

Envisioning a system where all Ohioans can access quality treatment responsive to their cultures, preferences and values.

CULTURAL COMPETENCE DISPARITIES REVIEW: SFY 2010-2011 COMMUNITY PLANS

Office of Community Supports and Emergency Preparedness



Ohio | Department of
Mental Health

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INTRODUCTION

The ***Cultural Competence Disparities Review: SFY 2010-2011 Community Plan*** project is a qualitative investigation to determine the “current state” of Ohio local systems effort to operationalize cultural competence into organizational practices and mental health treatment. The review is ODMH’s first step toward development of a statewide cultural competence plan. It is intended to help stakeholders identify appropriate strategies to reduce systemic disparities and improve integration of cultural competence concepts in behavioral health care. The information in this report was not obtained from any source other than SFY 2010-2011 community plans. Fourteen indicators (***see appendix***) were identified to gauge Alcohol, Drug Addiction and Mental Health (ADAMH) board progress in cultural competence. This report contains a summary of the community plan review, key community plan observations, board comments that highlight need for technical assistance, and a sample of statewide cultural competence strategies that can be used in the future by Ohio to reduce disparities in behavioral health care.

Local agencies and state departments often struggle with the concept of cultural competence and the challenges that come with eliminating disparities. The Ohio Department of Mental Health (ODMH) joined the Multiethnic Advocates for Cultural Competence and 10 state health and human service departments in 2010 to adopt a common statewide cultural competence definition in support of Ohio communities. The definition states:

“Cultural competence is a continuous learning process that builds knowledge, awareness, skills and capacity to identify, understand and respect the unique beliefs, values, customs, languages, abilities and traditions of all Ohioans in order to develop policies to promote effective programs and services.”

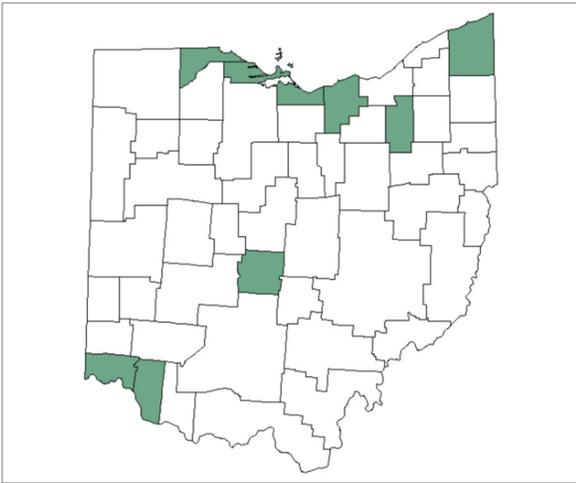
ODMH envisions the statewide definition and cultural competence plan, when implemented, will not only reduce disparities, but also decrease service cost and inefficiencies, thereby improving access to quality behavioral health care and other systems touched by consumers.

SUMMARY

The following summary and maps show the areas in cultural competence Boards reportedly addressed in their 2010-2011 community plans. A Board was given credit for addressing an indicator if it reported implementing or an intent to implement the indicator.

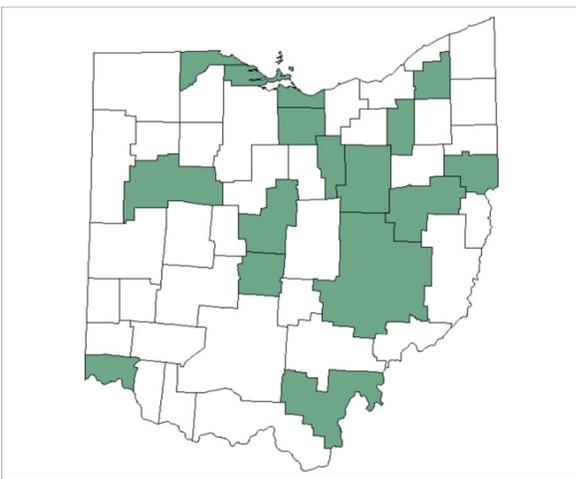
CLINICAL NEEDS OF UNDERSERVED POPULATIONS

(8) Boards mentioned use of resources such as Afrocentric teams, bi-lingual psychiatrists, and culturally appropriate services to address unique religious or ethnic issues. Also cited was use of SOQIC Diagnostic Assessments to ensure that culture is reviewed prior to diagnosis.



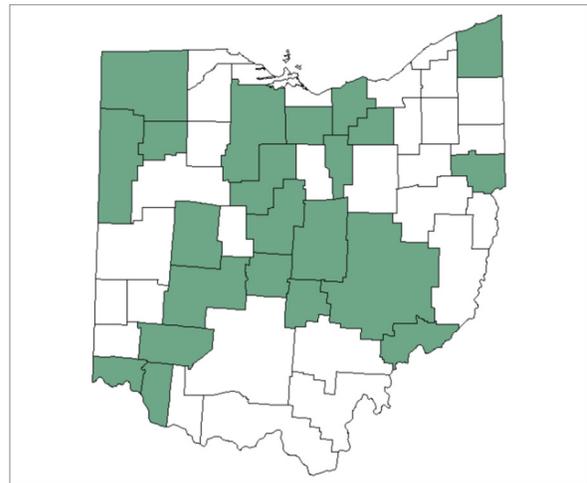
COLLABORATES WITH ORGANIZATIONS OF UNDERSERVED POPULATIONS

(15) Boards reported that they partnered with Black ministries, Amish bishops, and Hispanic/Latino coalitions to provide outreach services to improve treatment options for minorities in the local community.



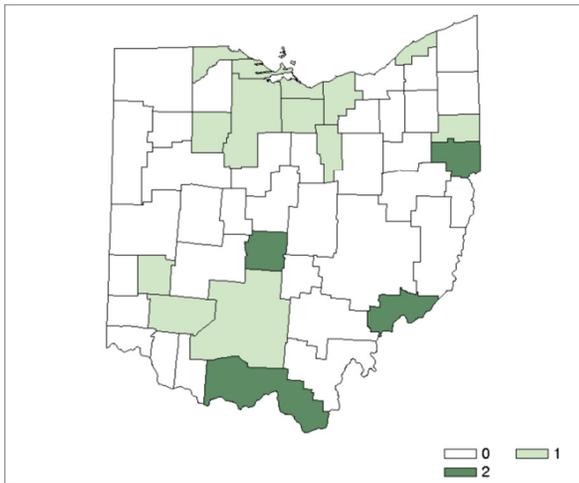
CONSUMER SATISFACTION

(22) Boards reported use of consumer satisfaction surveys to identify treatment barriers, service gaps, and disparities impacting minorities. Data was reportedly used to improve treatment outcomes, design training opportunities, and create cultural competence strategies to better serve minority consumers.



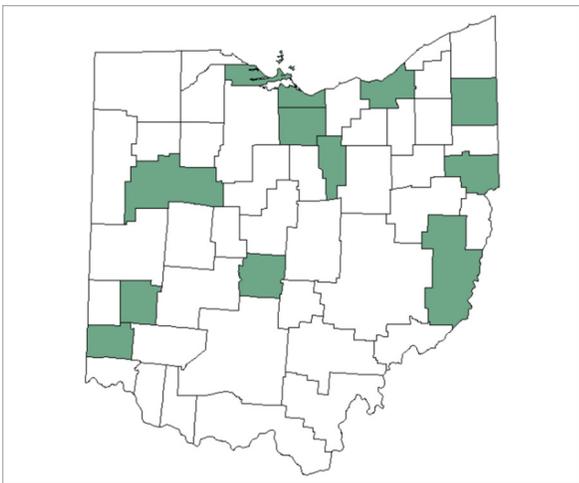
CULTURAL COMPETENCE IN MISSION, VISION, & VALUE STATEMENTS

Twenty percent of the Boards (10) have value statements that incorporate cultural competence. Fewer Boards (7) incorporated the concept into their vision, and only 3 include it in their mission statement. Four Boards integrated cultural competence into two of the three statements.



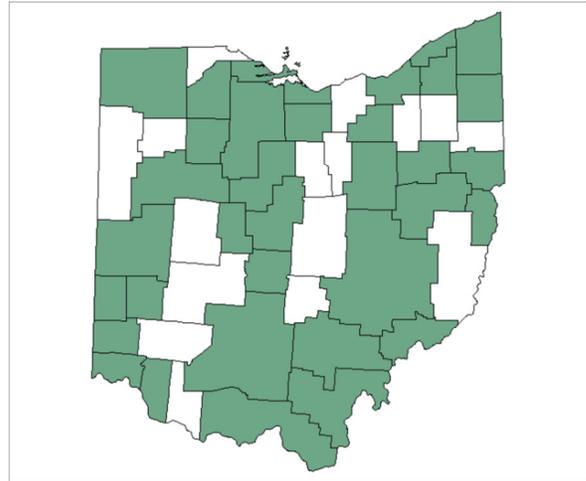
CULTURAL COMPETENCE STRATEGIES/PLAN

(11) Boards reported use of elements such as staff training, recruitment, and evaluation; consumer satisfaction; disparities in access; diversity awareness; as well as marketing and promotion in their cultural competence strategies or plan.



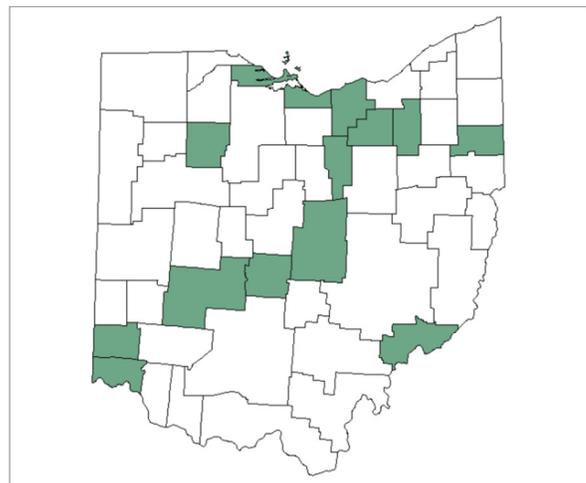
CULTURAL COMPETENCE TRAINING

(34) Boards mentioned use of staff training in the area of cultural competence. Training to address the culture of poverty was most commonly reported.



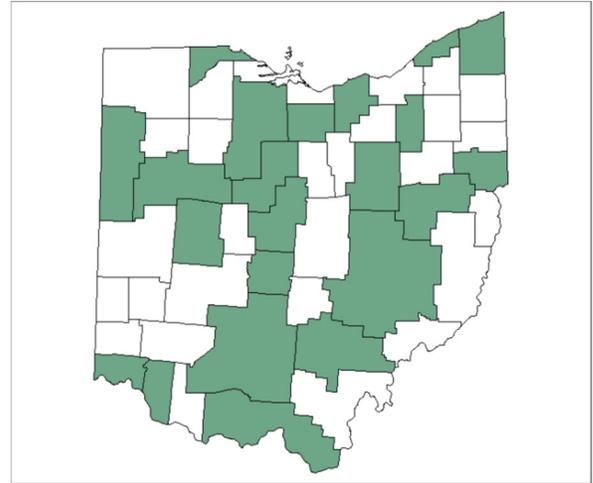
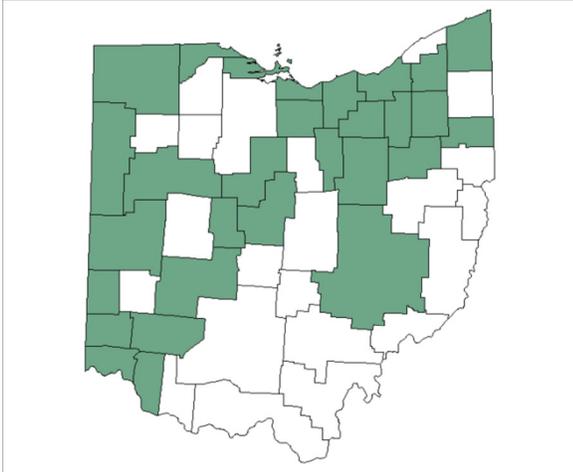
DISPARITIES

(13) Boards reported use of compliance audits, Ohio Scales data, Ohio Consumer Outcomes data, consumer satisfaction surveys, and MACSIS data to identify system disparities.



ILLUSTRATES POPULATION DEMOGRAPHIC ESTIMATES BY RACE & ETHNICITY

Fifty-six percent of the Boards (28) provided population demographics by race and ethnicity when asked to show population change within their community plan.

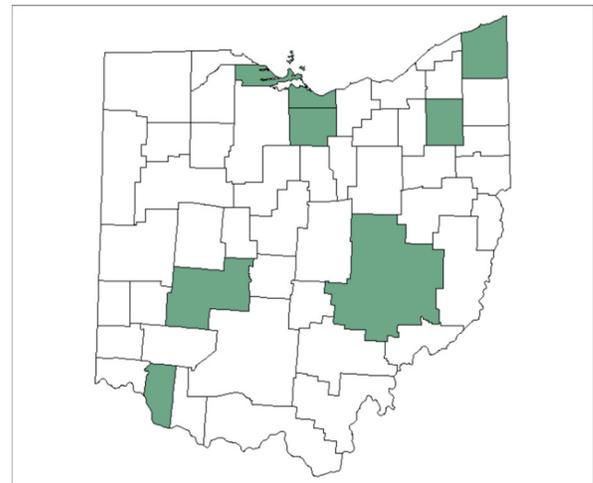
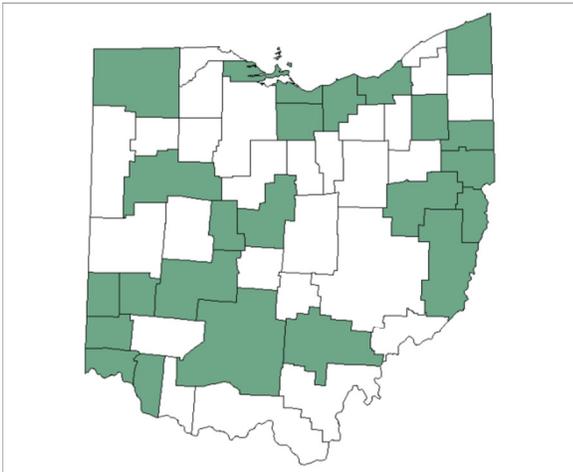


RACE/ETHNIC REPRESENTATION IN SERVICE UTILIZATION

Fourteen percent of the Boards (7) compared their county population (i.e. by race & ethnicity) to the population of those receiving treatment services; an activity done to determine the proportion at which race/ethnic populations are utilizing services.

ILLUSTRATES DEMOGRAPHICS OF CONSUMERS SERVED BY RACE & ETHNICITY

Forty-six percent of the Boards (23) provided demographics of consumers by race and ethnicity when asked to provide characteristics of clients receiving mental health treatment and recovery supports within their community plan.

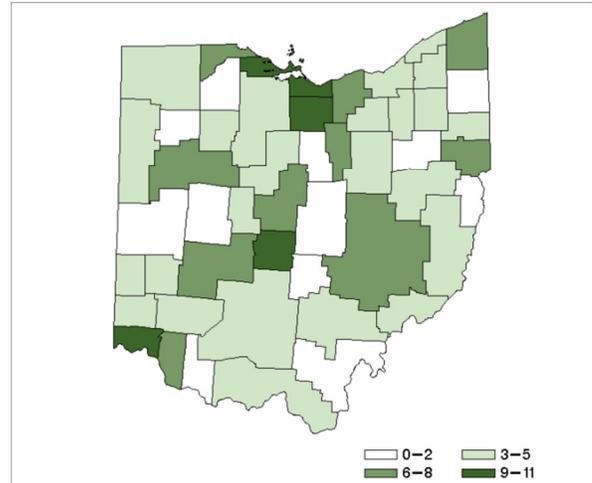
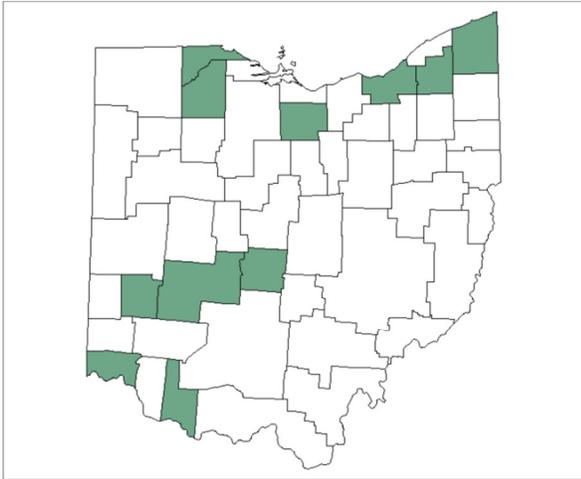


STAFF RECRUITMENT/REPRESENTATION OF MINORITY POPULATION SERVED.

(11) Boards reported that either they or their local agencies had staff that represented the minority population being served.

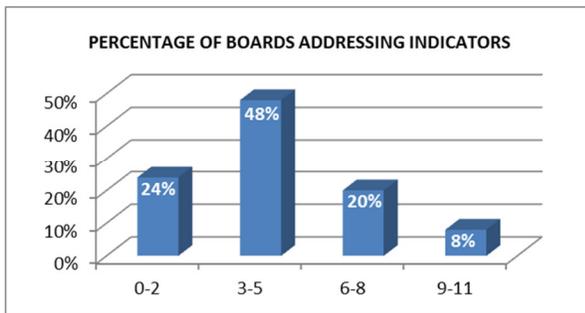
INTERPRETING & TRANSLATIONS

(22) Boards reported use of interpreters for consumers that are Hispanics/Latino, Somali, Chinese, and for those who are deaf and hard of hearing. Boards also mentioned translating signage and mental health materials into Spanish and Somali.



CULTURAL COMPETENCE AS A PRIORITY

Of the 14 indicators used to gauge progress in cultural competence, none of the Boards addressed all of them. Only one Board did not report any cultural competence activities from the list of indicators.



The average number of indicators discussed by Boards was approximately four. Based on the number and type of indicators addressed, the following assumptions can be made: there is no clear local or statewide vision for cultural competence; cultural competence activities vary by Board area and region; and Board areas with larger populations tend to have more activities associated with cultural competence.

KEY COMMUNITY PLAN OBSERVATIONS

- ✚ Franklin County was the only Board that mentioned it had CEO and leadership buy-in for integrating cultural competence within the local system.
- ✚ Crawford, Marion and Paint Valley were the only Boards that required service provider staff to participate in cultural competence training.
- ✚ Union County was the only Board that required its provider agency to conduct cultural competence training.
- ✚ Consumer satisfaction surveys were reported the most by Boards as a tool to monitor disparities.
- ✚ In Board areas of limited race/ethnic diversity, cultural competence training focused primarily on poverty.
- ✚ Only 23 Boards reported race/ethnic characteristics of clients receiving mental health treatment and recovery supports.
- ✚ Sixteen percent of the Boards reported use of specific resources that help address the clinical needs of minorities.
- ✚ Several rural Board areas reported that psychiatrists and clinicians often lose new skills after cultural competence training because of few opportunities to use it in practice.
- ✚ Staff diversity (i.e. race, ethnic, gender) is minimal.
- ✚ There is very little evidence to suggest cultural competence is integrated into Board policies and procedures.

BOARD COMMENTS THAT HIGHLIGHT NEED FOR TECHNICAL ASSISTANCE

The following are statements provided by Boards that may help the Ohio Department of Mental Health (ODMH), Multiethnic Advocates for Cultural Competence (MACC), and other stakeholders understand the challenges some encounter in their efforts to implement cultural competence:

- ✚ **(Ashland)** *Clearly state agencies, Boards, and provider agencies are still trying to articulate what is meant by a “Culturally Competent System of Care” and how such a system could be identified, on what criteria, according to whose standards, under what conditions, etc.*
- ✚ **(Ashtabula)** *The Board is currently under many financial challenges, which limits our ability to impact the system’s policies and practices to ensure a culturally competent system of care. However, we do work closely with agencies to help them access the limited resources available for persons who are deaf as well as translation services.*
- ✚ **(Belmont, Harrison, Monroe)** *All staff in all agencies and service areas are encouraged and/or required to become culturally competent, even though research has not yet generated a set of evidence based practices to achieve cultural competence.*
- ✚ **(Clermont)** *Clermont Counseling Center (CCC) One area of concern is the ability to attract and retain specialty positions, such as nurses and foreign language clinicians.*
- ✚ **(Columbiana)** *A challenge relevant to our local system in developing and maintaining a culturally competent system is ensuring that practices and services are configured and delivered in ways that are acceptable and relevant to the Appalachian culture. Intermittent challenges occur in ‘low incidence’ situations. For example, on rare occasions, service recipients do not speak English. The system relies on interpreters to bridge the language barrier. The system seeks consultation through MACC and, when appropriate, local universities when serving an individual or family with an ethnic background that is very low incidence in Columbiana County. For example, in the past year, consultation was sought by a case team working with a person of Asian descent who spoke only Chinese.*
- ✚ **(Four County)** *One of the challenges in our area is attracting minorities and men to our mental health/substance abuse prevention and treatment services. Men seemed to be more willing to get involved in the substance abuse treatment/prevention services than in mental health. While we have some male therapists we have only one male case manager. At one point, there were two African American female case managers but they have since left the agency where they were employed.*
- ✚ **(Huron)** *As a caveat to the cultural competency discussion, data analysis of patterns of use indicate that illegal immigrants generally seek behavioral healthcare treatment services on emergency bases only, creating the need for higher levels of care for some of these persons...A consistent national policy regarding this population would benefit Boards in Ohio, which currently are at risk for the high cost inpatient care being utilized by this population.*
- ✚ **(Licking, Knox)** *At this point the Board has extremely limited outcome data, making it difficult for us to assess outcomes for consumers by gender, age, or race and ethnicity. The Board is currently making improvements to data extraction and analysis practices to remedy this shortfall. The Board has hired a consultant who is now analyzing MACSIS data, including analysis of access to services by gender, race and ethnicity, and Medicaid/Non-Medicaid status. The Board will also be working with providers to improve outcomes submission rates, and subsequently will be able to look at outcomes by race and ethnicity and gender.*
- ✚ **(Seneca, Sandusky, Wyandot)** *Challenges in this Board area are: the ability to recruit bilingual staff in spite of extensive, costly marketing efforts; the ability to locate an interpreter service for deaf and hard of hearing populations in Wyandot County (as mentioned previously) and the cost of interpreter services. The provider is mandated to bear the full cost of interpreter services, which include travel time and direct service time. If the client attends the appointment, the interpreter fee often exceeds the billing for that service. If the client does not show for the appointment or call with adequate notice to cancel, the interpreter must still be paid.*

✚ (Wood) *We are not certain what our weaknesses are for cultural competency, given our input above. However, we once again would like to request dialogue with the Department about assessing our system and providing consultation regarding this very important area. We look forward to your assistance.*

STATEWIDE CULTURAL COMPETENCE STRATEGIES

The integration of cultural competency concepts into Ohio's behavioral health system may offer solutions to issues such as:

- ✚ Over utilization of inpatient services;
- ✚ Prevalence of comorbid diseases disproportionately affecting minority populations;
- ✚ Misdiagnosis;
- ✚ Errors in prescribing medications; and
- ✚ Linguistic barriers.

Such challenges increase clinical, organizational, and system costs. In an effort to address these issues, the mental health departments of states such as Massachusetts, California, Delaware, and New York developed a state cultural competence plan.

Results from the SFY 2010-11 community plan review suggest that behavioral health Boards in Ohio could also benefit from a state cultural competence plan. The following are goals used by other state agencies to address cultural competence:

1. **Identify disparities.** Use demographic (i.e. by race/ethnicity) information about consumers to monitor county population change, socio-economic factors (e.g. income, education, poverty, etc.), in/out patient service utilization, and clinical performance outcomes, to inform decisions about policy development, clinical practice, program development, service delivery and workforce development.
2. **Improve access.** Evaluate in-take and diagnostic assessments, Evidence-Based Practices (EBPs), interpreter/translation resources & procedures, and clinical processes for effectiveness in serving the local population.
3. **Enhance workforce skills.** Provide training that addresses the clinical needs of the local population and technical assistance to equip staff with the information needed to improve service outcomes.
4. **Operationalize cultural competence.** Integrate cultural competence concepts into organization mission, vision, value, and belief statements.
5. **Engage the community.** Partner with multicultural communities to develop cultural competence programs to improve consumer/family member engagement.
6. **Improve diversity in staff composition.** Partner with advocacy organizations and colleges/universities to recruit minority social workers, psychiatrists, psychologists, case managers, and administrative executives.

Future discussions regarding statewide cultural competence efforts should include convening a panel or committee that includes participation of Boards, providers, and key stakeholders like MACC. The panel could be instrumental in identifying appropriate strategies to implement, monitor, and measure the impact of cultural competence programs throughout Ohio.

APPENDIX

CULTURAL COMPETENCE INDICATOR CROSSWALK	BOARD AREAS													
	Incorporates Cultural Competence into Mission	Incorporates Cultural Competence into Vision	Incorporates Cultural Competence into Value Statements	Illustrates Population Demographic Estimates by Race & Ethnicity	Illustrates Demographics of Consumers Served by Race & Ethnicity	Estimates Race/Ethnic Representation in Behavioral Health System	Ensures Staff Represents Population Served	Addresses Clinical Needs of Underserved Populations	Promotes Cultural Competence Training	Ensures Availability of Interpreters and Translated Materials	Addresses Cultural Competence through Consumer Satisfaction	Addresses Systemic Disparities	Collaborates with Organizations of Underserved Populations	Currently Utilizes a Cultural Competence Plan or Set of Strategies
Adams, Lawrence, Scioto	✓		✓						✓	✓				
Allen, Auglaize, Hardin				✓	✓				✓	✓			✓	✓
Ashland			✓	✓									✓	✓
Ashtabula				✓	✓	✓		✓	✓	✓				
Athens, Hocking, and Vinton									✓	✓				
Belmont, Harrison, Monroe					✓									✓
Brown							✓							
Butler					✓				✓					✓
Clark, Greene, Madison				✓	✓	✓			✓	✓		✓		
Clermont				✓	✓	✓		✓	✓	✓				
Columbiana		✓	✓		✓				✓	✓	✓		✓	✓
Crawford, Marion				✓					✓	✓				
Cuyahoga				✓	✓		✓		✓	✓				✓
Delaware, Morrow				✓	✓				✓	✓	✓		✓	
Erie, Ottawa		✓		✓	✓	✓		✓	✓			✓	✓	✓
Fairfield									✓	✓				
Four County (Defiance, Fulton, Henry, Williams)				✓	✓				✓	✓				
Franklin		✓	✓				✓	✓	✓	✓	✓	✓	✓	✓
Gallia, Jackson, Meigs									✓				✓	
Geauga				✓			✓		✓				✓	
Hamilton				✓	✓			✓	✓	✓	✓	✓	✓	
Hancock			✓						✓			✓		
Huron		✓		✓	✓	✓	✓		✓	✓	✓	✓	✓	✓
Jefferson					✓				✓	✓				
Lake			✓						✓	✓				
Licking, Knox										✓		✓		
Logan, Champaign									✓	✓				
Lorain		✓		✓	✓				✓	✓	✓			
Lucas			✓				✓		✓	✓			✓	
Mahoning	✓			✓	✓							✓		
Medina				✓					✓	✓	✓			
Mercer, Van Wert, Paulding				✓					✓	✓				
Montgomery			✓		✓		✓		✓					✓
Mukingum Area (Coshocton, Guernsey, Morgan, Noble, Perry)				✓	✓	✓			✓	✓	✓		✓	
Paint Valley (Fayette, Highland, Pickaway, Pike, Ross)		✓			✓				✓	✓				
Portage				✓	✓	✓								
Preble				✓	✓				✓					
Putnam										✓				
Richland														
Seneca, Sandusky, Wyandot	✓								✓	✓	✓			
Stark				✓					✓					
Summit				✓				✓	✓			✓	✓	
Tri-County (Darke, Miami, Shelby)				✓					✓					
Trembell									✓					✓
Tuscarawas, Carroll					✓				✓	✓			✓	
Union				✓	✓				✓					
Warren, Clinton			✓	✓						✓				
Washington		✓	✓						✓	✓	✓			
Wayne, Holmes			✓						✓				✓	
Wood							✓		✓					