THE PENNSYLVANIA OFFICE

OF

MENTAL HEALTH AND

SUBSTANCE ABUSE SERVICES

STRATEGIC PLAN

FOR

CULTURAL COMPETENCE

SECOND EDITION

DEVELOPED IN COLLABORATION WITH

THE CULTURAL COMPETENCE ADVISORY COMMITTEE

DEPARTMENT OF PUBLIC WELFARE,

COMMONWEALTH OF PENNSYLVANIA

THE OFFICE OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

VISION STATEMENT

"Every person with a serious mental illness and/or addictive disease, and every child and adolescent who abuses substances and/or has a serious emotional disturbance will have the opportunity for growth, recovery, and inclusion in their community, have access to treatment and supports of their choice, and enjoy a quality of life that includes family and friends."

MISSION STATEMENT

"The Office of Mental Health and Substance Abuse Services, in collaboration with other appropriate state offices, will ensure local access to a comprehensive array of quality mental health and substance abuse services that are reflective of the needs of Pennsylvania citizens, effectively managed and coordinated, and responsive to a dynamic and changing health care environment."

MISSION FOR CULTURAL COMPETENCE

"Ensure that all programs, policies, program standards, special or new initiatives promote cultural competency in the public behavioral health system in order to guarantee the availability and access to services and supports that adapts to the individual's culture."

CULTURAL COMPETENCE ADVISORY COMMITTEE

MISSION STATEMENT

The Office of Mental Health and Substance Abuse Services (OMHSAS) Cultural Competency Advisory Committee is a standing committee of the Pennsylvania Planning Council. Its charge is to advise the Deputy Secretary of OMHSAS on the implementation of cultural competence and to enhance the level of cultural competence in the public behavioral health system. The committee will ensure that treatment and services are culturally relevant, effective and appropriate by reviewing programs and policies and making recommendations to the Deputy Secretary.

TABLE OF CONTENTS

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THE OFFICE OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

STRATEGIC PLAN

INTRODUCTION

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Over the next three to five years, guided by a strategic plan formulated by the Office of Mental Health and Substance Abuse Services (OMHSAS) in partnership with the Cultural Competence Advisory Committee, OMHSAS will continue implementing the plan through each phase of the process. The strategic plan represents an ongoing process to develop a culturally competent organization and a culturally responsive community system of care. OMHSAS remains committed to its vision, its mission, and its charge to provide effective treatment and appropriate services to people with Serious Mental Illness (SMI) and children with serious emotional disturbance (SED). Integral to this is the continual development and improvement of cultural competency to raise the level of clinical competency in Pennsylvania's behavioral health system. This is a particularly important step in addressing the strong evidence indicated in the Surgeon General's report that too great a proportion of persons with SMI are not receiving adequate treatment. Inequities in the mental health system have been associated with discrimination, structural discrimination (which is not a conscious discrimination) and individual and systematic lack of cultural competence. More simply characterized, the drive to increase cultural competency in Pennsylvania is powered by three main factors:

1) National and state-wide demographic trends indicate that increasing system responsiveness is required;

2) A pattern of historical inequities in service delivery which effect both access to care and quality outcomes for persons from different ethnic and cultural groups; and

3) To further a national momentum and mounting evidence supporting a need for operationalizing cultural competence throughout the behavioral health system. Responding to this need will contribute to a more skilled workforce as well as better and more effective clinical and social outcomes and ultimately, greater cost effectiveness.

The core definition of cultural competence emphasizes strongly that there must be philosophical and operational congruence among all three of the major administrative levels listed below, to achieve cultural proficiency: 1) attitudes, beliefs, values and skills at the

individual provider level; 2) policies which articulate requirements for care consistency and 3) the availability of supporting administrative structures and procedures. Collectively, cultural competency at all levels of organization will better *enable* the behavioral health system to become an effective cross-cultural system of care that functions effectively with consumers and families of all backgrounds (Cross, Bazron, Dennis & Issacs, 1989).

NATIONAL AND COMMONWEALTH DEMOGRAPHIC TRENDS:

The Commonwealth of Pennsylvania, following nation-wide trends, is showing evidence of growing cultural diversity. This has tremendous hard-to-predict implications not only for the political and social landscape, but also for the full range of human services. In the decade between 1980 and 1990, the Caucasian population in Pennsylvania showed little growth, increasing by just one percent. However, the ethnic Asian and Pacific Island populations increased by 114%, Native Americans by 56% and African Americans by four times the rate of the Caucasian population. Nationally, Latinos made up 9% of the population in 1990 and nearly a decade later, that percentage rose significantly to over 12%, but in Pennsylvania, this population rose tremendously, by 69.6%. In addition, the population category of "Other", which includes primarily those who identify themselves as persons of "mixed" ancestry increased by 79.1% (U.S. Bureau of Census, Census of Population, *Profile of General Demographic Characteristics for Pennsylvania* [1990] & [2000]).

When reviewing population changes as indicated above, we are left with questions about why this has happened and whether there continue to be strong effects contributing to these aspects of population growth. While this remains to be researched, certain causes may be surmised. The rapid overall growth of the Asian populations in Pennsylvania is, in all likelihood, attributable to the increase in migration spanning from the previous decade and the large statistical effect of any change on a small population. The large proportional increase in the number of American Indians is less clear to explain; migration may explain some growth but does not account for all of it. A likely contributor to this positive growth trend for Native Americans is that more individuals are tracing their ancestry and reclaiming their identity with this part of their heritage. Still, it should be noted that the American Indian population in Pennsylvania continues to be very small. African Americans remain the dominant racial minority in the state with a stable rate of growth at 4%. The overall rate of increase in diversity of the population means that Pennsylvania is fast becoming more pluralistic and multicultural in nature.

HISTORICAL INEQUITIES IN BEHAVIORAL HEALTH CARE:

Much of the anecdotal information reported and empirical research conducted over the last twenty-five years has consistently portrayed the central impact of culture on behavioral healthcare (i.e.- op cit). When cultural aspects have been ignored or misunderstood in treatment delivery and design, the following areas important to the recovery of consumers were shown to be negatively affected (i.e. - op cit):

  – Program access and engagement strategies
  – The experience of mental illness and symptom expression

- Receptivity to treatment through standard treatment media
- Problem conceptualization
- Diagnosis
- Problem resolution methods
- Help-seeking behaviors
- Culturally sanctioned coping styles
- Treatment goals
- Treatment interventions
- Family responsibilities

Below is a short summary of inequities and outcomes that suggest inequities, frequently noted anecdotally or as empirically stated observations in research and elsewhere in the literature (National Technical Assistance Center for State Mental Health Planning, 1977):

- Specific techniques based on assumed values are often applied regardless of their cultural appropriateness to a particular client;

- Treatment procedures are not specified for or tailored to cultural distinctions within broad ethnic groupings such as Latino, Asian and Native American;

- The insensitivity in diagnostic assessment instruments appears to result in higher rates of more severe diagnoses, such as schizophrenia, for certain cultural groups, such as African Americans and Latinos and an under reporting of other diagnoses, such as depression for these same population groups (Jones & Gray, 1986; Snowden & Cheung, 1990). Under managed care, providers evaluate their patients using standard protocols either provided by or approved by the Managed Care Organization that are often insensitive to culture influences on the behaviors of concern. Doing so runs the risk of misjudging symptoms and compounding errors in assessment and decision-making (Snowden, 1998);

- Pronounced racial discrepancies between non-whites and whites in admissions for involuntary commitments are suggestive of inequities in diagnosis and service identification. Non-white rates for involuntary criminal commitments are 3.5 times greater than white rates and nearly 2.5 times higher for involuntary non-criminal commitments (Rosenstein, Milazzo-Sayre, MacAskill & Mandescheid, 1987). Dangerousness to self or others is the major criteria for these involuntary commitments. This depends on clinical judgments and police actions that may be readily influenced by widely believed stereotyping of different peoples in combination with behaviors that are otherwise difficult to explain. In short, there is considerable room in the process for the intrusion of racial bias as an influence to diagnostic determination (Snowden, 1990);

- Other patterns of persisting racial and ethnic differences in utilization also remain unexplained. The advent and growth of managed health care has not been able to

either help to overcome or explain these racial and ethnic disparities (Snowden, 1998). Inconsistency such as these suggest the continued inadequacy of current approaches to a disparate population;

- Ethnic and cultural backgrounds provide clues to genetic differences that may affect the way pharmacological agents are metabolized and identify diseases distinct to the identified population (for example: sickle-cell anemia, familial Mediterranean fever and Tay Sacks disease). Likewise advanced age may indicate an expectation for differences in metabolism, due to physiological changes;

- Among older adults as a distinct population many with special needs and all with heritages based on cultural practices different from those practiced today, physicians are less likely to identify psychological problems and may often attribute symptoms simply to age. Consequently, older adults are not very likely to be referred for treatment to behavioral health specialists (Sue & Sue, 1999);

- Certain newer neuroleptics or other drugs such as antidepressants tend to be prescribed less frequently to consumers from different ethnic or cultural groups than for other consumers (Rabasca, 1999);

- The lack or limitations of private insurance coverage may further impede a consumer's access to certain drugs, such as antidepressants (Rabasca, 1999);

- That gay and lesbian youth are over four times more likely to attempt suicide than their heterosexual counterparts (Sue & Sue, 1999) suggests a serious problem in this population's access to behavioral health care and mental health interventions;

- Several researchers (Flaskerud, 1992; Garretson, 1993; Jones, 1986; Lawson et al, 1994) have indicated that the primary reason for the disproportionate rate of severe mental illness diagnoses is error. Diagnosticians who are unfamiliar with variation in the manifestation of mental illness in ethnic populations make these errors. There is a potential for significant cost savings to public and private systems from the introduction of cultural competence in the clinical evaluation process;

- There are major differences in help-seeking patterns by ethnic and cultural groups. Certain help-seeking values result in an unwillingness to seek help for psychiatric problems from formal behavioral health care systems until other community and familial resources have been exhausted or until the problem has grown too extreme to continue coping. Such reluctance to use the behavioral health system may contribute significantly to the current over utilization of emergency room services. Indeed, the National Medical Expenditure Survey (NMES) found that some cultural groupings are, in fact, clearly over represented among high-cost users of service and similarly, cultural groupings are over represented among recidivists (Snowden 1998);

- It has also been stated that the bureaucracy, formality and structure typically associated with managed care presents as more alienating and intimidating to consumers from cultures more accustomed to face-to-face transactions (Snowden, 1998).

CULTURAL COMPETENCE IN STATE AND LOCAL MENTAL HEALTH SYSTEMS: *(National Technical Assistance Center for State Mental Health Planning, 1997)*

- According to the Center for Mental Health Services, many states have developed positive initiatives in the area of cultural competence. However, it is also apparent that in most states cultural competence rests on a weak foundation. State mental health agencies need to embrace this stipulation more fully and develop a strategic planning approach to increasing cultural competence. Without benefit of a strategic plan and the development of momentum approaches to service delivery tend to remain stagnant. Approximately 20% of the states have a specially targeted cultural competence plan and there is growing interest nationwide that might not yet be reflected in the literature. Based on available reports; references there are a number of issues related to the implementation of cultural competence:

- There is a tendency to view cultural competence as an activity, an appreciation of symbols, festivals and style, or a particular educational or informational event, rather than as an ongoing developmental process which must occur on both the corporate and the individual level;

- Skill development in cultural competence needs to be driven by changing demographics;

- Indicative of the lack of research and evaluation on cultural competence in the United States, there are only 22% of the states focusing on the issue;

- There is a need for all the states to assess their cultural competence status and needs; approximately 40% of the states have completed an assessment of their cultural competence status or needs;

- Only a small number of states have successfully developed effective models and approaches to cultural competence; this needs to expand.

- More states need to include cultural competence criteria in certification standards, contracts or licensure; so far only 22% of the states have included this.

- At least 30% of states have established either special task forces or Cultural Competence advisory boards;

- Nearly 46% of states have job positions or units focused on Cultural Competency;
- Targeted populations of color are significantly under represented in the planning of change and in leadership positions in most states;

- Four mental health systems (Ohio, New York, California and Massachusetts) have identified performance measures to help evaluate how to increase the overall level of cultural competence within these respective systems of care.

"State Coordination of Cultural Competence Initiatives" (National Technical Assistance Center for State Mental Health Planning, 1997)

BENEFITS OF OPERATIONALIZING CULTURAL COMPETENCE IN THE BEHAVIORAL HEALTH SYSTEM:

- Ethnically oriented behavioral health programs appear to promote favorable utilization patterns and outcomes. These benefits have been realized through the employment of culturally competent practitioners, promotion of policies on cultural sensitivity and improvement in the organizational culture created by healthcare organizations and practitioners through their directed styles of practice and the skills they encourage (Snowden, 1998);

- Preliminary outcome data suggests that healthcare program activities specifically tailored to different cultural group member needs may increase attendance and agency engagement (Still, 1973; DMHAS, 2000);

  - National Institute on Drug Abuse (NIDA) studies to explore the role of ethnic identification and cultural factors in substance abuse prevention suggest that the incorporation of ethnic and cultural components into drug abuse prevention programs may make programs more effective by reducing risk or by enhancing protective factors that lead to lower stages of drug use (NIDA, 1999);

  - The Ohio Department of Mental Health has accumulated preliminary evidence that support reports of a reduction in psychiatric hospitalization and drug and alcohol relapses and an increase in customer satisfaction and job placements, as well as potential cost reductions (ODMH, 1997).

OMHSAS' DEVELOPMENT OF CULTURAL COMPETENCE:

In light of state-wide demographic trends, historical inequities in both access and service delivery for persons from different ethnic and cultural groups and the evolving systemic development of cultural competence, OMHSAS will promote the incorporation of cultural competence into all levels of its system, expanding cultural knowledge, skills and the adaptation of services to better address the unique needs of a diverse population. Already guidelines for providing culturally competent services are included in the HealthChoices contracts. These contracts require adherence to the Child and Adolescent Service System Program (CASSP) and the Community Support Program (CSP) principles, which include cultural competence as one of several principles. OMHSAS established outcome measures through the Performance Outcomes Management System (POMS) requirement and the Early Warning Data reporting requirement in HealthChoices. POMS open the way to view outcome discrepancies by age, race and ethnicity with respect to, among many parameters, service access and community integration. The Early Warning system provides a means to identify disparities in the behavioral health system in the HealthChoices counties. Now, efforts will be even more clearly defined. Through the development of its strategic plan, the OMHSAS cultural competence mission will:

> *Ensure that all programs, policies, program standards, special or new initiatives promote cultural competency in the public behavioral health system in order to guarantee the availability and access to services and supports that adapts to the individual's culture.*

Historically, the Office has had a long standing commitment to cultural competence beginning in the late 1980's as the Minority Initiatives Subcommittee (MIS) of the CASSP Advisory Committee under the direction of the Bureau of Children's Services. The Committee developed the "Pennsylvania Model of 'Towards a Culturally Competent System of Care'" in the early to mid 1990's based on the Federal CASSP monograph, "Towards a Culturally Competent System of Care." The committee also worked with the CASSP Training and Technical Assistance Institute to develop curriculum and provide a "Training of Trainers" (TOT) model for cultural competence.

In 1997 at the request of the Deputy Secretary, the Bureau of Consumer and Family Affairs convened a workgroup of minority representatives from CASSP and CSP to develop a protocol and establish a new Cultural Competence Advisory Committee. The mission of the newly formed group was to expand the original work of the MIS, which had focused on children and adolescents with serious emotional disturbance and their families, to the full age spectrum for which OMHSAS is responsible. Additionally, the newly formed Committee was charged with broadening cultural competence to include differences between urban and rural cultures, the deaf, hard of hearing, late deafened and deaf-blind populations, lesbian, gay, bi-sexual and transgender communities, and other ethnically or culturally defined groups within Pennsylvania.

The Cultural Competence Advisory Committee was organized into four subcommittees charged with training development, the development of standards incorporating cultural competency, OMHSAS policy review, and data analysis. The following is a summary of the activities conducted by these sub-committees for the behavioral health system:

- A training curriculum has been developed to train all OMHSAS staff including training specifically targeted to the OMHSAS Executive Team. Each bureau developed action plans that would further implement cultural competence practice and guidelines;

- The standards subcommittee had developed cultural competence rehabilitation/clinical standards for the Pennsylvania behavioral health system;

- The policy subcommittee continues to review and comment on various documents that govern or impact the delivery system of care. Comments have been forwarded to the Bureau of Policy and Program on the draft Targeted Case Management Medical Necessity Criteria; draft development of Psychiatric Rehabilitation Standards; County Mental Health Plan Guidelines, etc.;

- The data subcommittee has developed a summary document of national issues and trends in the delivery of behavioral health to persons from different cultural groups. The subcommittee is also reviewing reports from the OMHSAS Division of Management Information Systems relating to State Mental Hospitals and is exploring other possible data sources to evaluate access and treatment as it relates to specific ethnic and cultural populations;

- In the Fall of 2000, Deputy Secretary charged his Executive Team with the development of the first statewide Cultural Competence Strategic Plan. A collaborative partnership was recommended with designating staff from OMHSAS Executive Council and representatives from the Advisory Committee to form a Strategic Planning Ad Hoc Committee. The plan targets two main goals: 1) the development and support of a culturally competent OMHSAS organization and 2) the development of a community-based system of care that responds to an individual's culture.

- In November 2000, OMHSAS began a joint process with the Advisory Committee in the recruitment and select a Cultural Competence Coordinator. The Coordinator's primary responsibilities are to assist in the development and implementation of the OMHSAS Strategic Plan.

- The Strategic Planning Ad Hoc Committee will assist in the development and implementation of a consensus building, "roll out" plan to acquaint key stakeholders of intended OMHSAS initiatives.

> **GOAL 1:** **To develop the cultural competency of the Office of Mental Health and Substance Abuse Services (OMHSAS) and create the supports necessary to continue cultural competency within the organization and improving the clinical competence in Pennsylvania's mental health system.**

OBJECTIVE 1: *Implement the cultural competence (CC) strategic plan for OMHSAS.*

ACTION STEPS:

1. Present plan to the OMHSAS Deputy Secretary and the Executive Council for approval
2. Identify priorities for implementation
3. Define the roles and responsibilities for each OMHSAS Bureau
4. Establish the tools and resources to implement the plan
5. Present the plan to OMHSAS Mental Health Planning Council for adoption
6. Distribute and present the plan to a broad-based constituency

OBJECTIVE 2: *Ensure that OMHSAS staff receives orientation and ongoing training.*

ACTION STEPS:

1. Create and adopt an OMHSAS Cultural Competence training plan that is consistent with the Cultural Competence Advisory Committee training plan

   a. Develop an employee CC orientation including Cultural Competence for supervisors

   b. Integrate Cultural Competence into all OMHSAS training activities

2. Develop pre and post-test surveys to assess awareness of cultural issues, and the overall cultural competence of OMHSAS

3. Establish core cultural competencies consistent with staff responsibilities

OBJECTIVE 3: *Ensure that policies, training, programs and initiatives adhere to cultural competence standards.*

ACTION STEPS:

1. Review all appointed committee complements organized by OMHSAS and assess for membership diversity (with respect to race, gender, age, geography and consumer, provider/professional representation)

2. Incorporate cultural competence standards into committee activities

3. Incorporate cultural competence standards into the policies, training, programs and initiatives of each state mental health facility

4. Report annually on progress toward full implementation of the Cultural Competence plan

OBJECTIVE 4: *Recruit, promote and retain a culturally diverse OMHSAS staff at all levels, to reflect the cultural diversity of Pennsylvania.*

ACTION STEPS:

1. Enhance liaison relationships with civil service special recruiters

2. Facilitate Cultural Competency Advisory Committee collaboration with civil service in order to examine, understand and ensure cultural competency in the hiring system

3. Build on civil service activities to work with both the career centers and the academic departments of universities and colleges in culturally competent recruitment processes

4. Review welfare to work for resource development opportunity

5. Develop and implement a mentoring and grooming plan for staff promotional opportunities

6. Incorporate the following into job descriptions:

    a. cultural competence requirements
    b. application of Cultural Competence standards to specific jobs
    c. incorporate performance criteria to meet Cultural Competence standards

7. Reflect compliance with cultural competence standards in performance evaluations

OBJECTIVE 5: *Develop and nourish a climate that supports and promotes a*

diverse work group.

ACTION STEPS:

1. Conduct an annual "climate assessment" of the OMHSAS internal system including, but not limited to, turn-over rates, new hires, promotions, etc. Results should be incorporated in a QI initiative with recommendations and appropriate action plans

2. Incorporate cultural competency discussions and practices into OMHSAS newsletters

3. Explore existing celebratory activities offered by Department of Public Welfare and develop a strategy for OMHSAS to celebrate culture and diversity.

4. Encourage and support staff participation in cultural activities outside the Department.

5. Create a welcoming multi-cultural physical environment that reflects the persons who work there. This includes the physical atmosphere, such as pictures, magazines, artifacts and other furnishings, etc.

6. Explore the potential of benefits support to alternative family arrangements.

7. Assure that assistive communicative devices are available for persons with disabilities in accordance with the ADA.

8. Develop mechanisms/strategies to address and reduce cross-cultural tensions, i.e., supervisory, among peers and in professional relationships with individuals outside of the office.

OBJECTIVE 6: *Incorporate cultural competence as a part of the HealthChoices initiative and ongoing improvement process.*

ACTION STEPS:

1. Operationalize the standards and develop performance indicators that administrators require in order to implement Cultural Competence throughout the statewide system of care.

2. Collect and disseminate current information and resources regarding cultural competence.

3. Develop mechanisms for review and monitoring of the cultural competence strategic plan.

4. Develop an annual report for the review of cultural competence and incorporate findings into the plan for continuous quality improvement.

> **GOAL 2: To develop a community system of professional mental health and substance abuse care that responds to an individuals' clinical needs in the context of their culture.**

OBJECTIVE 1: *To promote state of the art information and training opportunities for community programs.*

ACTION STEPS:

1. Work with training institutes to ensure cultural competency is integrated throughout <u>all</u> curricula.

2. Ensure that the cultural competency training plan includes:

    a) A "promising" practices forum on cultural competence.
    b) Identification of professional cultural competencies.
    c) Four regional forums to focus on implementation strategies.
    d) Strategies to target and educate medical personnel regarding cultural competence.

3. Encourage state-wide associations to incorporate cultural competency in conference/training activities.

4. Provide selected training activities for consumers and other community organizations.

OBJECTIVE 2: *Develop incentives to promote integration of cultural competence at the local level.*

ACTION STEPS:

1. Recognize innovative cultural competency program practices (newsletters, certificates, recognition dinners, "promising practices" forums).

2. Invite broader local input and participation in state cultural competence initiatives.

3. Develop innovative cultural competence pilot projects.

4. Provide on-going progress reports to communities regarding cultural competence implementation.

5. Funding initiatives, agreements and contracts with counties, Managed Care Organizations and training institutes in the requirements for adherence to Cultural Competence standards.

6. Offer encouragement and training to Consumer Advocate organizations for working with legislators and legislative members of the Health and Human Services committee on cultural issues effecting the treatment and well being of consumers.

OBJECTIVE 3: *Incorporate cultural competence and anti-discrimination practices in program, practices, standards and guidelines.*

ACTION STEPS:

1. Continue inclusion of Cultural Competence Advisory Committee in development of new guidelines, standards and practices.

2. Promulgate clinical/rehabilitation cultural competence standards.

3. Ensure cultural competence in licensing and monitoring procedures and process.

4. Implement protocol for review of all policies and standards by Cultural Competence Advisory Committee to include:

    a) Policies and Procedures

    b) RFPs including HealthChoices behavioral health

    c) Training

    d) Service initiatives and grants

OBJECTIVE 4: *Assist and encourage external constituent groups to be more inclusive of diverse persons.*

ACTION STEPS:

1. Involve consumer and family members in Cultural Competence training activities.

2. Create relationships between Cultural Competence Advisory Committee and boards of directors for external constituent groups.

3. Require external advocacy organizations that are funded directly or indirectly by OMHSAS to demonstrate compliance with Cultural Competence standards.

4. Offer encouragement and training to Consumer Advocate organizations in working with legislators and legislative members of the Health and Human Services committee on cultural issues effecting the treatment and well-being of consumers.

OBJECTIVE 5: *Support the concept of consumer services within the context of his/her family, culture and community.*

ACTION STEPS:

1. Promote staff recruitment to best reflect communities served.

2. Incorporate unique cultural factors into all phases of treatment planning (e.g. assessment, goals, progress reporting, discharge and aftercare).

3. Reflect the needs of communities served in HealthChoices networks, including the development and provision of culturally specific programs and services.

4. Identify and validate programs demonstrating exemplary Cultural Competence practices.

5. Request that County Mental Health Plans include an assessment of unserved and underserved persons and plans to develop and provide culturally specific programs and services to meet the identified needs.

6. Require the County Mental Health Plans to incorporate a plan for implementation of Cultural Competence including specific requirements for service providers.

OBJECTIVE 6: *Evaluate the system's response and effectiveness in meeting the needs of its diverse customers.*

ACTION STEPS:

1. Coordinate the assessment of data analysis under HealthChoices Early Warning System with other monitoring function required to effectively implement Cultural Competence in Pennsylvania.

2. Monitor access to service system at multiple points along the service continuum per culture group.

3. Monitor utilization rate per ethnic cultural group.

4. Increase the number of underserved population in Behavioral Health services.

5. Monitor diagnosis per ethnic cultural group.

6. Monitor the administration of psychotropic medications and other medical interventions per ethnic cultural groups.

APPENDIX A

EARLY WARNING CARE MONITORING PROJECT

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The Early Warning Care Monitoring Project (EWP) is the result of a pilot project co-funded and sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Health Care Financing Administration (HCFA) in cooperation with the Commonwealth of Pennsylvania, Office of Mental Health and Substance Abuse Services. The pilot, conducted during the Southwest HealthChoices implementation in January 1999, was designed to test a limited set of indicators that would allow "early warning" detection of implementation problems with Medicaid managed care behavioral health services. The EWP has demonstrated that a limited set of carefully chosen, rapidly obtained measures have improved the oversight of managed care programs for Medicaid beneficiaries. The indicators measure access, quality of services, and BH-MCO functioning, from multiple data sources. Data is collected related to services authorization, denials, complaints, grievances, rate of re-hospitalization, rate of involuntary admissions, claims payment, telephone access, stakeholder feedback and provider satisfaction.

The process of developing and implementing the EWP has enhanced the atmosphere of collaborative public oversight. This broader involvement of the stakeholders has been critical in creating and sharing a core set of information that reflects current access to and quality of clinical services as well as BH-MCO and state operations. Involvement of stakeholders in the process began during the developmental stage with the creation of a workgroup consisting of county and BH-MCO Quality Management (QM) and Management Information System (MIS) staff to provide feedback regarding the proposed indicators. This allowed operational and system reporting barriers to be identified and corrected prior to implementation.

The EWP reports provide prompt up-to-date client information. This allows counties and BH-MCOs to investigate the findings to determine the appropriate course of action to be taken. The EWP lead to the investigation of issues in the following areas that resulted in prompt resolution:

- Data Validation

- Service Utilization

- Minority Utilization

- Inpatient Readmission

- Provider Satisfaction

- Member Telephone Access to BH-MCO

- Grievances

- Pharmacy Availability

- Transportation to Services

Based upon the current success of the program, the EWP will be expanding into all current and future mandatory managed care counties. Existing measures used to monitor the managed care program will be modified to conform to EWP standards.

The Early Warning Report monitors the utilization of Mental Health and Drug and Alcohol services by racial minorities. As a result of this monitoring activity, Community Care Behavioral Health Organization implemented an outreach initiative to identify underserved African-American Children. Beaver County funds the Family Services System Reform project which targets young parents in population center with high African American representation. Beaver County is engaged in discussions with a provider to expand services to these areas.

APPENDIX B

PERFORMANCE OUTCOME MANAGEMENT SYSTEM

PERFORMANCE OUTCOME MANAGEMENT SYSTEM

The Performance Outcome Management System (POMS) was designed to be an integral part of the monitoring and assessment of the HC program. The focus of POMS is to measure "quality of life" indicators. For the purpose of POMS, priority populations are considered to be persons with serious mental illness and children with, or at risk of, serious emotional disturbance. The counties report on the POMS indicators on a quarterly basis and each time a BH-MCO opens and closes a consumer's case. Operationalizing the performance indicators created challenges for OMHSAS. The first challenge was to develop an information system program that would allow the monitoring teams to incorporate the data into their ongoing quality improvement activities. The Division of Evaluation and MIS began the development of a user-friendly information system program during 1999. The program will allow the monitoring teams to have easy access to county specific data, to look at data for a specific period of time as well as trends over time. Fourteen indicators have been incorporated into the data program. The second challenge has been to verify the accuracy and completeness of the data. This has been an on-going process and has included providing technical assistance to counties and BH-MCOs.