identified threshold languages and the disparities or discrepancies in access and service delivery. The objectives shall be measurable and include specified activities to meet objectives, required resources and identified timelines. (Note: objectives may be listed together under Part II.)

PART II - ORGANIZATIONAL AND SERVICE PROVIDER ASSESSMENT

An organizational and service provider assessment is necessary to determine the readiness of the service delivery system to meet the cultural and linguistic needs of the Medi-Cal beneficiary population to be served under consolidation of specialty mental health services. Medi-Cal beneficiaries from culturally, ethnically and linguistically diverse backgrounds frequently require different and individual mental health service system responses. MHPs will need to determine their capacity to provide services to meet the potentially diverse needs of the Medi-Cal beneficiaries to be served. An organizational and service provider assessment shall identify current levels of cultural and linguistic competence as well as future staff and program development needs. The CCP shall include an organizational and service provider assessment that addresses at least the following components.

(Note: the regions for reporting are the regions or areas that are used by the MHP to subdivide the county for planning and service delivery.)

A. Overall MHP Policy and Administrative Direction

Requirement: A description of the MHPs policies and administrative practices that reflect the cultural, ethnic and linguistic diversity of the Medi-Cal beneficiary population to be served under consolidation of specialty mental health services, including the following:

1. Policies and procedures that reflect (or any plans to reflect) steps taken to institutionalize the recognition and value of cultural diversity within the MHP. For example, the importance of providing culturally and linguistically competent specialty mental health services shall be reflected in:

    a) mission statement;
    b) statements of philosophy;
    c) strategic plans;
    d) policy and procedure manuals;
    e) human resource training and recruitment policies;
    f) specialty mental health contract requirements; or
    g) other key documents.

2. Practices that reflect (or any plans to reflect) recognition and value of cultural, ethnic and linguistic diversity within the MHP in terms of the solicitation of diverse input to mental health planning and services, such as:

    a) relationship with and involvement of cultural, ethnic and linguistic diverse Medi-Cal beneficiaries, family members, advisory committees, local boards and commissions and community organizations in MHP planning for services, or
    b) working on skills development and strengthening of community organizations involved in providing essential services.

3. The process used or planned in the development of the CCP for consolidation of specialty mental health services. Note: it is recognized that many MHPs have already begun the developmental process to attain cultural competence. Therefore,

4. The response may include efforts at the policy and administrative level that already have taken place, are underway, or are planned in the development of a CCP. For example, MHPs shall address the following:

   a) expected involvement at various organizational levels, or
   b) plans for review of the CCP at all level within the organization.

B. Human Resources

Current Composition:

Requirement: A description of the overall composition of county mental health staff and current contract service providers, i.e., Short-Doyle contractors and other current contractors. (Note: information for new providers is requested under Part III, with a later submission date.) The description shall use unduplicated, full-time equivalents with data displayed as follows:

1. Ethnicity By Function:

   a) Administration/management;
   b) Direct services;
   c) Support services; and
   d) Interpreters.

2. Bilingual Staff By Function and Language:

   a) Administration/management;
   b) Direct services;
   c) Support services; and
   d) Interpreters.

3. Staff Proficiency in Reading and/or Writing in a Language Other Than English By Function and Language:

   a) Administration/management;
   b) Direct services;
   c) Support services; and
   d) Interpreters.

Location:

Requirement: Identification of the location of county mental health staff and current contract services providers, i.e., Short-Doyle contractors and other current contractors, by region. (Note: information for new providers is requested under Part III, with a later submission date.) The description shall use data displayed as follows:

1. Ethnicity By Function:

    a) Administration/management (related to contract services);
    b) Direct services;
    c) Support services; and
    d) Interpreters.

2. Bilingual Staff By Function and Language:

    a) Administration/management (related to contract services);
    b) Direct services;
    c) Support services; and
    d) Interpreters.

3. Staff Proficient in Reading and/or Writing in a Language Other Than English By Function:

    a) Administration/management (related to contract services);
    b) Direct services;
    c) Support services; and
    d) Interpreters.

Analysis:

Requirement: An annual analysis of the human resources composition by location data in contrast to the population needs assessment date for each population category, and conclusions drawn by the MHP in terms of designing and planning for the provision of appropriate and effective specialty mental health services.

- Identify any objectives related to the need for, and the provision of, culturally and linguistically competent services based on the population and human resources assessment.
- Identify any disparities between the Medi-Cal beneficiary population and the cultural, ethnic and linguistic diversity of the MHP's direct service providers.
- Compare the percentages of culturally, ethnically and linguistically diverse direct service providers to the same characteristics of the Medi-Cal beneficiary population. Any identified disparity must be addressed in the Cultural Competence Plan.

C. Quality of Care: Competency

Requirement: A description of how the MHP evaluates or plans to evaluate the abilities of staff and contract providers in providing culturally and linguistically competent services under the consolidation of specialty mental health services. (Note: A broad definition of staff is used and includes consumers and family members who are paid or volunteers providing specialty mental health services within the service delivery system.) The description shall address the following areas:

1. Client Culture. How the MHP incorporates within its staff and contractor competency training and evaluation plans, the culture of being a mental health client including the experience of having a mental illness and of the mental health system.

Note: the following explanation is offered to assist MHPs in understanding the issue to be addressed here. Cultural competence incorporates a set of values, experiences, and skills that practitioners are expected to attain to provide medically necessary specialty mental health services to Medi-Cal beneficiaries under Phase II Consolidation in a culturally competent manner. Training efforts should be concentrated in providing practitioners with cultural competence skills and an understanding of how the consumer, their mental illness, their experience with the mental health system and the stigma of mental illness have impacted the consumer. Consumers bring a set of values, beliefs and lifestyles that are molded as a result of their personal experiences with a mental illness, the mental health system and their own ethnic culture. These personal experiences and beliefs can be used to empower consumers to become involved in self-help programs, peer advocacy and support, education, collaboration and partnership in system change, alternative mental health services, and in seeking employment in the mental health system.

2. Consumers of Mental Health Services. The percentage of staff who have voluntarily self-identified as consumers of specialty mental health services, by ethnicity, by function, and region.

3. Competency Evaluation. The current or planned process for evaluating staff and contractor knowledge and ability to provide culturally competent specialty mental health services.

4. Selection of Contract Providers. How a contractor's ability to provide culturally competent specialty mental health services is taken into account in the selection of contract providers, including:

   a) identification of any cultural competence conditions in contracts with mental health providers.

5. Recruitment and Retention. The current or planned efforts to recruit and retain culturally competent staff and contract providers reflective of the population receiving services.

6. Training in Cultural Competence. The past (within the last three years), current or planned cultural competency training for mental health staff and contract providers.

7. Certification or Credentialing Processes. The process(es) used or planned to certify, credential or otherwise ensure staff proficiency in issues of cultural competence, including the provision of culture-specific services to Medi-Cal beneficiaries.

D. Quality Assurance

Requirement: A description of current or planned processes to assess the quality of care provided for all consumers (including ethnic consumers) under the consolidation of specialty mental health services. The focus is on the added or unique measures that shall be used or planned in order to accurately determine the outcome of services to consumers from diverse cultures including, but not limited to, the following:

1. Outcome Measures. Identification of any consumer outcome measures used by the MHP that are culture specific;

2. Staff Satisfaction. A description of methods, if any, used to measure staff experiences or opinion regarding the organization's ability to value cultural diversity in its workforce and culturally and linguistically competent services; and

3. Grievances and Complaints. A description of how Medi-Cal beneficiary grievance and complaint data is analyzed and any comparisons rates between the general beneficiary population and ethnic beneficiaries.

STANDARDS

This document establishes three **standards** for cultural and linguistic competence. The three standards address access, quality of care, and quality management. Each standard is followed by several **indicators** of performance that describe what shall happen and by when. While the indicators are not intended to be all-inclusive, they do represent key components that are likely to contribute to attainment of each standard. Subsequently, each indicator is followed by **measures** that describe how compliance with indicators will be determined.

Consistent with the philosophy that attaining cultural and linguistic competence is an ongoing, developmental process, there are some indicators that are required to be in place on the day that MHPs begin operation under Phase II consolidation. There are other indicators, however, that will require additional time for development and implementation. MHPs are expected to address each indicator that is required to be in place in their Cultural Competence Plan. MHPs are expected to begin to operationalize plans to meet the standards and remaining indicators.

I. ACCESS

Standard:

MHPs shall demonstrate evidence that medically necessary cultural and linguistic services are accessible under the consolidation of Medi-Cal specialty mental health services.

B. Language Accessibility

Indicators:

1. MHPs have a 24-hour phone line with statewide toll-free access that has linguistic capability, including TDD or California Relay Service, for all Medi-Cal beneficiaries. (Note: The use of the language line is viewed as acceptable in the provision of services only when other options are unavailable.)

Measure:

a. Evidence of operation of a 24-hour phone line with statewide toll free access that has language, including TDD or California Relay Service, capabilities for all Medi-Cal beneficiaries.

2. MHPs have identified populations meeting the threshold language requirement of 3,000 beneficiaries, or five (5) percent, of the Medi-Cal beneficiary population, whichever is lower, and whose primary language is other than English (Note: DMH will continue to provide threshold language data on an annual basis.)

Measure:

a. Identification in the Cultural Competence Plan Update of threshold languages for the MHPs total service area, which is defined as the county.

3. MHPs have policies and procedures for meeting consumer language needs.

Measures:

a. Documented evidence of policies and procedures for meeting consumer language needs that Limited English Proficient (LEP) individuals have meaningful access to mental health program.

b. Documented evidence of training interpreters about mental health.

c. Documented evidence of training staff in the use of mental health interpreters.

4. MHPs have at least interpreters available for the threshold languages at mandated key points of contact. (Note: The use of the language line is viewed as acceptable in the provision of services only when other options are unavailable.)

Measures:

a. Evidence that LEP individuals should be informed in a language they understand that they have a right to free language assistance services.

b. Evidence of at least interpreters for the threshold languages.

c. Documented evidence that mental health interpreter services are offered to consumers and the response to the offer is recorded.

d. Evidence of, providing contract or agency staff who are linguistically proficient in threshold languages during regular day operating hours.

e. Document what services are available for Medi-Cal beneficiaries in their primary language.

5. MHPs have policies and procedures for meeting language needs for consumers who do not meet threshold language criteria.

Measures:

a. Documented evidence of policies and procedures for meeting the needs of consumers who do not meet threshold language criteria.

b. Evidence that LEP individuals should be informed in a language they understand that they have a right to free language assistance services.

6. MHPs have policies and procedures that show evidence of the capability to refer and otherwise link Medi-Cal beneficiaries who do not meet the threshold language criteria LEP individuals who encounter the mental health system at all key points of contact, with culturally and linguistically appropriate services.

Measures:

a. Documented evidence that Medi-Cal beneficiaries who do not meet the threshold language criteria are assisted to secure or linked to culturally and linguistically appropriate services.

b. Document the progressive steps to assist Medi-Cal beneficiaries to obtain services in their primary language, i.e., if culturally and linguistically proficient staff or interpreters are unavailable.

c. Existences of policies that comply with Title VI (Civil Rights Act) requirements prohibiting the expectation that family members provide interpreter services. A consumer may choose to use a family member or friend as an interpreter after being informed of the availability of free interpreter services. (It is strongly recommended that minor children should not be used as interpreters).

B. Written Materials Should Be Available and Understandable

Indicators:

1. MHPs have available culturally and linguistically appropriate written information for identified threshold languages that assist Medi-Cal beneficiaries in accessing medically necessary specialty mental health services.

Measure:

a. Demonstrate the availability in threshold languages of general program literature used by the MHP to assist Medi-Cal beneficiaries access medically necessary specialty mental health services. The literature shall be at the literacy level as determined by field-testing to reflect the population to be served. General program literature includes but is not limited to:

- member service handbook or brochure
- general correspondence
- beneficiary problem resolution, grievance and fair hearing materials
- beneficiary satisfaction surveys

- informed consent for medication
- confidentiality and release of information form
- service orientation for clients
- mental health education materials.

2. Personal correspondence must be in the primary language of the client.

Measure:

a. Documented evidence in the clinical chart that personal correspondence is in the client's primary language.

3. MHPs have field-tested the written information specified under #1 above.

Measure:

a. Evidence of field testing of the specified information and appropriate modification of the materials as indicated by the field test(s).

4. MHPs have policies and procedures for the utilization and distribution of translated materials that assure availability to Medi-Cal beneficiaries.

Measure:

a. Evidence of policies and procedures to appropriately distribute and utilize translated materials.

5. The MHPs have completed a consumer satisfaction survey in the threshold language(s).

Measure:

a. At least 75 percent of Medi-Cal mental health clients responding to consumer satisfaction surveys shall indicate that they had access to written information in their primary language.

C. Responsiveness of Specialty Mental Health Services

Indicators:

1. MHPs have available, as appropriate or feasible, alternatives and options that accommodate individual preference and cultural and linguistic differences.

Measures:

a. Identify and develop a listing of available alternatives and options for cultural/linguistic services that shall be provided to the consumers upon request.

b. MHPs will inform beneficiaries of the availability of this listing in their member services handbook or brochure. If it is not already in the member services handbook or brochure, the MHP will include it in their next printing or within one year.

2. MHPs have available, as appropriate or feasible, program options in the system that include culture-specific MHP and community providers and programs.

Measures:

a. Evidence that the MHP is making efforts to include additional culture-specific community providers and services in the range of programs offered by the MHP.

3. MHPs have policies, procedures and practices to inform all Medi-Cal beneficiaries of available services under consolidation of specialty mental health services. (Outreach requirements as per Section 1810.310, 1A and 2B, Title 9)

Measures:

a. Evidence of community information and education plans or policies that enable Medi-Cal beneficiaries to access specialty mental health services.

b. Evidence of outreach for informing under-served populations regarding the availability of cultural and linguistic services and programs e.g., number of community presentations and/or forums used to disseminate information about specialty mental health services, etc.

4. MHPs have assessed factors and developed plans and evidence of implementation of these plans to facilitate the ease with which culturally and linguistically diverse populations can obtain services. Such factors should include:

- location, transportation, hours of operation or other relevant areas;
- adapting physical facilities to be comfortable and inviting to persons of diverse cultural backgrounds; i.e., posters, magazines, décor, signs; and
- locating facilities in settings that are non-threatening, including co-location of services and /or partnerships with community groups.

Measures:

a. Evidence of a study or analysis of the above factors.

b. Evidence that the MHPs program is adjusted and the plan is implemented based upon the findings of their study or analysis.

II. QUALITY OF CARE

Standard:

To ensure that accurate and appropriate clinical decisions are made relative to the consumers' concerns and that appropriate treatment and referral decisions are the result.

A. Consumer and Family Role in Service Development

Indicator:

1. MHPs have policies; procedures and practices that ensure that all consumers participate in the development of their medically necessary specialty mental health treatment services. Parents, family members and other advocates can be included in this process as selected by the adult consumer.

Measures:

a. Evidence of policies, procedures and practices that assure the involvement of consumers and families in mental health treatment services.

b. Clinical records will indicate consumers and/or family involvement, by ethnicity and primary language.

B. Competent Evaluation, Diagnosis, Treatment and Referral Services

Indicators:

1. MHPs have policies and procedures that contain requirements to assure that culturally and linguistically competent medically necessary services are available to meet the needs identified in the MHPs Population Assessment and Organizational and Service Provider Assessment.

Measures:

a. Evidence that MHP policies and procedures are present and contain language to assure those culturally and linguistically competent services are available.

b. MHP contracts for services will ensure representation of cultural and linguistic providers as available.

2. MHPs have policies, procedures and practices to assure that consumer requests to use culture-specific community providers, who are credentialed as network providers to render medically necessary specialty mental health services that are reimbursable under Medi-Cal, will be honored when feasible.

Measures:

a. Documented evidence that identifies consumer requests for culture-specific community providers, number actually referred to such providers, and the number receiving services from the available culture-specific community providers.

b. When appropriate, clinical records indicate culturally sensitive methods (DSM IV cultural formulation, acculturation scales, ethno-psychopharmacology, etc…) are used in the diagnosis, evaluation/assessment, treatment and referral process.

3. MHPs have a process to certify or otherwise ensure that all staff is able to provide culturally and linguistically competent medically necessary specialty mental health services for Medi-Cal beneficiaries under consolidation of specialty mental health services.

Measures:

a. Evidence that MHPs are working toward a process to evaluate the competencies of staff in providing culturally and linguistically competent specialty mental health services.

b. Evidence that MHPs are assessing staff training needs and providing training in evaluation, diagnosis, treatment and referral services for the multicultural groups in their service area.

c. Implementation of training programs to improve the cultural competence skills of all staffs and contract providers.

4. MHPs have a process to certify or otherwise assure the demonstrated ability of bilingual staff or interpreters to address the following cultural competency issues:

- Ability to communicate the ideas, concerns, and rationales, in addition to the translation of the words used by both the provider and consumer.
- Familiarity with the client's culture and degree of proficiency in the consumer's spoken, as well as non-verbal, communication.
- Familiarity with divergent world views and variant beliefs concerning the definition, presentation and clusters of symptoms, causal explanations and treatment of mental illness, as well as the risk that deviant behavior presents to the indigenous community.

Measures:

a. Implementation of training programs to improve the cultural competent skills of all staff and contract providers.

5. Evidence of trained staff and interpreters who are linguistically proficient in threshold languages.

Measures:

a. Existence of, or plans for evaluating the linguistic proficiency and training of staff and interpreters.

C. Competence in Client Culture

Indicators:

1. MHPs must have a process for the incorporation of client culture throughout the mental health system.

Measures:

a. Evidence of an annual training on client culture that includes a client's personal experience with:

- diagnosis/labeling
- medication
- hospitalization
- societal/familial stigma
- economic impact
- housing
- feeling different
- trauma
- culturally and linguistically incompetent services
- forced treatment

b. The training plan must also include, for children and adolescents, the parent and/or caretaker's personal experiences with:

- family focused treatment
- navigating multiple agency services

III. QUALITY MANAGEMENT

Standard:

To assess the access, appropriateness and capacity of services delivered by the MHP under the consolidation of Medi-Cal specialty mental health services.

A. Penetration/Retention

Indicator:

1. Persons of diverse ethnic background access the service system in numbers consistent with their representation in the Medi-Cal beneficiary population and relevant incidence and prevalence data. (Note: DMH will continue to provide penetration and retention data to facilitate compliance with these requirements.)

Measures:

a. Track penetration and retention rates by ethnic group.

b. Compare these rates across ethnic groups.

c. Compare these rates of ethnic groups in the Medi-Cal beneficiary population.

d. Analyze these rates for each ethnic group by factors including age, diagnosis, gender, and primary language of Medi-Cal mental health consumers to identify potential problem areas.

e. Establish a "percent improvement" for penetration and retention rates of ethnic groups with low penetration/retention rates.

f. Take specific actions to meet the "percent improvement" in "e" above.

B. Capacity of Service

Indicator:

1. Specialty mental health services are rendered by staff who is culturally competent and linguistically proficient to meet the needs of the population(s) served.

Measures:

a. Compare your baseline staffing to the current capacity of human resource assessment and whether or not there is improvement.

2. Performance outcomes achieved for culturally, ethnically and linguistically diverse communities will be equivalent to that of the service recipients in general.

Measures:

a. This will be measured by the county using either their own method or the method used by the State Quality Improve Committee performance outcome performance indicators.

- Measure the consumer perception of improvement in functioning for adults/older adults.
- Measure the perception of improvement in functioning and symptom reduction for youth.
- Measure the consumer perception of symptom reduction for adults/older adults.

C. Continuous Quality Improvement (CQI) Plan

Indicator:

1. MHPs must incorporate relevant cultural competence and linguistic standards in their approved quality improvement program and their annual QI work plan.

Measures:

a. Evidence of incorporation of relevant cultural competence and linguistic standards in annual QI work plan.

b. Evidence of progress in achieving objectives related to relevant cultural competence and linguistic standards within the annual QI work plan.

ATTACHMENT A

Current State Statutory, Regulatory and Policy Provisions Related to Cultural and Linguistic Competence

There are several provisions within current federal and state statutes, regulations and DMH policy letters related to cultural competence in the delivery of specialty mental health services. These provisions are notwithstanding other federal or state laws that prohibit discrimination based on race, color or national origin. The DMH specific provisions that guide the formulation of cultural competence plans are as follows:

State Statute

Welfare and Institutions Code (WIC) Section 4341 – relates to DMH activities and responsibilities in implementing a Human Resources Development Program and ensuring appropriate numbers of graduates with experience in serving mentally ill persons. Subsection (d) states: "Specific attention shall be given to ensuring the development of a mental health work force with the necessary bilingual and bicultural skills to deliver effective services to the diverse population of the state."

WIC 14684 (h) – "Each plan shall provide for culturally competent and age-appropriate services, to the extent feasible. The plan shall assess the cultural competence needs of the program. The plan shall include, as part of the quality assurance program required by Section 4070, a process to accommodate the significant needs with reasonable timelines. The department shall provide demographic data and technical assistance. Performance outcome measures shall include a reliable method of measuring and reporting the extent to which services are culturally competent and age-appropriate."

WIC Section 5600.2 – relates to the Bronzan-McCorquodale Act and general provisions to organize and finance community mental health services. "To the extent resources are available, public mental health services in this state should be provided to priority target populations in systems of care that are beneficiary-centered, culturally competent, and fully accountable, and which include the following factors:

WIC Section 5600.2 (g) – "Cultural Competence. All services and programs at all levels should have the capacity to provide services sensitive to the target populations' cultural diversity. Systems of care should: (1) Acknowledge and incorporate the importance of culture, the assessment of cross-cultural relations, vigilance towards dynamics resulting from cultural differences, the expansion of cultural knowledge, and the adaptation of services to meet culturally unique needs. (2) Recognize that culture implies an integrated pattern of human behavior, including language, thoughts, beliefs, communications, actions, customs, values, and other institutions of racial, ethnic, religious, or social groups. (3) Promote congruent behaviors, attitudes, and policies enabling the system, agencies, and mental health professionals to function effectively in cross-cultural institutions and communities."

WIC Section 5600.9 (a) – "Services to the target populations described in Section 5600.3 should be planned and delivered to the extent practicable so that persons in all ethnic groups are served with programs that meet their cultural needs."

WIC Section 5802 (a)(4) – relates to Adult and Older Adult Mental Health System of Care. "System of care services which ensure culturally competent care for persons with severe mental illness in the most appropriate, least restrictive level of care are necessary to achieve the desired performance outcomes."

WIC Section 5855 (f) – relates to Children's Mental Health System of Care. "Cultural competence. Service effectiveness is dependent upon both culturally relevant and competent service delivery."

WIC Section 5865 (b) – relates to County System of Care Requirement in place with qualified mental health personnel within three years of funding by the state. "(b) A method to screen and identify children in the target population...including persons from ethnic minority cultures which may require outreach for identification. (e) A defined mechanism to ensure that services are culturally competent."

WIC Section 5880 (b)(6) – relates to establishing beneficiary and cost outcome and other system performance goals for selected counties. "To provide culturally competent programs that recognize and address the unique needs of ethnic populations in relation to equal access, program design and operation, and program evaluation."

California Government Code (CGC) Section 7292 – relates to State agencies; bilingual employees. "Every state agency, as defined in Section 11000, except the State Compensation Insurance Fund, directly involved in the furnishing of information or the rendering of services to the public whereby contact is made with a substantial number of non-English-speaking people, shall employ a sufficient number of qualified bilingual persons in public contact positions to ensure provision of information and services to the public, in the language of the non-English-speaking person."

CGC Section 7295 – relates to Non-English translations. "Any materials explaining services available shall be translated into any non-English language spoken by a substantial number of the public served by the agency. Whenever notice of the availability of materials explaining services available is given, orally or in writing, it shall be given in English and in the non-English language into which any materials have been translated. The determination of when these materials are necessary when dealing with local agencies shall be left to the discretion of the local agency."

CGC Section 7296.2 – relates to Substantial number of non-English-speaking people. A "'substantial number of non-English-speaking people' are members of a group who either do not speak English, or who are unable to effectively communicate in English because it is not their native language, and who comprise 5 percent or more of the people served by any local office or facility of a state agency."

Federal Statute

Americans with Disabilities Act of 1990 – to provide a clear and comprehensive national mandate, and a strong, consistent, enforceable standards, for the elimination of and addressing discrimination against individuals with disabilities. The Nation's proper goals regarding individuals with disabilities are to assure equality of opportunity, full participation, independent living, and economic self-sufficiency for such individuals.

Federal Standards

National Standards for Culturally and Linguistically Appropriate Services (CLAS), in Health Care by the U. S. Department of Health and Human Services, Office of Minority Health, March 2001. The National standards were issued to respond to: 1) the need to ensure that all people entering the health care system receive equitable and effective treatment in a culturally and linguistically appropriate manner, and 2) a means to correct inequities that current exist in the provision of health service and to make these services more responsive to the individual needs of all consumers.

Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, Cultural Competence Standards in Managed Care Mental Health Services: Four Underserved/underrepresented Racial/Ethnic Groups –Final report from working groups on cultural competence in managed Mental Health Care Services. Prepared by Western Interstate Commission for Higher Education. (These standards have not been mandated by CMHS)

DMH Regulations

DMH Emergency Regulations for Managed Care, Title 9 of the California Code of Regulations, Section 1705 – "Culturally Competent Services means a set of congruent behaviors, attitudes and policies in a system or agency to enable effective service provision in cross-cultural settings."

DMH Letter

DMH Information Notice #: 94-17 issued on December 7, 1994 – requests all counties applying to become a Mental Health Plan to submit a written Implementation Plan for Psychiatric Inpatient Hospital Services Consolidation by January 1, 1995. Counties were required to describe the process they would implement to improve cultural competence and age-appropriate services to Medi-Cal beneficiaries.

Federal Waiver Request

DMH Waiver Request Submission to HCFA states: MHPs will be required to develop and implement a plan for the provision of culturally competent and age appropriate services to beneficiaries. At a minimum this plan must include maintaining a statewide 800 number with linguistic capability that is available 24 hours a day, and must include goals for improving cultural competence. DMH will establish a task force to address linguistic and cultural competence issues and may set additional statewide requirements for MHPs as a result of task force findings and recommendations.

Other General Provisions

Other provisions relate generally to quality and access provisions without specific reference to cultural competence. They include:

WIC Section 14683 and 14684 – require that the department establish minimum standards of quality and access for managed mental health care plans.

WIC Section 14683 (b) sets forth a requirement that managed mental health care plans include a system of "outreach to enable beneficiaries and providers to participate in and access mental health services under the plans, consistent with existing law."

ATTACHMENT B

CALIFORNIA DEPARTMENT OF MENTAL HEALTH
CULTURAL COMPETENCE ADVISORY COMMITTEE

Teri Barthels	Chief, System Implementation & Support, Department of Mental Health Sacramento, California
Gwendalle Cooper, Ed.D.	Hummingbird Consulting Service La Mesa, California
Maria Fuentes	Ethnic Populations/Services Specialist, Santa Clara County Mental Health San Jose, California
Eddie D. Gabriel, Jr.	Technical Assistance & Training, Systems of Care, Dept. of Mental Health Sacramento, California
Rachel Guerrero, LCSW	Chair, Chief, Office of Multicultural Services, Department of Mental Health Sacramento, California
Carl Havener, LCSW	Director, Tehama County Health Agency Red Bluff, California
Robbin Huff-Musgrove, Ph.D.	Director, Multicultural Education/Training, Patton State Hospital Patton, California
Pearl Johnson	California Network of Mental Health Clients Los Angeles, California
Erma Kendrick	California Alliance for the Mentally Ill Bakersfield, California
Evelyn Lee, MSSA, Ed.D.	Director, Richmond Multiservice Center San Francisco, California
Rudy Lopez	Director, San Bernardino County Department Behavioral Health San Bernardino, California
J. Ruben Lozano, Pharm.D.	Deputy Director, Program Compliance, Department of Mental Health Sacramento, California
Francis G. Lu, M.D., FAPA	Professor of Clinical Psychiatry, UCSF, San Francisco General Hospital San Francisco, California
Maria Maceira	El Hogar Mental Health Sacramento, California
Terry MacRae	Statistics and Data Analysis, Systems of Care, Dept. of Mental Health Sacramento, California
Matthew Mock, Ph.D.	Director, Family and Children's Services, Berkeley City Mental Health Berkeley, California
Edmond Pi, M.D.	Associate Center Director, Augustus F. Hawkins Mental Health Center Los Angeles, California

Josie Romero, LCSW	National Latino Behavioral Health Association Gilroy, California
Laura Span-Bonitto	Adult Services, Los Angeles County Mental Health Los Angeles, California
Christine Umeda	Sacramento, California
Tina Tong Yee, Ph.D.	Cultural Competence/Consumer Relations, San Francisco Co. Mental Health San Francisco, California