



## **Section 3.23** Cultural Competence

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### **3.23.1 Introduction**

- a. The purpose of this policy is to outline the culturally and linguistically competent framework which Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) has developed to meet Federal, State, Contract and Grant requirements. Furthermore, this policy is intended to communicate the expectation to delivery culturally and linguistically appropriate services in order to ensure that services are culturally competent for diverse, underserved and underrepresented populations.
- b. Tribal and Regional Behavioral Health Authorities (T/RBHAs) must ensure all contracted providers adhere to the requirements of this policy and [NARBHA Policy 9.1 Training Requirements](#)

### **3.23.2 Terms**

Definitions for terms are located online at <http://www.azdhs.gov/bhs/definitions/index.php> or <http://www.narbha.org/for-providers/provider-resources/provider-policy-manual/definitions>. The following terms are referenced in this section:

[CLAS Standards](#)

[Commonly Encountered Limited English Proficiency \(LEP\) Groups](#)

[Culture](#)

[Culturally Based](#)

[Cultural Need](#)

[Culturally Relevant](#)

[Disability](#)

[Health Disparities](#)

[Interpretation](#)

[Limited English Proficiency \(LEP\)](#)

[Linguistic Competence](#)



[Linguistic Need](#)

[Member Information Materials](#)

[Qualified Interpreter/Translator](#)

[Special Populations](#)

[Translation](#)

[Underrepresented/Underserved Populations](#)

### **Procedures 3.23.3**

#### **a. Cultural Competence Framework**

##### **i. Required Culturally and Linguistically Appropriate Services (CLAS) Standards:**

The Enhanced National CLAS Standards are intended to advance health equity, improve quality, and help eliminate health care disparities by establishing a blueprint for individuals as well as health care organizations to implement culturally and linguistically appropriate services. The Enhanced Standards are a comprehensive series of guidelines that inform, guide, and facilitate practices related to culturally and linguistically appropriate health services.

1. Principal Standard (Standard 1): Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.
2. Governance, Leadership, and Workforce (Standards 2-4): Provide greater clarity on the specific locus of action for each of these Standards and emphasizes the importance of the implementation of CLAS as a systemic responsibility, requiring the investment, support, and training of all individuals within an organization.
3. Communication and Language Assistance (Standards 5-8): Provides a broader understanding and application of appropriate services to include all communication needs and services, including sign language, braille, oral interpretation, and written translation.
4. Engagement, Continuous Improvement, and Accountability (Standards 9-15): Underscores the importance of establishing individual responsibility in ensuring that CLAS is supported, while retaining the understanding that effective delivery of CLAS demands across an organization. This revision focuses on the supports necessary for adoption, implementation, and maintenance of culturally and linguistically appropriate policies and services regardless of one's role within an organization or practice. All individuals are accountable for upholding the values and intent of the National CLAS Standards.
  - a. ADHS/RBHA contracts, ADHS/TRBHA Intergovernmental Agreements (IGAs) and T/RBHA Annual Cultural Competence plans require adherence to all areas of the CLAS standards.

#### **b. Language Access Services (LAS)**

- i. To comply with the LAS requirements, T/RBHAs and subcontracted providers must:



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1. Offer language assistance to individuals who have LEP and/or other communication needs, such as sign language interpreters and American Sign Language fluent staff, at no cost to them, to facilitate timely access to all health care and services;
  2. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing;
  3. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained family and friends and/or minors as interpreters should be avoided;
  4. Ensure providers identify the prevalent non-English language within provider service areas to ensure service capacity meets those needs;
  5. Provide easy-to-understand print and multimedia materials as well as signage in the languages commonly used by the populations in the service area. Have services provided in a culturally competent manner with consideration of members with LEP or reading skills and those with diverse cultural and ethnic backgrounds, including those who identify with deaf culture as well as members with visual or auditory limitations. Options include access to a language interpreter, a person proficient in sign language for the hearing impaired and written materials available in Braille for the blind or in different formats as appropriate;
  6. Ensure qualified oral interpreters and bilingual staff as well as certified sign language interpreters provide access to oral interpretation, translation, sign language and disability-related services, and provide auxiliary aids and alternative formats on request. Oral interpretation and sign language services are provided at no charge to Arizona Health Care Cost Containment System (AHCCCS) eligible persons and persons determined to have a Serious Mental Illness (SMI); and
  7. Conduct evaluations of the primary non-English languages spoken within the T/RBHA Geographical Service Areas (GSAs) and T/RBHA programs that affect cultural competence, access and quality of care.
- c. Accessing Oral Interpretation Services
- i. In accordance with [Title VI of the Civil Rights Act](#), Prohibition against National Origin Discrimination and the [President's Executive Order 13166](#), T/RBHAs and their subcontracted providers must make oral interpretation services available to persons with LEP at all points of contact. Oral interpretation services are provided at no charge to AHCCCS eligible persons and Non-Title XIX/XXI persons determined to have a SMI. Members must be provided with information instructing them how to access these services.
- d. Accessing Interpretation Services for the Deaf and the Hard of Hearing
- T/RBHAs and their subcontracted providers must adhere to the rules established by the Arizona Commission for the Deaf and Hard of Hearing, in accordance with [A.R.S. § 36-1946](#), which cover the following:
- i. Classification of interpreters for the Deaf and the Hard of Hearing based on the level of interpreting skills acquired by that person;
  - ii. Establishment of standards and procedures for the qualification and licensure of each classification of interpreters;



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- iii. Utilizing licensed interpreters for the Deaf and the Hard of Hearing; and
  - iv. Providing auxiliary aids or licensed sign language interpreters that meet the needs of the individual upon request. Auxiliary aids include computer-aided transcriptions, written materials, assistive listening devices or systems, closed and open captioning, and other effective methods of making aurally delivered materials available to persons with hearing loss.
    - 1. The Arizona Commission for the Deaf and the Hard of Hearing provides a listing of licensed interpreters, information on auxiliary aids and the complete rules and regulations regarding the profession of interpreters in the State of Arizona. (Arizona Commission for the Deaf and the Hard of Hearing <http://www.acdhh.org> or (602) 542-3323 (V/TTY)).
  - e. Translation of Written Material  
T/RBHAs and their subcontracted providers must ensure information disseminated to behavioral health members meets cultural competence and LEP requirements and make written translated materials available, when the T/RBHA is aware that a language is spoken by 3,000 or 10% (whichever is less) of the T/RBHA's members, to the commonly encountered LEP groups who are AHCCCS eligible and to persons determined to have a SMI.
  - f. All vital materials shall be translated when the T/RBHA is aware that a language is spoken by 1,000 or 5% (whichever is less) of the T/RBHA's members who also have LEP. Vital materials must include at a minimum;
    - i. Notice for denials, reductions, suspensions or termination of services;
    - ii. Service plans;
    - iii. Consent forms;
    - iv. Communications requiring a response from the behavioral health recipient;
    - v. Grievance notices; and
    - vi. Member handbooks.
  - g. All written notices informing members of their right to interpretation and translation services must be translated when the T/RBHA is aware that 1000 or 5% (whichever is less) of the T/RBHA's members speak that language and have LEP.
  - h. Members with LEP, whose languages are not considered commonly encountered, will be provided written notice in their primary or preferred language of the right to receive competent translation of written material and provide instructions for obtaining culturally competent materials. Members have the right to know which providers speak languages other than English.
- 4. Culturally Competent Care**
- a. To comply with the Culturally Competent Care requirements, T/RBHAs and subcontracted providers must:
    - i. Recruit, promote, and support culturally and linguistically diverse representation within governance, leadership, and the workforce that are responsive to the populations in the service area(s);



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- ii. Educate and train representatives within governance, leadership, and the workforce in culturally and linguistically appropriate policies and practices on an ongoing basis; Providers with direct care responsibilities must complete mandated Cultural Competence training (see [NARBHA Policy 9.1 Training Requirements](#) and the [Cultural Competence Plan](#));
  - iii. Guarantee a member's right to be treated fairly without regard to age, ethnicity, race, sex (gender), religion, national origin, creed, tribal affiliation, ancestry, gender identity, sexual orientation, marital status, genetic information, socio-economic status, physical or intellectual disability, ability to pay, mental illness, and/or cultural and linguistic need; and
  - iv. Provide culturally relevant and appropriate services for members of various populations including but not limited to: age groups, gender and sexual minorities, persons with disabilities, racial and ethnic groups, religious affiliations, socio-economic statuses, tribal nations, etc.
- b. Assessment
- i. If behavioral health recipients request a copy of the assessment, those documents must be provided to them in their primary/preferred language. Documentation in the assessment must also be made in English; both versions must be maintained in the recipient's record. This will ensure that if any persons, who must review the recipient's record for purposes such as coordination of care, emergency services, auditing and data validation, have an English version available.
- c. Individual Service Plan (ISP) and Inpatient Treatment and Discharge Plan (ITDP)
- i. The ADHS/DBHS Individual Service Plan (ISP) is intended to fulfill several functions, which include identification of necessary behavioral health services (as evaluated during the assessment and through participation from the person and the team), documentation of the person's agreement or disagreement with the plan, and notification of the person's right to a Notice of Action (See [NARBHA Policy 5.1 Notice Requirements and Appeal Process for Title XIX and Title XXI Eligible Persons](#)) or Notice of Decision and Right to Appeal (See [NARBHA Policy 5.5 Notice and Appeal Requirements \(SMI and Non-SMI/Non-Title XIX/XXI\)](#)) if the person does not agree with the plan. ADHS/DBHS provides the service plan templates in both English and Spanish. The individual service plan is a vital document as defined in the AHCCCS/ADHS contract, ADHS/RBHA contracts and ADHS/TRBHA IGAs.
    - 1. Service plans specifically incorporate a person's rights to disagree with services identified in the plan, if the plan is not in the person's preferred language, the person has not been appropriately informed of services they will be provided nor have they been afforded the opportunity to exercise their rights when there is a disagreement.
    - 2. In general, any document that requires the signature of the behavioral health recipient and contains vital information such as the treatment, medications or notices, or service plans must be translated into their preferred/primary language if requested by the behavioral health recipient or guardian.
    - 3. If the primary/preferred language of the behavioral health recipient is other than English and any of the service plans have been completed in English, the provider must ensure the service plans are translated into the behavioral health recipient's primary/preferred language for their signature. T/RBHAs and



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subcontracted providers must also maintain documentation of the ISP in both the preferred/primary language as well as in English.

4. These requirements apply also to the Inpatient Treatment and Discharge Plan (ITDP) in accordance with the [9 A.A.C. 21, Article 3](#).

### 5. Organizational Supports for Cultural and Linguistic Need

- a. Under ADHS/DBHS guidance, and to comply with the Organizational Supports for Cultural Competence, the T/RBHAs and subcontracted providers must:
  - i. Establish culturally and linguistically appropriate goals, policies, and management accountability and infuse them throughout the organization's planning and operations;
  - ii. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures and continuous quality improvement activities;
  - iii. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness;
  - iv. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area;
  - v. Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.
  - vi. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public;
  - vii. Ensure the use of multi-faceted approaches to assess satisfaction of diverse individuals, families, and communities, including the identification of minority responses in the analysis of client satisfaction surveys, the monitoring of service outcomes, member complaints, grievances, provider feedback and/or employee surveys;
  - viii. Include prevention strategies by analyzing data to evaluate the impact on the network and service delivery system, with the goal of minimizing disparities in access to services and improving quality; and
  - ix. Consult with diverse groups to develop relevant communications, outreach and marketing strategies that review, evaluate, and improve service delivery to diverse individuals, families, and communities, and address disparities in access and utilization of services.

### 6. Documenting Clinical Cultural and Linguistic Need

- a. To advance health literacy, reduce health disparities, and identify the individual's unique needs, T/RBHAs and subcontractors must:
  - i. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery;
  - ii. Ensure documentation of the cultural (for example: age, ethnicity, race, national origin, sex (gender), gender identity, sexual orientation, tribal affiliation, disability) and linguistic (for example, primary language, preferred language, language spoken at home, alternative language) needs within the medical records;
  - iii. Maintain documentation within the medical record of oral interpretation and written translation services provided in a language other than English. Documentation must include the date of service, interpreter name, type of language provided, interpretation duration, and type of interpretation services provided;



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- iv. Ensure that the cultural preferences of members and their families are assessed and included in the development of treatment plans; and
- v. Assess the unique needs of the GSA, as communities' cultural preferences are critical in the development of goals and strategies of prevention within documentation of cultural and linguistic need.

**7. Cultural Competence Reporting and Accountability**

- a. Reporting and accountability measures are intended to track, monitor, and ensure access to quality and effective care. Equity in the access, delivery, and utilization of services is accomplished by the T/RBHAs and subcontracted providers:
  - i. Conducting annually and ongoing strategic planning in Cultural Competence with the inclusion of national level priorities, contractual requirements, stakeholder input, community involvement and initiative development in areas, including but not limited to: Continuing Education, Training, Community Involvement, Health Integration, Outreach, Prevention, Data Analysis/Reporting, Health Literacy, and Policies/Procedures Development;
  - ii. Capturing and reporting on language access services which include: linguistic needs (primary language, preferred language, language spoken at home, alternative language); interpretive services; written translation services; and maintaining documentation on how to access qualified/licensed interpreters and translators; and
  - iii. Assessing and developing reports quarterly, semi-annually, and annually within the areas of cultural competence and workforce development to review the initiatives, activities, and requirements impacting diverse communities, GSAs, and the individuals accessing and receiving services.  
Continuous and ongoing reporting provides insight to strengths, gaps, and needs within communities served by T/RBHAs and T/RBHA subcontracted providers with a goal of health and wellness for all.

b. Cultural Competence Administrator

T/RBHAs must employ a Cultural Competence as key personnel and a point of contact to implement and oversee compliance requirements as described in the Annual Cultural Competence Plan, Cultural Competence Policy and Procedures and Provider Manual policies, and must participate in Cultural Competence Committees.

c. Cultural Competence Plan

- i. Each T/RBHA must develop and implement an Annual Cultural Competence Plan based on current initiatives in the field of cultural competence, with a focus on national level priorities, contractual requirements, and initiatives developed by internal and external stakeholders, including providers and experts in cultural competence. The Annual Cultural Competence Plan must be submitted to the ADHS/DBHS Cultural Competence Manager each year as required. The Annual Cultural Competence Plan must include the following areas:
  - 1. Education and Training,
  - 2. Collaborative Partnerships with Communities and Community Based Organizations,
  - 3. System Health Integration,
  - 4. Communications, Marketing and Outreach,
  - 5. Data Collection and Analysis,
  - 6. Policies, Procedures and Regulations



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- ii. Annually, T/RBHAs will develop and/or modify initiatives based on the identified needs of their GSAs, with a goal of eliminating health disparities.
- d. Cultural Competence Reporting
- ADHS/DBHS has developed a comprehensive service structure designed to address the needs of Arizona's diverse populations and underserved/underrepresented populations. The following reports assist in the analysis and evaluation of the system.
- i. Annual Effectiveness Review of the Cultural Competence Plan Report:
    1. Each T/RBHA will annually evaluate the impact of the annual cultural competence plan's initiatives and activities towards developing a culturally competent service delivery system. The report must be submitted to the ADHS/DBHS Cultural Competence Manager in accordance with RBHA contracts and T/RBHA IGAs.
  - ii. Cultural Competence and Workforce Development Quarterly Report:
    1. Each T/RBHA must submit quarterly reports to the ADHS/DBHS Cultural Competence Manager. Information reported connects data to initiatives and activities occurring within specific GSAs and provides a review and analysis of the efforts/initiatives that are impacting diverse communities, and assists in monitoring initiatives/deliverables throughout the year.
  - iii. Semi-Annual Language Services Report:
    1. Each T/RBHA must submit semi-annual reports to the ADHS/DBHS Cultural Competence Manager. The report captures linguistic need (primary language, Deaf and Hard of Hearing, sign language services, interpretive services, translation services, traditional healing services, and mental health services) and provides comprehensive lists of translator language abilities and billing unit usage.
- e. Workforce Development
- T/RBHAs and their subcontracted providers must:
- i. Ensure all staff receive training in cultural competence and culturally and linguistically appropriate services during new employee orientation;
  - ii. Provide annual training to all staff in diversity awareness and culturally relevant topics customized to meet the needs of their GSA;
  - iii. Provide continuing education in cultural competence, to include but not limited to: review of CLAS standards, use of oral interpretation and translation services, and alternative formats and services for LEP clients;
  - iv. Ensure all staff have access to resources for behavioral health recipients with diverse cultural needs;
  - v. Recruit, retain and promote, at all levels of the organization, a culturally competent, diverse staff and leadership;
  - vi. Maintain full compliance with all mandatory trainings; (See [NARBHA Policy 9.1 Training Requirements](#)); and
  - vii. Develop and implement cultural-related trainings/curriculums as determined by ADHS/DBHS, T/RBHAs, Cultural Competence Committees, policies, and contract requirements.





**8. Laws Addressing Discrimination and Diversity**

- a. T/RBHAs and provider agencies must abide by following referenced federal and state applicable rules, regulations and guidance documents:
  - i. [Title VI of the Civil Rights Act](#) prohibits discrimination on the basis of race, color, and national origin in programs and activities receiving federal financial assistance.
  - ii. Department of Health and Human Services - Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination affecting [Limited English Proficient](#) (LEP) Persons.
  - iii. [Title VII of the Civil Rights Act of 1964](#) prohibits employment discrimination based on race, color, religion, sex, or national origin by any employer with 15 or more employees. ([The Civil Rights Act of 1991](#) reverses in whole or in part several Supreme Court decisions interpreting Title VII, strengthening and improving the law and providing for damages in cases of intentional employment discrimination.)
  - iv. [President's Executive Order 13166](#) improves access to services for persons with Limited English Proficiency (LEP). The Executive Order requires each Federal agency to examine the services it provides and develop and implement a system by which LEP persons can meaningfully access those services consistent with, and without unduly burdening, the fundamental mission of the agency.
  - v. [State Executive Order 99-4](#) and [President's Executive Order 11246](#) mandates that all persons regardless of race, color, sex, age, national origin or political affiliation shall have equal access to employment opportunities.
  - vi. [The Age Discrimination in Employment Act \(ADEA\)](#) prohibits employment discrimination against employees and job applicants 40 years of age or older. The ADEA applies to employers with 20 or more employees, including state and local governments. The Older Workers Benefit Protection Act (Pub. L. 101-433) amends the ADEA to prohibit employers from denying benefits to older employees.
  - vii. [The Equal Pay Act \(EPA\)](#) and [A.R.S. 23-341](#) prohibit sex-based wage discrimination between men and women in the same establishment who are performing under similar working conditions.
  - viii. [Section 503 of the Rehabilitation Act](#) prohibits discrimination in the employment or advancement of qualified persons because of physical or mental disability for employers with federal contracts or subcontracts that exceed \$10,000. All covered contractors and subcontractors must also include a specific equal opportunity clause in each of their nonexempt contracts and subcontracts.
  - ix. [Section 504 of the Rehabilitation Act](#) prohibits discrimination on the basis of disability in delivering contract services.
  - x. [The Americans with Disabilities Act](#) prohibits discrimination against persons who have a disability. Providers are required to deliver services so that they are readily accessible to persons with a disability. T/RBHAs and their subcontracted providers who employ less than fifteen persons and who cannot comply with the accessibility requirements without making significant changes to existing facilities may refer the person with a disability to other providers where the services are accessible. A T/RBHA or its subcontracted provider who employs fifteen or more persons is required to designate at least one person to coordinate its efforts to comply with federal regulations that govern anti-discrimination laws.



### **3.23.4 References**

The following citations can serve as additional resources for this content area:

[29 U.S.C § 102](#)

[29 U.S.C. § 206 \(d\)](#)

[29 U.S.C § 501](#)

[29 U.S.C. § 621](#)

[29 U.S.C. § 626 \(e\)](#)

[29 U.S.C § 791](#)

[42 U.S.C. § 2000d et seq.](#)

[42 U.S.C. § 2000e et seq.](#)

[42 U.S.C. § 1981](#)

[42 U.S.C. § 12101 et seq.](#)

[Balanced Budget Act of 1997](#)

[45 CFR Section 80.3](#)

[42 CFR § 438.10](#)

[42 CFR § 438.206](#)

[42.CFR § 422.2264\(e\)](#)

[Title VI of the Civil Rights Act](#)

[ADA Accessibility Guidelines](#)

[The Age Discrimination in Employment Act \(ADEA\)](#)

[Culturally and Linguistically Appropriate Services \(CLAS\) in Healthcare Standards](#)

[Mental Health: Culture, Race and Ethnicity- Supplemental Report of the Surgeon General](#)

[U.S. Department of Health & Human Services - Office for Civil Rights – LEP recipients](#)

[U.S. Department of Health & Human Services - Office of Minority Health](#)

[U.S. Equal Employment Opportunity Commission](#)

[Indian Health Care Improvement Act - Provisions in the Patient Protection and Affordable Care Act \(P.L. 111-148\)](#)

[President's Executive Order No.13166](#)

[A.R.S. § 12-242](#)

[A.R.S. § 23-341](#)

[A.R.S. § 36-1946](#)

[R9-21-202](#)

[AHCCCS/ADHS Contract](#)

[AHCCCS Contractor Operations Manual \(ACOM\)](#)

[ADHS/RBHA Contracts](#)

[ADHS/Tribal IGAs](#)

[ADHS Tribal Consultation Policy](#)

[Section 3.9 Intake, Assessment and Service Planning](#)

[Section 3.13 Covered Behavioral Health Services](#)

[Section 4.2 Medical Record Standards](#)

[Section 5.1 Notice Requirements and Appeal Process for Title XIX and Title XXI Eligible Persons](#)

[Section 5.5 Notice and Appeal Requirements \(SMI and Non-SMI/Non-Title XIX/XXI\)](#)

[Section 9.1 Training Requirements](#)

[ADHS/DBHS Covered Behavioral Health Services Guide](#)

[ADHS/DBHS Cultural Competency Web page](#)

[The Adult Clinical Team Practice Protocol](#)

[The Child and Family Team Process Practice Protocol](#)



[The Prevention Framework for Behavioral Health, 2012 Revision](#)  
[Healthy People 2020 and Steps to a Healthier US: Leading Prevention Presentation](#)  
[Executive Order \(2006-14\), Consultation and Cooperation with Arizona Tribes](#)

**3.23.5 PM Forms**

None

**3.23.6 PM Attachments**

None

Signature on file	07/15/14
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Mary Jo Gregory President and Chief Executive Officer	Date

Signature on file	07/15/14
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Teresa Bertsch, MD Chief Medical Officer	Date

Reference [ADHS/DBHS Policy 407](#)