

# Cultural Competency Goals from TriWest Report

## Overview

Building the cultural competency of regional systems of care across the County of Santa Barbara is the overarching responsibility of the Cultural Competence Development Action Team, which begins by building on the partnerships across existing efforts to develop culturally and linguistically competent services, address health disparities, and promote health equity. It will likely be necessary for initial efforts to coordinate across existing groups focused on specific cultural sub-populations in the county (e.g., Latino, African American, Asian American and Pacific Islander, sexual and gender minorities, etc.), and then synthesize priorities for improvement (short and long-term) across these different populations, incorporating metrics such as those listed below.

## Cross-Cutting Recommendations from the Report that Apply to All Action Teams

**From page 31:** Help all ADMHS and contractor programs become:

- welcoming,
- recovery/resiliency-oriented,
- culturally competent,
- trauma-informed, and
- complexity capable.

This overarching clinical value set is embedded in the Guiding Principles being developed by the Systems Change Steering Committee and is intrinsic to the CCISC process guiding the consulting team.

## Recommendations Specific to Cultural Competency

**From page 59: Recommendation CO-2.1: Develop specific work groups as part of the broader quality improvement-driven System Change initiative to guide implementation of short-term changes (one to three months) and longer-term plans (six to 12 months and beyond) to systematically address the Clinical Operations findings.**

- Eliminating health disparities through cultural/linguistic competent systems of care; ***[This is the overarching goal for the Action Team.]***

***The Action Team is charged with pursuing both:***

- Short-term changes (substantive progress within 30 to 90 days, e.g., no later than end of October 2013, but preferably end of September 2013).
- Longer term plan (plan in place within 90 days – e.g., 11/1/2013).

**Potential partners abound (p. 29):** Cultural/linguistic competence: CBOs are key allies and community agencies such as La Casa de La Raza have strong community ties and expertise

essential to “meeting people where they are.” While MH/SA funds have been used to establish some focused collaboration, there is need of a broader strategic organizational improvement approach to address current health disparities and promote health equity more successfully within available resources. ***Note that La Casa de La Raza was chosen as an example of a small MHSA-funded partner, but there are multiple CBOs and other community partners serving and advocating for the needs of cultural minority groups.***

**P. 31:** The vision should be firmly rooted in the MHSA Guiding Principles:

- ***Cultural competence:*** *Adopting behaviors, attitudes and policies that enable providers to work effectively in cross-cultural situations.*

**Finding CO-2.3:** **Despite impressive improvements in the number of bilingual Spanish-speaking staff hired and the number of Latino / Hispanic people served each year, significant disparities related to race, ethnicity and culture persist. NOTE: This finding includes a considerable amount of relevant data to inform discussions on pp. 46-51.**

Cultural Competency development: ***The report identified numerous possible short and long-term changes.***

- Opportunities for improvement identified through the focused study informed by the Latino Advisory Committee: (pp. 49-50)
  - Promotion more broadly through multiple methods of welcoming, responsive services by “a person who speaks my language and truly understands my culture” (from the point of initial access to make an appointment through the entire process);
  - Expanding employment targets for bilingual staff to languages other than Spanish, development of standards and recruitment targets for bicultural staff, and targeting employment of culturally diverse staff for key positions such as managers and psychiatrists;
  - Expansion of support groups such as Nuevo Amanecer, specifically targeting expansion across North County, Lompoc and South County and encouraging ADMHS and CBO staff to form such groups;
  - More flexible scheduling at ADMHS clinics and CBOs, including evening times outside of normal working hours and promotion of family-inclusive services;
  - Development of SUD prevention, detox, residential, and treatment programs that are culturally and linguistically competent;
  - “Providing care where people are” – community settings, family resource centers, cultural centers, churches and faith-based settings, and primary care clinics;
  - Utilizing bilingual and bicultural staff and agencies (such as Casa de La Raza) to help “bridge” the gap to care, as well as expanding (and better coordinating with existing services) use of promotores and cultural brokers,<sup>1</sup> staff willing to serve as interpreters

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<sup>1</sup> See description of these promising practices in Appendix 2.

- and advocates, and natural supports such as priests, clergy, other human/community service agencies;
- Addressing barriers for individuals concerned about their legal status or documentation, including coordinated efforts with non-profit and faith-based partners;
  - Media campaigns in Spanish via Latino/Hispanic media – in partnership with other Latino community partners and leaders – to help combat stigma and increase awareness of available services;
  - Promoting Latino heritage by sponsoring events, fairs, and gatherings to reach Latino communities; and
  - Partnering with other agencies to support staff recruitment.
- Improving bilingual and bicultural care by involving key internal committees and broader external representation to update and formally adopt the 2010 Cultural Competency Plan, focusing on bicultural standards, improved access to interpreters, cross-system (including ADMHS) performance tracking, and enhanced service in community settings are potential early areas of emphasis and improvement. (p. 60) **NOTE that the 2010 Cultural Competency Plan** “defines culture broadly (including gender and sexual minorities, in addition to race and ethnicity) and also focuses on linguistic competency, including standards for using interpreters.” (p. 46) **It is critical that cultural competency efforts reach beyond simply a primary focus on Latino cultures and needs to also include other racial and ethnic groups (e.g., African American) and cultural minorities (e.g., sexual and gender minorities) experiencing health disparities.**
    - ADMHS could also develop means for contract providers to offer psychiatry to leverage their resources to expand access, particularly to child psychiatry and bicultural/bilingual physicians. (p. 59)
  - Potential metrics from Recommendation CO-2.2 (pp. 61-65) There are numerous indicators that could be developed to inform efforts to improve clinical practice and outcomes. Over 30 examples of potential metrics are described below, and this is by no means an exhaustive list: it is intended to stimulate efforts by the System Change work groups and ADMHS management to use data to improve practice. While it will not be feasible to immediately implement metrics in all of these areas, the following list offers a range of potential metrics to inform near and medium-term efforts. It is recommended that at least ten meaningful process metrics and two outcome metrics be developed over the next six months for each program type (regardless of whether the program is operated by ADMHS or a CBO). At least five of the ten process metrics should be standardized across all outpatient programs. The list includes an array of metrics related to this Action Team:
    - Racial and ethnic disparities (e.g., under-utilization of services by particular racial/ethnic groups) and cultural and linguistic competency using indicators consistent with the

National Standards on Culturally and Linguistically Appropriate Services (CLAS).<sup>2</sup> ADMHS's 2010 Cultural Competency Plan (discussed in more detail below) includes some initial ideas for routine indicators. Indicators should be tracked for all major racial and ethnic groups served, for refugees and new immigrants, for any Member speaking a primary language other than English, and for gender (transgender) and sexual (lesbian, gay, bisexual) minorities. Examples of potential indicators include:

- Access – Differences in service penetration rates across population groups;
- Service Utilization – Differences across population groups in dropout rates, in the amount of community-based versus restrictive care received, and in the chance to receive services in one's preferred language, including disproportionate use of restrictive settings (e.g., over-utilization of out-of-home [OOH] services by racial/ethnic minorities);
- Perceptions of Care – Differences across population groups' perceptions that services are effective, understandable and respectful (this includes consumer satisfaction);
- Outcomes – Differences across population groups in the results of services;
- Capacity to Provide Culturally Competent Care – The availability of personnel, programs, and organizations with capacity to deliver culturally competent services, including individual providers expert with each cultural and linguistic subgroup (physicians, other licensed professionals, clinical staff within agencies, certified peers) and agencies / organizations with culture-specific expertise, inclusive of "mainstream" agencies, culture-specific agencies, and peer/family/youth-operated organizations;
- Service utilization by program, including trends, outliers, expenditures, and length of stay in each service by level of care using standard measures, such as use/days per 1,000 Members (for Medi-Cal) and penetration rates by level of care and overall (with breakouts by age group, provider, race/ethnicity, language, and county region);
- The cultural and linguistic competency of both ADMHS and CBO programs (at the program level);

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<sup>2</sup> See <http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15> for more information. See also CiMH resources for addressing health disparities at <http://www.cimh.org/Services/Multicultural/Eliminating-Disparities.aspx>.