Behavioral Health Equity Plan: Cultural Competence Plan Requirements

Reporting Template for County Behavioral Health Plans

December 2023

Section 1: County Behavioral Health Plan (BHP) Information

County BHP Name	Lassen County Behavioral Health
County BHP Staff Name	Tiffany Armstrong
Telephone Number	530-251-8108
Email	tarmstrong@co.lassen.ca.us
Report Submission Due Date	December 31, 2023
Date Submitted	December 27, 2023

Section 2: Submission Requirements

County BHPs are required to submit a Comprehensive Behavioral Health Equity Plan every three years, focusing on community recommendations, priorities, goals, objectives, and identified targets. This Comprehensive Plan must be submitted by October 1 of each year to MCBHD.CCPR@dhcs.ca.gov.

An Annual Update shall be submitted in the interim years demonstrating progress on identified goals, objectives, and identified targets. County BHPs are expected to use annual updates to demonstrate reductions in disparities and increases in culturally responsive care. Annual updates are due to the department October 1 of each year to MCBHD.CCPR@dhcs.ca.gov.

This guidance aligns with the National Culturally and Linguistically Appropriate Services (CLAS) Standards and is applicable to both Mental Health Plans (MHPs) and counties operating under the Drug-Medi-Cal Organized Delivery System (DMC-ODS). County BHPs that have integrated both delivery systems are encouraged to submit one consolidated Three-Year Comprehensive Plan and the Annual Update to the department.

Section 3: Cultural Competence Plan Requirements (CCPRs)

Introduction:

The CCPRs are divided into three subsections:

I. Governance, Leadership, and Workforce;
II. Communication and Language Assistance; and
III. Engagement, Continuous Improvement, and Accountability**.**

Each subsection requires county BHPs to develop specific, measurable goals, objectives, strategies, and timelines. In addition, each section states the Three-Year Comprehensive Plan and the Annual Update submission requirements. The goal is for county BHPs to describe in the Three-Year Comprehensive Plan and in the Annual Updates how they will achieve reduction in disparities and provide culturally responsive care to their beneficiaries. Each subsection prescribes length of descriptions to enable county BHPs to focus on essential information and data only.

When developing priorities, measurable goals, objectives, strategies, and timelines in each subsection of the CCPRs, county BHPs should consider the following guiding questions:

- What are your county BHP's priorities over the next three years to address disparities?
- How will you ensure community stakeholder participation in this process?
- How will the county BHP measure the goal(s) to determine progress, including timeline and milestones?
- What is the methodology for data collection and analysis to accurately determine the outcome of services to beneficiaries from diverse cultures?
- What type of behavioral health equity-focused interventions are needed to address priorities and goals?
- What challenges do you anticipate, and what strategies will your county BHP employ to mitigate/avoid these challenges, and/or unintended consequences?

I. Governance, Leadership, and Workforce (CLAS Standards 2, 3, and 4)

a. Cultural Competence/Ethnic Service Managers

Each county BHP is required to have a designated Cultural Competence/Ethnic Services Manager (CC/ESM). The CC/ESM is responsible for promoting and monitoring quality and anti-racist equitable care as they relate to diverse racial, ethnic, and cultural populations served by both county-operated and contracted behavioral health programs (CLAS Standards 2, 3). [1] [2]

Three-Year Comprehensive Plan Requirement

1. Does your county BHP have a dedicated CC/ESM with prescribed roles and responsibilities related behavioral health equity?

☐Yes ☒ No

If you marked "No" above, please explain using the space below. Please limit your response to 300 words or less.

[1] 42 U.S.C. 2000d; Title 9, CCR Section 3200.100

[2] Cal. Code Regs. Tit. 9, § 1810.410 - Cultural and Linguistic Requirements

Since Lassen County is a small rural community, LCBH lacks staff and fiscal capacity to afford a full time Cultural Competence/Ethnic Services Manager (CC/ESM).
Lassen County Behavioral Health has designated BH Analysists, MHSA Program manager and the Behavioral Health Advisory Board members to provide the duties of the County's CC/ESM. In addition to their regular duties, they are responsible for facilitating the promotion of behavioral health services that meet the needs of our diverse population. They promote the delivery of culturally sensitive services. They also facilitate the Cultural Competency meetings among community partners. The Cultural Competency Committee will report to, and/or have direct access to, the Behavioral Health Director regarding issues impacting behavioral health issues related to the racial, ethnic, cultural, and linguistic populations within the county and provides leadership and mentoring to other staff.

2. Does the CC/ESM working closely with the BHP Director and their staff?

☒Yes ☐ No

If you marked "No" above, please explain using the space below. Please limit your response to 300 words or less.

3. Please provide an organizational chart with the location of the CC/ESM position within your county BHP.

Annual Update Requirement

1. Were there any changes to the CC/ESM position and responsibilities within the last year?

☐Yes ☒ No

If "yes", please describe using the space below. Please limit your response to 300 words or less.

b. County BHP Policies

Advance and sustain organizational governance and leadership that promotes CLAS and racial health equity through policy, practices, and allocated resources (CLAS Standard 2). [3]

Organizations must maintain a commitment to culturally responsive and linguistically appropriate care services by incorporating the CLAS standards into the organization's mission, goals, and policies, ensuring that these standards are central to the organization's functions. County BHPs shall regularly review and update the following documents ensuring a culturally responsive and equitable approach is incorporated into the following documents:

- Mission Statement
- Statements of Philosophy
- Strategic Plans
- Policy and Procedure Manuals
- Other Key Documents (Counties may choose to include additional documents to show system-wide commitment to cultural and linguistic appropriate practices)

Three-Year Comprehensive Plan Requirement

1. Using the space below, please describe how the county BHP's Mission, Statement of Philosophy, Strategic Plans, and Policy Procedure manual, and other key documents demonstrate the organization's commitment to ending inequities and disparities, how these reflect inclusivity, and the promotion of culturally responsive and equitable care.
2. Using the space below, please describe and demonstrate how policies are relevant and committed to removing institutional racism and barriers to care.
3. Using the space below, please identify the county BHP's processes to regularly review and update relevant documents.
4. Using the space below, please describe how this is communicated and reflected throughout the county BHP including but not limited to leadership and service delivery.

Please limit your response to one page. Please do not attach any of the above documents to this CCPR document.

LCBH's commitment to cultural competence is reflected in the department's mission statement, strategic planning efforts, policies and procedures manual and on-going training protocols. LCBH strives to meet CLAS Standards with every encounter.

[3] 42 U.S.C. 2000d; W&I Code Section 5600.2(g); Title 9, CCR Section 3200.210

LCBH has several established policies and procedures to assure outreach and engagement of culturally diverse and underserved community populations, to meet the CLAS standards and for equity in Governance, Leadership and Workforce.

LCBH abides by the County's Bilingual Salary Differential Allowance for nonsupervisory employees required to use a second language critical to day-to-day operations.

Considering the diverse cultures in Lassen County, it is essential for LCBH to work with Lassen County Cultural Competency Committee to develop culturally sensitive approaches to reach all members of the community. LCBH recognizes that cultural competency is a fluid process that requires continuous monitoring, evaluation, and change as LCBH implements its Cultural Competency Plan throughout the County. To better incorporate this growth, LCBH strives to include a variety of individuals with different points of view, and will emphasize on reaching out to the community for the services that LCBH is planning to provide. Community input is invaluable in preventing oversight of key components as well as developing and understanding any missing components needed for future outreach efforts.

Currently Lassen County Behavioral Health contracts with Judy's House (non-profit peer run organization). The program enables the County to provide an array of services for transitional aged youth, adults and older adults of all ethnically and culturally diverse populations of the county. The program currently offers:

- Peer support socialization in partnership with the county and other community organizations.
- One-on-one interaction and the ability to co-facilitate group support services to identified behavioral health beneficiaries. Judy's House further offers individual consumer peer support.
- Trained individuals to provide non-clinical, person-centered, strength based, wellness focused and trauma informed support
- Helping ensure the persons' wellness- recovery plan reveals the needs and preferences of the person being served to complete their measurable and personalized goals.

As part of LCBH's efforts for inclusion with identified underserved communities, Grand Care units are simple touchscreen computers that can be utilized by clients in their home. LCBH has also installed a portable system at Banner Lassen Emergency Room, so therapists can see clients in crisis at the ER if they are not able to attend in person for the crisis evaluation. This has proven helpful with afterhours contracted crisis providers who are not physically located in Susanville. A Grand Care system is set up in the Westwood Resource Center. On an as needed basis the Grand Cares are set up in client's homes in the Big Valley and Fort Sage region (South County).

Lassen County has a variety of Native American populations. Some identified tribes include Maidu, Paiute, Pit River and Washoe. LCBH recognizes the need to be culturally responsive to Hispanics, Native Americans, and other minority groups in our county. By providing treatment in a manner that is responsive and demonstrates an understanding of the client's heritage, history, traditions, and beliefs, we hope to engage more members of diverse populations within our community. LCBH is working to establish an MOU with the local Tribal Leaders within the next three years.

c. Workforce

Recruitment, Hiring, and Retention of a multicultural governance, leadership, and workforce that are responsive to the populations served (CLAS Standards 2, 3, 4, 5, and 7). [4,5]

Three-Year Plan Requirement

1. Workforce Assessment

Using the table below, please provide a summary of your current workforce. This table is a suggested format. You may include an attachment or a link to a document demonstrating workforce development using your county BHP's Human Resources data, or other supporting information, regardless of funding source.

Race/Ethnicity /Demographic/Language Information							
BHP Positions	**Black/African American**	**Asian American/ Pacific Islander**	**American Indian/ Native American**	**Hispanic/ Latino**	**White/ Caucasian**	**Gender Identity/** SOGI	**Bi-Lingual Capacity**
Licensed Clinicians			<15	<15	<15	M: 0 F: <15	
Certified Behavioral Health Staff					<15	M: 0 F: <15	
Non-clinical/ Non-certified county BHP staff				<15	<15	M: <15 F: <15	<15
Contractor staff							
Totals			<15	<15	<15	**M:**<15 **F:** <15	<15

[4] W&I Code Sections 5600.9(a), 5802(a)(4), 5807, 5822(d) and (i)
[5] Title 9, CCR Section 3610(b)(1)

Using the space below, please provide an analysis of your county BHP's workforce assessment data reflective of community needs, including any gaps that your county BHP needs to address.

Please limit your response to one page.

Race/Ethnicity/ Language: n = 13
Gender: n = 9

All contracted and non-contracted providers that agreed to share race/ethnicity/demographic/language information represents 39% of LCBH staff. 33% of responses were indicated as Licensed Clinicians, 13% Certified Behavioral Health Staff, 53% Non-clinical/Non-certified county BHP staff, and 0% contracted staff. Of all responding staff, 15% of individuals identified as more than one race. Of the responses to race/ethnicity information, 7% are Native American, 27% are Hispanic/Latino, and 67% white/Caucasian. There were no other racial or ethnic groups represented.

For gender identity, 27% of staff responded, with 11% identifying as male, and 89% identifying as female.

With this data representing less than half of staff, LCBH acknowledges the need of increased internal surveying to better paint how staff demographic makeup is reflective of the community. Of the respondents, a large proportion of the staff identified as Hispanic/Latino. This is certainly contrasted by the long-running low penetration rate of the Hispanic/Latino population. This over representation in staff can be beneficial in ensuring a culturally sensitive environment for those in need of services that are underrepresented.

The largest gap indicated is that of gender. The beneficiary population, as well as the population of Lassen County is comprised of almost evenly male-identifying and female-identifying individuals. However, for LCBH, there is a large under representation of male-identifying staff. Recruitment of male-identifying staff would be crucial in ensuring proportional representation between staff and beneficiaries, as well addressing underutilization of overall services while overutilization of crisis services for male-identifying beneficiaries.

2. Using the space below, please describe current strategies used to recruit, hire, and retain a workforce that reflects the racial, ethnic, gender, sexual, and cultural diversity of the community served and provides culturally responsive services and supports, inclusive of contracted providers.
Consider the following:

- Integration of community health workers, promotores, peer support specialists, and traditional health practitioners
- Creation and retention of a culturally inclusive workplace for people of color,

LGBTQ+ people, people with lived experience, and other intersectional cultural identities
- Opportunities for professional development and promotion including paraprofessionals (e.g., community health workers and peer support specialists)
- Outreach to underrepresented groups in recruitment processes

Please limit your response to one page.

LCBH has been successful in hiring and retaining staff who are culturally, ethnically, and linguistically representative of the community. LCBH also worked to implement the CLAS standards as part of the Department as a whole. The implementation of Grand Care Units has also decreased disparities among individuals living in rural parts of the areas who cannot access services in Susanville.

LCBH is an equal opportunity employer and encourages bilingual and bicultural persons to apply for available positions. Exceptional efforts are made to recruit bilingual, bicultural individuals who are representative of the community to be members of the staff. LCBH is actively recruiting for peer supports who have lived experience, with one staff member currently certified as a peer support specialist. LCBH always strives for an environment of openness, acceptance, and equitable treatment of all staff regardless of culture, race, gender, orientation, etc.

3. Using the space below, please develop one or more goals that address one or more priorities for workforce, governance, and/or leadership.

Please limit your response to one page.

The following priorities have been set for 2024:

a. Mobile Crisis Unit: Mobile crisis services are services provided by health professionals at the location where an individual experiences a crisis, including at home, work, school, or any other locations, excluding hospitals or other facility setting. Mobile crisis services are available 24 hours a day, 7 days a week, and 365 days a year. LCBH will be contracting with an outside provider or hire more staff to provide this service to Lassen County. LCBH is actively seeking to recruit staff who are culturally, ethnically, and linguistically representative of the community.
b. Peer Support Services: Peer Support Services are culturally competent individual and group services that promote recovery, resiliency, engagement, socialization, self-sufficiency, self-advocacy, development of natural supports, and identification of strengths through structured activities. The Peer Specialist is an individual who has lived experience with mental health or substance use conditions, is in recovery, has completed the requirements of a county's State-approved certification program, is certified by the counties, and who provides

these services under the direction of a Behavioral Health Professional who is licensed, waivered, or registered with the State of California.

c. To incorporate cultural competency meetings into already existing County meetings (Children and Adult System of Care, Housing, etc.) throughout the County. Many community partners do not have extra time to participate in another stand alone meeting on Cultural Competency.

e. <u>Training</u>

County BHPs must have a plan and process to provide training to staff and contractors regarding CLAS Standards, diversity, equity, and inclusion, cultural humility, community-defined practices, and other competencies related to behavioral health equity (CLAS Standard 4).

Training must consider and address structural and institutional racism and health inequities and their impact on consumers and providers. The training(s) must include, but are not limited to, the following requirements:

- Promote access and delivery of services in a culturally responsive manner to all consumers and potential consumers, regardless of sex, race, color, religion, ancestry, national origin, creed, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, health status, marital status, gender, gender identity, and sexual orientation; and

- Information about the health inequities and identified cultural groups in the county's service area which includes but is not limited to: the groups' beliefs about illness and health; need for gender affirming care; methods of interacting with providers and the health care structure; community defined evidence practices; and language and literacy needs.

- Example topics include, but are not limited to:
  - History of Underserved Communities and how social determinants of health (SDOH) that may impact client care
  - Cultural Formation
  - Understanding intersectional identities
  - Multicultural knowledge

<u>Three-Year Comprehensive Plan Requirement</u>

- Using the space below, the county BHP shall develop a Three-Year Training Plan that includes the following:
  - Identify proposed training topics and rationale for the trainings the county BHP intends to provide in the Three-Year Comprehensive Plan, based on the needs assessment and input from the Cultural Competence Committee.
  - Discuss how you will measure the effectiveness of the training(s), identifying

outcomes and how the training advances the county BHP's identified goal(s) of reducing disparities and advancing culturally responsive care.

- Describe how behavioral health equity and culturally responsive approaches will be embedded in all training activities provided by the county BHP, including integration of culturally linguistic components. This includes components of diversity, equity, inclusion, antiracism, and client culture.
- Based on assessments and the training plan identify a minimum threshold for training requirements and the county BHP's plan to ensure this requirement is met.

Please limit your response to two pages, and attach your training plan related behavioral health equity topics.

LCBH staff are provided cultural humility training which disseminates the CLAS Standards; enhances cultural and linguistic respect and sensitivity; and promotes culturally- and linguistically-appropriate services to ensure positive outcomes and also to improve culturally competent skills.

Required Annual Trainings that are discussed at QI meetings to ensure the provision of culturally competent services for people providing Specialist Mental Health Services employed by or contracting with LCBH.

The plan for cultural competency training:

- CLAS Standards (examples)
    - Partnership HealthPlan Cultural Competency
    - Working with Military & Veteran Clients
    - LGBTQIA+ Health Awareness
    - Customer Services & De-escalation
    - Workplace of Equal Opportunity
    - Sociocultural Risk
    - LGBTQ+ Youth and Families
    - Delivering Culturally Responsive Suicide Interventions in Community Settings
    - Structural and Systemic Factors that Impact Suicide Treatment
    - Eliminating Inequities in Behavioral Heath

As needed Trainings

- How to use the Language Line/Using an Interpreter
- CLAS Standards
- Cultural Humility Training (Unserved and Underserved) Populations
- LCBH Written Material in Spanish
- Unconscious Bias in the Workplace
- Culture-specific approaches to treatment and recovery; Understanding client culture; and other subjects such as SOGIE trainings.

LCBH provides 6 hours of cultural competency training per year. All policies were or are currently being revised to include CLAS standards. LCBH will use consumer perception surveys to evaluate the outcome of cultural competency training of staff.

II. Communication and Language Assistance (CLAS Standards 5, 6, 7, and 8)

a. Language translation, print, signage, and multimedia resources (CLAS Standards 5, 6, 8).[6]

Three-Year Comprehensive Plan Requirement

The county BHP is responsible for providing behavioral health-related informational materials in applicable threshold languages that meet the communication and cultural needs of all residents in order to facilitate access to all health care and services. Please mark below that the documents listed below have been updated and translated in applicable threshold languages. The documents need to be available during audits and compliance reviews.

- ☒Member service handbook or brochure
- ☒General correspondence issued by the county
- ☒Beneficiary problem, resolution, grievance, and fair hearing materials
- ☒Beneficiary satisfaction surveys
- ☒Informed Consent for Medication form
- ☒Confidentiality and Release of Information form;
- ☒Service orientation for clients;
- ☒Behavioral health education materials, and
- ☒Evidence of appropriately distributed and utilized translated materials.
- ☒Documented evidence in the clinical chart that clinical findings and reports are communicated in the clients' preferred language, culturally responsive, and affirming manner.
- ☒Documentation reflecting the client's lived name, gender, and pronouns, where applicable.
- ☒Consumer satisfaction survey translated in threshold languages, including a summary report of the results (e.g., back translation and culturally appropriate field testing).

[6] 42 U.S.C. 2000d; W&I Code Section 5600.3; CGC Section 7290-7299.8; Title 9, CCR Sections 1810.410(a-e), 3610(b)(1)

Using the space below please describe the following:

- Mechanism for ensuring accuracy of translated materials in terms of both language and culture (e.g., back translation and culturally appropriate field testing).
- Mechanism for ensuring translated materials is at an appropriate reading level.
- Mechanism demonstrating the capability to refer or link beneficiaries to culturally and linguistically appropriate services, including outreach activities to beneficiaries and informing them about the availability of behavioral health services and programs.

Please limit your response to one page.

Lassen County currently does not have a threshold language; however, LCBH registration paperwork and brochures are in Spanish. These materials are reviewed and approved by Spanish speaking staff and confirmed with beneficiaries via consumer perception survey for accuracy and appropriate reading level. LCBH conducts regular outreach, informing all beneficiaries that paperwork and brochures are available in Spanish. If greater needs for appropriate services are required, LCBH works with Carelon to transition their services.

b. <u>Evidence of policies, procedures, and practices in place for meeting clients' language needs, including the following: (CLAS Standards 5, 7, 8)</u>

1. A 24-hour phone line with statewide toll-free access that has linguistic capability, including TDD or California Relay Service, shall be available for all individuals.

NOTE: The use of the language line is viewed as acceptable in the provision of services only when other options are unavailable. Least preferable are language lines. Consider use of new technologies, such as video language conferencing, to grow language access capacity.

<u>Three-Year Comprehensive Plan Requirement</u>

- Using the space below, please provide a description of the protocol used for implementing language access through the county BHP's 24-hour phone line with statewide toll-free access.
- Using the space below, please provide a description how the county BHP ensures that staff receive appropriate training on how to utilize an interpreter when a client requires language assistance services, including American Sign Language Services and TDD or California Relay Services.
- Using the space below, please provide a description of evidence of availability of interpreters (e.g., posters/bulletins) and/or bilingual staff for clients who speak threshold languages.
- Using the space below, please describe how clients who need services in a language other than English receive referrals and linkages to appropriate services are made at all key points of contact.
- Using the space below, please provide a description how your county BHP test

call data will be used to ensure that the 24/7 Access Line is functional.

Please limit your response to one page.

In compliance with federal and state regulations, the LCBH Language Assistance Services (LAS) are obtained through the AT&T Language Line. The language line provides staff with telephonic interpretations services to enrollees and potential enrollees at no cost. The AT&T Language Line is also available at all points of contact and serves as a secondary strategy to assure services for clients, which meet the CLAS standards for Communication and Language Assistance.

A 24-hour phone line with statewide toll-free access that has linguistic capability, including TDD or California Relay Service, is available for all individuals. Note: The use of the language line is viewed as acceptable in the provision of services only when other options are unavailable. The LCBH Mobile Crisis Unit will also have access to the 24/7 Access Line for any calls in the field as needed. Staff are required to receive annual language line training covered in the mandatory 6 hours of Cultural Competency training.

c. Describe your county BHP's approach to ensuring that language assistance is provided by appropriate and linguistically competent people (e.g., professional interpreters, bilingual staff) (CLAS Standard 7).[7]

Three-Year Comprehensive Plan Requirement

1. Using the space below, please provide evidence that the county/agency accommodates persons who have Limited English Proficiency (LEP) by employing a multilingual workforce and using interpreter services when needed.
2. Using the space below, please provide evidence of contract or agency staff who are linguistically proficient in threshold languages during regular day operating hours. This can include the certification process used for agency staff to receive bilingual status. Include documentation of proficiency in medical and behavioral health terminology.
3. Using the space below, please provide evidence that counties have a process in place to ensure that interpreters are trained and monitored for competence in language, cultural practices and philosophies (e.g., formal testing).
4. Using the space below, please report the number of staff who are bilingual; include languages spoken and identify whether they are direct service providers or support staff.

Please limit your response to one page.

Lassen County currently does not have a threshold language; however, LCBH registration paperwork and brochures are in Spanish. These materials are reviewed and approved by Spanish speaking staff and confirmed with beneficiaries via consumer perception survey for accuracy and

[7] CGC Section 7290-7299.8

appropriate reading level. LCBH conducts regular outreach, informing all beneficiaries that paperwork and brochures are available in Spanish. If greater needs for appropriate services are required, LCBH works with Carelon to transition their services.

d) Describe the county BHP's priorities for assessing and enhancing language assistance services and informing materials in the period covered by this plan.

Three-Year Comprehensive Plan Requirement

Using the space below, please identify gaps in culturally and linguistically appropriate services and create a plan addressing those gaps.

Please limit your response to one page.

LCBH is looking to vet our brochures and materials in our MHSA stakeholder group meetings to get feedback from providers and consumers to identify gaps culturally and linguistically in our services.

LCBH is actively recruiting more staff from diverse cultural and ethnic backgrounds to provide more representation in services for the Lassen county population.

III. Engagement, Continuous Improvement, and Accountability (CLAS Standards 9, 10, 11, 12, 13, 14, and 15)

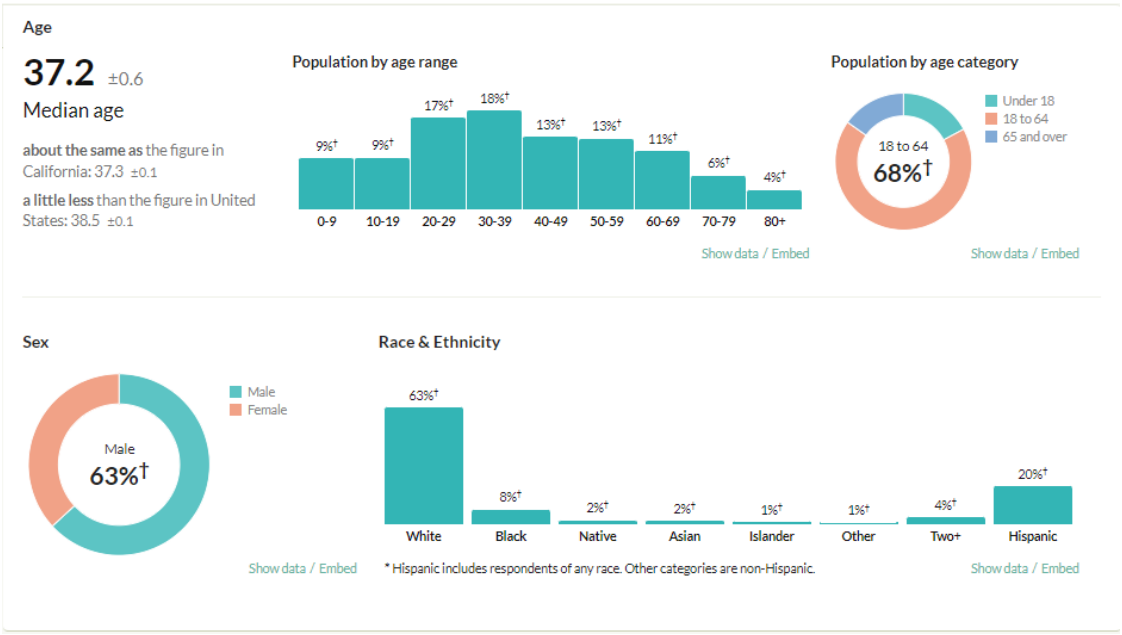
a. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery (CLAS Standards 10, 11, 12).[8]

Needs Assessment and Identifying Populations of Interest

The needs assessment requires the evaluation of several different datasets, including county-wide population demographics and Medi-Cal client and non-Medi-cal usage data. The needs assessment also requires analysis of these data to identify prevention and early intervention (PEI) populations for ongoing monitoring. This process will require collaborative data analysis partnerships and consultation. The county's collaborative advisory committee should be directly involved in the needs assessment to gain community-level insight and guidance on the data interpretation.

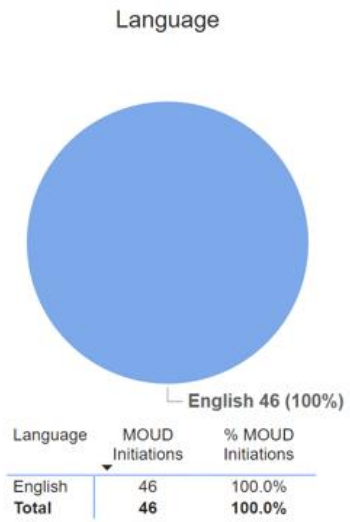
[8] W&I Code Sections 3200.100, 5840(b) and (e), 5848, 5865(b), 5855(f), 5878.1, 5880(b)(6), 14683(b); Title 9, CCR Sections 1810.310 1(a-b), 3300

1a: Overall County Population Data



Lassen County's population data does include the prisoner population from the three surrounding prisons, one of which closed in June 2023.

1b: Threshold Languages[9] - LCBH has no threshold language.



[9] BHIN 20-070; https://data.chhs.ca.gov

Lassen MHP		
Threshold Language	**Unduplicated Annual Count of Beneficiaries Served by the MHP**	**Percentage of Beneficiaries Served by the MHP**
No Threshold Languages	*	n/a
Total	**868**	**100%**
Threshold language source: DHCS BHIN 20-070.		
Other Languages include English		

1c: Utilization/Encounter Data[10]

All Services and Clients Q3-Q4 CY 2023

Category	Cohort	Number of services	% of total services	# individuals served	% of total clients	Over/underutilization by cohort	Average # of services per client
Language	English	5789	99.62%	618	98.72%	0.90%	9.37
	Unknown / Not Reporte	22	0.38%	8	1.28%	-0.90%	2.75
Gender	Female	**3329**	**57.29%**	**328**	**52.40%**	**4.89%**	10.15
	Male	2439	41.97%	296	47.28%	**-5.31%**	**8.24**
	Other	**43**	**0.74%**	**2**	**0.32%**	0.42%	**21.50**
Race	White	**4736**	**81.50%**	**505**	**80.67%**	0.83%	9.38
	Non-White-Other	169	2.91%	18	2.88%	0.03%	9.39
	Native American	356	6.13%	39	6.23%	-0.10%	9.13
	Laotian	191	3.29%	15	2.40%	**0.89%**	**12.73**
	Unknown / Not Reporte	192	3.30%	25	3.99%	**-0.69%**	7.68
	Asian-Other	**23**	**0.40%**	5	0.80%	-0.40%	**4.60**
	Black / African America	96	1.65%	14	2.24%	-0.58%	6.86
	Other Pacific Islander	24	0.41%	**3**	**0.48%**	-0.07%	8.00
Ethnicity	Not Hispanic	**5089**	**87.58%**	**546**	**87.22%**	**0.35%**	9.32
	Other Hispanic / Latino	207	3.56%	22	3.51%	0.05%	**9.41**
	Mexican American / Ch	335	5.76%	37	5.91%	-0.15%	9.05
	Unknown / Not Reporte	**180**	**3.10%**	**21**	**3.35%**	**-0.26%**	**8.57**
Age Group	0-2	**21**	**0.36%**	**3**	**0.48%**	-0.12%	7.00
	3-5	85	1.46%	11	1.76%	-0.29%	7.73
	6-11	496	8.54%	38	6.07%	**2.47%**	**13.05**
	12-17	854	14.70%	86	13.74%	0.96%	9.93
	18-20	213	3.67%	33	5.27%	**-1.61%**	**6.45**
	21-44	**2423**	**41.70%**	**269**	**42.97%**	-1.27%	9.01
	45-64	1277	21.98%	137	21.88%	0.09%	9.32
	65+	442	7.61%	49	7.83%	-0.22%	9.02

[10] Behavioral Health Reporting (ca.gov)

Services – Gender

Services	Female	Male	Other
MHIndRehab	57%	41%	1%
ODS Group	40%	60%	0%
MH Med Dr	62%	38%	0%
MHMedNurse	62%	37%	0%
MHIndThrpy	64%	35%	0%
MHPlanDev	53%	47%	0%
MH CaseMgt	55%	44%	1%
MH Assess	48%	51%	1%
MHACScreen	45%	55%	0%
MH Crisis	45%	54%	1%
MHGrpRehab	72%	28%	0%
IHBSRehab	26%	74%	0%
MH ICC/CFT	56%	44%	0%
MH ICC	32%	68%	0%
ODSIndvCou	18%	68%	14%
ODSCareCor	0%	100%	0%
IHBSTherap	81%	19%	0%
ODSAssesmt	32%	66%	1%
IHBSPLANDV	0%	100%	0%
MHGrpTher	100%	0%	0%
MHICCPLNDV	25%	75%	0%
MH TBS	0%	100%	0%

Services – Language

Services	English	Unknown / Not Reported
MHIndRehab	100%	0%
ODS Group	99%	1%
MH Med Dr	100%	0%
MHMedNurse	100%	0%
MHIndThrpy	100%	0%
MHPlanDev	100%	0%
MH CaseMgt	99%	1%
MH Assess	100%	0%
MHACScreen	98%	2%
MH Crisis	98%	2%
MHGrpRehab	100%	0%
IHBSRehab	100%	0%
MH ICC/CFT	100%	0%
MH ICC	100%	0%
ODSIndvCou	95%	5%
ODSCareCor	100%	0%
IHBSTherap	100%	0%
ODSAssesmt	95%	5%
IHBSPLANDV	100%	0%
MHGrpTher	100%	0%
MHICCPLNDV	100%	0%
MH TBS	100%	0%

Services – Ethnicity

Services	Not Hispanic	Other Hispanic / Latino	Mexican American / Chicano	Unknown / Not Reported
MHIndRehab	85%	4%	8%	3%
ODS Group	96%	0%	4%	0%
MH Med Dr	92%	3%	4%	1%
MHMedNurse	92%	3%	4%	1%
MHIndThrpy	85%	4%	7%	4%
MHPlanDev	82%	4%	11%	3%
MH CaseMgt	88%	3%	6%	4%
MH Assess	81%	6%	11%	3%
MHACScreen	83%	4%	10%	3%
MH Crisis	80%	3%	5%	12%
MHGrpRehab	90%	10%	0%	0%
IHBSRehab	80%	0%	0%	20%
MH ICC/CFT	69%	0%	3%	28%
MH ICC	74%	4%	0%	22%
ODSIndvCou	97%	0%	3%	0%
ODSCareCor	100%	0%	0%	0%
IHBSTherap	76%	0%	5%	19%
ODSAssesmt	92%	1%	5%	1%
IHBSPLANDV	100%	0%	0%	0%
MHGrpTher	100%	0%	0%	0%
MHICCPLNDV	50%	25%	0%	25%
MH TBS	100%	0%	0%	0%

Services – Race

Services	White	Non-White-Other	Native American	Laotian	Unknown / Not Reported	Asian-Other	Black / African American	Other Pacific Islander
MHIndRehab	81%	2%	5%	6%	2%	0%	3%	0%
ODS Group	90%	0%	1%	4%	0%	0%	5%	0%
MH Med Dr	86%	2%	6%	3%	1%	0%	1%	0%
MHMedNurse	86%	2%	6%	3%	1%	0%	1%	0%
MHIndThrpy	80%	4%	5%	4%	4%	1%	1%	1%
MHPlanDev	78%	4%	4%	4%	6%	1%	1%	1%
MH CaseMgt	81%	3%	8%	2%	3%	0%	2%	0%
MH Assess	73%	5%	8%	3%	5%	1%	3%	2%
MHACScreen	75%	4%	7%	2%	5%	2%	3%	1%
MH Crisis	74%	0%	6%	4%	9%	0%	4%	0%
MHGrpRehab	76%	7%	14%	3%	0%	0%	0%	0%
IHBSRehab	80%	0%	0%	0%	20%	0%	0%	0%
MH ICC/CFT	53%	0%	14%	0%	31%	0%	0%	3%
MH ICC	76%	0%	2%	0%	22%	0%	0%	0%
ODSIndvCou	80%	0%	15%	3%	0%	0%	3%	0%
ODSCareCor	100%	0%	0%	0%	0%	0%	0%	0%
IHBSTherap	76%	5%	0%	0%	19%	0%	0%	0%
ODSAssesmt	81%	1%	7%	3%	1%	0%	7%	0%
IHBSPLANDV	100%	0%	0%	0%	0%	0%	0%	0%
MHGrpTher	100%	0%	0%	0%	0%	0%	0%	0%
MHICCPLNDV	75%	0%	0%	0%	25%	0%	0%	0%
MH TBS	100%	0%	0%	0%	0%	0%	0%	0%

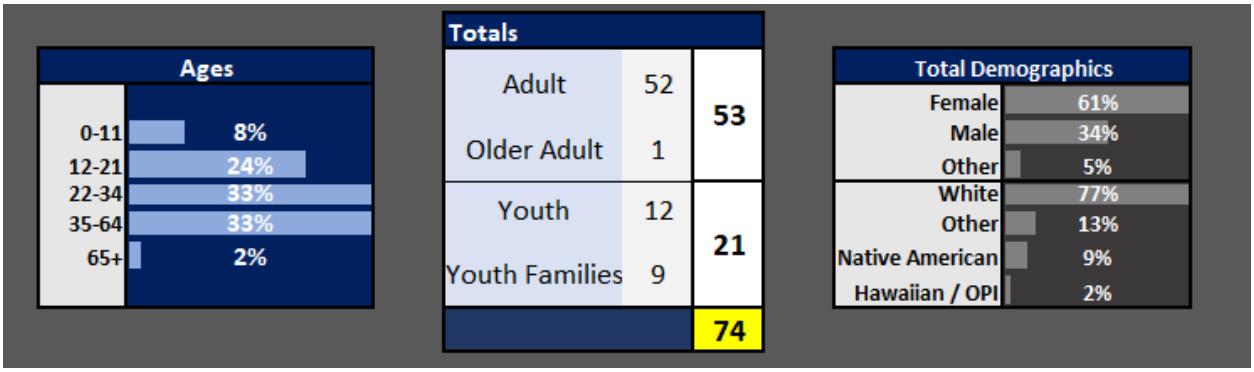
Services – Ages

Services	0-2	3-5	6-11	12-17	18-20	21-44	45-64	65+
MHIndRehab	1%	4%	15%	13%	7%	40%	16%	5%
ODS Group	0%	0%	0%	0%	1%	81%	19%	0%
MH Med Dr	0%	0%	4%	9%	4%	42%	29%	13%
MHMedNurse	0%	0%	4%	9%	4%	42%	28%	13%
MHIndThrpy	0%	1%	8%	19%	4%	40%	21%	7%
MHPlanDev	1%	10%	11%	32%	4%	31%	7%	4%
MH CaseMgt	0%	1%	3%	20%	6%	40%	26%	5%
MH Assess	1%	6%	12%	20%	3%	43%	15%	1%
MHACScreen	1%	6%	8%	16%	3%	47%	17%	2%
MH Crisis	1%	0%	1%	19%	3%	43%	26%	7%
MHGrpRehab	3%	2%	53%	13%	0%	14%	11%	4%
IHBSRehab	0%	0%	54%	46%	0%	0%	0%	0%
MH ICC/CFT	0%	0%	36%	64%	0%	0%	0%	0%
MH ICC	0%	0%	34%	64%	2%	0%	0%	0%
ODSIndvCou	0%	0%	0%	2%	1%	74%	23%	0%
ODSCareCor	0%	0%	0%	0%	0%	0%	100%	0%
IHBSTherap	0%	0%	52%	48%	0%	0%	0%	0%
ODSAssesmt	0%	0%	0%	3%	4%	73%	19%	1%
IHBSPLANDV	0%	0%	0%	0%	100%	0%	0%	0%
MHGrpTher	0%	0%	0%	0%	0%	100%	0%	0%
MHICCPLNDV	0%	0%	25%	75%	0%	0%	0%	0%
MH TBS	0%	0%	0%	100%	0%	0%	0%	0%

*Other emerging demographic, social, and cultural groups as data becomes available, (e.g., SOGI data)

1d: Beneficiary Satisfaction Survey Data (include MH And SUD)

Mental Health Survey Data:

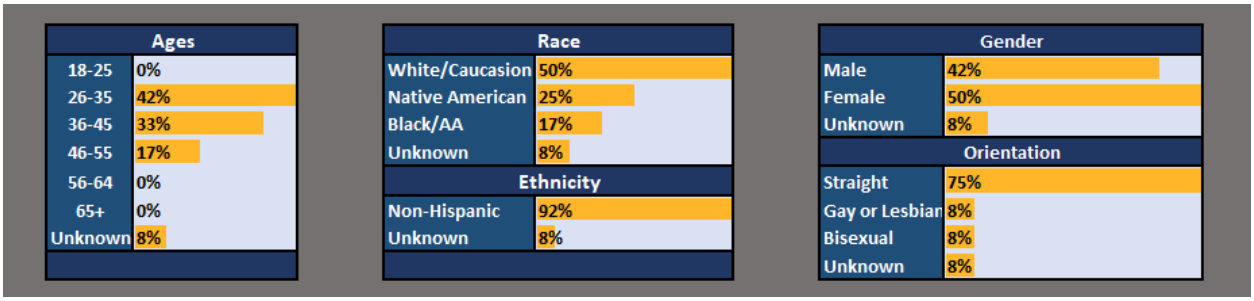


Ages	
0-11	8%
12-21	24%
22-34	33%
35-64	33%
65+	2%

Totals		
Adult	52	53
Older Adult	1	
Youth	12	21
Youth Families	9	
		74

Total Demographics	
Female	61%
Male	34%
Other	5%
White	77%
Other	13%
Native American	9%
Hawaiian / OPI	2%

SUD Survey Data:



Ages	
18-25	0%
26-35	42%
36-45	33%
46-55	17%
56-64	0%
65+	0%
Unknown	8%

Race	
White/Caucasion	50%
Native American	25%
Black/AA	17%
Unknown	8%

Ethnicity	
Non-Hispanic	92%
Unknown	8%

Gender	
Male	42%
Female	50%
Unknown	8%

Orientation	
Straight	75%
Gay or Lesbian	8%
Bisexual	8%
Unknown	8%

2. Using the space below, please provide a data analysis using the above data elements and information. Your county BHP's analysis should include service utilization trends, including differences and disparities in different service types and levels of care, summarizing any other observable trends and/or disparities in the data analysis that the county BHP needs to address in this Behavioral Health Equity Plan.

Please limit your response to one page.

In July of 2023, LCBH transitioned to a new EHR with expanded data management capability compared to prior applications. In Q3-Q4 of Calendar Year 2023, LCBH delivered 5811 billable services. Those services were provided to 626 unique clients. Of those clients 98.72% identified as English speaking with the remainder identified as unknown or not reported. For this period there was no indication of any specific primary language outside of English. Given that the 2020 Census reports 18% of Lassen County residents speaking languages other than English at home, this finding points to a discrepancy between the MHP population served and the county population.

The majority of services were provided to female-identifying beneficiaries (57% of all services were provided to females, 42% to males). The degree of the majority stands in contrast with the demographic makeup of the LCBH beneficiary population, where 52% of beneficiaries identify as female, 47% as male. This indicates a higher utilization for female than male beneficiaries. This higher utilization is reflected in all services except for Youth Intensive Services (35% female; 65% male), Crisis services (45% female; 54% males) and ODS Services (30% female; 65% male). Those identifying as Other represented less than 1% of total services and further analysis cannot be published for reasons of ensuring confidentiality of a population under 15 individuals.

The racial and ethnic makeup of the beneficiary population is fairly representative of the Lassen County population with 81% of clients identifying as white (87% of all beneficiaries as non-Hispanic). The next largest racial minority is that of Native American (6%), with next ethnic minority being Mexican American / Chicano at 6%. According to 2020 Census data, Lassen County has a population of 20.3% Hispanic, and 1 % Native American. Compared to the beneficiary population it is clear that Native Americans make up of a heightened penetration rate while the penetration rate is significantly low for the Hispanic population.
Of the beneficiary population by race, self-identified Laotians utilize services more as a proportion of their population than any other race, averaging 12.73 services per client, 3.35 services more than the next highest utilizer, white identifying beneficiaries (9.38). Asian-other identifying beneficiaries utilize least out of their population but due to limited size of population, this finding can't be applied to the wider Asian-other population. In terms of specific services, white identifying beneficiaries made of the majority of all services provided, averaging 82% of all services, followed by Unknown/Not Reported (7%), and Native American (5%).

The majority of beneficiaries served, and services provided, were to individuals aged 21-44 (43% of all beneficiaries; 42% of all services). Of their populations it is noted that the largest discrepancies in utilization can be found with those aged 6-11 and 18-20. Those aged 6-11 make of 6% of beneficiaries, but 8.5% of all services are provided to this population, averaging 13 services per person. This is in contrast with the population of 18-20, who make up almost the same proportion of total beneficiaries (5.3%). Those in this cohort make up only 3.7% of all services provided, averaging 6.5 services per person – the least amount of services per person than any other age group. This finding indicates that while those aged 6-11 are receiving heightened care (as would be reflective in Intensive Service requirements for youth), those 18-20 are underutilizing services.

What all these findings indicate is a need for LCBH to prioritize diversity and inclusion in practice and in outreach. It will be important to address why male-identifying beneficiaries are underutilizing total services but make up the largest share of Crisis encounters. It is a necessary and continuing goal of LCBH to increase penetration rates among the Hispanic, Asian, and non-English speaking populations through increased and culturally responsive outreach in order to be more reflective of the county population. And additionally, these findings indicate a need to prioritize increasing service utilization, not just increasing penetration rates, for young adults aged 18-20.

3. In alignment with DHCS' Comprehensive Quality Strategy, county BHPs are required to report behavioral health equity data on the following performance measures.

a. For Mental Health Plans:

1) Follow-Up After Emergency Department Visit for Mental Illness (FUM): 7 days

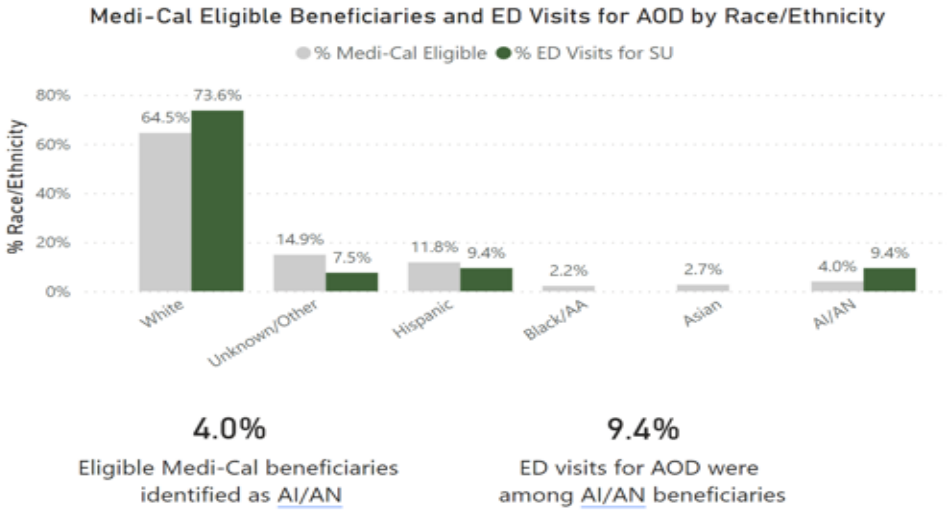
Race		7 Day	% 7 day	30 Day	% 30 day	None	% None
White	61	37	61%	45	74%	16	26%
AI/AN	8	2	25%	3	38%	5	63%
Unknown/ Not Reported	7	0	0%	0	0%	7	100%
Black/African American	2	2	100%	2	100%	0	0%
Laotian	1	0	0%	0	0%	0	0%

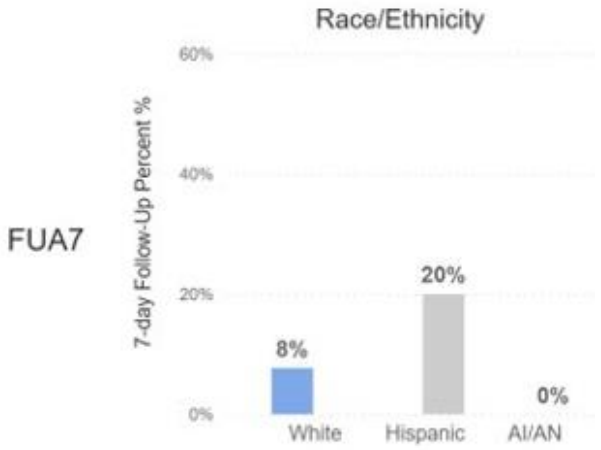
2) Follow-Up After Emergency Department Visit for Mental Illness (FUM): 30 days

Race		7 Day	% 7 day	30 Day	% 30 day	None	% None
White	61	37	61%	45	74%	16	26%
AI/AN	8	2	25%	3	38%	5	63%
Unknown/ Not Reported	7	0	0%	0	0%	7	100%
Black/African American	2	2	100%	2	100%	0	0%
Laotian	1	0	0%	0	0%	0	0%

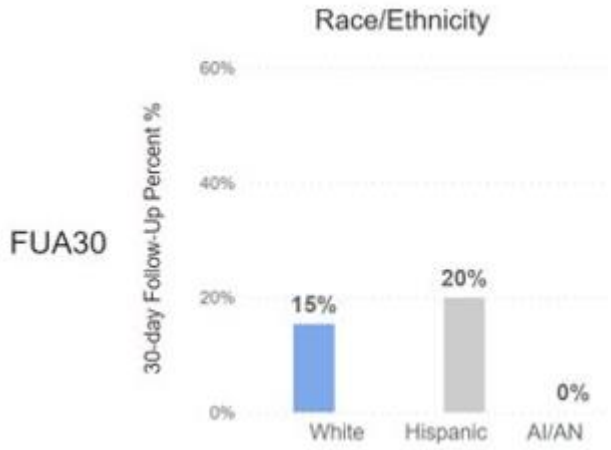
b. For DMC-ODS Counties

1) **Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA): 7 days**

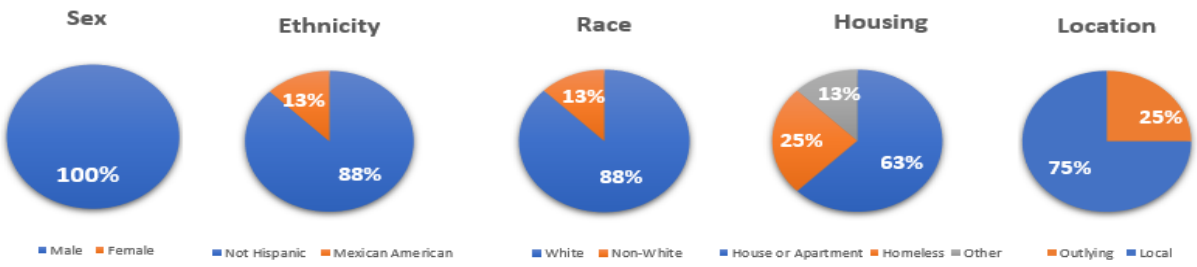


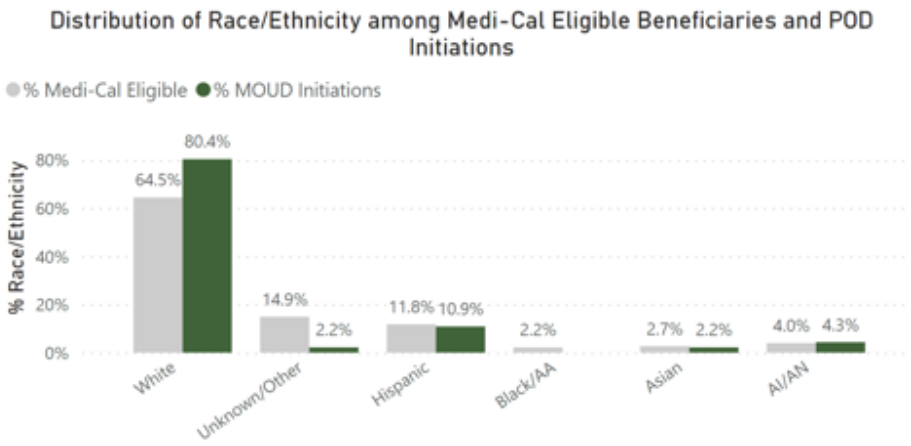


2) Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA): 30 days



3) Pharmacotherapy for Opioid Use Disorder (POD)





b. <u>Establish culturally and linguistically appropriate, and affirming goals, policies and accountability, infusing them throughout the organizations planning and operations; developing strategies for addressing disparities among identified populations of interest; and conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities (CLAS Standards 9, 10, 11, 12, 13, 14, 15).</u> [11]

<u>Three-Year Comprehensive Plan Requirement</u>

- Using the space below and the information from the Needs Assessment above, please identify priorities, goals, and strategies.
- Examples of improvement goals:
  - **Example 1:** A County has identified a disparity based on language when looking at rates of follow-up after emergency department presentations for mental illness, and Spanish-speaking beneficiaries were less likely to follow-up compared to English-speaking beneficiaries. In response, the County establishes a goal of closing the disparity in follow-up by 50% in the next 1 year and chooses the strategy of outreach calls by language-concordant community health workers.
  - **Example 2:** A County has identified through utilization data that beneficiaries who identify as Black are less likely to be engaged in buprenorphine-based care for opioid use disorder compared to beneficiaries identifying as white. In response, the County establishes a goal of understanding this disparity in greater detail in the next 1 year and chooses the strategy of holding a series of interviews and focus groups with beneficiaries to learn more about this phenomenon and potential barriers in care.

Please limit your response to one page.

[11] W&I Code Sections 3200.100, 5840(b) and (e), 5848, 5865(b), 5855(f), 5878.1, 5880(b)(6), 14683(b); Title 9, CCR Sections 1810.310 1(a-b), 3300

LCBH has been revising policies to make sure they include CLAS standards. LCBH plans to use the MHSA Stakeholder meeting as an avenue to identify gaps in the BH Equality standards to develop plans going forward. LCBH uses community outreach in the form of twice monthly visits to the local food bank and Judy's House to assess needs in the community as they relate to cultural competency. LCBH utilizes Consumer Perception Surveys for beneficiary feedback, and will increase use of surveys to help identify beneficiary views on reasons for disparities as identified in II(c). With increased outreach, training on cultural responsiveness, and beneficiary feedback, LCBH intends to work with the community to increase penetration rates of underserved groups and increase utilization of groups underutilizing services.

c. <u>The county BHP must have a collaborative advisory committee (e.g., Cultural Competence Committee; Cultural Humility Committee; Diversity, Equity and Inclusion Committee) responsible for helping to guide the county behavioral health system toward reducing behavioral health disparities. Committee representation and participation should reflect county and contractor staff, peer and family supports, and culturally, ethnically, and linguistically diverse community members (CLAS Standard 13).</u>

<u>Three-Year Comprehensive Plan Requirement</u>

1. Does your county BHP have a separate Cultural Competence Plan Committee?
   ☒Yes ☐ No

2. If you marked "No," are topics related to cultural humility and disparities reduction discussed in one of the below committees?

   ☐Quality Improvement Committee

   ☐Committee related to MHSA Planning

   ☐Other; please specify in the space below

3. Please briefly provide the current committee composition, structure and meeting frequency in the space below.

   Please use 300 words or less.

The Cultural Competence Committee is an extension of our LCBH Advisory Board, and meets on a monthly basis. Due to many agencies in the county being short staffed as well as in the private sector, LCBH is having a difficult time recruiting members for a separate cultural competency committee. As such, cultural competency has been adopted into the LCBH Advisory Board and the MHSA Stakeholder meetings to help identify community needs and concerns.

4. Please check which of the following tasks committee members perform actively:

☒Participates in CCP development
☒Participates in the review of county BHP's disparities data review and provides feedback
☐Reviews of services/programs with respect to health equity issues at the county
☒Provides reports to Quality Assurance/Quality Improvement Program in the county
☐Participates in overall planning and implementation of services at the county
☐Reporting requirements include directly transmitting recommendations to executive level and transmitting concerns to the Behavioral Health Director
☒Participates in and reviews the county MHSA planning process and stakeholder engagement
☐Participates in and reviews client developed programs (wellness, recovery, and peer support programs)

5. Please describe in the space below how you ensure enclosure of diverse community stakeholders in committee activities.

Please use 300 words or less.

LCBH Case Managers go into the community at least twice monthly to engage the community in services and identify community needs. During outreach, LCBH is actively recruiting beneficiary involvement in committees. LCBH will also incorporate cultural competency into the MHSA Stakeholder meetings to help identify community needs as well. During outreach, LCBH is actively recruiting beneficiary involvement in committees.

Appendices

Appendix A:

Federal and State Statutes; National Culturally and Linguistically Appropriate Services (CLAS) Standards; and Mental Health Services Act (MHSA) Guidelines

Federal Statute

Title VI of the Civil Rights Act of 1964-"No person in the United States shall on the ground of race, color, or national origin be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance" (42 U.S.C. 2000d).

As pertains to language access: Title VI of the Civil Rights Act prohibits recipients of federal funds from providing services to limited English proficient (LEP) persons that are limited in scope or lower in quality than those provided to others. An individual's participation in a federally funded program or activity may not be limited on the basis of LEP. Since Medi-Cal is partially funded by federal funds, all MHPs must ensure that all Medi-Cal LEP members have equal access to all mental health care.

Executive Order 13160 of June 23, 2000. Nondiscrimination on the Basis of Race, Sex, Color, National Origin, Disability, Religion, Age, Sexual Orientation, and Status as a Parent in Federally Conducted Education and Training Programs. To ensure that persons with limited English skills can effectively access critical health and social services, the Office of Civil Rights (OCR) published policy guidance which outlines the responsibilities under federal law of health and social services providers who receive Federal financial assistance from HHS to assist people with limited English skills.
As pertains to language assistance to persons with limited English proficiency (LEP). The guidance explains the basic legal requirements of Title VI of the Civil Rights Act of

1964 (Title VI) and explains what recipients of Federal financial assistance can do to comply with the law. The guidance contains information about best practices and explains how OCR handles complaints and enforces the law.

Title 42 – The Public Health and Welfare, Chapter 126, Equal Opportunity For Individuals with Disabilities Section 12101. Findings and Purpose. [Section 2}
-- to provide a clear and comprehensive national mandate, and a strong, consistent, enforceable standard, for the elimination of and addressing discrimination against individuals with disabilities. The Nation's proper goals regarding individuals with disabilities are to assure equality of opportunity, full participation, independent living, and economic self-sufficiency for such individuals.

California State Statute

Welfare and Institutions Code (WIC), Section 4341 -- relates to DMH activities and responsibilities in implementing a Human Resources Development Program and ensuring appropriate numbers of graduates with experience in serving mentally ill persons. Subsection (d) states: “Specific attention shall be given to ensuring the development of a mental health work force with the necessary bilingual and bicultural skills to deliver effective services to the diverse population of the state.”

WIC, Section 5600.2 -- relates to the Bronzan-McCorquodale Act and general provisions to organize and finance community mental health services. “To the extent resources are available, public mental health services in this state should be provided to priority target populations in systems of care that are beneficiary-centered, culturally competent, and fully accountable…”

WIC, Section 5600.2(g) -- “Cultural Competence. All services and programs at all levels should have the capacity to provide services sensitive to the target populations’ cultural diversity. Systems of care should: (1) Acknowledge and incorporate the importance of culture, the assessment of cross-cultural relations, vigilance towards dynamics resulting from cultural differences, the expansion of cultural knowledge, and the adaptation of services to meet culturally unique needs. (2) Recognize that culture implies an integrated pattern of human behavior, including language, thoughts, beliefs, communications, actions, customs, values, and other institutions of racial, ethnic, religious, or social groups. (3) Promote congruent behaviors, attitudes, and policies enabling the system, agencies, and mental health professionals to function effectively in cross-cultural institutions and communities.

WIC, Section 5600.3—Relates to populations targeted for services. This section details the target populations that shall be served by mental health funds. Target populations include the following: Seriously emotionally disturbed children and adolescents, adults and older adults who have serious mental disorders, adults or older adults who require or are at risk of requiring acute treatment, and those persons who need brief treatment as a result of natural disaster or severe local emergency.

WIC, Section 5600.9(a) -- “Services to the target populations described in Section 5600.3 should be planned and delivered to the extent practicable so that persons in all ethnic groups are served with programs that meet their cultural needs.”

WIC, Section 5802. (a)(4) -- relates to Adult and Older Adult Mental Health System of Care. “System of care services which ensure culturally competent care for persons with severe mental illness in the most appropriate, least restrictive level of care are necessary to achieve the desired performance outcomes.”

WIC, Section 5807. – relates to Human Resources, Education, and Training

Programs. Requires counties to work in an interagency collaboration (and public and private collaborative programs) to effectively serve target populations to assure service effectiveness and continuity and help set priorities for services.

WIC, Section 5813.5 (d)(3) – relates to distribution of funds, services to adults and seniors, funding, and planning for services. “Planning for services shall be consistent with the philosophy, principles, and practices of the Recovery Vision for mental health consumers…to reflect the cultural, ethnic and racial diversity of mental health consumers.”

WIC, Section 5820. – relates to Human Resources, Education, and Training Programs. This section details “the intent to establish a program with dedicated funding to remedy the shortage of qualified individuals to provide services to address severe mental illnesses.” A needs assessment is required of the mental health programs in each county that detail anticipated staff shortages where the county will need to fill positions in order to meet requirements in reducing discrimination and improving services for underserved populations as detailed in WIC, Section 5840.

WIC, Section 5822 (d) and (i) – relates to Human Resources, Education, and Training Programs. Relates to the State Department of Mental Health. Section 5822 (d) requires an establishment of regional partnerships among mental health and educational systems to expand outreach to multicultural communities and increase the diversity of the mental health workforce. Section 5822 (i) requires promotion of the inclusion of cultural competency in training and educational programs.

WIC, Section 5840 (b) and (b)(4) and (e)– relates to Prevention and Early Intervention Programs. This section requires programs to reduce discrimination and improve services for underserved populations. Additionally, this section requires the department to revise elements of the program to reflect lessons learned. “The program shall emphasize improving timely access to services for underserved populations.” “Reduction in discrimination against people with mental illness.” “In consultation with mental health stakeholders, the department shall revise the program elements in Section 5840 applicable to all county mental health programs in future years to reflect what is learned about the most effective prevention and intervention programs for children, adults and seniors.”

WIC, Section 5848– relates to the development of prevention and early intervention plans with local stakeholders. This section requires stakeholder participation in the development of the PEI plan.

WIC, Section 5855. (f) -- relates to Children’s Mental Health System of Care. “Cultural competence. Service effectiveness is dependent upon both culturally relevant and competent service delivery.”

WIC. Section 5865. (b) -- relates to the county System of Care Requirement

in place with qualified mental health personnel within three years of funding by the state. “(b) A method to screen and identify children in the target population including persons from ethnic minority cultures which may require outreach for identification. (e) A defined mechanism to ensure that services are culturally competent.”

WIC Section 5878.1—relates to establishing programs that assure services are culturally competent. “It is the intent of this act that services provided under this chapter to severely mentally ill children are accountable, developed in partnership with youth and their families, culturally competent, and individualized to the strengths and needs of each child and their family.”

WIC. Section 5880. (b)(6) -- relates to establishing beneficiary and cost outcome and other system performance goals for selected counties. “To provide culturally competent programs that recognize and address the unique needs of ethnic populations in relation to equal access, program design and operation, and program evaluation.”

WIC, Section 14683 (b) -- requires the department establish minimum standards of quality and access for managed mental health care plans. This section sets forth a requirement that managed mental health care plans include a system of “outreach to enable beneficiaries and providers to participate in and access mental health services under the plans, consistent with existing law.”

WIC, Section 14684 (h) -- “Each plan shall provide for culturally competent and age- appropriate services, to the extent feasible. The plan shall assess the cultural competence needs of the program. The plan shall include, as part of the quality assurance program required by Section 4070, a process to accommodate the significant needs with reasonable timelines. The department shall provide demographic data and technical assistance. Performance outcome measures shall include a reliable method of measuring and reporting the extent to which services are culturally competent and age-appropriate.”

California Government Code (CGC) Section 7290-7299.8 – “This chapter may be known and cited as the Dymally-Alatorre Bilingual Services Act." Relates to the Legislature’s findings and declarations regarding rights and benefits to those precluded from utilizing public services because of language barriers. This section details the need for effective community between the government and its citizens and describes legislative intention to provide for effective communication to those that either do not speak or write English at all or their primary language is other than English.

California Code of Regulations

California Code of Regulations (CCR), Title 9, Rehabilitative and Developmental Services. Division 1, Department of Mental Health, Chapter 10, Medi-Cal Psychiatric Inpatient Hospital Services, Article 1, Section 1704 “Culturally Competent Services means a set of congruent behaviors, attitudes and policies in a

system or agency to enable effective service provision in cross-cultural settings."

CCR, Title 9, Rehabilitative and Developmental Services. Division 1, Department of Mental Health, Chapter 11, Medi-Cal Specialty Mental Health Services, Article 4, Section 1810.310 1(a-b) Implementation Plan. This section discusses how an MHP must submit an Implementation Plan with procedure details for screening, referral and coordination with other necessary services and "Outreach efforts for the purpose of providing information to beneficiaries and providers regarding access under the MHP."

CCR, Title 9, Rehabilitative and Developmental Services. Division 1, Department of Mental Health, Chapter 11, Medi-Cal Specialty Mental Health Services, Article 4, Section 1810.410 (a-e), Cultural and Linguistic Requirements. This section provides an in-depth listing of cultural and linguistic requirements. "Each MHP shall develop and implement a Cultural Competence Plan that includes…" provisions of the CCPR that work to improve cultural and linguistic competence. "The MHP shall submit the Cultural Competence Plan to the Department for review and approval in accordance with these timelines. "The MHP shall update the Cultural Competence Plan and submit these updates to the Department for review and approval annually."

Cultural Competence Plan provisions in this section include but are not limited to the following: strategies and objectives, cultural and linguistic assessments, resource listing of linguistically appropriate services, and cultural and linguistic training for mental health workers. MHPs shall have a statewide, toll-free number, oral interpreters available, referrals for linguistic and cultural services the MHP does not provide, policies and procedures to assist beneficiaries who need interpreters in non-threshold languages, and general program literature in threshold languages

CCR, Title 9. Rehabilitative and Development Services, Division 1. Department of Mental Health, Chapter 14. Mental Health Services Act, Article 2: Definitions, Section 3200.100. Cultural Competence. This section provides an in depth definition of "Cultural Competence". It identifies nine goals to incorporate in all aspects of policy- making, program design, administration and service delivery and assist in the development of an infrastructure of a service, program or system, as necessary in achieving these goals.

CCR, Title 9, Rehabilitative and Developmental Services, Division 1, Department of Mental Health, Chapter 14. Mental Health Services Act, Article 2, Definitions, Section 3200.210. "Linguistic Competence" means organizations and individuals working within the system are able to communicate effectively and convey information in a manner that is easily understood by diverse audiences, including individuals with Limited English Proficiency; individuals who have few literacy skills or are not literate; and individuals with disabilities that impair communication. It also means that structures, policies, procedures, and dedicated resources are in place that enables organizations and individuals to effectively respond to the literacy needs of the populations being served.

CCR, Title 9, Rehabilitative and Developmental Services, Division 1, Department of Mental Health, Chapter 14. Mental Health Services Act, Article 2,

Definitions, Section 3200.260. "'Small County' means a county in California with a total population of less than 200,000, according to the most recent projection by the California State Department of Finance."

CCR, Title 9, Rehabilitative and Developmental Services, Division 1, Department of Mental Health, Chapter 14. Mental Health Services Act, Article 3, General Requirements, Section 3300. Community Program Planning Process. This section provides requirements related to designated positions for community planning processes and details minimum Community Program Planning Process requirements. The planning process shall include opportunities for stakeholder participation of "unserved and/or underserved populations" and their family members as well as to "stakeholders who reflect the diversity of the demographics of the County, including but not limited to, geographic location, age, gender, and race/ethnicity."

CCR, Title 9, Rehabilitative and Developmental Services, Division 1, Department of Mental Health, Chapter 14. Mental Health Services Act, Article 6, General Requirements, Section 3610 (b)(1). General Community Services and Supports. "The County shall conduct outreach to provide equal opportunities for peers who share the diverse race/ethnic, cultural, and linguistic characteristics of the individuals/clients served."

The National CLAS Standards

Principal 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.

Governance, Leadership and Workforce

2. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.
3. Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.
4. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

Communication and Language Assistance

5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.
6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.

7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.
8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

Engagement, Continuous Improvement, and Accountability

9. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.
10. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.
11. 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.
12. 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.
13. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.
14. Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.
15. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.

MHSA Guidelines

Prevention and Early Intervention: Cultural Competence

"Improving access to mental health programs and interventions for unserved and underserved communities and the amelioration of disparities in mental health across racial/ethnic and socioeconomic groups are priorities of the MHSA. Therefore, cultural competence must be emphasized in PEI programs."

Cultural Competence means incorporating and working to achieve cultural competence goals into all aspects of policy-making, program design, and administration and service delivery. (Source: PEI, 2007, p. 2).

Workforce Education and Training: Cultural Competence

Guides counties for the "development and implementation of recruitment, retention and promotion strategies for providing equal employment opportunities to administrators, service providers, and others involved in service delivery who share the diverse racial/ethnic cultural and linguistic characteristics of individuals with severe mental illness/emotional disturbance in the community." "Staff, contractors and other individuals who deliver services are trained to understand and effectively address the needs and values of the particular racial/ethnic, cultural, and /or

linguistic population or community they serve." (Source: WET, 2007, p.4-5)

Workforce Education and Training: Objectives in the Five Year Plan
Guides counties in the "development of strategies for the meaningful inclusion of individuals with mental health client and family member experience, and incorporate their viewpoints and experiences in all training and education programs." (Source: WET, 2007, p.6)

Workforce Education and Training: Workforce Needs Assessment
Guides counties to "establish a current, standardized baseline set of workforce data that depicts personnel shortages and the needs of ethnic/racial and culturally underrepresented populations." (Source: WET, 2007, p.11)