Madera County Behavioral Health Services
Cultural Competence Plan
November 2018

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The Cultural Competence Plan is required by CCR Title 9, Chapter 11, § 1810.410, updated annually based on the most recently issued state Cultural Competence Plan Requirements (see Department of Mental Health Information Notice No. 10-02).

2018 UPDATE:
Madera County Behavioral Health Services Cultural Competency Plan

California Department of Health Care Services Cultural Competence Plan Requirements

COVER SHEET

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CRITERION 1

COMMITMENT TO CULTURAL COMPETENCE

I. County Mental Health System commitment to cultural competence

A. *Policies, procedures, or practices that reflect steps taken to fully incorporate the recognition and value of racial, ethnic, and cultural diversity within the County Mental Health System.*

Madera County Behavioral Health Services (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 Mental Health System and to 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.

The Department is committed to embedding cultural sensitivity and inclusiveness into all its activities. It maintains close oversight of this value and requires all planning efforts directly address cultural competence.

The Cultural Competence Plan is solely dedicated to advancing the Department's overall cultural competence. This annually updated plan derives its goals from two sources: 1) the Cultural Competence Committee's 3-year strategic plan and 2) the Annual Quality Management/Improvement Work Plan.

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

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

B. The county shall have the following available on site during the compliance review copies of the following documents to ensure the commitment to cultural and linguistic competence services are reflected throughout the entire system:

1. *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. *Policies and Procedure Manuals*;

   Please refer to the list of policies and procedures listed above.

4. *Human Resources Training and Recruitment Policies*;
   a. ADM 05.00 – Cultural Competence Plan
   b. ADM 42.00 – Bilingual Compensation

5. *Contract Requirements* (contained in the MCBHS Master Services Agreement template, page 22, item 18 (Cultural Competence)

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

MCBHS expects that all network and organizational contract providers will be accountable for providing culturally and linguistically competent specialty mental health services and reporting applicable information to be included in the Cultural Competence Plan.

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 shall have a written policy and procedure that ensure organizational and individual compliance by its staff and providers. Contractors shall comply with any and all requests from MCBHS for a list of cultural competency trainings and sign in sheets of staff attending those trainings.

A. A description of practices and activities that demonstrate community outreach, engagement, and involvement efforts with identified racial, ethnic, cultural, and linguistic communities with mental health disparities; including, recognition and value of racial, ethnic, cultural, and linguistic diversity within the system. That may include the solicitation of diverse input to local mental health planning processes and services development.

The Fiscal Year (FY) 2016-17 Cultural Competence Plan goals and outcomes include the following strategies:

1. Goal B-1: Develop and implement a plan to provide outreach services to the older adults in Madera County**.** During FY 16-17, outreach services were provided to the Madera Senior Center with a prevention staff person attending the facility three times a week. Mental Health First Aid along with other mental health topics of interest were presented to the senior population attending the facility.

2. Goal E-1: Use peer staff training in Promatores de Salud, parenting classes, Whole Health Workshop, California Association of Social Rehabilitation curriculum and Mental Health First Aid to provide outreach and education to targeted community individuals and groups. Prevention, education and outreach services were provided to the following number of unduplicated clients of diverse racial/ethnic backgrounds: Hope House (492 clients), Mountain Wellness Center (413 clients), CalWORKS (42 clients), and Youth Empowerment Program (91 clients). Community Health Worker training and Mental Health Education outreach and training was also provided.

FY 2017-18 Cultural Competence Plan goals included the following outreach and education strategies:

1. Goal A-1: Increase the Latino penetration rate by targeting outreach and education programs to Latinos aimed a) increasing awareness of MCBHS services and b) building trust to seek services.

2. Goal C-1: Develop and implement a plan to provide outreach services to the older adults in Madera County (continuation of FY 2016-17 Goal B-1).

B. *A narrative description addressing the county's current relationship with, engagement with, and involvement of, racial, ethnic, cultural, and linguistically diverse clients, family members, advisory committees, local mental health boards and commissions, and community organizations in the mental health system's planning process for services*.

During the stakeholder process to develop the most recent Mental Health Services Act (MHSA) Three-Year Plan, two interagency community planning meetings were held. The draft Three- Year Program and Expenditure Plan or Annual Update was circulated to representatives of stakeholder interests and any interested party for 30 days for review and comment and a public hearing was held by the Madera County Behavioral Health Board.

During the first interagency meeting, a MHSA presentation was provided to the Interagency Children and Youth Services Council. This group is comprised of leaders from Madera County Departments of Behavioral Health Services (mental health and substance use), Public Health, Social Services, and Office of Education. In addition, it includes the following community organizations: Big Brothers/Big Sisters, Camarena Health Federally Qualified Health Center (FQHC), Community Action Partnership of Madera County, general community members, Cornerstone Family Counseling Services, First 5 Madera County, Madera City Housing Authority, local child care providers, Madera City Parks and Recreation, and Valley Children's Hospital.

The second interagency meeting where MHSA information was provided was the Madera Community Action Partnership's Social Agencies Linking Together (SALT) meeting, which has a wide range of stakeholders. The SALT meeting included representation from Madera County schools, the County Department of Social Services, the Chamber of Commerce, Madera First 5, Chowchilla Police Department, faith-based organizations, City of Madera, Employment Development Department, Madera County Board of Supervisors, Workforce Connection, and Madera Food Bank.

The information regarding the community planning meetings at the local libraries was disseminated at these two inter-organizational groups. In addition, the information was disseminated to their email lists.

The County library settings were chosen for the community meetings because these sites are non-stigmatizing sites and have handicap access. Presenting information and discussion at ongoing collaborative meeting allowed MCBHS to connect with underserved populations and other stakeholder that don't typically attend MCBHS' meetings.

The Hope House and Youth Empowerment Program community meetings included consumers and family members. An advocate for veterans also attended the Oakhurst meeting.

Stakeholder feedback included responses from a diverse range of racial, ethnic and cultural groups, including Hispanic/Latino (42), White (15), Asian (2), Pacific Islander (1) and multiple racial/ethnic groups (2).

Stakeholder meetings for the current annual update were held in 2018 in the following locations:

- April 5th Madera Library 1:30pm - 3p
- April 10 Chowchilla Library 1pm - 3pm
- April 12th Madera Ranchos Library 1pm - 3pm
- April 13th North Fork Library 1pm - 3pm
- April 19th Oakhurst Library 1pm - 3pm

C. *A narrative, not to exceed two pages, discussing how the county is working on skills development and strengthening of community organizations involved in providing essential services.*

As described above, during the stakeholder outreach and education process for development of the MHSA Plan, interagency meetings were held to obtain input on prioritization of populations and programs to be funded. Community organizations that participated in the stakeholder process included Big Brothers/Big Sisters, Camarena Health FQHC, Community Action Partnership of Madera County, Cornerstone Family Counseling Services, First 5 Madera County, Madera City Housing Authority, local child care providers, Madera City Parks and Recreation, and Valley Children's Hospital, the Madera Chamber of Commerce, Chowchilla Police Department, faith-based organizations, the Madera County Employment Development Department, Madera County Board of Supervisors, Workforce Connection, and Madera Food Bank

Through the MHSA program, MCBHS has opened the Community Outreach and Wellness Centers, which has two “drop-in-centers” with the primary goal of providing outreach and education services for community members to prevent the risk factors that contribute to the development of disability related to mental illness. This was accomplished by providing environments that purposefully reduce factors that compromise a person’s mental health and can lead to or exacerbate a person’s mental illness. In addition, it provides individuals with services to build mental health protective factors, such as access to daily living resources, which promote their independent living skills and social skills. One of the Wellness Centers, Hope House, is operated by Turning Point Community Programs, a community organization.

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

MCBHS has both formal and informal ways to collect feedback and input. Acknowledging the informal networks is an important way to get information and build bridges with diverse communities. The Mental Health Director and senior staff prioritize meetings with individual community members or small groups in order to obtain all feedback and input.

E. Identify county technical assistance needs.

None applicable at the present time.

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

The CC/ESM will report to, and/or have direct access to, the Mental Health Director regarding issues impacting mental health issues related to the racial, ethnic, cultural, and linguistic populations within the county.

The county shall include the following in the CCPR:

A. *Evidence that the County Mental Health System has a designated CC/ESM who is 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.*

1. Governance
   The Director, Senior Management Team and the MCBHS Advisory Board have the authority and responsibility to integrate cultural competency throughout the MCBHS operation.

2. Ethnic Services Manager (ESM)
   The Director has delegated the development and oversight of cultural competence to the Division Manager of the Quality Management Program who also serves as the ESM.

3. The ESM works closely with the Director and is a member of the Executive Management Team. 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.

4. Planning Process
   The Quality Management Committee (QMC), under the direction of the ESM, is responsible for the cultural competence planning process. The QMC currently meets monthly, but eventually will move to quarterly meetings and has the following membership:

   MCBHS Staff:
   - Director
   - 3 Division Managers
   - QMC Program Supervisor
   - 5 Supervising Mental Health Clinicians
   - 2 Cultural Competence Chairs
   - Intake Program Supervisor
   - Medical Records/Front Desk Supervisor
   - Compliance Officer
   - Client Advocate
   - Community Service Liaison (peer worker)
   - 2 Administrative Analysts
   - 1 Kings view Data Management/Network Analyst – contracted

B. *Written description of the cultural competence responsibilities of the designated CC/ESM.*

   Please refer to the response above under III.A.2 and III.A.3.

IV. Identify budget resources targeted for culturally competent activities

Funds applicable to culturally competent activities are part of our training funds, but not specifically broken out. We consider culturally competent activities to be embedded into our entire behavioral health system and therefore not able to be broken out from each part of our system or budget.

CRITERION 2

UPDATED ASSESSMENT OF SERVICE NEEDS

I. General Population

A. *Summarize Medi-Cal population and client utilization data by race, ethnicity, age, and gender (other social/cultural groups may be addressed as data is available and collected locally).*

Table 2.1: Total Population of Madera County by Gender and Race/Ethnicity for CY 2016

Gender	***Population***	***Percent***
Male	74035	48%
Female	79331	52%
Race/Ethnicity	***Population***	***Percent***
White/Caucasian	54887	36%
Hispanic/Latino	86265	56%
Black/African American	4679	3%
Asian, Pacific Islander	3359	2%
Native American	1450	1%
Multi Race/Ethnicity	2726	2%
Total Population	**153,366**	**100%**

Table 2.2: Total Population of Madera County by Age Group for CY 2016

Age Group	***Population***	***Percent***
Youth Total Population (0-17)	42662	28%
Adult Total Population (18+)	110704	72%
Total Population	**153,366**	**100%**

Table 2.3: Total Youth Population (0-17) of Madera County by Age, Gender, Race/Ethnicity for CY 2016

Age	***Population***	***Percent***
(0-5)	14207	33%
(6-11)	14931	35%
(12-17)	13524	32%
Gender	**Population**	**Percent**
Male	21639	51%
Female	21023	49%
Race/Ethnicity	**Population**	**Percent**
White/Caucasian	9130	21%
Hispanic/Latino	30930	73%
Black/ African American	811	2%
Asian, Pacific Islander	683	2%
Native American	597	1%
Multi Race/Ethnicity	512	1%
Youth Total Population	**42,662**	**100%**

Table 2.4: Total Adult Population age (18+) of Madera County by Age, Gender and Race/Ethnicity for CY 2016

Age (18+)	***Population***	***Percent***
18-20	15532	14%
21-24	21230	19%
25-34	19138	17%
35-44	18219	16%
45-54	8773	8%
55-64	8101	7%
65+	19711	18%
Total	**110704**	**100%**
Gender	**Population**	**Percent**
Male	52396	47%
Female	58308	53%
Race/Ethnicity	***Population***	***Percent***
White/Caucasian	45757	41%
Hispanic/Latino	55335	50%
Black / African American	3868	3%
Asian, Pacific Islander	2676	2%
Native American	853	1%
Multi Race/Ethnicity	2214	2%
Adult Total Population	**110704**	**100%**

II. Medi-Cal Population Service Needs (Use current External Quality Review Organization [EQRO] data if available.)

A. *Summarize Medi-Cal population and client utilization data by race, ethnicity, language, age, and gender (other social/cultural groups may be addressed as data is available and collected locally).*

Table 2.5: Countywide Estimated Population Enrolled in Medi-Cal for Madera County by Ethnicity, race, age & gender, for CY 2016 and Penetration Rate for Fiscal Year (FY) 2015-16.

Race/Ethnicity	***County Population***	***Medi-Cal Eligible***	***Medi-Cal Beneficiaries Served***	***Penetration Rate***	***Statewide Penetration Rate****
White/Caucasian	54887	12321	1144	9.3%	5.5%
Hispanic/Latino	86265	45051	1514	3.4%	3.9%
Black/African American	3359	1243	32	2.6%	6.9%
Asian, Pacific Islander	4679	1417	171	12.1%	1.7%
Native American	1450	465	44	9.5%	6.4%
Multi Race	2726				
Total	**153366**	**60497**	**2905**	**4.8%**	**4.2%**

Age					
0-5	14207	10099	139	1.4%	1.6%
6-17	28455	17899	1053	5.9%	5.5%
18-59	90993	34253	1708	5.0%	4.4%
60+	19711	3831	86	2.2%	1.7%
Gender					
Female	79331	35255	1632	4.6%	3.8%
Male	74035	30827	1353	4.4%	4.5%

*****Statewide penetration rates were adapted from The DHCS Statewide Aggregate Specialty Mental Health Services Performance Dashboard, pages 12 and 25, on the web page https://www.dhcs.ca.gov/services/MH/Documents/2018_SMHS_Dash_Combined_Report_non-ADA_7-18.pdf

Table 2.6: Countywide Estimated Population Enrolled in Medi-Cal for Madera County by Threshold Language for (FY) 2015-16.

Language Name*	***Population***	***Percent***
Arabic	14	0%
Armenian	7	0%
Cambodian	8	0%
Cantonese	19	0%
English	37802	57%
Farsi	0	0%
Hmong	0	0%
Korean	0	0%
Mandarin	0	0%
Other Chinese	516	1%
Russian	9	0%
Spanish	27698	42%
Tagalog	9	0%
Vietnamese	0	0%
Grand Total	**66082**	**100%**

B. *Provide an analysis of disparities as identified in the above summary.*

The main areas of disparity in the data from the tables summarized above are shown in Table 2.5, Countywide Estimated Population Enrolled in Medi-Cal for Madera County by Ethnicity, race, age & gender, for CY 2016 and Penetration Rate for Fiscal Year (FY) 2015-16. Although nearly 75% of the Medi-Cal beneficiaries in Madera County are Hispanic/Latino, the penetration rate for Hispanic/Latinos is 3.4%, which is below the statewide rate of 3.9%. The penetration rate is also lower than the statewide average for Black/African American, comprising 2% of the Medi-Cal beneficiaries and with a penetration rate of only 2.6% compared to the statewide average of 6.9%. Conversely, the penetration rate for White/Caucasian (20% of the Medi-Cal population) is 9.3% compared to 5.5% statewide. The penetration rates for Asian/Pacific Islander and Native American are also much higher than the statewide average.

Based on these trends we need to prioritize strategies to improve the penetration rates for Hispanic/Latino and Black/African American beneficiaries though our goals and

objectives in Criterion 3. It should be noted that the previous year's Cultural Competence Plan included several goals and objectives to increase the Latino penetration rate.

Based on Table 2.6, it is also important to note that 42% of the estimated population enrolled in Medi-Cal have identified their preferred language as Spanish. This will be addressed in Criterion 3 as well.

***Note**: Objectives for these defined disparities will be identified in Criterion 3, Section I.*

III. 200% of Poverty (minus Medi-Cal) Population and Service Needs

A. *Summarize the 200% of poverty (minus Medi-Cal population) and client utilization data by race, ethnicity, language, age, and gender (other social /cultural groups may be addressed as data is available and collected locally).*

Table 2.7: Countywide Non-Medi-Cal Population Living at or Below 200% FPL for Madera County by Race/Ethnicity, Age and Gender for CY 2016 (Census Bureau Data) and Clients Served "not covered by Medi-Cal" for Fiscal Year (FY) 2015-16 (Penetration Rate Report).

Race/Ethnicity	***200% Poverty (minus Medi-Cal)***	***Clients Served "not covered by Medi-Cal"***
White/Caucasian	6905	326
Hispanic/Latino	23471	474
Black/African-American	1107	34
Asian, Pacific Islander	102	6
Native American	521	9
Age		
0-17	13543	256
18+	18500	612
Gender		
Female	17589	484
Male	14454	383

Table 2.8: Countywide Clients Served "not covered by Medi-Cal" for Fiscal Year (FY) 2015-16 (Penetration Rate Report) by Threshold Language. Note: [MCBHS was not able to obtain the Countywide Non-Medi-Cal Population Living at or Below 200% FPL by preferred language for Madera County.]

Language Name*	***200% Poverty (minus Medi-Cal)***	***Clients Served "not covered by Medi-Cal"***
Arabic		
Armenian		
Cambodian		
Cantonese		
English		753
Farsi		
Hmong		
Korean		
Mandarin		

Other Chinese		
Russian		
Spanish		109
Tagalog		
Vietnamese		
Grand Total		862

B. *Provide an analysis of disparities as identified in the above summary.*

Due to the lack of available information on the number and percentage of individuals in Madera at 200% of Poverty who are not Medi-Cal beneficiaries, we do not believe any additional significant conclusions can be made based on analysis of Tables 2.7 and 2.8. We do note that a majority of individuals under 200% of Poverty are Hispanic/Latino. MCBHS was not able to obtain information on preferred language for individuals under 200% of Poverty. Two of the goals in Criterion 3 relate to increasing the penetration rate for Latinos and increasing the penetration rate for clients with a primary language of Spanish. These goals are consistent with the only disparity we found for individuals under 200% of Poverty, especially because the objectives include focused outreach and education about Behavioral Health Services to Spanish speaking community members. Besides these, no specific objectives for disparities in services to individuals under 200% of Poverty are identified in Criterion 3.

Note*: Objectives for these defined disparities will be identified in Criterion 3, Section I.*

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

A. *Summarize the MHSA population and client utilization data by race, ethnicity, language, age, and gender (other social/cultural groups may be addressed as data is available and collected locally).*

Table 2.9: Estimated Countywide Total Population Served through MHSA by Ethnicity for FY 2015-16

Clients Served by MHSA from FY to FY by Ethnicity		
Ethnicity	***# of Clients***	***% of Clients***
Black/African American	20	2%
Asian/Pacific Islander	7	1%
Hispanic/Latino	441	37%
Native American	8	1%
White/Caucasian	240	20%
Other than specified	470	40%
Total	1186	

Table 2.10: Estimate Countywide Total Population Served through MHSA for Madera County by Age Group for FY 2015-16

Clients Served by MHSA from FY to FY by Age Group		
Age Group	***# of Clients***	***% of Clients***
Children	225	19%
TAY	113	10%
Adults	733	62%
Older Adults	115	10%
Total	1186	

Table 2.11: Estimate Countywide Total Population Served through MHSA for Madera County by Gender for FY 2015-16

Clients Served by MHSA from FY to FY by Gender		
Gender	***# of Clients***	***% of Clients***
Males	565	48%
Females	621	52%
Other	0	0%
Total	1186	

B. *Provide an analysis of disparities as identified in the above summary*.

The number of clients served through MHSA funds do not appear to show any significant disparities based on ethnicity. The majority of clients served are Hispanic/Latino, which is consistent with countywide population. One possible disparity among age groups is the relatively low percentage of children (19%) and Transition Age Youth/TAY (10%) served through MHSA programs compared to adults (62%). This data will be examined in Criterion 3. Another potential problem is that there were 40% with ethnicity "other than specified." We will want to identify the root cause of this data result and see if there are errors in reporting of ethnicity, or possibly clients did not identify with any of the ethnic groups listed.

Note*: Objectives for these defined disparities will be identified in Criterion 3, Section I.*

CRITERION 3

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

I. Identified strategies/objectives/actions/timelines

List the strategies and any new strategies identified for each targeted areas and as noted in Criterion 2 in the following sections:

A. Medi-Cal population
B. 200% of poverty population (combined with strategies for the Medi-Cal population in the form of focused outreach and education to communities with identified disparities)
C. MHSA/CSS population

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

FY 2017-18 Cultural Competence Goals:

A. Culturally and Linguistically Appropriate Services (CLAS) 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.

Goal A1: Increase the Latino penetration rate by targeting outreach and education programs to Latinos aimed 1) increasing awareness of BHS services and 2) building trust to seek services.

Goal A2: Provide two cultural competence trainings for staff including:

- Training in Promotores De Salud for peer staff and other topics aimed at assisting staff to more effective serve the Latino population.
- Training on culture of persons with disabilities.

Goal A3: Place taglines for mandated languages on all the MHP brochures, etc., per the MHP contract during FY 17-18. Have all of the MHP brochures and other mandated documents in font size 12 and 18.

B. CLAS Standard 9:
Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.

Goal B1:
Restructure the QMC planning process and membership to better integrate cultural competence planning throughout the department.

C. CLAS Standard 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.

Goal C1: Develop and implement a plan to provide outreach services to the older adults in Madera County**.**

Goal C2: Routinely monitor and conduct annual audits of BHS facility ADA compliance and implement identified needed corrections and improvements.

FY 2018-19 Cultural Competence Goals:

Standards indicated below are based on the 2013 Enhanced National CLAS Standards.

A. **CLAS 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.

Goal 1A: Increase the penetration rates for Hispanic/Latino beneficiaries (3.4% compared to 3.9% statewide).

Objective 1A1: The BHS Cultural Competence Committee will assess the status and progress on how successful we were in meeting 2017-18 Goal A1 as a basis to consider strategies and interventions in addition to Objectives 1A2 and 1A3 below.

Objective 1A2: Increase the Latino penetration rate by targeting outreach and education programs to Latinos aimed a) increasing awareness of BHS services and b) building trust to seek services.

Objective 1A3: Provide two cultural competence trainings for staff including:
- Training in Promotores De Salud for peer staff and other topics aimed at assisting staff to more effective serve the Latino population.
- Training on culture of persons with disabilities.

Goal 1B: Increase the penetration rates for Black/African American beneficiaries (2.6% compared to 6.9% statewide). Only 32 African American clients were served in CY 2016 compared to 1,213 Medi-Cal enrollees and 3,359 total county population.

Objective 1B1: Solicit input from cultural brokers who are members of the local African American community to develop outreach strategies and identify forums where they are likely to be receptive to education and outreach

Objective 1B2: Conduct targeted outreach to the local African American community using cultural brokers who are members of their community. Conduct focus groups and interviews with African American community members to solicit input on culturally and linguistically appropriate approaches to mental health services to their community.

Objective 1B3: Conduct targeted outreach to the local African American community using cultural brokers to provide education programs to their community aimed at increasing awareness of BHS services and building trust to seek services.

B. **CLAS Standard 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.

Goal 2: Increase the penetration rate for Latinos, with emphasis on those with a primary language of Spanish. The Madera County penetration rate for Latinos in CY 2016 was 3.4%, compared to the statewide penetration rate of 3.9%. 42% of the Medi-Cal beneficiaries in Madera County have a primary language of Spanish.

Objective 2A: The BHS Cultural Competence Committee will assess the status and progress on how successful we were in meeting 2017-18 Goal A1 as a basis to consider strategies and interventions in addition to Objectives 2B, 2C and 2D below.

Objective 2B: Solicit input from cultural brokers who are members of the local Spanish speaking community to develop outreach strategies and identify forums where Spanish speaking individuals are likely to be receptive to education and outreach as described in Objectives 2C and 2D below.

Objective 2C: Conduct targeted outreach to the Spanish speaking community using cultural brokers who are members of their community. Conduct focus groups and interviews with Spanish speaking community members to solicit input on culturally and linguistically appropriate approaches to providing mental health services to the Spanish speaking community in modalities that will be welcoming, non-threatening and non-stigmatizing.

Objective 2D: Conduct targeted outreach to the Spanish speaking community using cultural brokers to provide education programs to Spanish speakers aimed at increasing awareness of BHS services and building trust to seek services.

C. CLAS Standard 9:
Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.

Goal 3: Increase the percentage of children/youth and TAY served through MHSA. In FY 2015-16, children comprised 19% of the clients served through MHSA and TAY comprised 10% (62% of those served were adults and 10% older adults).

Objective 3A: The BHS Cultural Competence Committee will meet with BHS management including MHSA managers and supervisors to consider the reasons for disproportionately low percentages and identify

Objective 3B: Based on the reasons why there are low percentages of children and TAY served through MHSA, the group from Objective 3A, the CCC will identify strategies to increase the percentage of children, youth and TAY served through MHSA and implement those interventions.

D. CLAS Standard 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.

Goal 4: Determine why 40% of the clients served by MHSA were identified as ethnicity "other than specified," meaning they did not get included with White/Caucasian, Hispanic/Latino, Black/African American, Asian/Pacific Islander or Native American.

Objective 4A: The BHS Cultural Competence Committee will meet with BHS management including MHSA managers and representatives of Information Technology to identify reasons why so many clients served by MHSA had their ethnicity identified as "other than specified."

Objective 4B: Based on the reasons identified why 40% of the clients served by MHSA were identified as "other than specified," the group from Objective 4A will

determine strategies to more accurately identify more accurately the ethnic groups of MHSA clients and implement those interventions.

Note: *New strategies for FY 2018-19 are in response to the analysis completed in Criterion 2.*

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.

The Cultural Competence Committee (CCC) will measure and monitor the effects of the identified strategies and objectives for reducing disparities. The CCC meets monthly and will review new data on percentages of clients and penetration rates by ethnicity, language, age and gender. The CCC meets with BHS management once a year and will discuss effectiveness of strategies during the annual meeting and will meet more frequently if significant data findings emerge.

III. Identify any MHP technical assistance needs and challenges.

No technical assistance needs or challenges have been identified at this time.

CRITERION 4

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

I. The county has a Cultural Competence Committee, or other group that addresses cultural issues and has participation from cultural groups, that is reflective of the community.

A. *Brief description of the Cultural Competence Committee or other similar group (organizational structure, frequency of meetings, functions, and role).*

The QMC, under the direction of the ESM, is responsible for the cultural competence planning process. The QMC participates in overall planning and implementation of services at the county, provides reports to the Quality Improvement Committee, and is responsible for completing the Annual Report of Cultural Competence Activities.

The CCC is responsible for monitoring activities and progress toward meeting the goals and objective identified in the Cultural Competence Plan.

B. *Policies, procedures, and practices that assure members of the Cultural Competence Committee will be reflective of the community, including county management level and line staff, clients and family members from ethnic, racial, and cultural groups, providers, community partners, contractors, and other members as necessary;*

The CCC convenes monthly. In addition, the CCC meets jointly with the Management Team at least once a year to provide a status report of the year's activities and introduce the plan for the upcoming year. (See Attachment 1–Cultural Competence Committee Minutes and Management Team Minutes)

The Department is committed to embedding cultural sensitivity and inclusiveness into all its activities. It maintains close oversight of this value and requires all planning efforts directly address cultural competence.

The Cultural Competence Plan is solely dedicated to advancing the Department's overall cultural competence. This annually updated plan derives its goals from two sources: 1) the CCC's 3-year strategic plan and 2) the Annual Quality Management/Improvement Work Plan.

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.

C. *QMC Committee membership roster:*

MCBHS Staff:

- Director
- 3 Division Managers
- QMC Program Supervisor
- 5 Supervising Mental Health Clinicians
- 2 Cultural Competence Chairs
- Intake Program Supervisor
- Medical Records/Front Desk Supervisor
- Compliance Officer
- Client Advocate
- Community Service Liaison (peer worker)
- 2 Administrative Analysts
- 1 Kings view Data Management/Network Analyst – contracted

CCC membership roster:

- MCBHS Director
- QMC Coordinator/Division Manager
- 2 Cultural Competence Committee Co-Chairs
- MHSA Behavioral Health Supervisor
- 2 Peer Workers
- 2 Clinicians
- Case Worker
- Program Assistant (front desk)

II. The Cultural Competence Committee, or other group with responsibility for cultural and linguistic competence, is integrated within the County Mental Health System.

The Director, Senior Management Team and the BHS Advisory Board have the authority and responsibility to integrate cultural competency throughout the MCBHS operation.

The Director has delegated the development and oversight of cultural competence to the Division Manager of the Quality Management Program who also serves as the ESM.

The ESM works closely with the Director and is a member of the Executive Management Team. 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.

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

B. As evidenced by committee meeting minutes and agendas, the Cultural Competence Committee participates in all of the activities listed in II.A above.

C. 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.

CRITERION 5

CULTURALLY COMPETENT TRAINING ACTIVITIES

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

The list below which are available cultural competence courses through Relias Learning Management System has been forwarded to the Cultural Competence Chair. The list will be discussed by the Cultural Competence Committee, who will decide which courses will become mandatory for all staff.

The plan is to have one course completed every quarter. Courses will be completed through Relias Learning, using an online training module for assigned courses. Tracking completion of courses will also be through Relias software.

A. A Culture-Centered Approach to Recovery
B. Advocacy and Multicultural Care
C. Best Practices for Working with LGBTQ Children and Youth
D. Cultural Competence Path Assessment
E. Cultural Diversity
F. Cultural Issues in Treatment for Paraprofessionals
G. Diagnostic and Statistical Manual of Mental Disorders (DSM-5) Overview
H. Family Psychoeducation: Introduction to Evidence-Based Practices
I. Groundwork for Multicultural Care
J. Identification, Prevention, and Treatment of Suicidal Behavior for Service Members and Veterans
K. Infusion of Culturally Responsive Practices
L. Military Cultural Competence
M. Patient Cultural Competency For Non-Providers
N. Relapse Prevention: Cultural Issues
O. Substance Use Disorder Treatment and the LGBTQ Community
P. The Role of the Behavioral Health Interpreter
Q. Using Communication Strategies to Bridge Cultural Divides

II. Recent Cultural Competence Trainings

The following table shows in-person training completed recently to date.

Training Event	Description of Training	How long and often	Attendance by Function	No. of Attendees and Total	Date of Training	Name of Presenter
LGBT Cultural Competence Training	*Improving Care to the LGBT Community*	*2 hours*	**Direct Services* **Direct Services Contractors* **Administration* **Interpreters*	*67* *31* *4*	*02/11/16*	Doug Greco
Interpreter Training	*Interpreting for Doctors*	*2 hours*	**Direct Services* **Direct Services Contractors* **Administration* **Interpreters*	 *4*	*02/25/16*	Eva Weikel
Working with Transgender Individuals	*Understanding Specific Challenges*	*3 hours*	**Direct Services* **Direct Services Contractors* **Administration* **Interpreters*	*47*	*02/25/16*	Douglas Greco
Interpreter Training	*Interpreting for Doctors*	*3 hours*	**Direct Services* **Direct Services Contractors* **Administration*		*04/28/17*	Eva Weikel

			**Interpreters*	*4*		
Interpreter Training	*Interpreting for Doctors*	*3 hours*	**Direct Services* **Direct Services Contractors* **Administration* **Interpreters*	 *4*	*03/23/18*	Eva Weikel

Our plan going forward is to include the following topics in our annual training courses:

A. Cultural Formulation;
B. Multicultural Knowledge;
C. Cultural Sensitivity;
D. Cultural Awareness; and
E. Social/Cultural Diversity (Diverse groups, LGBTQ, SES, Elderly, Disabilities, etc.).
F. Mental Health Interpreter Training
G. Training staff in the use of mental health interpreters
H. Training in the Use of Interpreters in the Mental Health Setting
I. Client Culture Training

III. Client Culture Training

Client Culture training will be provided in the upcoming year that includes a client's personal experience inclusive of racial, ethnic, cultural, and linguistic communities. Topics for Client Culture training may include the following:

- 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

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

Table 6.1: Workforce recruitment for Madera County

		Race/Ethnicity of FTEs currently in the workforce						
Major Group and Positions	***FTE Staff***	***White/ Caucasian***	***Hispanic/ Latino***	***Black/ African American***	***Asian/ Pacific Islander***	***Native American***	***Multi Race or other***	***Threshold Language***
Licensed Mental Health Staff (direct service):	79	20	48	4	4	0	3	37
County (employees, independent contractors, volunteers):	14	7	7	0	0	0	0	6
Governance and Leadership	5	4	1	0	0	0	0	1
Non-Direct Service staff (Analyst, Tech Support, QA, Clerical, Support)	43	13	20	3	2	0	5	18
County Totals	141	44	76	7	6	0	8	62

Table 6.2: Compare the workforce assessment data with the general population, Medi-Cal population, and 200% of poverty data and service data for Madera County

Race/Ethnicity	***County Population***	***Medi-Cal Population***	***200% Population***	***Consumers Served***	***County Staff***	***Direct Service***	***Non-Direct Service***
White/Caucasian	54,887	12,321	6,905	1,144	44	27	17
Hispanic/Latino	86,265	45,051	23,471	1,514	76	55	21
Black/African American	4,679	1,417	1,107	32	7	4	3
Asian, Pacific Islander	3,359	1,243	102	171	76	4	2
Native American	1,450	465	521	44	0	0	0
Other	2,729				8	3	5
TOTAL	153,369	60,497	32,106	2,905	141	93	49

Rationale: Will give ability to improve penetration rates and eliminate disparities.

CRITERION 7

LANGUAGE CAPACITY

I. Increase bilingual workforce capacity.

A. *Evidence of dedicated resources and strategies counties are undertaking to grow bilingual staff capacity.*

1. As evidenced by Table 6.1 in Criterion 6, MCBHS employs 62 staff (44%) of 141 total staff who speak Madera County's threshold language of Spanish.
2. Additional languages spoken by MCBHS staff include Punjabi, Hindi, Thai, Lao, Cambodian, Gujarati, Kochi and Italian.

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

A. *Evidence of policies, procedures, and practices in place for meeting clients' language needs.*

MCBHS utilizes beneficiary handbooks, posters and signage informing clients of procedures, and practices in place 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. The use of the language line utilized in the provision of services only when other options are unavailable.
2. MCBHS utilizes video remote interpretation when needed through a contract with CyraCom, LLC.
3. Description of protocol used for implementing language access through the county's 24-hour phone line with statewide toll-free access.
4. The MHP provides training for the staff responsible for the statewide toll-free 24-hour telephone line to ensure linguistic capabilities to meet the clients' linguistic needs.

B. *Evidence that clients are informed in writing in their primary language, of their rights to language assistance services. Including posting of this right.*

Clients are informed in writing in their primary language, of their rights to language assistance services, including posting of this right in all service locations. Clients are also informed of their rights to language assistance services in the beneficiary handbook and by service providers if it is evident that a client or family member's preferred language is other than English.

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

MCBHS uses bilingual staff or interpreter services to accommodate persons who have Limited English Proficiency.

1. *Share lessons learned around providing accommodation to persons who have LEP and have needed interpreter services or who use bilingual staff.*

2. MCBHS is able to provide linguistically appropriate services through bilingual staff or interpreters, so no specific lessons learned are notable at this time.

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

No historical challenges or technical assistance needs are noted at this time.

E. Identify county technical assistance needs.

Not applicable as we are able to meet our client's needs in this area.

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

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

MCBHS utilizes bilingual staff for the threshold language of Spanish or if interpretation services through our contractor CyraCom if none are available. Posters, signage, the beneficiary handbook and the toll-free access line all provide 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.*

When bilingual staff are not available, interpreter services are offered and provided to clients and the response to the offer 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.*

MCBHS utilizes staff who are linguistically proficient in threshold languages during regular day operating hours and utilizes contracted interpretation services through CyraCom, LLC if bilingual staff are 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 as evidenced by our training outline 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.

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 the county uses 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.*

BHS has developed policy MHP 13.00 (Language Translation and Interpretation Services) and MHP 14.00 (BHS Services for Individuals with Special Language Needs),

which 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 how to access said services via all our services brochures in our lobbies, the Beneficiary Handbook, and posters and flyers displayed at our provider sites.

Upon beneficiary request MCBHS will provide a listing of specialty mental health and culture-specific providers via the Provider Directories which include 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).

C. *Policies, procedures, and practices that comply with the following Title VI of the Civil Rights Act of 1964 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.*

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 chose to utilize someone else against MCBHS advise (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

A. *Culturally and linguistically appropriate written information for threshold languages:*

Culturally and linguistically appropriate written information in Spanish (our threshold language) are provided in the following documents which are distributed to clients in the manner and locations required in the MHP contract between the California Department of Health Care Services (DHCS) and MCBHS:

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.*

Consistent with policy MHP 13.00, communication with clients regarding clinical and any other treatment related issues are done so in the client's preferred language directly through bilingual staff or by use of interpretation services.

C. *Consumer satisfaction survey translated in threshold languages, including a summary report of the results.*

MCBHS uses the Consumer Perception Survey provided by DHCS through its contractor California Institute for Behavioral Health Solutions, which is translated into Spanish and several other languages.

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

As stated in policy MHP 13.00, to assure accuracy of written translations the process should include the following:

1. Utilize qualified MCBHS translators, if available,
2. Review by a second qualified MCBHS translator, and/or;
3. Review by target audience groups and periodic updates.
4. Forward and back translation.
5. Complex documents shall be reviewed by a second qualified translator for accuracy and equivalency of register (6th grade reading level).
6. Sole reliance on internet or translation software for the translation of client documents is discouraged.

E. *Mechanism for ensuring translated materials is at an appropriate reading level (6th grade).*

Mechanism for ensuring translated materials is at an appropriate reading level (6th grade): The MHP will ensure the use of easily understood language and format for all informing material. Reading level of informing material will be at 6th grade reading level. Designated MCBHS Staff will use proven readability techniques to evaluate the reading level of threshold and non-threshold informing materials before distribution.

CRITERION 8

ADAPTATION OF SERVICES

I. Client driven/operated recovery and wellness programs

A. *List and describe the county's/agency's client-driven/operated recovery and wellness programs.*

1. The Community Outreach & Wellness Centers, which has two "drop-in-centers" with the primary goal of providing outreach and education services for community members to prevent the risk factors that contribute to the development of and disability related to mental health illness.
2. 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 focuses on providing services in the local high schools and outreach in community events where TAY are likely to attend.
3. Using MHSA Innovation funding, MCBHS has developed the Perinatal Mental Health Integration Project (PMHIP), which was named Nurture2Nurture Madera. This project was contracted with the California Health Collaborative to implement this service and evaluation. Within the first year, the stakeholders named the coalition group the Maternal Wellness Coalition.
4. 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, in concert with multiple organizations.
5. The Adult/Older Adult Full Services 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.

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.

Two examples of alternatives and options that accommodate individual, cultural and linguistic preference are as follows:

1. The Community and Family Education program builds community protective social factors. It does this through educating the community on how to recognize someone that is at risk of or is experiencing mental illness and how to support them to access behavioral health services if needed. This program offers training in specific educational curriculums to any member of the public including clients, client family members, and staff, such as Mental Health First Aid, ASIST, SafeTALK and evidenced based and culturally based parenting classes.

2. Madera County Department of Behavioral Health Services has 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.

   Using the Institute of Medicine's model of interventions as a reference, these include services that fall in the areas of Promotion and Prevention including the categories of Universal, Selective and Indicated Prevention. Categories of services were created that could be counted across all prevention programs. These categories are listed below were:

   - Information Dissemination,
   - Education,
   - Problem Identification and Referral,
   - Community Based Process,
   - Alternatives, and
   - Environmental.

   The first two categories have to do with exchanging information to promote people's mental health. Problem Identification and Referral services occur when staff encounter a person that may have serious mental illness symptoms and who staff refer for a clinical assessment for treatment. Community Based Process and Environment services attempt to change the social environment in communities to promote mental health and reduce risk of mental illness development or exacerbation. Alternative interventions have to do with purposefully creating a particular activity or venue that has reduced mental illness risk factors and promote mental health protective factors.

B. *Evidence that the county informs clients of the availability of culturally specific services in their member services brochure.*

   The beneficiary brochure states that BHS will provide a combination of culturally specific approaches to address various cultural needs that exist in the Madera County to create a safe and culturally responsive system. 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. (Outreach requirements as per Section 1810.310, 1A and 2B, Title 9)*

   Informing materials in English and Spanish are available at all service locations and on the MCBHS website at https://www.maderacounty.com/government/behavioral-health-services. Many community outreach and education forums, including informing under-served populations of the availability of cultural and linguistic services and programs are described in the MCBHS MHSA Three Year Plan, which is also on the website.

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;*

   MCBHS service locations are in the major population areas of Madera County, including central Madera, Chowchilla and Oakhurst. These locations are accessible to public transportation. Hours are 8 am to 5 pm, but crisis response and services to treat urgent conditions are available through the crisis and toll-free access line 24 hours per day, 7 days per week. As described above, language capacity is provided through Spanish speaking staff at all service locations 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*

   All MCBHS provider sites meet the requirement of the Americans with Disabilities Act (ADA) and have upgraded their waiting rooms to be more client and culturally-friendly and inviting.

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.*

   All MCBHS provider sites are designed to be client-friendly and age-appropriate so as to reduce stigma.

III. Quality of Care: Contract Providers

A. *Evidence of how a contractor's ability to provide culturally competent mental health services is taken into account in the selection of contract providers, including the identification of any cultural language competence conditions in contracts with mental health providers.*

MCBHS expects that all network and organizational contract providers will be accountable for providing culturally and linguistically competent specialty mental health services and reporting applicable information to be included in the Cultural Competence Plan.

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 shall have a written policy and procedure that ensure organizational and individual compliance by its staff and providers. Contractors shall comply with any and all requests from MCBHS for a list of cultural competency trainings and sign in sheets of staff attending those trainings.

IV. 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. *List if applicable, any outcome measures, identification, and descriptions of any culturally relevant consumer outcome measures used by the county.*

MCBHS provides outcome measurements for children adults to DHCS as required for the Performance Outcome System, which can be accessed on the web page https://www.dhcs.ca.gov/services/MH/Pages/SMHS_Performance_Dashboard.aspx.

Regarding consumer satisfaction, MCBHS uses the Consumer Perception Survey provided by DHCS through its contractor California Institute for Behavioral Health Solutions, which is translated into Spanish and several other languages.

B. *Staff Satisfaction: A description of methods, if any, used to measure staff experience or opinion regarding the organization's ability to value cultural diversity in its workforce and culturally and linguistically competent services*; and

MCBHS has not utilized staff satisfaction surveys or other methods to statistically measure staff's ability to value cultural diversity and culturally and linguistically competent services, but we may consider doing so in the future. MCBHS is proud of its diverse workforce, which consists of 54% Hispanics/Latinos and 44% who speak our threshold language, Spanish. We feel the workforce accurately reflects our community.

C. *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 Improvement Committee (QIC) 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 QIC 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 also has an MHSA Issue Resolution Process to handle client disputes related to the provision of their mental health services funded through the MHSA. 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 QIC similar to the process described for Medi-Cal beneficiary grievances and appeals.