Cultural Awareness Plan

Three Year Strategic Plan

Madera County

Behavioral Health Services

2021-2023

TABLE OF CONTENTS

CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES CULTURAL COMPETENCE PLAN REQUIREMENTS

COVER SHEET

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CHECKLIST OF THE CULTURAL COMPETENCE PLAN REQUIREMENTS MODIFICATION (2010) CRITERIA

☒ CRITERION 1: COMMITMENT TO CULTURAL COMPETENCE

☒ CRITERION 2: UPDATED ASSESSMENT OF SERVICE NEEDS

☒ CRITERION 3: STRATEGIES AND EFFORTS FOR REDUCING RACIAL, ETHNIC, CULTURAL, AND LINGUISTIC MENTAL HEALTH DISPARITIES

☒ CRITERION 4: CLIENT/FAMILY MEMBER/COMMUNITY COMMITTEE: INTEGRATION OF THE COMMMITTEE WITHIN THE COUNTY MENTAL HEALTH SYSTEM

☒ CRITERION 5: CULTURALLY COMPETENT TRAINING ACTIVITIES

☒ CRITERION 6: COUNTY'S COMMITMENT TO GROWING A MULTICULTURAL WORKFORCE: HIRING AND RETAINING CULTURALLY AND LINGUISTICALLY COMPETENT STAFF

☒ CRITERION 7: LANGUAGE CAPACITY

☒ CRITERION 8: ADAPTATION OF SERVICES

Purpose

The Cultural Competence Plan Requirements (CCPR) establishes new standards and criteria for the entire County Mental Health System, including Medi-Cal services, Mental Health Services Act (MHSA), and Realignment as part of working toward achieving cultural and linguistic competence.

Each county must develop and submit a cultural competence plan consistent with these CCPR standards and criteria (per California Code of Regulations, Title 9, Section 1810.410). The CCPR seeks to support full system planning and integration. It includes the most current resources and standards available in the field of cultural and linguistic competence and is intended to move toward the reduction of mental health service disparities identified in racial, ethnic, cultural, linguistic, and other unserved/underserved populations. The revised CCPR works toward the development of the most culturally and linguistically competent programs and services to meet the needs of California's diverse racial, ethnic, and cultural communities in the mental health system of care.

CCPR Modification

Madera County Behavioral Health Services (MCBHS) will be completing the CCPR Modification version of this report. In response to small county requests, the Department of Mental Health (DMH) worked closely with the California Mental Health Director's Association Small Counties' Committee to develop an abridged version of the full CCPR. The modified version of the full CCPR shall from herein be called the CCPR Modification.

The California Department of Mental Health is using the California Code of Regulations, Title 9, Section 3200.260, for the definition of eligible "Small Counties".

Background

DMH seeks to keep the County Mental Health System updated with the latest studies and applications in the field of cultural and linguistic competence, so that the mental health system functions as a highly efficient organization with the ability to provide effective and integrated services to its ethnic/racial and cultural communities. The

CCPR Modification serves to operationalize cultural competence at both the organizational and contractor level.

The basis for the revised CCPR and the CCPR Modification criteria is the Department of Health and Human Services, Office of Minority Health (2001) *National Standards for Culturally and Linguistically Appropriate Services in Health Care: Executive Summary* (CLAS). The revised CCPR Modification criteria were developed from a compilation of the CCPR, CLAS, and other current cultural competence organizational assessment tools. Combined, these documents incorporate eight domains that cover a system in its entirety:

- Domain 1. Organizational Values;
- Domain 2. Policies/Procedures/Governance;
- Domain 3. Planning/Monitoring/Evaluation;
- Domain 4. Communication;
- Domain 5. Human Resource Development;
- Domain 6. Community and Consumer Participation; Domain 7. Facilitation of a Broad Service Array; and
- Domain 8. Organizational Resources.

Research on the above eight domains included review and analysis of 17 organizational level cultural competence assessment tools being used in the field today. The research yielded a compilation of the eight significant assessment domains as focus areas for assessing and integrating cultural competence into mental health programs. The domains work to create an organizational model for operationalizing cultural competence into systems. The inclusion of these eight domains is necessary for a County Mental Health System to effect change and progress towards a culturally competent mental health system of care in California. From the above eight *domains*, eight *criteria* were developed to encompass the revised CCPR Modification and assist counties in identifying and addressing disparities across the entire mental health system. Those eight criteria are as follows:

- Criterion I: Commitment to Cultural Competence
- Criterion II: Updated Assessment of Service Needs
- Criterion III: Strategies and Efforts for Reducing Racial, Ethnic, Cultural, and Linguistic Mental Health Disparities
- Criterion IV: Client/Family Member/Community Committee: Integration of the Committee Within the County Mental Health System
- Criterion V: Culturally Competent Training Activities
- Criterion VI: County's Commitment to Growing a Multicultural Workforce: Hiring and Retaining Culturally and Linguistically Competent Staff
- Criterion VII: Language Capacity
- Criterion VIII: Adaptation of Services

These eight criteria are a mechanism to examine where counties lie on the scale of cultural competence. Having used the criteria to form a logic model, the CCPR Modification's development and inclusion of the eight criteria allow counties to implement cultural and linguistic competence in a variety of settings and move toward operationalizing the concept of cultural competence. The assessment portion of the CCPR Modification (2010) will identify areas the county may need resources, supports, and leverage to support its efforts in operationalizing cultural competence.

The County Mental Health System in California has changed greatly with the passage of the MHSA. The MHSA has opened many doors for unserved/underserved individuals and works toward increasing the county workforce. As MHSA expands and increases services, DMH recognizes that county reporting requirements have also increased.

The CCPR Modification takes this into consideration and has focused on omitting reporting redundancies by developing one, single plan that will be applied to all programs throughout the system. Where applicable, the CCPR Modification requires copies or updates of areas already addressed in other reports or plans. Some areas will apply to Medi-Cal only, while other areas will apply to the entire system; these are delineated throughout the CCPR Modification.

Current State and Federal statutory, regulatory, and authority provisions related to cultural and linguistic competence and other policies, statutes, and standards

This CCPR Modification includes listings of required Federal and State statutes, regulations, and DMH policy letters related to cultural and linguistic competence in the delivery of mental health services. These provisions are in addition to other Federal or State laws that prohibit discrimination based on race, color, or national origin.

CRITERION 1:
COMMITMENT TO CULTURAL COMPETENCE

This section is an organizational and service provider assessment. This assessment is necessary to determine the readiness of the service delivery to meet the cultural and linguistic needs of target populations. Individuals from racial, ethnic, cultural, and linguistically diverse backgrounds frequently require different and individual Mental Health Service System responses.

I. County Mental Health System commitment to cultural competence

A. ***The following information is available to ensure that Madera County Behavioral Health Services commitment to cultural and linguistically competence services are reflected throughout the entire system:***

1. Mission Statement

Mission Statement

To promote the prevention of and recovery from mental illness and substance abuse for the individuals, families, and communities we serve by providing accessible, caring, and culturally competent services.

2. Statements of Philosophy

Vision

We envision a world where all persons with addictions and mental illness can achieve recovery and can live with dignity and respect as valued members of their families and communities.

Core Values

We, the employees of Madera County Behavioral Health Services, value: • The promotion of wellness and recovery. • The integrity of individual and organizational actions.• The dignity, worth, and diversity of all people.• The importance of human relationships.• The contribution of each employee.

3. Strategic Plans;

Madera County Behavioral Health Services (MCBHS) plan is to integrate culturally competent practices in all areas of functionality. That way needed services can be delivered respectfully to a diverse group in an effective and equitable manner. MCBHS has many policies, procedures and practices in place that reflect steps taken to fully incorporate the recognition and value of racial, ethnic, and cultural diversity within the County's Mental Health System.

The Cultural Competence Plan is solely dedicated to advancing the Department's overall cultural competence. We strive to establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organizations' planning and operations. This 3-year plan derives its goals from four sources:

1) Quality Management Meetings (a.k.a. QIC)/Cultural Competence Committee
2) Provider Input/Feedback
3) Annual Quality Management Improvement Work Plan

4) CLAS National Standards

4. Policy and Procedure Manuals;

Policies, procedures, and practices include the following and are available upon request:

- MHP 13.00 – Language Interpretation, Informing Material Translation and Distribution
- MHP 14.00 – Services for Individuals with Special Language Needs
- MHP 14.A1 – CyraCom Quick Start (accessing a medical interpreter)
- MHP 14.A2 – CyraCom VRI Quick Start Guide
- MHP 14.A3 – Non-English-Speaking Calls – CyraCom
- MHP 14.A4 – Interpreter Services Waiver
- MHP 14.A5 – Interpreter Services Waiver (Spanish)
- MHP 43.00 – Administration of Bilingual Pay
- MHP 44.00 – Cultural Competence Plan (policy)
- QMP 24.00 – Consumer Satisfaction Survey (in threshold languages)

5. Other Key Documents (Counties may choose to include additional documents to show system-wide commitment to cultural and linguistic competence).

Human Resources Training and Recruitment Policies;

- ADM 05.00 – Cultural Competence Plan
- ADM 42.00 – Bilingual Compensation

II. County recognition, value, and inclusion of racial, ethnic, cultural, and linguistic diversity within the system.

A. ***Provide a copy of the county's CSS plan that describes practices and activities that demonstrate community outreach, engagement, and involvement efforts with identified racial, ethnic, cultural, linguistic, and other relevant small county cultural communities with mental health disparities.***

Madera County is a small rural county with limited resources. Due to the limited resources, many of the Community Services and Supports (CSS) outreach and engagement activities occurred within the Full-Service Partnership (FSP) and General

Systems Development (GSD) while engaging consumer, family members, and potential consumers. Once the Prevention and Early Intervention (PEI) program was approved in 2010, the Wellness Center programs fell under the PEI category and not CSS. However, FSP still heavily relies on the Wellness Centers (*Hope House and Mountain Wellness Center*). FSP staff refer and recommend classes, group session and/or services to keep their population engaged. The Wellness Centers also provide supportive services such as food, clothing, and shelter. Outreach events are also held by our Wellness Centers throughout the year and demographic information is collected when possible to ensure we are reaching our diverse racial, ethnic, cultural, and linguistic community.

Our PEI team provides education/training and outreach to MCBHS' clients, caregivers, and community members. These programs are designed to identify individuals who are at risk of developing mental illness and who are demonstrating early signs of mental illness and/or emotional disturbance. Once identified, they are connected to different types of resources. Services aim to strengthen skills, reduce risk factors and to enhance resilience through education, training, and treatment. MCBHS is committed to keeping people healthy by providing early intervention services, thus drastically reducing susceptibility to the negative effects of mental illness. The CSS plan identified that the county would need to focus on the Hispanic/Latino community and the TAY population.

MCBHS requires all network and organizational contract providers to deliver culturally and linguistically competent specialty mental health services. Contracts include a provision on Cultural Competence (page 22 of the Master Services Agreement template) stating that the contractor shall use a set of professional skills, behaviors, attitudes, and policies that enable the system, or those participating in the system, to work effectively in meeting the cross-cultural needs of MCBHS clients. Contractors are to have a written policy and procedure that ensure organizational and individual compliance by its staff and providers. Contractors are to provide a list of cultural competency trainings and sign in sheets with attendee information if requested.

B. A one-page description addressing the county's current involvement efforts and level of inclusion with the above identified underserved communities on the advisory committee.

Unfortunately, in 2020 due to the COVD-19 pandemic and gathering restrictions, the PEI outreach team was not able to conduct their typical outreach events. We are still amid the pandemic and unable to perform business as usual. Outreach efforts were made by linking with community partners to provide service information via a virtual platform. MCBHS will remain flexible to meet the needs of the community. In the planning phase and during the Quality Management Meeting (QMM), it was agreed that the best thing to do would be to open the committee meetings to community members. Outreach efforts were made through our texting service and through social media. Community members were invited to virtually attend management meetings to help us better understand community needs. Unfortunately, although some expressed interest, none have participated.

C. Share lessons learned on efforts made on the items A and B above and any identified county technical assistance needs. Information on the county's current MHSA Annual Plan may be included to respond to this requirement.

An area of improvement is with Madera County Behavioral Health Services' (MCBHS) electronic health record (EHR). MCBHS has found discrepancies in recorded numbers. There are several different outcomes reported for the same category and different paths for attaining that information. This makes it hard to measure our level of efficiency when engaging our community. To correct the issue, MCBHS is moving towards a new EHR system which will help to accurately compile data. This is set to launch in December 2020. This new EHR system should help BHS extract accurate data to assist in our analysis and to better understand the effectiveness of our outreach efforts.

MCBHS also had a hard time getting stakeholder/community participation. And since we are unable to do recruitment events, MCBHS will be focusing on creating a social

media presence and video content to get information out and hopefully create interest and engage our clients to participate.

III. Each county has a designated Cultural Competence/Ethnic Services Manager (CC/ESM) person responsible for cultural competence

A. Detail who is designated the county's CC/ESM responsible for cultural competence and who promotes the development of appropriate mental health services that will meet the diverse needs of the county's racial, ethnic, cultural, and linguistic populations.

Madera County has appointed Administrative Analyst, Ambar Mojica as the Cultural Competence/Ethnic Services Manager (CC/ESM). Mrs. Mojica serves concurrently as an Analyst for MHP and MHSA. She reports to and has direct access to the Mental Health Director regarding issues related to racial, ethnic, cultural, and linguistic populations within the county that impact mental health issues. In her capacity as Ethnic Services Manager, Mrs. Mojica participates in the monthly Quality Management meetings. It is in those meetings that Mrs. Mojica presents information and advocates for the diverse needs of the community.

The CC/ESM works closely with the Director. In this high-level administrative capacity, the ESM is instrumentally involved in the long range strategic and operational planning and implementation of all MCBHS services and activities. Thus, the ESM is critically positioned to ensure the diverse needs of the county's racial, ethnic, cultural and linguistic populations are infused into all management planning and decisions.

IV. Identify budget resources targeted for culturally competent activities

Funds related to any culturally competent services are part of our training funds. They are not specifically broken down since Madera County Behavioral Health Services (MCBHS) embeds culturally competent activities into our entire behavioral health system. Therefore, we are not able to identify funds broken down in any part of our budget for culturally competent services.

CRITERION 2:
UPDATED ASSESSMENT OF NEEDS

Rationale: *A population assessment is necessary to identify the cultural and linguistic needs of the target population and is critical in designing, and planning for, the provision of appropriate and effective mental health services.*

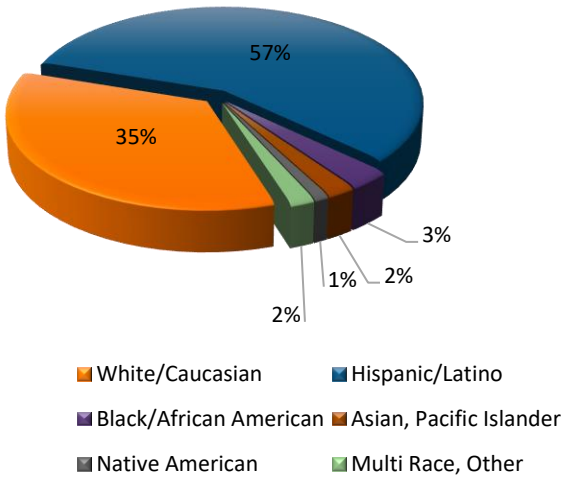
General Population

I. The county shall include the following:

A. Provide a description of the county's general population by race, ethnicity, age, gender, and other relevant small county cultural populations. The summary may be a narrative or as a display of data (other social/cultural groups may be addressed as data is available and collected locally). If appropriate, the county may use MHSA Annual Update Plan data here to respond to this requirement.

According to the US Census fact finder, in 2017 Madera County had 154,440 residents. The Department of Finance calculates that as of July 2019, County of Madera has about 159,536 residents in the county.

Population by Race/Ethnicity



Population estimate breakdown for Race/Ethnicity is as follows:

1. Hispanic/Latino:	57%
2. White/Caucasian:	35%
3. Black/African American:	3%
4. Asian, Pacific Islander:	2%
5. Multi-race, other:	2%
6. Native American:	1%

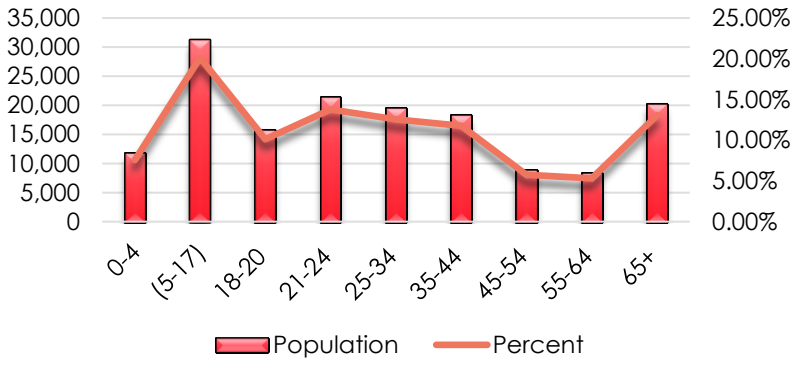
Table 2.1: Total Population of Madera County by Race/Ethnicity

Race/Ethnicity	***Population***	***Percent***
White/Caucasian	54,145	35%
Hispanic/Latino	87,852	57%
Black/African American	4,753	3%
Asian, Pacific Islander	3,225	2%
Native American	1,647	1%
Multi Race, Other	2,818	2%
Total:	**154,440**	**100%**

Madera is a small county; there are two dominant populations. Those populations are Hispanic/Latino and White/Caucasian. Latinos make up 57% of the population and the White/Caucasian community occupies 35% of the population. They are then followed by the African American population who occupy 3% of the population.

*Data Source: Fact Finder tool, 2017 U.S. Census Bureau

Population by Age



Age breakdown:

0-4: 7.57%

5-17: 20.11%

18-20: 10.10%

21-24: 13.76%

25-34: 12.57%

35-44: 11.77%

45-54: 5.74%

55-64: 5.31%

65+: 13.07%

Table 2.2: Total Population of Madera County by Age Groups

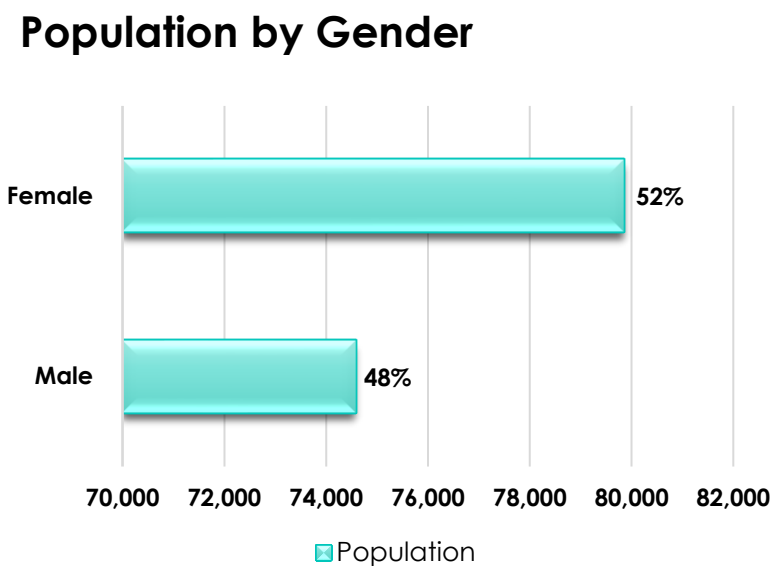
Age	***Population***	***Percent***
0-4	11,695	7.57%
5-17	31,052	20.11%
18-20	15,597	10.10%
21-24	21,251	13.76%
25-34	19,412	12.57%
35-44	18,171	11.77%
45-54	8,870	5.74%
55-64	8,201	5.31%
65+	20,191	13.07%
Total:	**154,440**	**100.00%**

Table 2.3: Total Population of Madera County by Youth vs. Adult

Age Group	***Population***	***Percent***
Youth Total Population (0-17)	42,747	28%
Adult Total Population (18+)	111,693	72%
Total:	**154,440**	**100%**

Approximately 51.54% of the population is under 25 years old, while 35.39% of the population is 25 - 64 years of age. The senior population is relatively small, with only 13.07% being over the age of 65. With that information highlighted, 75.87% of the population is 44 and younger and only 24.13% is 45 and older which emphasizes the fact that Madera County has a younger population. The age range between 5-17 years old has the highest percentage with 20.11% in that age range.

*Data Source: Fact Finder tool, 2017 U.S. Census Bureau



There are 6% more females than males in Madera County.

Table 2.4: Total Population of Madera County by Gender

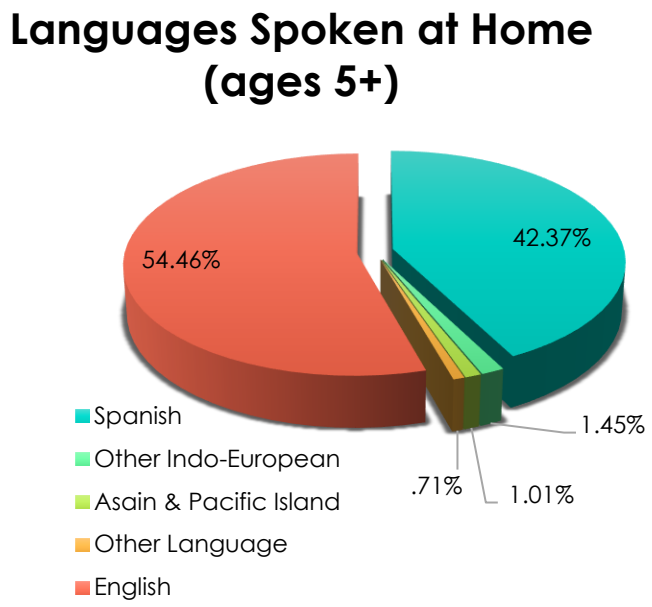
Gender	Population	Percent
Male	74,583	48%
Female	79,857	52%
Total:	**154,440**	**100%**

Table 2.5: Total Population of Madera County Gender by Youth vs. Adult

Gender	Population	Percent
Youth Male	21,742	14.08%
Youth Female	21,005	13.60%
Adult Male	52,841	34.21%
Adult Female	58,852	38.11%
Total:	**154,440**	**100%**

Overall, Madera County has a lot more females than males; However, if you look at the breakdown between youth and adult, it seems that the lead comes from the adult population since youth males slightly surpass female youth.

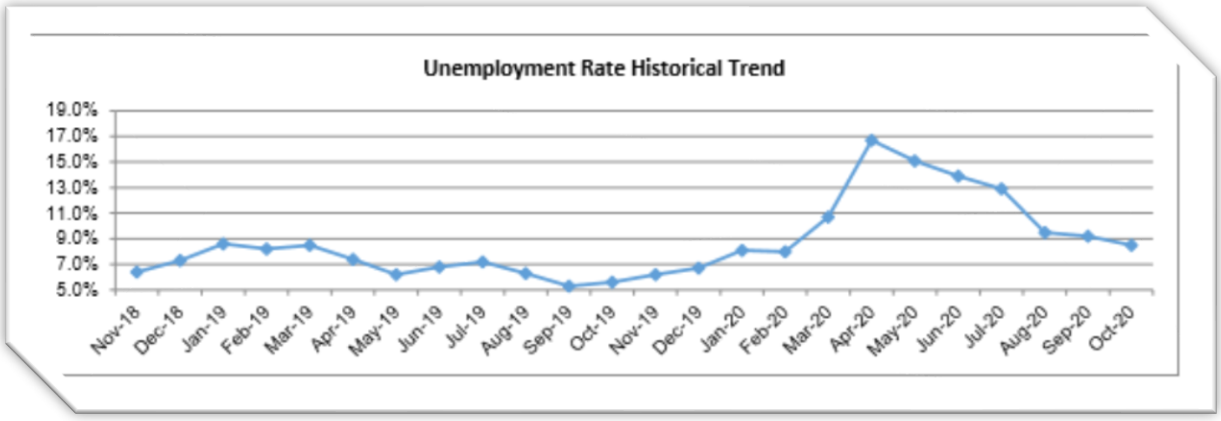
*Data Source: Fact Finder tool, 2017 U.S. Census Bureau



The top two languages spoken at home are English and Spanish. Spanish is a threshold language in the County of Madera.

*Data Source: Fact Finder tool, 2017 U.S. Census Bureau

The unemployment rate in Madera County was 8.5 percent in October 2020, down from a revised 9.2 percent in September 2020 and above the prior year estimate of 5.6 percent. This compares with an unadjusted unemployment rate of 9.0 percent for California and 6.6 percent for the nation during the same period.



The COVID-19 pandemic began in March 2020 which is where the graph shows a spike in our unemployment rate. The economy took a strong hit but the trend is showing signs of recovery. However, according to CBS and several other news outlets, infection numbers for the virus are increasing. CBS reported that

"unemployment claims are at their highest level in months. The latest numbers show California jobless claims have risen to nearly 178,000" as of December 10, 2020.

**Data Source: State of California, Employment Development Department*

II. Medi-Cal population service needs

A. Summarize the following two categories by race, ethnicity, language, age, gender, and other relevant small county cultural populations:

1. The county's Medi-Cal population
2. The county's client utilization data

Table 2.5: Countywide Estimated Population Enrolled in Medi-Cal for Madera County by Ethnicity, Race, Age & Gender, for CY 2019 and Penetration Rate for Fiscal Year CY19.

Race/Ethnicity	*County Population*	*Medi-Cal Eligible*	*Medi-Cal Beneficiaries Served*	*Madera Penetration Rate*	*Statewide Penetration Rate*[1]
White/Caucasian	54,145	12,279	1,009	8.22%	6.73%
Hispanic/Latino	87,852	48,080	1,558	3.24%	4.08%
Black/African American	4,753	1,467	143	9.75%	8.49%
Asian, Pacific Islander	3,225	1,140	35	3.07%	2.26%
Native American	1,647	428	31	7.24%	7.50%
Multi Race, Other	2,818	0	0	N/A	N/A
Unknown/Other	0	8,064	349	4.33%	5.1%
Age					
0-5	11,695	10,262	138	1.34%	2.23%
6-17	31,052	21,162	1,100	5.20%	6.88%
18-59 [2]	83,301	33,424	1,655	4.95%	5.06%
60+ [3]	28,392	6,608	232	3.51%	2.90%
Gender					
Female	79,857	38,084	1,711	4.49%	4.48%
Male	74,583	33,372	1,414	4.24%	5.31%

*Information retrieved from DHCS Approved Claims and MMEF data for CY2019.

Table 2.6: Madera County Penetration rate history CY2017 - 19

Race/Ethnicity	Madera penetration rate CY2017	Madera penetration rate CY2018	Madera penetration rate CY2019
White	7.93%	↑ 8.50%	↓ 8.22%
Hispanic/Latino	**3.33%**	↑ **3.39%**	↓ **3.24%**
African American	9.90%	↑ 10.30%	↓ 9.75%
Asian/Pacific Islander	3.25%	↓ 2.35%	↓ 3.07%
Native American	5.95%	↑ 6.59%	↑ 7.24%
Other	6.59%	↓ 4.95%	↓ 4.33%

*Information retrieved from DHCS Approved Claims and MMEF data for CY2019.

B. Provide an analysis of disparities as identified in the above summary. This can be a narrative discussion of the data. Data must support the analysis.

Per Table 2.5, most categories are performing better than the statewide penetration rate. However, Table 2.6 highlights the fact that our penetration rate has slightly dropped in most categories from the previous calendar year. For the Black/African American community we experienced a drop from CY 2018 to CY 2019. In the previous year, Madera County reported a 10.30% penetration rate in comparison to CY 2019 which stands at 9.75%. The area that needs immediate attention is the Hispanic/Latino community. This rate has slightly dropped in comparison to the previous year and we fall below the statewide average. MCBHS used EQRO data which also compares MCBHS to other small county's average rates. Small counties are showing a rate of 4.47% which is even higher than the state average of 4.08%. This data highlights the need to place more focus on improving our reach in the Hispanic/Latino population which is underserved in our community. One area that has shown improvement has been in our Native American population. Our Native American penetration rate went from 6.59% to 7.24%.

III. 200% of Poverty (minus Medi-Cal) population and service needs.

(Please note that this information is posted at the DMH website at http://www.dmh.ca.gov/News/Reports_and_Data/default.asp.)

A. Summarize the 200% of poverty (minus Medi-Cal population) and client utilization data by race, ethnicity, language, age, gender, and other relevant small county cultural populations.

As a small county, we were not able to collect a breakdown for the 200% poverty data. The above link is also not active.

B. Provide an analysis of disparities as identified in the above summary. This can be a narrative discussion of the data. Data must support the analysis.

The data is not available; therefore, we are unable to provide an analysis.

IV. MHSA Community Services and Supports (CSS) population assessment and service needs

A. From the county's approved CSS plan, extract a copy of the population assessment and summarize population and client utilization data by race, ethnicity, language, age, gender, and other relevant small county cultural populations.

During Fiscal Year FY 2018-19 Madera County served **4,105** which is slightly lower than FY 2017-18, in which 4,518 were reported served. Per data issues previously disclosed, numbers below will vary slightly.

Table 2.7: Estimate Countywide Total Population Served through MHSA for Madera County FY 2018-19

Mental Health Treatment Services	**# of clients**
MHSA FSP	380
MHSA General Systems Development	3,660
Total	**4,040**

*reported 4,105 served in CPPP presentation for CSS but compiled by program adds up to 4,040

Table 2.8: Estimate Countywide Total Population Served through MHSA for Madera County by Age Group for FY 2018-19

Age Group	# of clients	% of clients
0-15	1,082	27%
16-25 (TAY)	893	22%
26-59	1,768	44%
60+	297	7%
Total	**4,040**	**100%**

*reported 4,105 served in CPPP presentation for CSS but compiled by age adds up to 4,040

Table 2.9: Estimate Countywide Total Population Served through MHSA for Madera County by Ethnicity/Race for FY 2018-19

Ethnicity/Race	# of clients	% of clients
Asian Indian	5	0.12%
Asian Other	9	0.22%
Black/African AM	222	5.37%
Cambodia	1	0.02%
Chinese	2	0.05%
Eskimo/Alaskan Native	3	0.07%
Filipino	5	0.12%
Japanese	1	0.02%
Korean	1	0.02%
Laotian	1	0.02%
Native American	47	1.14%
Non-White Other (includes Hispanic)	1,996	48.28%
Other Pacific /Islander	3	0.07%
Hmong	2	0.05%
Multiple	15	0.36%
Unknown	28	0.68%
Vietnamese	1	0.02%
White	1792	43.35%
Total	**4,134**	100.00%

*reported 4,105 served in CPPP presentation for CSS but compiled by Race/Ethnicity adds up to 4,134

B. Provide an analysis of disparities as identified in the above summary. This can be a narrative discussion of the data. Data must support the analysis.

Although the graph is showing Non-White as being inclusive of Hispanic, our current system does not allow services to be broken down accurately by Ethnicity/Race so this information derives from different sources/reports. While the top two populations served in MHSA are Hispanic and White, Table 2.5 highlights the fact that we have

almost four times more Hispanics eligible than White, yet we serve almost the same amount. This has been the biggest gap found when looking at the data. The most significant increase found has been in Transition Age Youth (TAY, Ages:16-25) which went from 16% in FY 2017-18, to 27% in FY 2018-19.

V. Prevention and Early Intervention (PEI) Plan: The process used to identify the PEI priority populations.

A. Describe which PEI priority population(s) the county identified in their PEI plan and describe the process and rationale used by the county in selecting them. PEI Plan sections should be used to respond to priority populations identified by the county.

Madera County, as other comparable counties, has had a hard time attracting Spanish speakers. For example, during our planning process we sent out a survey to collect feedback regarding needed services and only received 10% overall participation from our Spanish speaking population. The County of Madera will need to focus on finding better methods of outreach to the Spanish speaking population to have a better grasp of the services needed within that community. We will also be focusing on our 25 and younger (TAY) population. Our PEI team was to begin placing more emphasis on schools but due to the COVID-19 pandemic, our usual methods of recruitment are no longer possible with students learning in an online environment.

CRITERION 3:

STRATEGIES AND EFFORTS FOR REDUCING RACIAL, ETHNIC, CULTURAL, AND LINGUISTIC MENTAL HEALTH DISPARITIES

Rationale: "*Striking disparities in mental health care are found for racial and ethnic populations. Racial and ethnic populations have less access to and availability of mental health services, these communities are less likely to receive needed mental health services, and when they get treatment, they often receive poorer quality of mental health care. Although they have similar mental health needs (as other populations) they continue to experience significant disparities, if these disparities go unchecked, they will continue to grow and their needs continue to be unmet...*" *(U.S. Department of Health and Human Services, Surgeon General Report, 2001).*

I. Identified strategies/objectives/actions/timelines

A. List the strategies and any new strategies identified for each targeted area and as noted in Criterion 2 in the following sections (use current plans and documents):

i. Medi-Cal population

ii. 200% of poverty population

iii. MHSA/CSS population

Note: *New strategies must be related to the analysis completed in Criterion 2.*

This year (CY 2020) has proven to be a challenging year. Many communities are standing against human rights violations, fighting for systemic change and equality all while dealing with a world-wide pandemic which has drastically affected the way we function as a society. For this plan to be successful and to be able to meet many of our objectives, Madera County Behavioral Health Services (MCBHS) will need to remain flexible in our approach to addressing our targeted areas. MCBHS will be using the National CLAS standards as a guideline for our strategies in creating a more culturally responsive framework.

OUR OVERALL GOAL:

The Principal Standard

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.

OUR STRATEGIES:

Governance, Leadership, and Workforce

1. Increase transparency, communication, and education/support/resources for BHS staff and contractors

a. Keep staff connected and engaged with cultural competence issues
   i. Use our agency wide newsletter, "The Buzz" to continue keeping staff engaged and informed of what is going on in terms of cultural understanding
   ii. Use online resources to post related information

b. Provide relevant and targeted trainings
   i. More education on LGBTQ+, especially transgender
   ii. More training on the Latino community, especially from the region of Oaxaca
   iii. Give staff resources and trainings on understanding their own biases

c. Deliver an ongoing and consistent training schedule
   i. Continue to provide a training schedule of at least one every quarter
   ii. Gather feedback and checking for comprehension

2. Use the Quality Monitoring Meeting (QM) to keep management informed and to assess the overall effectiveness of plan objectives

a. The CC/ESM will present information, advocate for the community, and receive feedback

b. Give feedback to other departments if something presented does not seem to meet cultural competence standards.

c. Ensure cultural competence is properly integrated into all aspects of agency functionality.

Communication and Language Assistance

3. Focus on increasing our penetration rates for the Hispanic/Latino population by increasing our online/social media presence

a. Use the online/social media platform to engage and educate the community on services offered/provided
b. Provide content in our threshold language, Spanish
c. Create relevant content

Engagement, Continuous Improvement, and Accountability

4. Increase engagement for *all* BHS clients through an online/social media platform to help reduce stigma

a. Use an online/social media presence to engage and educate
b. Create relevant online/social media content that is informative and educational
c. Create informational video to play in our clinics to provide visuals and information on accessing our services.

5. Conduct and create methods of accountability for culturally conducive practices

a. Conduct site audits to make a needs assessment and to ensure we are responsive to cultural and linguistic diversity of the populations in the service area.
b. Create methods of tracking progress
c. Concentrate on finding ways to continuously improve CLAS related activities

6. Use, learn and adapt our new EHR system to collect accurate data

a) Collect and maintain accurate and reliable demographic data to measure our level of success

7. Focus on community partnerships that are beneficial for our clients to help evaluate policies and practices that ensure cultural and linguistic appropriateness. Especially for the following populations:
    a. Hispanic/Latino
        i. Oaxaca region organizations
        ii. Spanish speaking organizations
    b. TAY population
        i. School/Club partnerships

B. Share what has been working well and lessons learned through the process of the county's development of strategies, objectives, actions, and timelines that work to reduce disparities in the county's identified populations within the target populations of Medi-Cal, CSS, and PEI.

This past year the CC/ESM has been posting monthly articles in the agency wide Buzz newsletter. At first, the CC/ESM was not receiving a lot of feedback but eventually many Behavioral Heath staff began commenting on the articles/information presented. The feedback was positive, and many stated how informative and educational they were. Since it has received positive feedback and has been gaining traction, this will be continued until further notice and may also be used to obtain optional feedback and/or surveys.

A lesson learned through developing the new strategies was that we were not communicating enough with staff on their needs. In previous years, we would assign trainings based on our assumption of what was necessary. Often, those trainings were not conducive to what they really needed. This year our CC/ESM met with units and spoke directly to staff to get a better understanding of areas in which they felt they needed further support. It was surprising how much was learned during those conversations. For example, our clinicians informed the CC/ESM that they were seeing more LGBTQ+ clients, specifically transgender and they needed more training to better understand how to help those clients. We would not have known until further down the line (after extracting data) that support was needed in this area.

Therefore, communicating more with staff will help us anticipate what services/trainings/etc will be needed in real time. For that reason, this plan places a lot of emphasis on communication with our staff so we can give them the resources needed to be more effective at addressing the needs of the community

II. Discuss the mechanism(s) the county will have or has in place to measure and monitor the effect of the identified strategies, objectives, actions, and timelines on reducing disparities identified in Section I of Criterion 3. Discuss what measures and activities the county uses to monitor the reduction or elimination of disparities.

Data will constantly be looked at and updated monthly. The CC/ESM will be constantly tracking progress and presenting the information to the committee which meets monthly. The Cultural Competence Committee (CCC) will measure and monitor the effects of the identified strategies and objectives for reducing disparities.

III. Identify any MHP technical assistance needs and challenges.

There are none currently identified. Our new EHR will hopefully assist in correcting our data issues.

CRITERION 4:

CLIENT/FAMILY MEMBER/COMMUNITY COMMITTEE: INTERGRATION OF THE COMMITTEE WITH THE COUNTY MENTAL HEALTH SYSTEM

Rationale: *A culturally competent organization views responsive service delivery to a community as a collaborative process that is informed and influenced by community interests, expertise, and needs. Services that are designed and improved with attention to community needs and desires are more likely to be used by patients/consumers, thus leading to more acceptable, responsive, efficient, and effective care (CLAS, Final Report).*

I. The county has a Cultural Competence Committee, or similar group that addresses cultural issues, has participation from cultural groups, that is reflective of the community, and integrates its responsibilities into the mental health system.

A. If so, briefly describe the committee or other similar group (organizational structure, frequency of meetings, functions, and role). If the committee or similar group is integrated with another body (such as a Quality Improvement Committee), The so inclusive committee shall demonstrate how cultural competence issues are included in committee work.

The Cultural Competence Committee (CCC) assists with monitoring and planning all activities for cultural compliance and addresses issued during its monthly meeting. Because MCBHS' goal is to integrate cultural competence into our entire system, this meeting is also combined with compliance, contracts, Utilization Management/Quality Improvement/Quality assurance (QMM Committee). The committee maintains close oversight and requires all planning efforts directly address cultural competence. The CC/ESM is responsible for attending these meetings and presenting/addressing/reporting any cultural issues.

Policy and procedure MHP 44.00 provides information about the composition of the Cultural Competence Committee, which is reflective of the community, clients, family members, racial and ethnic groups and other community partners as much as possible.

As demonstrated by Policy MHP 44.00 and Quality Management Committee and Cultural Competence Committee minutes, the Cultural Competence Committee's activities include all the following:

1. Reviews of all services/programs/cultural competence plans with respect to cultural competence issues at the county;
2. Provides reports to Quality Assurance and Performance Improvement Program in the county;
3. Participates in overall planning and implementation of services at the county;
4. Reporting requirements include directly transmitting recommendations to executive level and transmitting concerns to the Mental Health Director;
5. Participates in and reviews county MHSA planning process;
6. Participates in and reviews county MHSA stakeholder process;
7. Participates in and reviews county MHSA plans for all MHSA components;
8. Participates in and reviews client developed programs (wellness, recovery, and peer support programs); and
9. Participates in revised Cultural Competence Plan Update development.

The MCBHS Annual Report of the Cultural Competence Committee's activities include:

1. Detailed discussion of the goals and objectives of the committee;
    a. Were the goals and objectives met?
        - If yes, explain why the county considers them successful.
        - If no, what are the next steps?
2. Reviews and recommendations to county programs and services;
3. Goals of cultural competence plans;
4. Human resources report;
5. County organizational assessment;
6. Training plans; and
7. Other county activities, as necessary.

B. If so, briefly describe how the committee integrates with the county mental health system by participating in and reviewing MHSA planning process.

To be successful with integrating and reviewing the MHSA planning process, the MHSA program manager and Division Manager also attend the monthly Quality Monitoring meetings. Our CC/ESM is also the analyst for MHSA. She has been taking over some of the day-to-day functions of MHSA reporting and attends all MHSA related meetings.

CRITERION 5:
CULTURALLY COMPETENT TRAINING ACTIVITES

Rationale: *Staff education and training are crucial to ensuring culturally and linguistically appropriate services. All staff will interact with clients representing different countries or origins, acculturation levels, and social and economic standing. Staff refers not only to personnel employed by the organization but also its subcontracted and affiliated personnel (CLAS, Final Report).*

I. The county system shall require all staff and shall invite stakeholders to receive annual cultural competence training.

A. The county shall develop a three-year training plan for required cultural competence training that includes the following:

1. Steps the county will take to provide required cultural competence training to 100% of their staff over a three-year period.

This year has been different for Madera County due to the COVID-19 pandemic. The original plan was to provide training every quarter on the topic of cultural competence. Half of the trainings were to be in person and the other half were to be provided online. For the in-person trainings, all contracted staff were to be invited. Online trainings were through our Relias Learning Management system which is only available to Behavior Health staff. Q1 & Q3 were to be online, while Q2 & Q4 were to be in person. In March 2020, California ordered a lock down and implemented social gathering restrictions. MCBHS cancelled the Q2 training and switched the Q4 in person training to an online training. For these reasons, MCBHS plans to tentatively shift ALL trainings to an online platform for the next three years until all restrictions are lifted. MCBHS will have to remain flexible and may eventually shift back to in person trainings. MCBHS will be looking for trainers who can hold live virtual trainings on cultural competence. We will still maintain a quarterly training schedule. Most organizations are still adjusting and transitioning but once live virtual trainings are identified, ALL providers (county and contracted) will be invited to attend.

2. How cultural competence has been embedded into all trainings.

The Behavioral Health Department has been working diligently to holistically incorporate cultural competence into every aspect of our department. Since Madera County is a small county, we do not have the resources to validate every training offered to staff for proper cultural sensitivity. However, all staff have received cultural competence training and are aware that we are working towards a culturally proficient work environment, so any trainings that are not up to par can be reported directly to the Cultural Competence/Ethnic Service Manager (CC/ESM). The ESM has personally attended unit meetings to get feedback and let staff know that she has an open-door policy for any issues, concerns or ideas regarding cultural sensitivity. If there are ever any concerns regarding a training, this open-door policy allows staff to report any concerns directly to the CC/ESM. Since the CC/ESM also writes articles in our agency wide newsletter "The Buzz," her contact information is shared monthly.

3. A report list of annual training for staff, documented stakeholder invitation. Attendance by function to include: Administration/Management; Direct Services, Counties; Direct Services, Contractors, Support Services; Community Members/General Public; Community Event; Interpreters; Mental Health Board and Commissions; and Community- based Organizations/Agency Board of Director, and if available, include if they are clients and/or family members.

The list below features cultural competence courses offered through Relias Learning Management System. The list is presented to the Cultural Competence Committee (CCC), who then decides which courses are most appropriate and needed to become mandatory for all staff.
Assigned courses are to be completed through Relias Learning, which uses an online training module. Tracking course completion will also be through the Relias software.

- A Culture-Centered Approach to Recovery
- Behavioral Health Services and the LGBTQ+ Community
- Best Practices for Working with LGBTQ Children and Youth

- Building a Multicultural Care Environment
- Cultural Awareness and the Older Adult
- Cultural Competence
- Cultural Competence and Sensitivity in the LGBTQ Community - California
- Cultural Competence Path Assessment
- Cultural Dimensions of Relapse Prevention
- Cultural Issues in Treatment for Paraprofessionals
- Cultural Responsiveness in Clinical Practice
- Effective Telehealth When Working Communities Color
- End of Life Cultural Considerations: Religion and Spirituality
- How Culture Impacts Communication
- Implementation Guidelines for Telehealth Practitioners
- Identification, Prevention, and Treatment of Suicidal Behavior for Service Members and Veterans
- Individual and Organizational Approaches to Multicultural Care
- Patient Cultural Competency For Non-Providers
- Reducing Health Disparities: A Culturally Sensitive Approach for Busy Primary Care Providers
- Substance Use Disorder Treatment and the LGBTQ Community
- The Role of the Behavioral Health Interpreter
- Using Communication Strategies to Bridge Cultural Divides

B. Annual cultural competence trainings topics shall include, but not be limited to the following:

1. Cultural Formulation;
2. Multicultural Knowledge;
3. Cultural Sensitivity;
4. Cultural Awareness; and
5. Social/Cultural Diversity (Diverse groups, LGBTQ, SES, Elderly, Disabilities, etc.).
6. Interpreter Training in Mental Health Settings
7. Training Staff in the Use of Mental Health Interpreters

Training Event	Description of Training	How long and often	Attendance by function	No. of Attend-ees	Date of Training	Name of Presenter
How Culture Impacts Communication (Q1)	Learn about the importance of achieving a proper mindset for cross-cultural communication. Explore aspects of cultures that affect how people communicate across cultural boundaries. Learn considerations for speaking and writing in cross-cultural environments.	30 min	**Direct Services* **Direct Services Contractors* **Administration* **Interpreters*	109	Jan – March 31, 2020	Relias Learning Manager
Building a Multicultural Care Environment (Q3)	Explain how cultural differences can contribute to healthcare disparities. Describe identities, affiliations, beliefs, and aspects of individual or group diversity that may contribute to the cultural identity of the person served. Explain how cultural humility and improved cultural competency can positively affect healthcare services.	1.75 hours	**Direct Services* **Direct Services Contractors* **Administration* **Interpreters*	95	April – June 30, 2020	Relias Learning Manager

Training Event	Description of Training	How long and often	Attendance by function	No. of Attend-ees	Date of Training	Name of Presenter
Cultural Competence (Q4)	As workplaces become more diverse, effective, and successful employees must become more knowledgeable of other cultural norms, be respectful of the wide range of cultural behaviors, and effectively communicate with people of various backgrounds. This course provides important information about becoming more respectful and culturally competent.	30min	**Direct Services* **Direct Services Contractors* **Administration* **Interpreters*	88	Oct – Dec 31 ,2020	Relias Learning Manager

**Q2 in person training cancelled due to gathering restrictions, Q4 in person training moved to an online platform.*

The CC/ESM met with staff to better understand and support their needs. Are they struggling or need more support? Was it with a particular community and/or knowledge base? Below are the top two requests that were brought up during those meetings:

- Support with LGBTQ+ *(brought up in 4 separate unit meetings)*
    - Specifically, transgender, need more training/information, they are seeing an increase of these clients *(brought up in 3 separate unit meetings)*
- Support with community from Oaxaca, *(brought up in 3 separate unit meetings)*

There is a big community in Madera. They are not sure of the cultural norms. Their language is also different. More outreach and interpreters needed for that community.

The above topics are set to be included in our training plan.

II. Counties must have a process for the incorporation of Client Culture Training throughout the mental health system.

A. Evidence of an annual training on Client Culture that includes a client's personal experience inclusive of racial, ethnic, cultural, linguistic, and relevant small county cultural communities. Topics for Client Culture training are detailed on page 18 of the CCPR (2010) from DMH Information Notice 10-02.

B. The training plan must also include, for children, adolescents, and transition age youth, the parent's and/or caretaker's, personal experiences with the following:

1. Family focused treatment;
2. Navigating multiple agency services; and
3. Resiliency.

Responses for A – B

Unfortunately, in 2020 due to the COVID-19 pandemic, all in person trainings were cancelled which included our Client Culture training. We are uncertain when this training will be able to resume. Until social distancing mandates are removed and clients once again feel comfortable participating, this will be postponed until further notice. Client Culture training topics (which includes a client's personal experience inclusive of racial, ethnic, cultural, and linguistic communities) may include:

- Culture-specific expressions of distress (e.g., nervios);
- Explanatory models and treatment pathways (e.g., indigenous healers);
- Relationship between client and mental health provider from a cultural perspective;

- Trauma;
- Economic impact;
- Housing;
- Diagnosis/labeling;
- Medication;
- Hospitalization;
- Societal/familial/personal;
- Discrimination/stigma;
- Effects of culturally and linguistically incompetent services;
- Involuntary treatment;
- Wellness;
- Recovery; and
- Culture of being a mental health client, including the experience of having a mental illness and of the mental health system.

CRITERION 6:

COUNTY'S COMMITMENT TO GROWING A MULTICULTURAL WORKFORCE: HIRING AND RETAINING CULTURALLY AND LINGUISTICALLY COMPETENT STAFF.

Rationale: *The diversity of an organization's staff is necessary, but not a sufficient condition for providing culturally and linguistically appropriate health care services. Although hiring bilingual individuals from different cultures does not in itself ensure that the staff is culturally competent and sensitive, this practice is a critical component to the delivery of relevant and effective services for all clients. Staff diversity at all levels of an organization can play an important role in considering the needs of clients from various cultural and linguistic backgrounds in the decisions and structures of the organization. (CLAS, Final Report).*

I. Recruitment, hiring, and retention of a multicultural workforce from, or experienced with, the identified unserved and underserved populations

A. Extract and attach a copy of the Mental Health Services Act (MHSA) workforce assessment submitted to DMH for the Workforce Education and Training (WET) component. Rationale: Will ensure continuity across the County Mental Health System.

B. Compare the WET Plan assessment data with the general population, Medi- Cal population, and 200% of poverty data. Rationale: Will give ability to improve penetration rates and eliminate disparities.

C. Provide a summary of targets reached to grow a multicultural workforce in rolling out county WET planning and implementation efforts.

D. Share lessons learned on efforts in rolling out county WET implementation efforts.

E. Identify county technical assistance needs.

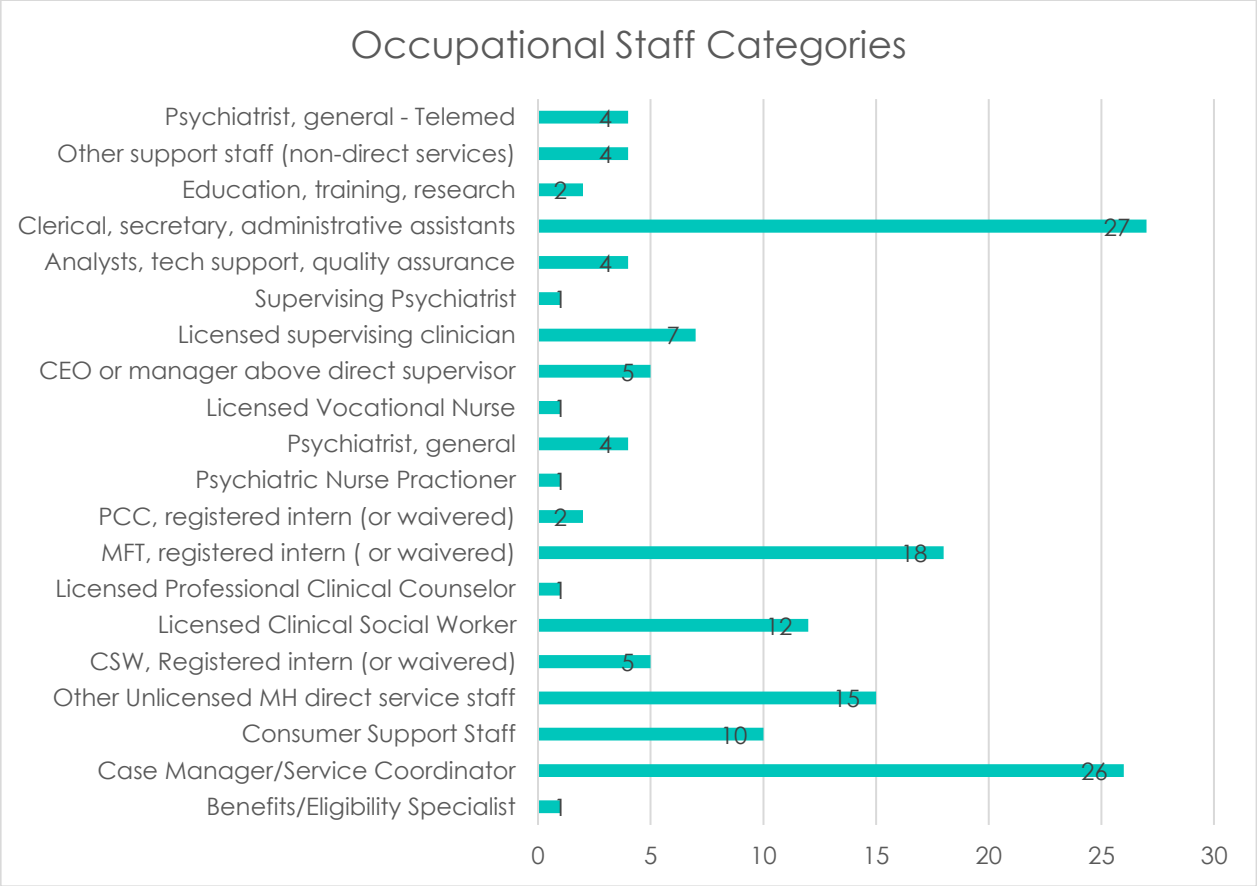
Getting another round perhaps next year, add more information.

Responses for A – E

The Workforce Education & Training (WET) component provided an opportunity to increase the diversity of the workforce that provides services to Madera County. This was accomplished by training staff, clients, and community members to develop skills and maintain a culturally and linguistically competent workforce that can provide

client and family driven services. It also served to provide outreach to unserved and underserved populations. This service was a onetime 10-year project. The funding has ended so this program has been closed. Although the program has ended, our efforts to maintain an appropriately diverse workforce is ongoing by continuous open recruitments of certain positions, incentive/grants programs and a university partnership. For additional information on the strategies mentioned, please refer the efforts outlined in Criterion 7.

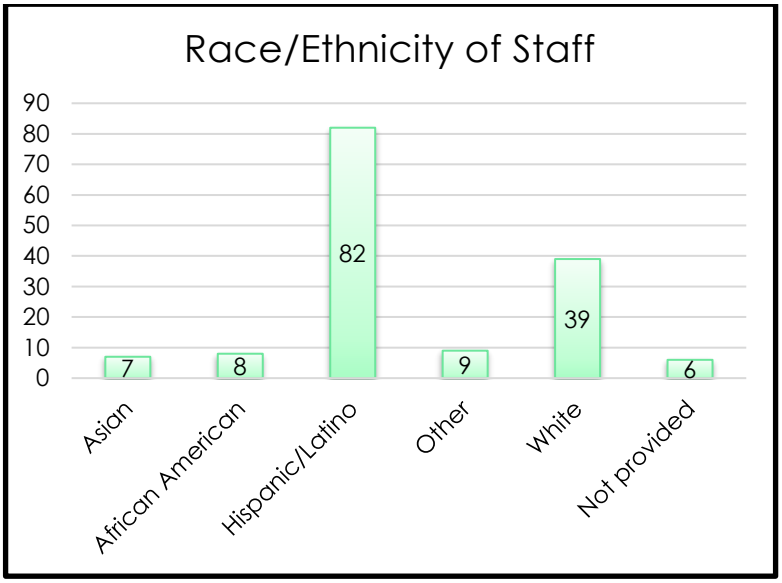
Table 6.1: Staff Occupation Categories



*As of December 2020

Madera County Behavioral Health Services (MCBHS) staff information is listed above. MCBHS has 150 people employed in their department as of December 2020. This is about the same from FY 2018 - 19 when MCBHS had a total of 151 employees.

Table 6.2: Race & Ethnicity of Staff



For FY 2018-2019, the Race/Ethnicity of most staff stayed consistent in comparison to the previous fiscal year. There was however a 5% decrease in White personnel from FY 2017-18 to FY 2018-19.

Table 6.3: Staff Languages

Staff languages spoken other than English			
Armenian	**1**	**Spanish**	**64**
Gujarati/ Kutchi	**1**	**Italian**	**1**
Hmong	**1**	**Thai**	**1**
Hindi /Punjabi	**2**	**Laos**	**1**
	1	**Conv. Cambodian**	**1**

A total of 74 employees reported speaking another language other than English which translates into 49% of MCBHS' workforce who identify as bilingual, 42% being bilingual in the threshold language of Spanish.

CRITERION 7:
LANGUAGE CAPACITY

Rationale: *Accurate and effective communication between clients, providers, staff, and administration is the most essential component of the mental health encounter. Bilingual providers and other staff who communicate directly with clients must demonstrate a command of both English and the threshold language that includes knowledge and facility with the terms and concepts relevant to the type of encounter (CLAS, Final Report). The DMH will provide threshold language data to each county.*

I. Increase bilingual workforce capacity

A. Evidence of dedicated resources and strategies counties are undertaking to grow bilingual staff capacity, including the following: (Counties shall document the constraints that limit the capacity to increase bilingual staff.)

1. Evidence in the Workforce Education and Training (WET) Plan on building bilingual staff capacity to address language needs.
2. Updates from Mental Health Services Act (MHSA), Community Service and Supports (CSS), or WET Plans on bilingual staff members who speak the languages of the target populations.
3. Total annual dedicated resources for interpreter services in addition to bilingual staff.

Responses for A1-A3

The WET service was a onetime 10-year project. The funding has ended so this program has been closed.

Although WET funds have been exhausted, as a rural community, MCBHS encourages staff to apply for federally funded programs. Staff is provided with resources and information on which programs may be available to them like the National Health Service Corps (NHSC) Loan Repayment Program. The NHSC through Health Resources and Services Administration (HRSA) is an award given to clinical staff in exchange for 2 years of full-time clinical service with Madera County. A continuous and open County recruitment has also been established for Licensed and Pre-Licensed clinicians in hopes that it will boost our staffing efforts.

A relationship with California State University Fresno (CSUF) master's in social work program has been developed to attract social work students to come to Madera County for their internship. Madera County uses an MHSA stipend to support these students while they complete their clinical internship with MCBHS. The students are included in all supervision and trainings. This was done to give students the experience of working in Madera County with the hopes that it would encourage them to apply for positions upon graduation. This has been an effective tool and a positive mutual relationship. Madera County has been able to hire several of these students upon graduation, allowing an increase in bilingual staff. MCBHS expects the relationship with CSUF to further help fill the need for clinicians which will help tackle the needs of Madera County.

II. Provide services to persons who have Limited English Proficiency (LEP) by using interpreter services.

A. Evidence of policies, procedures, and practices for meeting clients' language needs, including the following:

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.
2. Least preferable are language lines. Consider use of new technologies such as video language conferencing as resources are available. Use new technology capacity to grow language access.
3. Description of protocol used for implementing language access through the county's 24-hour phone line with statewide toll-free access including staff training protocol.

Responses for A1-A3

In all MCBHS buildings, our posters, signage, and beneficiary handbooks inform clients of policies, procedures, and practices which includes our Spanish threshold language. We provide a 24-hour phone line with statewide toll-free access that has linguistic capability, including TDD or California Relay Service. Staff responsible for the

statewide toll-free 24-hour telephone line receive training to ensure linguistic capabilities that meet the client's linguistic needs. This service is available for all individuals. We use the language line only when other options are unavailable. MCBHS utilizes video remote interpretation when needed through a contract with CyraCom, LLC. We also have a contract with the Centro Binacional Para El Desarrollo Indígena Oaxaqueño (CBDIO) who help provide translation in Spanish and in other indigenous Oaxacan languages. Madera County has a large Oaxacan population and with CBDIO we can provide translations services in the dialects of Mixteco Bajo/Alto, Triqui Bajo/Alto, and Zapoteo Alto.

B. Evidence that clients are informed in writing in their primary language, of their rights to language assistance services.

All service locations have client rights information posted in English and Spanish which informs them of their rights to receive language assistance services in their primary language. The beneficiary handbook also provides this information. And if it is evident that a client or family member prefer a language other an English, service providers will provide information of their rights.

C. Evidence that the county/agency accommodate persons who have LEP by using bilingual staff or interpreter services.

MCBHS uses both bilingual staff and/or an interpreter service to accommodate clients who have Limited English Proficiency.

Madera recently rolled out a language badge identifier to make our bilingual staff more approachable to our monolingual population. This came as a suggestion from a Clinical Supervisor. When the staff was polled earlier this year, 73% of bilingual staff stated they would like a language identifier. CY 2021 will be the first full year the language identifier will be displayed.

D. Share historical challenges on efforts made on the items A, B, and C above. Share lessons learned.

Since MCBHS uses both bilingual staff and/or an interpreter service to accommodate clients who have Limited English Proficiency, we cannot provide any notable lessons learned at the current moment.

E. Identify county technical assistance needs. (DMH is requesting counties identify language access technical assistance needs so that DMH may aggregate information and find solutions for small county technical assistance needs.)

Not applicable.

III. Provide bilingual staff and/or interpreters for the threshold languages at all points of contact.

Note: The use of the language line is viewed as acceptable in the provision of services only when other options are unavailable. Counties should train their staff for the proper use of language lines but should seek other options such as training interpreters or training bilingual community members as interpreters.

A. Evidence of availability of interpreter (e.g. posters/bulletins) and/or bilingual staff for the languages spoken by community.

MCBHS uses bilingual staff, CyraCom and the Centro Binacional Para El Desarrollo Indígena Oaxaqueño for interpretation services if no staff is available. Signage is also available in the form of posters and brochures in both English and Spanish. The beneficiary handbook also provides information about the availability of direct services in Spanish or through interpretation.

B. Documented evidence that interpreter services are offered and provided to clients and the response to the offer is recorded.

Once interpreter services are offered and provided to clients, the information is recorded in the client record.

C. Evidence of providing contract or agency staff that are linguistically proficient in threshold languages during regular day operating hours.

Staff that is linguistically proficient in Spanish (MCBHS threshold language) is utilized during operating hours and contracted interpretation services through CyraCom, LLC and the Centro Binacional Para El Desarrollo Indígena Oaxaqueño (CBDIO) are used if bilingual staff is not available.

D. Evidence that counties have a process in place to ensure that interpreters are trained and monitored for language competence (e.g., formal testing).

MCBHS provides training to interpreters and presentation materials from Mental Health Interpreter's Project Building Bridges for Better Communication, National Asian American Pacific Islander Mental Health Association, and other sources. However, this past year, due to the COVID-19 pandemic, our interpreter training was cancelled.

IV. Provide services to all LEP clients not meeting the threshold language criteria who encounter the mental health system at all points of contact.

A. Policies, procedures, and practices that include the capability to refer, and otherwise link, clients who do not meet the threshold language criteria (e.g., LEP clients) who encounter the mental health system at all key points of contact, to culturally and linguistically appropriate services.

Policy MHP 13.00 (Language Translation and Interpretation Services) and MHP 14.00 (BHS Services for Individuals with Special Language Needs), describe the procedures and practices to refer and link clients whose preferred language is a non-English language other than Spanish to culturally and linguistically appropriate services.

B. Provide a written plan for how clients who do not meet the threshold language criteria, are assisted to secure, or linked to culturally and linguistically appropriate services.

MCBHS informs beneficiaries of their right to receive mental health services in their primary or preferred language at no cost as well as language interpretation services to include TTY/TDD services (refer to MHP 14.00). Beneficiaries are also informed on how to access services via the services brochures in our lobbies, the beneficiary handbook, posters, and flyers displayed at our provider sites.
Upon a beneficiary request, MCBHS will provide a listing of specialty mental health and culture-specific providers via the Provider Directories which includes names, addresses, telephone numbers, hours of operation, types of specialty mental health services (SMHS), age groups served, and non-English languages offered including American Sign Language (ASL) and cultural consideration in provider locations (MHP 05.00). The Provider Directories can also be found on our website and are updated monthly.

C. Policies, procedures, and practices that comply with the following Title VI of the Civil Rights Act of 1964 (see page 27) requirements:

1. Prohibiting the expectation that family members provide interpreter services;
2. A client may choose to use a family member or friend as an interpreter after being informed of the availability of free interpreter services; and
3. Minor children should not be used as interpreters.

Responses for C1-C3

MHP 13.00 (Language Translation and Interpretation Services), states that, "Family members and friends will not be used as interpreters unless strongly desired by the individual requesting services. The client and family member will sign a waiver stating they acknowledge an MCBHS staff interpreter was offered free of charge, but they opted to use someone else against MCBHS' advisement. The practice will be discouraged whenever possible. If Spanish speaking staff is not available, CyraCom services will be used."

V. Required translated documents, forms, signage, and client informing materials

The county shall have the following available for review during the compliance visit:

A. Culturally and linguistically appropriate written information for threshold languages, including the following, at minimum:

1. Member service handbook or brochure; √
2. General correspondence; √
3. Beneficiary problem, resolution, grievance, and fair hearing materials; √
4. Beneficiary satisfaction surveys; √
5. Informed Consent for Medication form; √
6. Confidentiality and Release of Information form; √
7. Service orientation for clients; √
8. Mental health education materials, and√
9. Evidence of appropriately distributed and utilized translated materials. √

B. Documented evidence in the clinical chart, that clinical findings/reports are communicated in the clients' preferred language. √

C. Consumer satisfaction survey translated in threshold languages, including a summary report of the results (e.g., back translation and culturally appropriate field testing). √

D. Report mechanisms for ensuring accuracy of translated materials in terms of both language and culture (e.g., back translation and culturally appropriate field testing). √

E. Report mechanisms for ensuring translated materials are at an appropriate reading level (6th grade). Source: Department of Health Services and Managed Risk Medical Insurance Boards. √

CRITERION 8:
ADAPTATION OF SERVICES

Rationale: *Organizations should ensure that clients/consumers receive from all staff members, effective, understandable, and respectful care, provided in a manner compatible with their cultural health beliefs and practices and preferred language (CLAS Final Report).*

I. Client driven/operated recovery and wellness programs

A. List client-driven/operated recovery and wellness programs and options for consumers that accommodate racially, ethnically, culturally, and linguistically specific diverse differences.

The department of Behavioral Health Services (BHS) has different programs for consumers which welcome everyone from different racial, ethnic, linguistic, and cultural background, they are:

- Community Outreach & Wellness Centers. BHS partners with Turning Point Community Program which has two "drop-in-centers" called Hope House. They provide outreach and educational services for community members to prevent the risk factors that contribute to the development of and disability related to mental health illness. Those involved with Hope house have either been in the program themselves or they have had a family member who was a participant.
    - Some of their services for TAY include:
        - Game time
        - Ted Talks (Anxiety, Depression etc.)
        - Movie Time
        - Self-care
        - Art Classes
        - Cooking
    - Some of their services for ADULTS include:
        - Peer Support Groups
        - Consumer Employment Opportunities
        - Socialization Skills

- Art Class
- Exercise Class
- Life Skills Instruction
- Addiction Recovery Groups
- Computer Lab
- Laundry Facilities
- Showers

- Kings View Skills 4 Success, The Youth Empowerment Program, was developed using Prevention and Early Intervention (PEI) funding to focus specifically on the transition age youth (TAY) age group (16-25), who are at risk for developing serious mental illness. This program provides services in the local high schools and outreach in community events where TAY are likely to attend. Teens can refer themselves but are often referred by school administration, counselors, and teachers. Some are also referred from probation and social services. As needed, referrals are made to mental health services for both youth and their families. The program uses a group facilitation method with a focus on encouraging youth participation. Teens begin by establishing group rules, guidelines, and confidentiality agreements. They tend to develop a sense of community and begin to disclose problems. The program works to identify the early warning signs and symptoms of mental illness and provide age-appropriate tools to manage them.
  - Some of the services and information provided include:
    - Life skills
    - Strategies and support systems
    - Help with self-esteem
    - Anger management
    - Suicide
    - Leadership
    - Communication skills
    - Depression and Bi-Polar
    - Stigma

- Positive mental health
- Bullying
- Building positive decision making
- Relationship building
- Life choices.

- The Children/TAY Full Service Partnership (FSP) serves children and youth ages 0 – 25, including foster youth and their families, who are experiencing serious emotional and behavioral disturbances. This team provides wrap-around/system of care like services, simultaneously with multiple organizations.

- The Adult/Older Adult Full Service Partnership, which serves TAY, adults and seniors with serious and persistent mental illness. The services provided comply with WIC § 5806 and WIC § 5813.5 and are modeled after the Assertive Community Treatment model and Mentally Ill Offender Crime Reduction (MIOCR) services.

FSP utilizes the Wellness Centers (*Hope House and Mountain Wellness Center*) to recommend classes, group session and/or services to keep their population engaged.

II. Responsiveness of mental health services

A. Documented evidence that the county/contractor has available, as appropriate, alternatives and options that accommodate individual preference, or cultural and linguistic preferences, demonstrated by the provision of culture-specific programs, provided by the county/contractor and/or referral to community- based, culturally-appropriate, non-traditional mental health provider.

(Counties may develop a listing of available alternatives and options of cultural/linguistic services that shall be provided to clients upon request. The county may also include evidence that it is making efforts to include additional culture-specific community providers and services in the range of programs offered by the county).

MCBHS has two alternatives of cultural/linguistic services that are provided to the clients upon request. They are:

1. Community and Family Education program - this program builds community strength through education and enables community members to recognize if someone is experiencing mental illness, or at risk and teaches how to support them (by accessing behavioral health services if needed). This program offers training in specific educational curriculums to any member of the public free of charge. Examples of classes are:
   a. Mental Health First Aid
   b. ASIST
   c. SafeTALK
   d. Evidenced based & culturally based parenting classes.

2. MCBHS has also initiated the development of outcomes for its MHSA funded prevention services, based on the models developed for substance use prevention services in the California Outcome Measurement System (CalOMS). These services do not include clinical treatment services such as therapy and medication services.

B. Evidence that the county informs clients of the availability of the above listing in their member services brochure. If it is not already in the member services brochure, the county will include it in their next printing or within one year of the submission of their CCPR.

To create a safe and culturally responsive system, Madera County includes information regarding a culturally specific approach to various cultural needs in our beneficiary handbook/brochure. The beneficiary handbook states that BHS encourages the delivery of services in a culturally competent manner to all people, including those with limited English proficiency and varied cultural and ethnic backgrounds.

C. Counties have policies, procedures, and practices to inform all Medi-Cal beneficiaries of available services under consolidation of specialty mental health services.

All informing materials in English and Spanish are available and posted at all Behavioral Health locations. This information is also available on our website: https://www.maderacounty.com/government/behavioral-health-services in our brochures section. These programs are also described in our MHSA three-year plan which can also be found on our website under the MHSA tab. Due to COVID-19, MCBHS is also moving to provide more information through an online platform.

D. Evidence that the county has assessed factors and developed plans to facilitate the ease with which culturally and linguistically diverse populations can obtain services. Such factors should include:

1. Location, transportation, hours of operation, or other relevant areas;

Although Madera County is a rural community, all MCBHS service locations are in a central part of town in Madera, Chowchilla and Oakhurst. Locations are also accessible through public transportation. While our hours are listed from 8am to 5pm, crisis response and services are provided 24 hours a day, 7 days a week by calling our toll free access line: 888-275-9779. Linguistic services are provided through our bilingual staff and through our contracted interpretation services.

2. Adapting physical facilities to be accessible to disabled persons, while being comfortable and inviting to persons of diverse cultural backgrounds (e.g., posters, magazines, décor, signs); and

MCBHS understands the importance of adapting our physical facilities and ensuring we represent the community we serve. We recently began conducting site audits to ensure all sites are providing an accessible, welcoming and inviting environment to people of all backgrounds. All sites meet the requirements of the Americans with Disabilities Act (ADA).

3. Locating facilities in settings that are non-threatening and reduce stigma, including co-location of services and /or partnerships, such as primary care and in community settings.

Since our facilities are in the central parts of town, they are all engulfed in the surrounding culture. For example, our main building (7th street) is located a block away from the downtown area, yet within two blocks of a neighborhood. Because we are very much immersed in the community, our visibility helps reduce stigma by raising awareness that mental health services are available and needed in the community.

III. Quality Assurance

Requirement: A description of current or planned processes to assess the quality of care provided for all consumers under the consolidation of specialty mental health services. The focus is on the added or unique measures that shall be used or planned in order to accurately determine the outcome of services to consumers from diverse cultures including, but not limited to, the following:

A. Grievances and Complaints: Provide a description of how the county mental health process for Medi-Cal and non-Medi-Cal client Grievance and Complaint/Issues Resolution Process data is analyzed and any comparison rates between the general beneficiary population and ethnic beneficiaries.

As part of the MCBHS Quality Assurance and Performance process, the Quality Management meeting (QMM) conducts regular monitoring activities of the resolution of beneficiary grievances and appeals and submits an Annual Beneficiary Grievance and Appeal Report to DHCS analyzing trends. The QIC examines rate of grievances based on the ethnicity and other demographic characteristics. When issues arise due to individual grievances and appeals, or if unexpected trends emerge based on numbers and percentages, the QM looks for root causes and determines appropriate follow-up interventions to positively impact beneficiaries system-wide. The results of follow-up actions are evaluated at least annually.

MCBHS maintains a log to record issues submitted as part of the Issue Resolution Process. The log includes the date the issue was received; a brief synopsis of the issue;

the final issue resolution outcome; and the date the final issue resolution was reached. Trend analysis is conducted by the QM similar to the process described for Medi-Cal beneficiary grievances and appeals.

For MHSA, if any issues should arise, clients have the right to express any concerns or problems. Besides a matter covered by a formal Appeal, complaints are considered grievances. There will not be any discrimination against clients who file a grievance. A priority of Madera County is to ensure that clients and community stakeholders have access to a dedicated grievance process and resolve dissatisfaction with the MHSA community program planning process, delivery of MHSA funded mental health services, appropriate use of funds, and/or consistency between program implementation and approved MHSA plans. Problem resolution brochures and posters are available at all sites providing county mental health services and on the county website. Clients and community stakeholders may file a grievance at any time either orally or in writing. Grievance forms and self-addressed envelopes are available for clients and community stakeholders at all provider sites.