NORTH COUNTRY COMMUNITY MENTAL HEALTH
ADMINISTRATIVE MANUAL

CHAPTER: One - Administration
PLAN: CULTURAL COMPETENCY PLAN
EFFECTIVE DATE: April 1, 2026

Policy

It is the policy of North Country Community Mental Health (NCCMH) to ensure staff and contracted providers take reasonable steps to facilitate appropriate cultural competence in the provision of behavioral health and intellectual or developmental disability services.

Application

All NCCMH programs.

Purpose

To provide equitable treatment in a culturally and linguistically appropriate manner to individuals regardless of an their race, creed, color, sex, gender, pregnancy or pregnancy related conditions, ancestry, national origin, marital/familial status, military status, height, weight, age, religion, disability, veteran's status, genetic information, sexual orientation, ability to pay for services or any other classification protected by law. Compliance is best assured through a focus on improvement, utilizing objective data, systems analysis, and feedback.

Administrative Responsibilities

Primary responsibility for implementing and monitoring compliance with the Cultural Competency Plan shall be assigned to the Human Resource Manager. The Human Resource Manager will, with oversight of the Chief Executive Officer, perform the following activities:

- Review and amend the Cultural Competency Plan (CC Plan), as necessary, based on changes in the laws and regulations that govern cultural competency standards.
- Develop methods to ensure that employees and provider organization staff are aware of the CC Plan and related policies and procedures and are aware of the importance of ensuring equitable treatment in a culturally and linguistically appropriate manner.
- Ensure that employees and provider organization staff are educated and trained in the cultural competence standards.
- Monitor at least annually for appropriate training of staff, and that appropriate data gathering is occurring.
- Initiate corrective actions for identified deficiencies in implementation and maintenance of cultural competence standards.
- Develop processes to identify the number or proportion of culturally diverse persons in the population to be served or likely to be encountered by the provider or service.
- Develop processes for identifying and reporting data pertinent to tracking culturally diverse person's needs and future needs.

Plan Elements

The Cultural Competency Plan shall, at a minimum, include the following features:

- Written policies and procedures for operational activities undertaken by the organization personnel, including relevant specialty specific standards;
- Education and training programs to ensure staff have a working knowledge of cultural competency standards;
- A system ensuring and documenting that all new personnel receive training regarding cultural competency standards;
- A system ensuring and documenting that staff receive annual cultural competency training;

- A system that tracks the cultural diversity in service requests and provision of services, as well as issues that have been raised within the organization and the resolution of those issues;
- A process to assess and analyze community need, and implementation of policy/procedure to meet needs identified.
- A process for availability of interpreter services when needed.

Definitions

Culture: A set of values, beliefs, systems of language, communication, and practices that people share in common and that can be used to define them as a collective.

Cultural Awareness: The recognition and understanding of differences and similarities between cultures. This involves acknowledging and respecting the diverse ways in which people live, work, communicate, and interact.

Cultural Knowledge: Knowledge of selected cultural characteristics, history, values, belief systems, and behaviors of the members of another cultural group .

Cultural Sensitivity: Knowing that cultural differences as well as similarities exist, without assigning values, i.e., better or worse, right or wrong, to those cultural differences. (

Cultural Competence; A set of congruent behaviors, attitudes, and policies that come together in a system and enables that system to work effectively in cross-cultural situations. Operationally defined, cultural competence is the integration and transformation of knowledge about individuals and groups of people into specific standards, policies, practices, and attitudes used in appropriate cultural settings to increase the quality of health care.

REFERENCE: OPHS – Office of Minority Health; "National Standards for Culturally and Linguistically Appropriate Services in Health Care" FINAL REPORT, March 2001, Washington, D.C.
The Office of Minority Health, Public Health Services, U.S. Department of Health and Human Services – Cultural Competence Standards, "Assuring Cultural Competence in Health Care", Summary
National Standards for CLAS in Health Care
SAMHSA'S National Mental Health Information Center; Cultural Competence Standards in Managed Care Mental Health Services, Section II – Overall System Standards and Implementation Guidelines
Federal Register: December 22, 2000 (Volume 65, Number 247); Notices: Page 80865 – 80879
CARF 2025 Standard 1.A 5

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APPROVED BY SIGNATURE:

03/30/2026

Chief Executive Officer — Date

03/28/2026

NCCMH Board Chair — Date

Standard 1.

NCCMH will ensure that individuals served receive from all staff members effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.

Respectful care includes taking into consideration the values, preferences, and expressed needs of the person served. Understandable care involves communicating in the preferred language of the individual and ensuring that they understand all clinical and administrative information. Effective care results in positive outcomes including satisfaction; appropriate preventive services, diagnosis, and treatment; adherence; and improved health status.

Cultural competence includes being able to recognize and respond to health-related beliefs and cultural values, disease incidence and prevalence, and treatment efficacy. Examples of culturally competent care include striving to overcome cultural, language, and communications barriers; providing an environment in which people from diverse backgrounds feel comfortable discussing their health beliefs and practices in the context of negotiating treatment options; using community workers as a check on the effectiveness of communication and care; encouraging clients to express their spiritual beliefs and cultural practices; and being familiar with and respectful of various traditional healing systems and beliefs and, where appropriate, integrating these approaches into treatment plans. When individuals need additional assistance, it may be appropriate to involve a patient advocate, case manager, or ombudsperson with special expertise.

Standard 2.

NCCMH will make a good faith effort to implement strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area in age, ethnicity, gender, sexual orientation, spiritual belief, and socioeconomic status.

Diverse staff is defined as being representative of the diverse demographic population of the service area and includes the leadership of the organization, its governing boards, clinicians, and administrative personnel. Building staff that adequately mirrors the diversity of the population served should be based on continual assessment of staff demographics (collected as part of organizational self-assessment in accordance with Standard 9) as well as demographic data from the community maintained in accordance with Standard 11.

NCCMH focuses not on numerical goals or quotas, but rather on the continuing efforts of an organization to design, implement, and evaluate strategies for recruiting and retaining a diverse staff as well as continual quality evaluation of improvements in this area.

NCCMH should encourage the retention of diverse staff by fostering a culture of responsiveness toward the ideas and challenges that a diverse staff offers.

Standard 3.

NCCMH incorporates training on culturally and linguistically appropriate service delivery culture competency in all staff training plans at all levels and across all disciplines.

Training is relevant to the particular functions of the individual trained and the needs of the specific populations served, and over time training includes the following topics:

- Effects of differences in the cultures of staff and those served on clinical and other workforce encounters, including effects of the culture of American medicine and clinical training;
- elements of effective communication among staff and people of different cultures and different languages, including how to work with interpreters and telephone language services;

- strategies and techniques for the resolution of racial, ethnic, or cultural conflicts between staff and individuals served;
- written language access policies and procedures, including how to access interpreters and translated written materials;
- applicable provisions of Title VI of the Civil Rights Act of 1964, 42 U.S.C. §2000d, 45 C.F.R. §80.1 et seq. (including Office for Civil Rights Guidance on Title VI of the Civil Rights Act of 1964, with respect to services for (LEP) individuals (65 Fed. Reg. 52762-52774, August 30, 2000);
- NCCMH's complaint/grievance procedures;
- effects of cultural differences on health promotion and disease prevention, diagnosis and treatment, and supportive, rehabilitative, and end-of-life care;
- impact of poverty and socioeconomic status, race and racism, ethnicity, and socio-cultural factors on access to care, service utilization, quality of care, and health outcomes;
- differences in the clinical management of preventable and chronic diseases and conditions indicated by differences in the race or ethnicity of patients/consumers; and
- effects of cultural differences among those served and staff upon health outcomes, patient satisfaction, and clinical management of preventable and chronic diseases and conditions.

Standards 4, 5, 6, and 7 are based on Title VI of the Civil Rights Act of 1964 (Title VI) with respect to services for limited English proficient (LEP) individuals. Title VI requires all entities receiving Federal financial assistance, including NCCMH, take steps to ensure that LEP persons have meaningful access to the health services that they provide.

Language services include, as a first preference, the availability of bilingual staff who can communicate directly with patients/consumers in their preferred language. When such staff members are not available, face-to-face interpretation provided by trained staff, or contract or volunteer interpreters, is the next preference. Telephone interpreter services should be used as when an interpreter is needed instantly, or appropriately credentialed bilingual staff are not available. The competence and qualifications of individuals providing language services are discussed in Standard 6.

Standard 4.

NCCMH offers and provides language assistance services at no cost to each client with limited English proficiency at all points of contact, in a timely manner during all hours of operation.

Standard 5.

NCCMH provides to individuals receiving services in their preferred language both verbal and written notices informing them of their right to receive language assistance services.

LEP individuals are informed in a language they can understand that they have the right to free language services and that such services are readily available.

NCCMH uses methods of informing patients/consumers about language assistance services that include:

- using language identification or "I speak . . ." cards;
- creating uniform procedures for timely and effective telephone communication between staff and LEP persons; and

- including statements about the services available and the right to free language assistance services in appropriate non-English languages.

Standard 6.

NCCMH must assure the competence of language assistance provided to LEP individuals by interpreters and bilingual staff. Family and friends are not used to provide interpretation services (except on request by the client).

Accurate and effective communication between clients and clinicians is the most essential component of the healthcare encounter. Individuals cannot fully utilize or negotiate other important services if they cannot communicate with the nonclinical staff. When language barriers exist, relying on staff who are not fully bilingual or lack interpreter training frequently leads to misunderstanding, dissatisfaction, omission of vital information, misdiagnoses, inappropriate treatment, and lack of compliance. NCCMH does not use any apparently bilingual person for delivering language services. Interpretive service providers are assessed to ensure the training and competency of the individuals who deliver such services.

Bilingual clinicians and other staff who communicate directly with patients/consumers in their preferred language must demonstrate a command of both English and the target language that includes knowledge and facility with the terms and concepts relevant to the type of encounter.

To ensure complete, accurate, impartial, and confidential communication, family, friends or other individuals, should not be required, suggested, or used as interpreters. A client may choose to use a family member or friend as an interpreter after being informed of the availability of free interpreter services unless the effectiveness of services is compromised or the LEP person's confidentiality is violated. NCCMH staff should suggest that a trained interpreter be present during the encounter to ensure accurate interpretation and should document the offer and declination in the LEP person's file. Minor children should never be used as interpreters, nor be allowed to interpret for their parents when they are the receiving services.

Standard 7.

NCCMH must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.

Commonly encountered languages are languages that are used by a significant number or percentage of the population in the service area.

NCCMH should develop policies and procedures to ensure development of quality non- English signage and patient-related materials that are appropriate for their target audiences. At a minimum, the translation process should include translation by a trained individual, back translation and/or review by target audience groups, and periodic updates.

Standard 8.

NCCMH should consider CLAS standards when developing the strategic plan. Successful implementation of the CLAS standards depends on an organization's ability to target attention and resources on the needs of culturally diverse populations. It also allows NCCMH to identify, monitor, and evaluate system features that may warrant implementing new policies or programs consistent with the overall mission.

Standard 9.

NCCMH will conduct initial and ongoing organizational self-assessments not less than annually of CLAS-related activities. A work plan to integrate cultural and linguistic competence-related measures into our internal audits, performance improvement programs, patient satisfaction assessments, and outcome-based evaluations will be maintained.

The purpose of ongoing organizational self-assessment is to obtain baseline and updated information that can be used to define service needs, identify opportunities for improvement, develop action plans, and design programs and activities. The self-assessment should focus on the capacities, strengths, and weaknesses of the organization in meeting the CLAS standards.

Individuals served and community surveys and other methods of obtaining input are important components of organizational self-assessment activities.

Standard 10.
NCCMH will ensure that data on the individual's race, ethnicity, and spoken and written language are collected and updated in health records as required by MDHHS. The purposes of collecting information on race, ethnicity, and language are to:

- Adequately identify population groups within a service area;
- ensure appropriate monitoring of individual needs, utilization, quality of care, and outcomes;
- prioritize allocation of organizational resources;
- improve service planning to enhance access and coordination of care; and
- assure that health care services are provided equitably.

Standard 11.
NCCMH maintains current demographic profile of the community as well as a needs assessment as required by MDHHS to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.

Standard 12.
NCCMH relies on community partners in delivering collaborative service to those we serve. NCCMH utilizes a variety of formal and informal mechanisms to facilitate community and client involvement in designing and implementing CLAS-related activities.

Clients and community representatives are actively consulted and involved in a broad range of service design and delivery activities. Community stakeholders are surveyed for input on broad organizational prioritized as part of the Annual Submission to MDHHS.

Standard 13.
NCCMH will ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by patients/consumers. NCCMH incorporates cultural sensitivity training into staff training plans including staff who handle complaints and grievances or other legal or ethical conflict issues.

Standard 14.
NCCMH makes available to the public information about our LEP services and provides translation of our website and utilizes media other than written text to communicate essential information.