

Cultural Competence Standards

**In Managed Care
Mental Health Services**

For Native Americans

EXECUTIVE SUMMARY

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Funded by

The Center for Mental Health Services
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I. Introduction

This Executive Summary provides an overview of the Native American component of the Managed Care Initiative funded by the Center for Mental Health Services (CMHS) and the Substance Abuse and Mental Health Services Administration (SAMHSA). The Managed Care Initiative is a multi-year endeavor coordinated by the Center for Mental Health Policy and Services Research, University of Pennsylvania, in conjunction with the Western Interstate Commission for Higher Education (WICHE) Mental Health Program. The Managed Care Initiative aims to develop managed care expertise in public sector mental health administrators and staff. A primary objective is to establish competency standards for mental health service providers within a managed care setting, with special attention to various under served populations including Native Americans.

The Native American Panel is one of eight panels that were created to meet this objective. The Native American Panel is comprised of 16 nationally recognized practitioners, consumers, advocates, governmental representatives and researchers. The Panel produced three reports designed to be used together - 1) Literature Review; 2) Cultural Competence Standards; 3) Strategic Plan for Implementation. The purpose of this Executive Summary is to summarize the contents of these reports, including guiding principles and recommendations.

The Native American panel had many concerns about managed care as a model of health care delivery for Native Americans. Of particular concern is the use of a prepaid or capitated approach to service payment. Issues effecting Native people are complex and linked to historical events and current experiences that are perpetuated by current events that, on the surface, do not seem related. However, because of the historic trauma suppressed by many Native Americans, subtle messages which communicate a lack of belonging to contemporary American society, and the continuing assault on Indian sovereignty serve to perpetuate mental health problems. Managed care organizations which do not address these complex issues in a careful and thoughtful manner with Native American consumers, sovereign tribal nations, native organizations, and relevant federal agencies will only add to the oppression experienced by Native Americans for decades.

Having stated these concerns, the Native American Panel offers the following guidelines toward the goal of developing culturally competent managed care organizations who would serve Native Americans in ever increasingly effective and respectful ways. In reviewing the system and clinical guidelines, we agreed that guidelines for Provider Competencies would be the same regardless of the setting (urban, suburban, rural, reservation), but all other guidelines were

reviewed with the rural-reservation managed care settings in mind separately from the review with urban-suburban settings in mind. It is highly likely that the urban-suburban managed care settings would be non-Native and most likely, non-minority specific. In considering the rural/reservation situation, we found it useful to use the Navajo Nation as a reference point. The Navajo Nation has sovereign nation status over its membership residing on or near the reservation, a very large geographic area located in three states (Arizona, New Mexico and Utah). This illustrates the complexity in developing culturally competent health care for one tribal nation.

II. Literature Review

The importance of mental health services to Native people must be understood in view of historical, geographical, educational, and tribal contexts. Census data report that there are approximately 1.9 million American Indian, Eskimo, and Aleut people in the United States (U.S. Bureau of the Census, 1990). About half live on federal Indian reservations in 33 states, mostly located in the western states. The other half of the population live in urban areas, although some reside in small off-reservation communities. The Native population is young, approximately half are 18 years of age or younger (Nelson, McCoy, Stetter, & Vanderwagen, 1992). There are over 500 federally-recognized tribes and over 250 distinct languages among these tribes.

Of great importance is understanding the impact of history, particularly the effects of colonization on Indian people and the corresponding issues of mental health (Duran & Duran, 1995). These factors include: broken treaties, forced relocation, boarding school education, forced assimilation, and cultural neglect. Additional factors include poverty, reservation/rural/urban issues, alcoholism, and physical health problems.

In terms of health care, the U.S. government has had the responsibility through the obligations of many treaties. Typically, these obligations were carried out through the Public Health Service via Indian Health Service (IHS) and Bureau of Indian Affairs (BIA). The Public Health Service in 1955 assumed primary responsibility for providing health care to Indians and currently the IHS services approximately 60% of the Indian population (Johnson, 1995). Under Nixon's self-determination policy, tribes were encouraged to take over the governing of their health care programs (Flack, 1995).

Presently, there are numerous agencies/departments involved in various degrees in the provision of mental health services to Native people. At the broad systems level, there is a lack of clarity regarding the roles of IHS, the BIA, the state, counties, cities, and tribes in mental health care. There are relatively few working agreements between these service delivery systems (WICHE, 1993).

III. Cultural Competency Standards

The Cultural Competency Standards addresses a growing problem; that mainstream service providers are having difficulty working with and providing effective treatments for Native American clients. There are seven guiding principles that embody the issues pertinent to effective mental health service delivery to Native Americans within a managed care environment. These are: 1) Principle of Sovereign Nation Status; 2) Principle of Cultural Competence; 3) Principle of Consumer-Driven System of Care; 4) Principle of Community-Based System of Care; 5) Principle of Quality of Care; 6) Principle of Natural Support; and 7) Principle of Prevention.

The Cultural Competency Standards are partitioned into three primary areas: 1) Overall System Standards and Guidelines; 2) Provider Competencies; and 3) Clinical Standards and Guidelines. All three areas are comprised of several individual standards. Each of these standards is accompanied by implementation guidelines and recommendations for performance indicators. The goal of these Standards is to establish a system of care that incorporates at all levels of operation, 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.

A. Overall System Standards and Guidelines

1. Cultural Competence Planning

A Native American Cultural Competence Plan for both public and private sectors shall be developed and integrated within the overall organization and/or provider network plan, using an incremental strategic approach for its achievement, to assure attainment of cultural competence within manageable but concrete timelines. Development and integration of the Cultural Competency Plan shall be achieved with the participation and representation of top and middle management administrators, front-line staff, consumers and/or their families, and tribal sovereign nations, and community stakeholders. A culturally-competent individual at the executive level, shall have authority to monitor implementation of the Cultural Competence Plan. Additionally, each individual shall be accountable for the success of the Plan based on his/her level within the organization.

2. Ongoing Program Development

Ongoing program development for Native American consumers shall include a full array of available treatment modalities, particularly modalities that are culturally competent and effective with this population (e.g., family therapy, specialized group therapy, behavioral approaches, use of traditional healers and outreach).

3. Governance

Each health plan's governing entity should incorporate a board, advisory committee, or policy making and influencing group representative of the consumer populations served and the community at large, including age and ethnicity. In this manner, the community served will guide policy formulation and decision making, including Request for Proposals development and vendor selection. The administrator responsible for the Health Plan should be accountable for its successful implementation, including its cultural competence provisions.

4. Benefit Design

The Health Plan shall ensure equitable access and comparability of benefits across Native American populations and age groups. Coverage shall provide for access to a full continuum of care (including prevention programs) from most to least restrictive in ways which are comparable, though not identical, acknowledging that culturally competent practice provides for variance in individualized care.

5. Quality Monitoring and Improvement

The Health Plan shall have a regular quality monitoring and improvement program with defined indicators applicable to evaluating services to Native American populations, and that ensures: 1) access to a full array of culturally competent treatment modalities; 2) comparability of benefits, and 3) comparable successful outcomes for all service recipients.

6. Decision Support and Management Information Systems

The Health Plan shall be develop and maintain a database which shall track utilization and outcomes for Native Americans across all levels of care. It shall also develop and manage databases of social and mental health indicators on the covered Native American populations and the community at large. The data base shall include qualitative and quantitative data that accurately reflects the Native American populations and shall be collected and interpreted in a culturally competent manner at a national, state, and local levels. Findings from these data shall be used in a culturally competent manner to continually assess, improve, and inform strategic planning for services to Native American consumers and families. For purposes of accountability, the Health Plan shall report to the governing entity, in a regular and timely manner, performance and outcome data specific to Native American consumers and families.

7. Human Resource Development

Staff training and development in the areas of Native American cultural competence and mental health shall be implemented at all levels and across disciplines (e.g., for leadership and governing entities, as well as for management and support staff). The strengths brought by cultural competence shall form the foundation for system performance rather than detract or formulate separate agendas.

B. Provider Competencies

1. Knowledge and Understanding, Skills, and Attitudes

Knowledge and understanding, skills, and attitudes shall all be essential components of core continuing education to ensure Native American cultural competence among clinical staff, and promote effective response to the mental health needs of Native American consumers. Knowledge and understanding shall include: consumer populations' background, clinical issues, how to provide appropriate treatment, and the agency/provider role in the treatment process. Skills shall include: communicating effectively across cultures, using consumer's preferred language in treatment, formulating and implementing quality care and treatment plans, appropriately addressing race/ethnicity issues in treatment, effectively using one's self and knowledge in the treatment process, and conducting quality research. Attitudes shall include: respect for diverse heritages, cultures, and experiences (e.g., a consumer's experience of poverty, education, or acculturation), willingness to work with diverse consumer populations including Native Americans, and recognition of how one's self as provider (especially one's culture, race, ethnicity, and gender) may influence the therapeutic relationship.

2. Prevention, Education and Outreach

Each Health Plan shall include a prevention, education, and outreach program that is an integral part of the Plan. Each Plan shall incorporate Native American culturally competent approaches, behaviors, and communication styles in its development and implementation of such programs. In the development and implementation phases, Native American consumers, their families, community organizations, and tribes shall be involved. The prevention, education, and outreach (PE&O) programs shall include Native American culturally specific knowledge of psychiatric impairment and treatment as these apply to the occurrence of mental illness, its distributional pattern, and help seeking behaviors of this consumer population.

C. Clinical Standards and Guidelines

1. Access and Service Authorization

No one shall be denied services because of insurance coverage, and/or language. Access to services shall not be individually-oriented only, but also family-oriented (including consumer defined family) in the context of Native American values. Access criteria for different levels of care shall include health/medical, behavior, and functioning in addition to diagnosis. Criteria shall be multidimensional in six domains: psychiatric, medical, spiritual, social functioning, behavior, and community support.

2. Triage and Assessment

Assessment shall include a multi-dimensional focus including individual, family, community/tribe, functional, psychiatric, medical, and social status. Social support systems such as family support, tribal community strengths shall be included in the assessment. Additionally, an evaluation of degree of acculturation, as well as cultural and socio-economic stressors and factors shall be completed. The assessment shall be of appropriate breadth and depth to establish the nature of problems, the consumer's willingness and ability to work, and the provider's ability to deliver culturally competent services. All assessment scales and measurement tools shall be culturally valid and reliable, and administered, scored, and interpreted by culturally competent Mental Health Specialists.

3. Care Planning

Care plans for Native American consumers shall be compatible with the conceptual framework and community environment of Native American consumers and family members. Native American consumers and family members shall be equal participants except when clinically and culturally contraindicated in care planning. Care plans shall involve culturally indicated family leaders and decision-makers.

4. Plan of Treatment

The treatment plan for Native American consumers shall be relevant to their culture and life experiences. The treatment plan shall be developed by an Native American culturally competent Mental Health Specialist in conjunction with the consumer and family, where appropriate. In the absence of an Native American culturally competent Mental Health Specialist to provide direct services, review of the proposed plan of treatment and supervision by a consultant with this expertise shall be mandatory.

5. Treatment Services

The Health Plan shall include a full array of available treatment modalities, particularly modalities which are culturally acceptable and effective among Native American populations (e.g., psycho-education, psychosocial rehabilitation, family therapy, specialized group therapy, behavioral approaches, use of traditional healers, outreach). Consideration shall be given to the likelihood of the Native American consumer to accept and implement the treatment plan.

6. Case Management

Case management shall be central to the operation of the interdisciplinary treatment team and shall be based on the diagnosed level of care needed by the primary consumer. Case managers for Native American consumers shall require special skills in advocacy, access of community-based services and systems, and interagency coordination. Case management shall also be consumer- and family-driven. Case managers shall be accountable for the cost and appropriateness of the services they coordinate. The Health Plan shall maintain responsibility for the successful and appropriate implementation of the Case Management Plan and the provision of adequate administrative resources and endorsement.

7. Communication Styles and Linguistic support

Cross cultural communication support shall be provided at the option of the Native American consumers and families at no additional cost to them. Native American consumers may speak a variety of dialects or languages, and may communicate nonverbally in culturally-specific ways. Access to these services shall be available at the point of entry into the system and throughout the system. Trained interpreters, who are paid for their services, shall be utilized only in the absence of Native American culturally competent and multi-lingual Mental Health Specialists.

8. Self Help

Native American culturally competent self help groups shall be created to provide services to consumers and their families. The self help groups shall function as part of a seamless continuum of care. Self help groups for Native American consumers shall incorporate consumer-driven goals and objectives that are functionally defined and oriented towards rehabilitative and recovery outcomes. Equal consideration and support shall be given to family and primary consumer self help groups.

9. Discharge Planning

Discharge planning for Native American consumers and families shall include involvement of the consumer and family in the development and implementation of the plan and evaluation of outcomes. Discharge planning shall be done within a Native American culturally competent framework and in a communication style congruent with the consumer's values. The plan shall allow for transfer to less restrictive levels of care in addition to termination of treatment based on accomplishment of mutually agreed terms of the treatment contract. The discharge plan shall include case management and aggressive outreach with the Native American consumer and family, to minimize "administrative" termination which is typically the result of culturally inappropriate services.

IV. Strategic Plan for Implementation

Achieving culturally competent service delivery requires a long-term, highly specialized, multi-stage developmental implementation process. For this reason, the Native American Panel has delineated a list of recommendations to support the successful implementation of these Cultural Competence Standards.

A. Maintaining the Integrity of the Standards

The Panel strongly recommends that any participating public or private organization should utilize qualified Native American Mental Health Specialists and consultants during the implementation process of these Standards. This requirement is necessary to maintain the integrity of the goals, objectives, and "best practices standards" which are inherent in the Cultural Competence Standards, and to promote total quality management standards during the implementation process within various organizations.

B. Commitment of Participating Agencies

Agency participation and cooperation during the implementation process of the Cultural Competence Standards is critical. Participating agencies should demonstrate a defined commitment to serve Native American consumers (i.e., establish good cultural competence practices, have clinically qualified and diversified staffing, provide resources for cultural competence activities).

C. Management/Oversight of Implementation Process

An administrative unit should be established to manage the Cultural Competence Implementation Process. The administrative unit responsibilities should include:

- 1) management of staff and consultants;
- 2) management and negotiation of contracts with participating organizations;
- 3) coordination of arrangements and activities;
- 4) management of budgets and payments;
- 5) fund development.

D. Participation of the Native American Panel in the Implementation Processes

The ongoing participation of the Native American Panel in the implementation process is necessary to maintain the integrity of the goals, objectives, and "best practices standards" which are inherent in the Cultural Competence Standards, and to promote total quality management standards during the implementation process within various organizations. The Panel's responsibilities should include:

- 1) ongoing development and refinement of the Standards;
- 2) development of strategies to upgrade the guidelines to professional standards;
- 3) decisions regarding dissemination of materials;
- 4) development of implementation plan procedures, training materials, and quality management measures;
- 5) development of training methods and consultation fee structures to provide training and/or technical assistance to agencies;
- 6) management of sponsorship for conducting training activities and continued refinement of these activities;
- 7) advocacy with payers to incorporate Standards.