Cultural Competence Plan

2022 Update

Madera County

Department of Behavioral Health Services

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CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES CULTURAL COMPETENCE PLAN REQUIREMENTS

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CHECKLIST OF THE CULTURAL COMPETENCE PLAN REQUIREMENTS

MODIFICATION (2010) CRITERIA

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Purpose

The Cultural Competence Plan Requirements (CCPR) establishes 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 the most recent CCPR criteria established by the California Department of Health Care Services (DHCS) and standards (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 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 Department of Behavioral Health Services (MCDBHS) 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.

DHCS uses the California Code of Regulations, Title 9, Section 3200.260, for the definition of eligible "Small Counties".

Background

DHCS 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 CCPR 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 CCPR 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 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.

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

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 Department of Behavioral Health Services (MCDBHS) 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. MCDBHS 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 plan derives its goals from four sources:

1) Quality Management Meetings (a.k.a. QIC)/Cultural Competence Advisory Committee
2) Provider Input/Feedback
3) Annual Quality Assurance and Performance Improvement (QAPI) 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 MCDBHS' clients, family 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. MCDBHS 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. Two populations with the lowest penetration rates within the County.

MCDBHS requires all network and organizational contract providers to deliver culturally and linguistically competent specialty mental health services. Contracts include a provision on Cultural Competence 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 MCDBHS 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. MCDBHS will remain flexible to meet the needs of the community. In the planning phase and during the Quality Improvement Committee (QIC), 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.

In the year 2021, the PEI Outreach Team was able to reconnect with the community via Zoom meetings, phone conference and drive through events. The team's focus was on the Hispanic/Latinx and Native American community. We partnered with local community-based organizations that served the Latinx and Native American population in these efforts. In total, 16 presentations and engagement events took place that served the target population. Feedback and input were provided regarding service delivery. Drive through events presented the opportunity to provide education - 13 drive through events were conducted in the year 2021. As COVID restrictions lifted and schools reopened, the PEI Team was able to reach out to the TAY population. Although not all schools were ready to accept visitors on campus, the PEI Team was able to access 8 school sites and 1 local community college.

In the year 2022, the PEI Outreach Team has increased their Outreach numbers to 15 school sites and 1 Community College. These events continue to provide education to the community with focus on the Hispanic and TAY population. During these events, services are being distributed to the community with a focus on retention within these targeted populations.

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 MCDBHS' electronic health record (EHR). MCDBHS 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, MCDBHS launched a new EHR system in December 2020. This new EHR system should help MCDBHS extract accurate data to assist in our analysis and to better understand the effectiveness of our outreach efforts. We are still working on how to best utilize the new EHR system for accurate data analysis.

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 Behavioral Health Services Division Manager, Nick Avila-Montes as the Cultural Competence/Ethnic Services Coordinator (CC/ESM). He 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 his capacity as Ethnic Services Coordinator, Mr. Avila-Montes will participate in the Quality Improvement Committee meetings. It is in those meetings that Mr. Avila-Montes will present information and advocate 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 MCDBHS services and activities. Being fully bilingual, Mr. Avital-Montes, in his role as ESM will be critical in ensuring 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 MCDBHS embeds culturally competent activities into our entire behavioral health system. For this reason, we are unable to identify funds broken down in any part of our budget for culturally competent services. We may also be able to use MHSA PEI funds for cultural outreach activities. MCDBHS is currently working on setting up a budget for the Cultural Competence funds, aiming to have it for FY 2023-24.

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.*

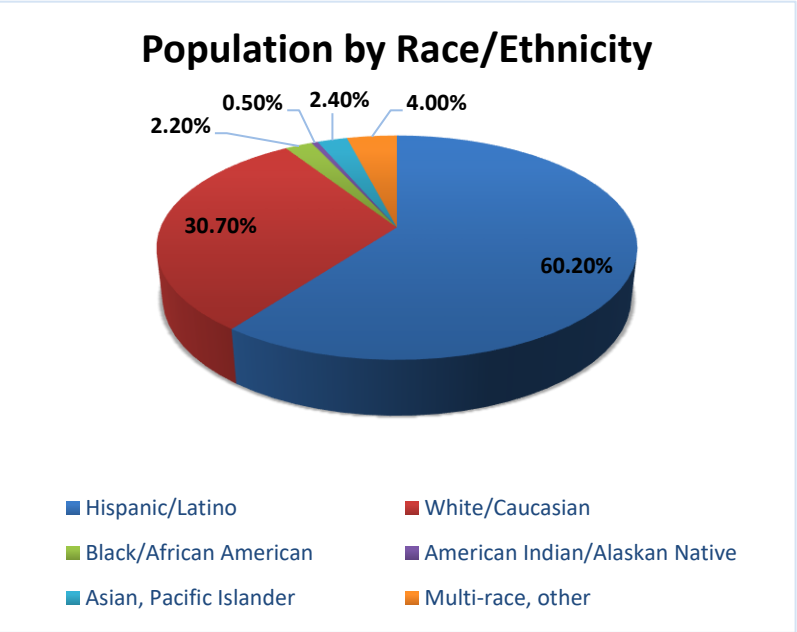
General Population

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 2021 Madera County had 159,410 residents. The Department of Finance calculates that as of January 2022, the County of Madera has about 157,396 residents in the county.

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



Population estimate breakdown for Race/Ethnicity is as follows:

1. Hispanic/Latino:	60.2%
2. White/Caucasian:	30.7%
3. Multi-race, other:	4.0%
4. Asian, Pacific Islander:	2.4%
5. Black/African American:	2.2%
6. Am. Indian/Alaska Native:	0.5%

Madera is a small county; there are two dominant populations. Those populations are Hispanic/Latino and White/Caucasian. Latinos make up 60.2% of the population and the White/Caucasian community occupies 30.7% of the population.

Data Source: Fact Finder tool, 2021 U.S. Census Bureau

Total Population of Madera County by:

Table 2.2.1: Population by Age

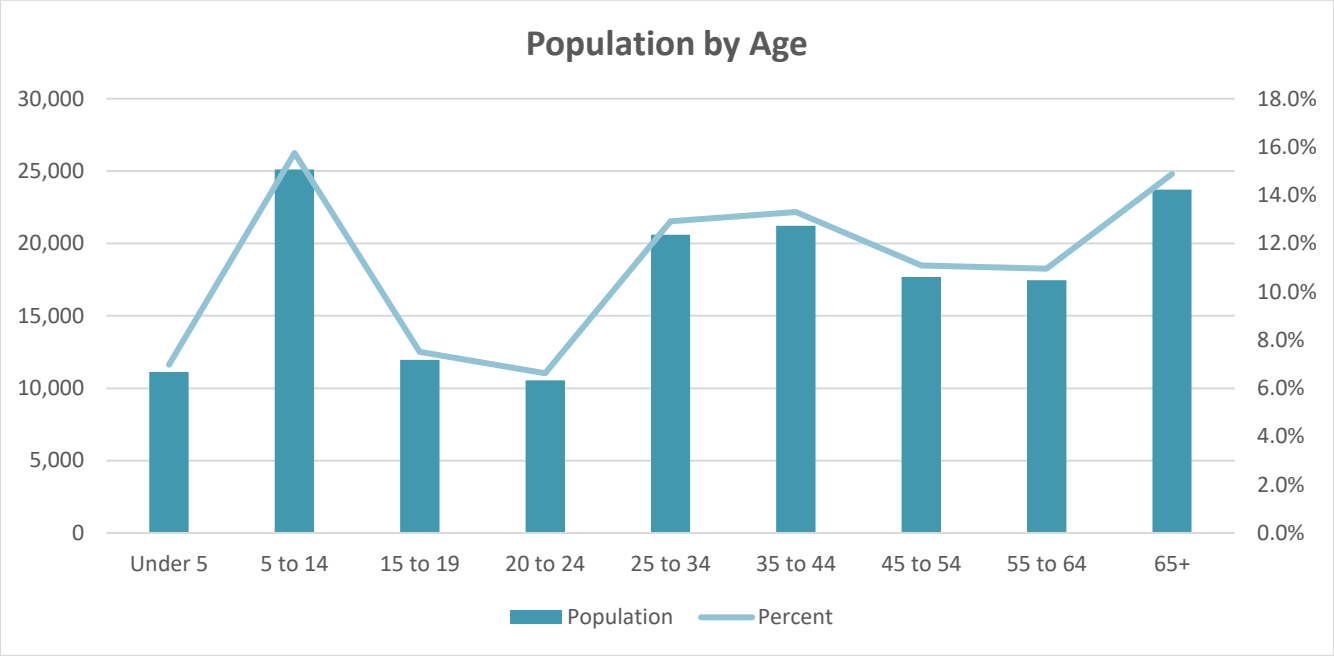
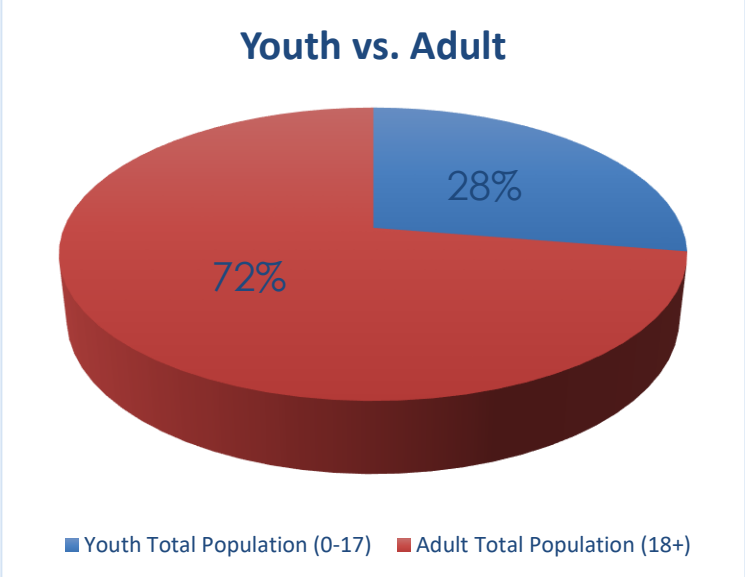


Table 2.2.1: Age Groups

Age	Population	Percent
0 to 4	11,123	7.0%
5 to 14	25,107	15.7%
15 to 19	11,961	7.5%
20 to 24	10,552	6.6%
25 to 34	20,602	12.9%
35 to 44	21,215	13.3%
45 to 54	17,681	11.1%
55 to 64	17,455	10.9%
65+	23,714	14.9%
Total	**159,410**	**100%**

Census - Table Results

Table 2.3: Youth vs. Adult



Approximately 36.9% of the population is under 25 years old, while 48.3% of the population is 25 - 64 years of age. The senior population is relatively small, with only 14.9% being over the age of 65. With that information highlighted, 63.1% of the population is 44 and younger and only 36.9% is 45 and older which emphasizes the fact that Madera County has a younger population. The age range between 5-14 years old has the highest percentage with 15.7% in that age range.

*Data Source: Fact Finder tool, 2021 U.S. Census Bureau & Census - Table Results

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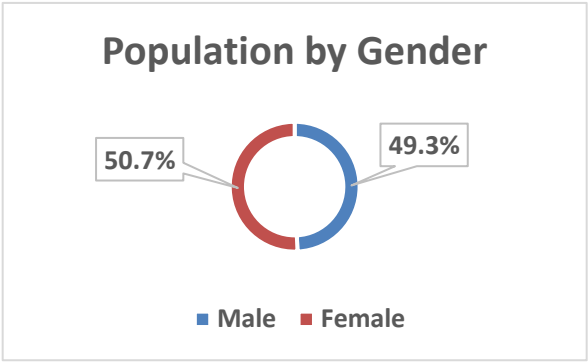
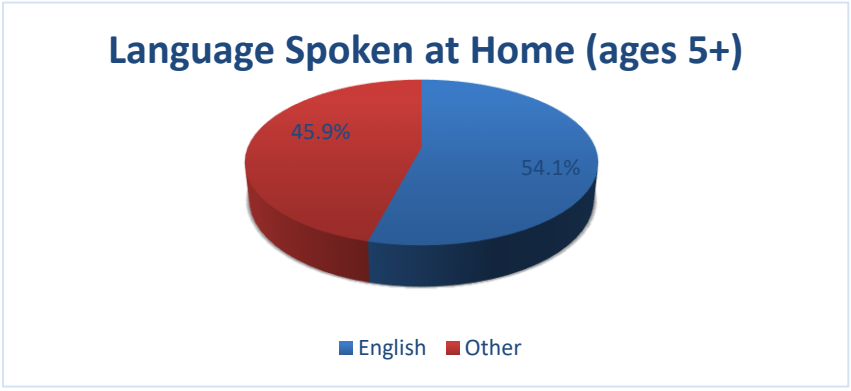
Table 2.4: Total Population of Madera County by Gender

Gender	Population	Percent
Male	78,590	49.3%
Female	80,820	50.7%
Total:	**159,410**	**100%**

*Data Source: Fact Finder tool, 2021 U.S. Census Bureau

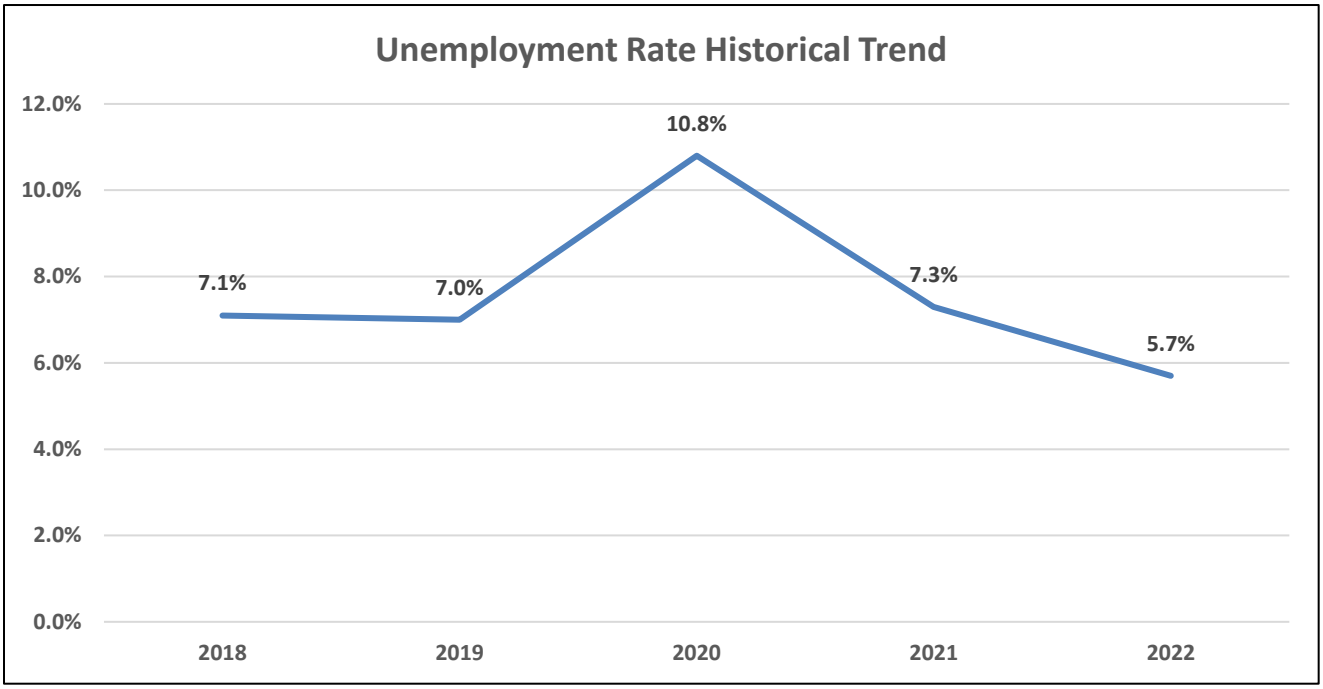




*Data Source: Fact Finder tool, 2021 U.S. Census Bureau

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

The unemployment rate in Madera County was 7.0 percent in 2019, down from 7.1 percent in 2018. However, in 2020 the rate spiked to 10.8 percent then decreasing to 7.3% in 2021 matching the overall state unemployment rate. In April of 2022, Madera County's unemployment rate decreased to 5.7%, with a consistent downward trend bringing the unemployment rate to 4.9% in May 2022.



In March 2020 when the COVID-19 pandemic began, the graph shows a spike in our unemployment rate. The economy took a strong hit; however, the trend is shows signs of recovery in 2021 and 2022.

**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 2021 and Penetration Rate for Fiscal Year CY 2021.

Race/Ethnicity	*County Population*	*Medi-Cal Eligible*	*Medi-Cal Beneficiaries Served*	*Madera Penetration Rate*	*Statewide Penetration Rate*[1]
White/Caucasian	48,906	13,096	656	5.01%	5.32%
Hispanic/Latino	96,013	53,230	982	1.84%	3.29%
Black/African American	3,526	1,511	92	6.09%	6.83%
Asian, Pacific Islander	3,749	1,282	15	1.17%	1.90%
Native American	866	467	18	3.85%	5.58%
Multi Race, Other	6,350	N/A	N/A	N/A	N/A
Unknown/Other	N/A	9,637	218	2.26%	3.72%
Age					
0-5	N/A	10,134	84	0.83%	1.59%
6-17	N/A	22,644	625	2.76%	5.20%
18-59 [2]	N/A	38,788	1,167	3.01%	4.03%
60+ [3]	N/A	7,655	105	1.37%	2.59%
Gender					
Female	80,820	42,002	1,121	2.67%	3.74%
Male	78,590	37,218	860	2.31%	3.97%

*Information retrieved from EQRO's Approved Claims and MMEF data for CY2021.

Table 2.6: Madera County Penetration rate history CY2018 – 21

Race/Ethnicity	Madera penetration rate CY2018	Madera penetration rate CY2019	Madera penetration rate CY2020	Madera penetration rate CY2021
White	8.50%	↓ 8.22%	↓ 6.76%	↓ 5.01%
Hispanic/Latino	**3.39%**	↓ **3.24%**	↓ **2.66%**	↓ **1.84%**
African American	10.30%	↓ 9.75%	↓ 7.77%	↓ 6.09%
Asian/Pacific Islander	2.35%	↑ 3.07%	↓ 2.20%	↓ 1.17%
Native American	6.59%	↑ 7.24%	↓ 5.31%	↓ 3.85%
Other	4.95%	↓ 4.33%	↓ 3.22%	↓ 2.26%

*Information retrieved from DHCS Approved Claims and MMEF data for CY2021.

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.

Analysis for CY 2020:

Per Table 2.5, most categories are not performing better than the statewide penetration rate. 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 2019 to CY 2020. In the previous year, Madera County reported a 9.75% penetration rate in comparison to CY 2020 which stands at 7.77%. The penetration rate for the Black/African American community will be address with improved social media reach and collaboration with MCDBHS Community Partners and their outreach efforts. The area that needs immediate attention is the Hispanic/Latino community. This rate has slightly dropped in comparison to the previous year and is well below the statewide average. MCDBHS used EQRO data which also compares MCDBHS to other small county's average penetration rates. Small counties are showing a rate of 4.53% which is slightly lower than the state average of 4.55%. This data highlights the need to place more focus on improving our reach in the Hispanic/Latino population which is underserved in our community.

Updated Analysis for CY 2021:

Penetration rates for all race/ethnicities decreased in CY 2021, which correlates with the challenges in providing and receiving services during the COVID-19 pandemic.

For CY 2022 we will address the disparities for Hispanic/Latinos and service provision in general while continuing to come out of the COVID-19 pandemic. Said efforts will include continued provision of services in person and telehealth and engaging more clients to transition back to in-person service delivery.

Our PEI team was able to make MCDBHS more of a presence by increasing public events in the community to provide the public with information related to MCDBHS events and encourage community engage.

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, gender, and other relevant small county cultural populations.

	Madera County	California	Disparity
July 1, 2021			
Population Estimate	159,410	39,237,836	N/A
	%	%	%
2020-2021 Growth	2	-0.8	2.8
2016-2020 Foreign Born	20.4	26.6	-6.2
Poverty Rate			
Persons in Poverty	14.1	12.3	1.8
Gender			
Female	51.4	50	1.4
Male	48.6	50	-1.4
Age			
Persons under 5	6.8	5.7	1.1
Persons 6-17	27.4	22.4	5
Persons 18-64	51.5	56.7	-5.2
Persons 65+	14.3	15.2	-0.9
Race/Ethnicity			
White/Caucasian Not Hispanic	31.7	35.2	-3.5
Latino/Hispanic	60.2	40.2	20
African American	4.2	6.5	-2.3
Native American	4.5	1.7	2.8
Asian	2.8	15.9	-13.1
Native Hawaiian/Pacific Islander	0.3	0.5	-0.2
Multi-race/Other	2.8	4.2	-1.4
Language			
Other than English spoken at home age 5+ (2016-2020)	45.2	43.9	1.3

https://www.census.gov/quickfacts/fact/dashboard/maderacountycalifornia/PST045221
https://www.census.gov/quickfacts/fact/dashboard/CA,maderacountycalifornia/PST045221

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.

Overall, Madera County's poverty level exceeds that of the State of California.

Our two main targeted populations the TAY and Hispanic/Latino, have the highest poverty levels. The Language category shows that more individuals speak a language other than English at home by 1.3 percentage points in comparison with the overall state rate. MCDBHS will incorporate these statistics to help identify underserved populations and create opportunities to help decrease the rates for these identified groups. Some potential strategies may leverage Partner Programs for MCDBHS to help with housing, food, utility assistance among other services meant to assist those with financial or housing hardships to meet their basic needs.

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 2021-22 Madera County served **3,889** clients which is an increase from FY 2019-20, in which 1,415 clients were reported served. Per data issues previously disclosed, numbers below may vary slightly.

Table 2.7: Estimate Countywide Total Population Served through MHSA for Madera County FY 2021-2022

Mental Health Treatment Services	**# of clients**
MHSA FSP	72
MHSA General Systems Development	3,817
Total	**3,889**

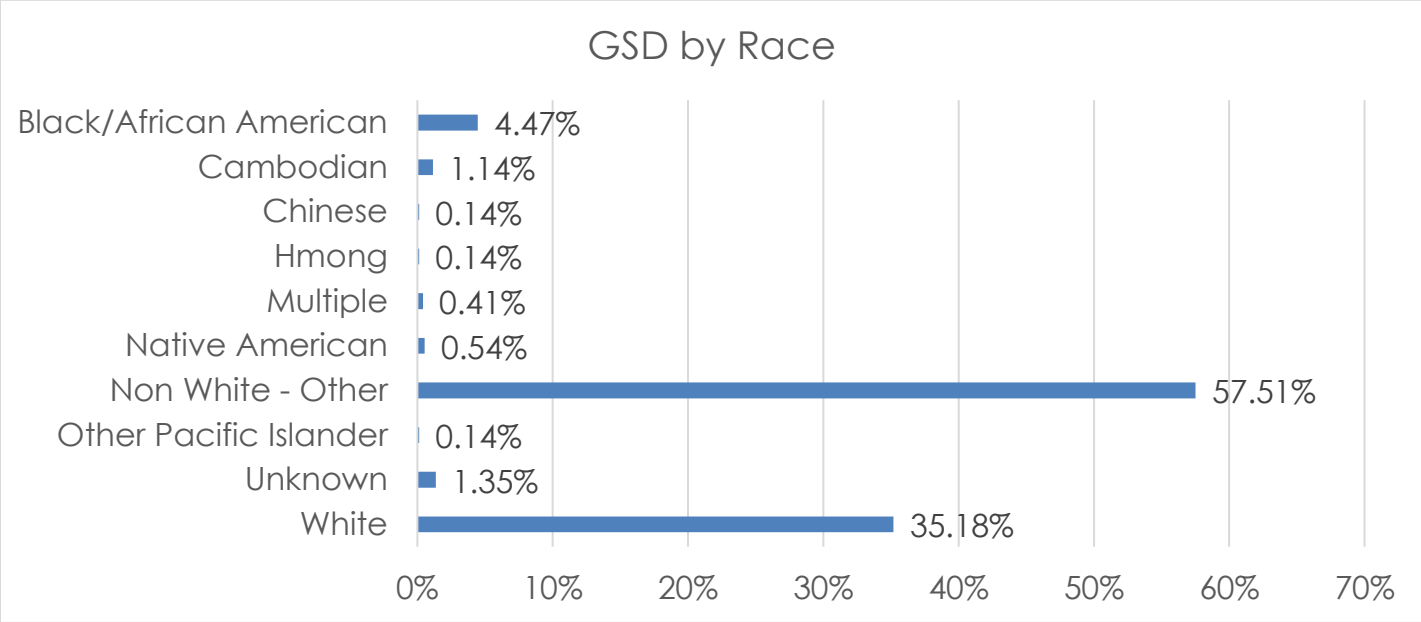
*InSync Healthcare Solutions, EHR Data Report FY21-22

Table 2.8: Estimate Countywide Total Population Served through MHSA for Madera County by Age Group for FY 2021-2022

Age Group	**# of clients**	**% of clients**
0-15	989	25%
16-25 (TAY)	831	21%
26-59	1797	46%
60+	272	7%
Total	**3,889**	**100%**

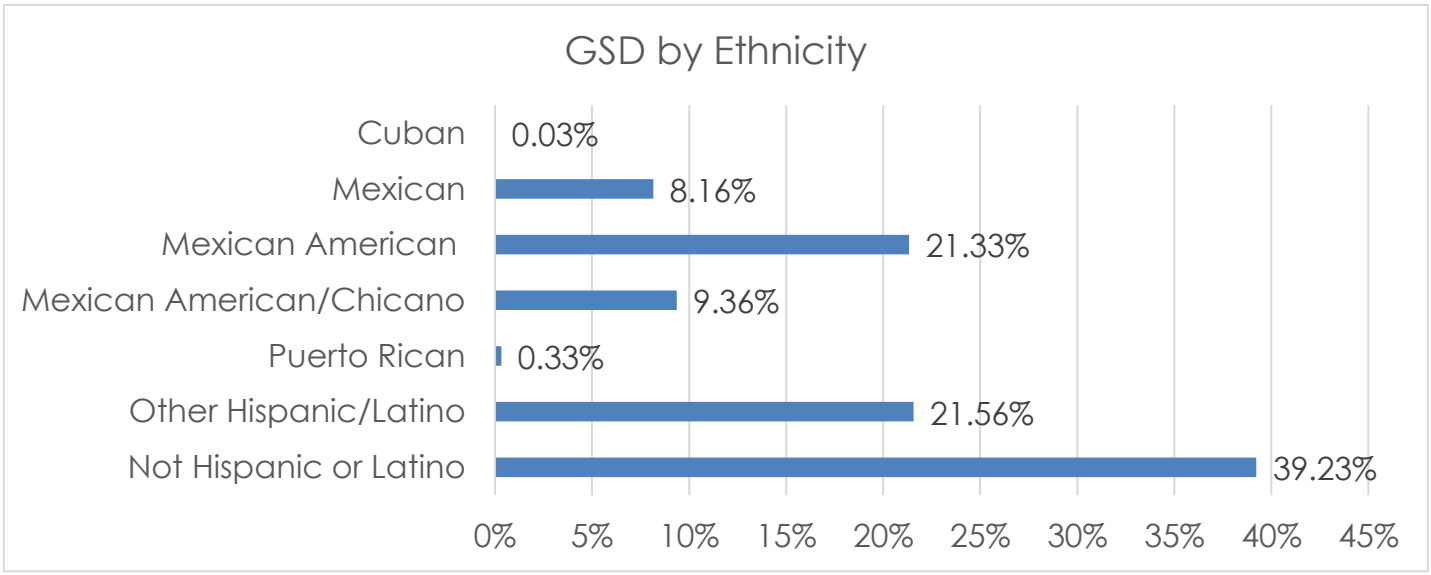
*InSync Healthcare Solutions, EHR Data Report FY21-22

Table 2.9: Estimate Countywide Total Population Served through MHSA General Systems Development for Madera County by Race for FY 2021-2022



*InSync Healthcare Solutions, EHR Data Report FY21-22

Table 2.10: Estimate Countywide Total Population Served through MHSA General Systems Development for Madera County by Ethnicity for FY 2021-2022



*InSync Healthcare Solutions, EHR Data Report FY21-22

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.***

It's important to point out that the "Non-White – Other" race category in table 2.9 above is inclusive of all individuals who do not identify as white and do not find any other category with which they identify. For this reason, we can only speculate that many Hispanic/Latinos select the "Non-White – Other" category as they would not necessarily fit into any of the other available race selections. It can also be assumed

that most of the individuals utilizing this race category will then select an ethnicity category that more accurately reflects their ethnic background. However, as found in table 2.10, ethnicity options also offer a not Hispanic or Latino which makes it that much more complicated to calculate an accurate count of those who identify as Hispanic/Latino. The reason for this complexity comes from the fact that it is most probable to have duplicated counts when, for instance, an individual whose race is White also identifies as Cuban, in which case the same individual would be counted as white and as Cuban.

Despite any possible variation in race/ethnicity counts the Hispanic and White are the top two populations served by MHSA. This can be presented by adding all ethnicities except for "Not Hispanic or Latino" for a total of 61% and by looking at "White" in table 2.9 which is at 35%. The trend can further be observed in table 2.5, where Hispanic/Latino surpass the White population in Medi-Cal eligibility.

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.

Due to clear disparities in penetrations rates per EQRO's Approved Claims and MMEF data for CY2021 in the Hispanic Latino and the 6-17 age group, Madera County will be investing its efforts in improving engagement with both the Hispanic Latino with a focus on the Spanish speaking monolingual population, as well as the 16-25 years of age TAY population.

Madera County, as other comparable counties, has encountered challenges in engaging the Spanish speaking population. This was evident when surveys were sent out to Spanish speaking stakeholders as part of the planning process to collect feedback regarding needed services and receiving only 10% back. As a result, more strategic steps have been developed and planned to reach this stakeholder group, said efforts will include leveraging social media capabilities in the Spanish language. IN addition, our outreach efforts will also make added efforts in engaging the 16-25 years of age TAY population which has also been identified with a low penetration

rate in our County.

Through years of ongoing collaborations with community partners, our PEI team and MCDBHS has established strong roots across the County. Special focus and efforts have been in local schools, where PEI team members take part in local school community event planning meetings as well as on the attendance review board. This collaborative relationship will enable the PEI team to reach the TAY population, to learn from them and their needs and bring supports necessary as needed.

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.*

The last three years (CYs 2020, 2021 and 2022) have proven to be challenging years. 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 set objectives, MCDBHS will remain flexible in its approach to addressing targeted areas. MCDBHS will be using the National CLAS standards as a strategic guideline 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 MCDBHS 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. Mandatory trainings for LGBTQ+, especially transgender education
      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

Assessment of progress toward meeting goals:

"The Buzz" a monthly agency newsletter covering updates and informational content continued to be published through October 2021. As of January 2023, "The Buzz" will be updated to include various topics chosen by MCDBHS staff gathered via an online survey to align content with interest.

In October 2021, MCDBHS hosted Día de Los Muertos activities in satellite clinics including altars and meals. Then in October 2022, Día de Los Muertos events once again took place at all MCDBHS clinic sites and in addition, MCDBHS participated in an outreach event with the local Community Hospital where an altar was also created for display.

MCDBHS has leveraged the Relias online training portal much more during COVID times. In the third quarter of 2021 a training on understanding your biases was rolled out, then in the fourth quarter of the same year an LGBTQ+ training was completed. In 2023, the "BHS News" MCDBHS newsletter will contain a

cultural component where staff will be updated on upcoming trainings and be provided information regarding cultural topics. These efforts will be launched to provide additional understanding in cultural backgrounds and to emphasize how much more similar than different we are.

2. The Quality Improvement Committee (QIC) Meeting will be utilized to keep MCDBHS management and contracted partners 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.

Assessment of progress toward meeting goals:

CC/ESM met with QIC in March 2021 to provide updates on Cultural Competence activities. During this meeting the ESM communicated the ESM onboarding workgroup draft which has been developed to guide the ESM's responsibilities and apply a layer of accountability. During this meeting, the ESM also shared planned training through an agreement with El Centro Binacional para el Desarrollo Indígena Oaxaqueño (CBDIO) as well as additional outreach efforts with the PEI team.

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

Assessment of progress toward meeting goals:

Our website has been revamped to include social media presence; our website language preferences have been updated to give community members the opportunity to select their preferred language. In addition, Spanish language

content has been posted directly onto MCDBHS' website pages so the public can immediately access information in their preferred language without the need to select preferred language from a drop-down menu. Since the pandemic first occurred, MCDBHS began to develop strategies to maximize the use of our website as well as online presence via social media to engage and provide information about our events and services to our clients and overall members of the public. Today, we continue to expand outreach activities via social media platforms by maintaining an ongoing stream of updated information to best engage the community we serve. To better understand how the public utilizes our website and tailor it to the community's needs we conducted focus groups in English and Spanish to collect input from those who can benefit from said information.

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, educate and retain.
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.

Assessment of progress toward meeting goals:

We have active Twitter and Facebook accounts, Instagram currently in the approval process, which are utilized to help increase engagement for all MCDBHS clients and reduce stigma through information sharing. By using these forms of social media outlets, we can distribute informational posts for the community to interact regarding services and events. Posts are uploaded in both English and our threshold language, Spanish, to help our target population. Our website has been revamped to be more user friendly and for our monolingual Spanish speaking population to access content in Spanish.

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

Assessment of progress toward meeting goals:

Test calls are conducted at least every quarterly to our ACCESS and Toll-Free lines to ensure we are culturally and linguistically responsive to the public and service is provided in a timely manner. Data is tracked by our Quality Improvement Team.

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 compliance and assess areas of improvement

Assessment of progress toward meeting goals:

In 2021, a new CC/ESM was hired to help us define strategies and determine what information will be needed in this area. The CC/ESM has and will continue to work with the QI team to compile, export, and prepare meaningful data to support and reflect efforts made system wide.

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
    iii. Cognitive Behavior Therapy Groups conducted in Spanish

b. TAY population
    i. School/Club partnerships

Assessment of progress toward meeting goals:

In 2021, MCDBHS worked closely with Centro Binacional Para El Desarrollo Indígena Oaxaqueño (CBDIO) to obtain feedback on how to appropriately reach out to the identified Oaxaqueño population to best guide, grow and improve our efforts. MCDBHS' outreach team was able to provide educational sessions at 8 school sites and 1 local community college as COVID restrictions were lifted. In 2022, educational

sessions increased to 15 school sites and 1 community college with educational sessions addressing suicide prevention, self-care, safety planning, and dealing with stress. During these educational sessions, participation from students, faculty, and parents was encouraged.

New Strategies for 2023:

Continue work on strategies 1 through 7 with additional attention on Strategy 4 (***Increase engagement for all BHS clients through an online/social media platform to help reduce stigma***) and begin working on the following new strategies:

8. The CC/ESM will solicit advice from a newly developed Cultural Competence Advisory Committee (CCAC) to develop successful outreach and engagement strategies to increase the penetration rate for Latinx/Hispanic clients and find better methods of outreach to engage the Spanish speaking population.

a. These strategies will be developed based on what community members feel will be helpful, comfortable, and welcoming to achieve community defined solutions.
b. Utilize existing studies on Latinx/Hispanic outreach including the following:
    i. "Community-Defined Solutions for Latino Mental Health Care Disparities" published by the California Reducing Disparities Project, 2012.
    ii. "Best Practice Highlights Latino/as and Hispanics" published by the American Psychiatric Association, prepared by Lisa Fortuna, M.D.
c. The CC/ESM will report to the CCAC on progress toward identifying and implementing these strategies as described above in Strategy 2.

9. Given continued COVID-19 restrictions, the Quality Improvement Committee (QIC) will discuss the best method to offer services (in- person or telehealth) and how this may affect services to the Hispanic population. QIC will discuss the balance between offering online/telehealth services and in person services to better engage clients and increase penetration rates for all clients as we emerge from the COVID-19 pandemic. CCAC will be consulted when questions arise about how service mix applies to specific diverse populations.

10. Integrate questions about diversity capabilities during the recruitment process

to understand candidate's ability to help minorities and clients of differing socioeconomic backgrounds.

11. MCDBHS will increase collaboration with community partners, Kingsview, Turning Point and California Health Collaborative with the D.A.D's Project to ensure their agencies are providing quarterly Cultural Competency trainings for their staff.

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.

In 2021, the CC/ESM has been posting monthly articles in the agency wide Buzz newsletter through October. In mid-late October, the department distributed informational content to staff to inform them of facts related to Dia De Los Muertos, The Day of the Dead, leading up to the event. Our team worked on the decoration and display of an "Ofrenda", alter, it to be viewed by our staff/clients/partners/community members at our satellite clinic on 7th Street. This was received well by our stakeholders and will use this as a learning experience to further promote engagement in cultural competence events/activities Many staff reported that this was the first time Dia De Los Muertos was celebrated in the department and would like to see us continue to celebrate or bring recognition to other cultural events. In 2022, this holiday continues to be celebrated within the department and alters displayed for the community at all our sites.

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 be compiled, analyzed, and prepared at least quarterly for monitoring purposes. The CC/ESM will track progress and present information to the Cultural Competence Advisory Committee (CCAC) which meets quarterly. The CCAC will measure and monitor the effects of the identified strategies and objectives for reducing disparities to ensure progress or define additional improvement necessary to meet goals. Data will include service, demographic, as well as social media likes and interaction to determine level of ongoing engagement.

III. Identify any MHP technical assistance needs and challenges.

Currently, MCDBHS does not require technical assistance.

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 Advisory Committee (CCAC) will assist with monitoring and planning all activities for cultural compliance and will also address issues during its quarterly meeting. The committee will maintain close oversight and will require that all planning efforts directly address cultural competence goals. The CC/ESM is responsible for attending these meetings and presenting/addressing/reporting any cultural issues.

The CCAC will be reflective of the community, clients, family members, racial and ethnic groups, and other community partners as much as possible. The core members of the CCAC are as follows:

- Ethnic Services Manager (ESM)
- Madera County Department of Behavioral Health Services (MCDBHS) Division Manager
- MCDBHS Director

- MCDBHS Health Education Coordinators (PEI Team)
- MCDBHS direct service staff (clinicians/case managers)
- Client and family members and community representatives. (MCDBHS will offer honorary stipends to community members to encourage participation)
- Community Based Organizations
- Member from the Department of Social Services
- Member from the Board of Supervisors
- Member from the Behavioral Health Board

The Cultural Competence Advisory Committee's (CCAC) 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 (QAPI) 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 Behavioral 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 MCDBHS Annual Report of the Cultural Competence Advisory Committee's (CCAC) 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 Analyst and BHS Division Manager overseeing MHSA also attend the monthly Quality Improvement Committee (QIC) meetings. The Cultural Competence Ethic Services Manager (CC/ESM) and the MHSA Analyst(s) are responsible for MHSA reporting and attend all MHSA related meetings.

CRITERION 5:
CULTURALLY COMPETENT TRAINING ACTIVITIES

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.

MCDBHS has adapted its training efforts since 2020 through 2022, due to ongoing and ever changing COVID-19 pandemic restrictions. MCDBHS planned to provide a cultural competence related training every quarter with two (Q2 and Q4) in-person trainings and two (Q1 and Q3) provided through the Relias training portal. Furthermore, in-person trainings were to be made available to contracted providers.

In March 2020, California ordered a lock down and implemented social gathering restrictions. To ensure staff's health and safety, MCDBHS cancelled the Q2 in-person training and switched its Q4 in-person training to an online training. Until COVID-19 restrictions are lifted, MCDBHS will complete trainings via Relias or other online platforms while remaining flexible and adaptable. MCDBHS will be looking for trainers who can hold live virtual trainings on cultural competence to ensure it keeps with a quarterly training schedule in 2023 as it has since calendar year 2020.

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

MCDBHS has been working diligently to holistically incorporate cultural competence into every aspect of daily operations. Through ongoing trainings and an inclusive approach, MCDBHS is working towards a culturally proficient work environment. Communication from all staff is also welcomed and valued by the ESM who maintains 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 Ethnic Services Manager.

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 Advisory Committee (CCAC), which then decides which courses are most appropriate and needed to become mandatory for all staff.

Assigned courses are to be completed through Relias Learning, through online training modules. The learning software allows for tracking and monitoring of course completion which is used ensure compliance with training requirements.

- 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
- Understanding and Addressing Racial Trauma in Behavioral Health
- Your Role in Workplace Diversity

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 Attendees	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
Cultural Competence (Q4)	As workplaces become more diverse, effective, and successful employees must become more	30 min	*Direct Services *Direct Services Contractors *Administration *Interpreters	88	Oct – Dec 31 ,2020	Relias Learning Manager

Training Event	Description of Training	How long and often	Attendance by function	No. of Attendees	Date of Training	Name of Presenter
	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.					
Understanding and Addressing Racial Trauma in Behavioral Health (Q1)	This course moves beyond a discussion of diversity and cultural competence by exploring current research and best practices for identifying implicit bias, understanding cultural contexts, and effectively addressing racial trauma with clients.	1.5 hours	**Direct Services* **Direct Services Contractors* **Administration* **Interpreters*	107	Jan – March 2021	Relias Learning Manager
El Puente: Indigenous People of Oaxaca (Q2)	Participants learned about Indigenous Cultures from Oaxaca, Mexico, their heritage, cultural traditions, family structure, migration to the U.S., and how to reach and improve services to indigenous communities.	2 hours	**Direct Services* **Direct Services Contractors* **Administration* **Interpreters*	100	April -June 2021	Binational Center for the Development of Oaxacan Indigenous Communities

Training Event	Description of Training	How long and often	Attendance by function	No. of Attendees	Date of Training	Name of Presenter
Best Practices for Working with LGBTQ Children and Youth (Q2)	Participants received basic information on gender and sexual identities in LGBTQ+ children and youth to better inform their practice. This course also discussed the effects of institutional, cultural, and social discrimination on LGBTQ+ youth as well as the impact of complex trauma. It explored assessment practices, treatment models and methods for building resilience in LGBTQ+ children and youth.	1.25 hours	**Direct Services* **Direct Services Contractors* **Administration* **Interpreters*	81	April -June 2021	Relias Learning Manager
Your Role in Workplace Diversity (Q3)	Participants explored strategies to help them become aware of their attitudes toward diversity, how to increase their acceptance of diverse cultures, people, and ideas, and how to become an advocate for diversity within the workplace.	1 hour	**Direct Services* **Direct Services Contractors* **Administration* **Interpreters*	126	July – Sept 2021	Relias Learning Manager
Beyond the Binary (Q4)	To become more LGBTQ+ affirming.	2 hours	**Direct Services* **Direct Services Contractors* **Administration*	96	Oct – Dec 2021	Fresno Economic Opportunities

Training Event	Description of Training	How long and often	Attendance by function	No. of Attendees	Date of Training	Name of Presenter
			*Interpreters			Commission – LGBTQ Resource Center
Cultural Responsiveness in Clinical Practice (Q1)	*How Cultural responsiveness practice can have a positive effect on your service delivery*	*1.5 hours*	*Direct Services *Direct Services Contractors *Administration *Interpreters*	*68*	*Jan – Mar 2022*	*Relias Learning Manager*
Patient Cultural Competency for Non- Providers (Q1)	*How non provider staff's ability to deliver interactions in a culturally sensitive manner is critical to ensure all people in the community are satisfied with services provided.*	*1.0 hours*	*Direct Services *Direct Services Contractors *Administration *Interpreters*	*29*	*Jan – Mar 2022*	*Relias Learning Manager*
Latino MH Equity Summit (Q2)	*A forum to stimulate open learning/conversations of the MH needs and solutions for Latino Communities (multiple presenters)*	*5.0 hours*	*Direct Services *Direct Services Contractors *Administration *Interpreters*	*60*	*Apr – Jun 2022*	*Ana Nogales PhD/Sergio Aguilar-Gaxiola MD, PhD/Gustavo Loera EdD/Lupita Rodriguez MS/Arcenio Lopez/ Richard Cervantes PhD*
Using Communication Strategies to Bridge Cultural Divides (Q2)	*Learning how to deal with effectively with cultural difference to improve cross cultural communication and build rapport*	*0.50 hours*	*Direct Services *Direct Services Contractors *Administration *Interpreters*	*48*	*Apr – Jun 2022*	*Relias Learning Manager*
Understanding and Minimizing Cultural Bias for Paraprofessionals (Q3)	*Goal of course was to provide paraprofessionals in health/ human services with information/strategies on how to reduce the impact of cultural biases.*	*1.00 hours*	*Direct Services *Direct Services Contractors *Administration *Interpreters*	*108*	Jul -Sept 2022	*Relias Learning Manager*

**Q2 in person training cancelled, Q4 in person training moved to virtual platform due to COVID-19.*

The ESM met with staff in 2021 to better understand and support their needs and determine if they're struggling or need more support with any 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.

These populations continue to be underserved with low penetration rates and thus will continue to be populations addressed in our training schedule.

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, from 2020 through 2022, 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., nervous).
- 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.***

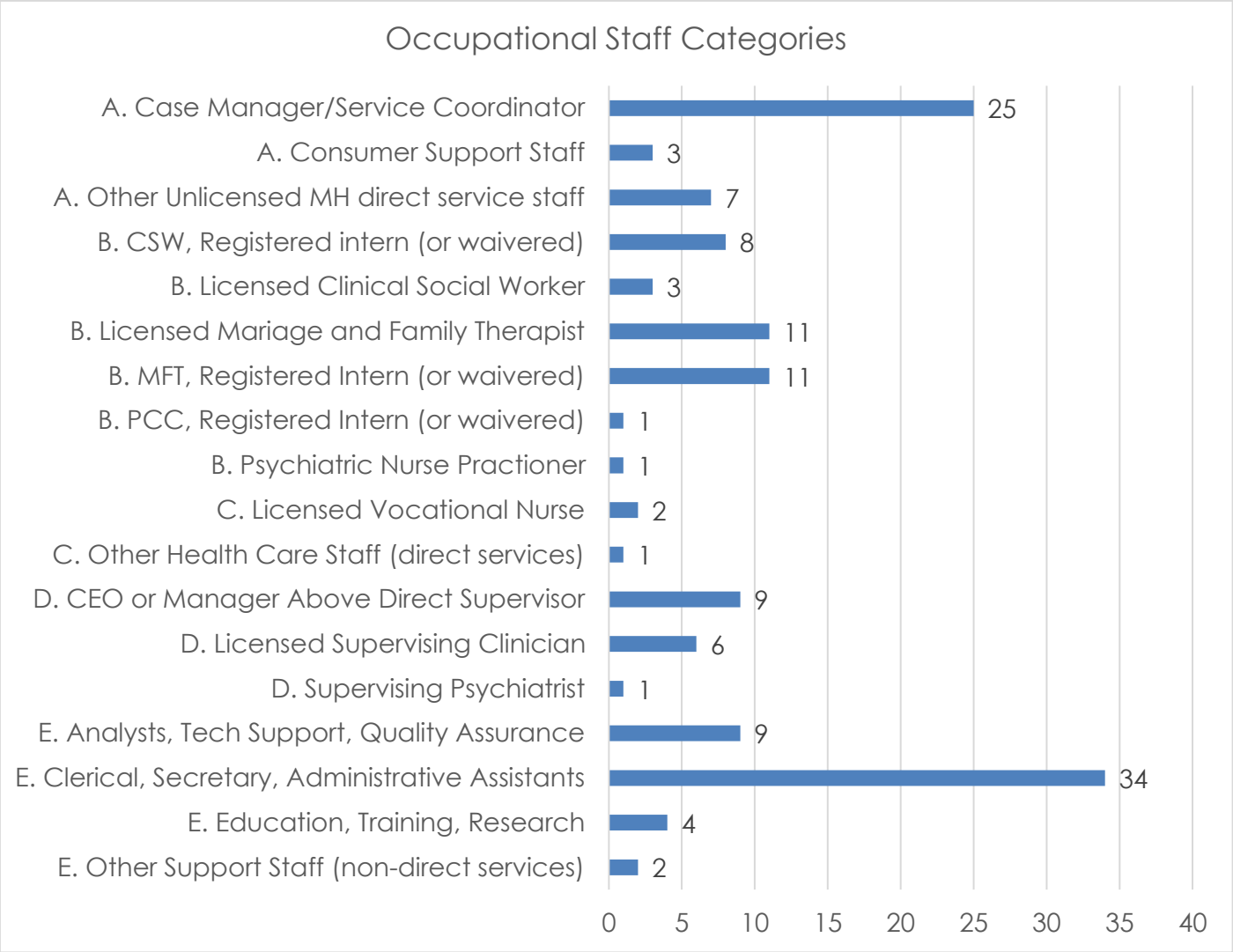
Getting another round perhaps next year, add more information.

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. MCDBHS currently has WET funds through CalMHSA for workforce development to continue with its efforts to maintain an appropriately diverse workforce. Continuous open recruitments of certain positions, incentive/grants programs, loan forgiveness and a university partnership program are efforts leveraged to make working for MCDBHS more enticing. In the past year MCDBHS has further incentivized employment as an employee retention strategy for hard-to-recruit positions and our rural Oakhurst location. Some of these incentives are a monthly incentive pay for employees regularly assigned to the Oakhurst clinic, streamline of bilingual pay for employees if requested by the department head, a retention bonus (one-time payment) and monthly incentive pay for classifications designated as hard-to-recruit. Clerical and Technical, Mid-Management and Professional Units are all part of the targeted areas. Some of the hard-to-recruit classifications include Supervising Mental Health Clinician, Licensed Clinician and Pre-Licensed Clinician. In the coming years MCDBHS plans to reassess positions where the strategies mentioned can be beneficial in staff retention.

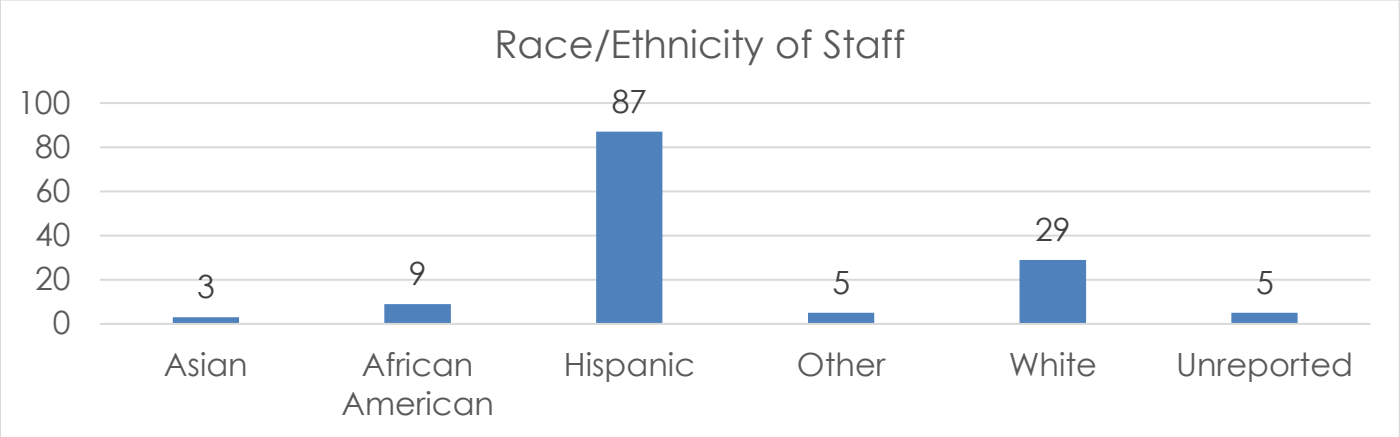
Table 6.1: Staff Occupation Categories



*As of October 2022. Source: Agency Staff List.

MCDBHS has 138 direct service providers employed as of October 2022. This is an increase of 7 from November 2021 when MCDBHS had a total of 131 direct service providers. This trend upward could be interpreted as a sign that our system of care is on the rebound inching closer to a total employment of 151 direct service providers in December of 2020.

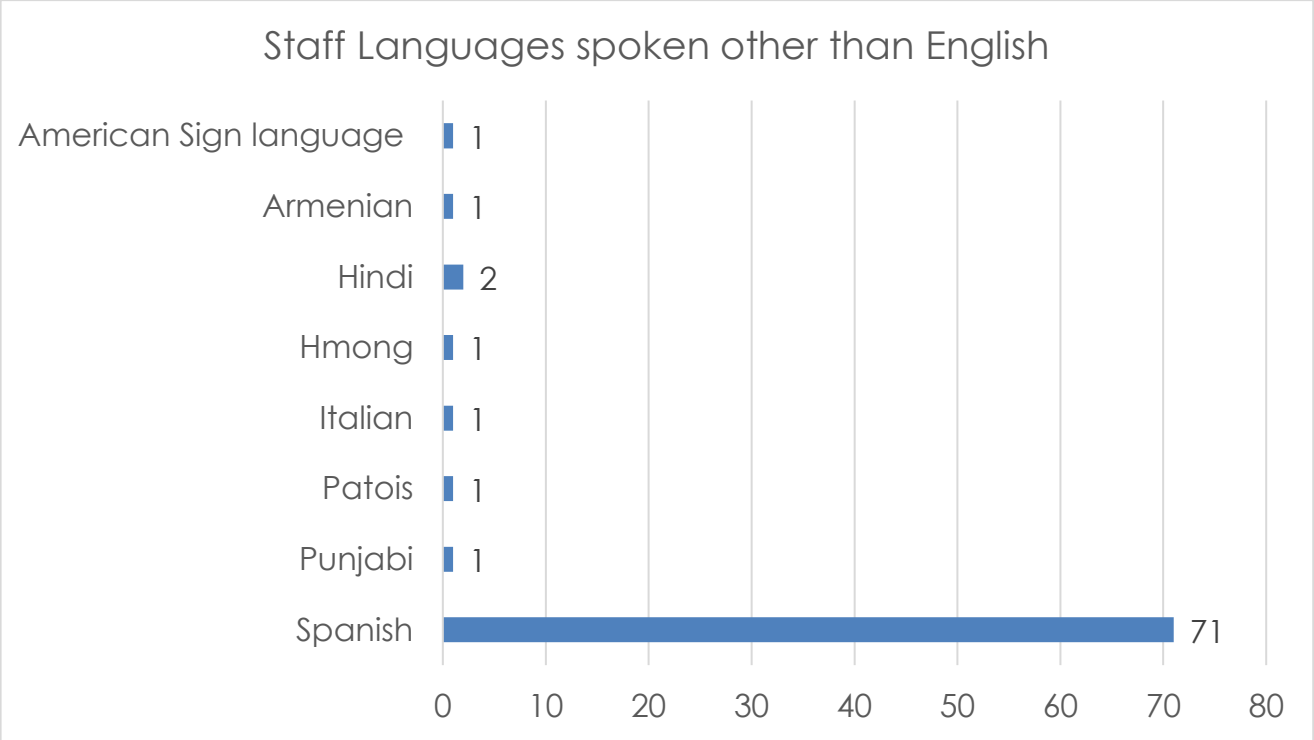
Table 6.2: Race & Ethnicity of Staff



*As of October 2022. Source: Agency Staff List.

In October 2022 compared to November 2021 there was an increase in the percentage of Hispanic/Latino staff from 62% to 63%. During the same time there was a decrease in the percentage of White staff from 22% to 21%.

Table 6.3: Staff Languages



*As of October 2022. Source: Agency Staff List.

A total of 79 of 138 employees reported speaking another language other than English which translates into 57.2% of MCDBHS' workforce who identify as bilingual with 51.4% being bilingual in the threshold language of Spanish.

Table 6.4: Compare the workforce assessment data with the general population, Medi-Cal population, and service data for Madera County

Race/Ethnicity	County Population	Medi-Cal Population	Medi-Cal Beneficiaries Served	County Staff	Direct Service	Non-Direct Service
White/Caucasian	48,906	13,096	656	29	17	12
Hispanic/Latino	96,013	53,230	982	87	52	35
Black/African American	3,526	1,511	92	9	6	3
Asian, Pacific Islander	3,749	1,282	15	3	2	1
Native American	866	467	18	0	0	0
Multi-Race, Other	6,350	N/A	N/A	N/A	N/A	N/A
Unknown, Other	N/A	9,637	218	5	4	1
TOTAL	159,410	79,223	1,981	133	81	52

In the past year the percentage of Hispanic/Latino staff had dropped by 1 percentage point at 63% which continues to be reflective of the Medi-Cal population which identifies as 67% Hispanic/Latino.

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

MCDBHS has WET funding through a regional contract with CalMHSA.

MCDBHS 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, Pre-Licensed clinicians and other continuous positions, 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, as of November 2022, there are 2 active interns in the Department. Madera County uses an MHSA stipend to support these students while

they complete their clinical internship with MCDBHS. The students are included in all supervision and trainings to give them the experience of working in Madera County with the hopes that it will encourage them to apply for positions with MCDBHS upon graduation. This has been an effective tool and a positive mutual relationship resulting in the hiring of several of these students upon graduation, allowing an increase in bilingual staff.

An additional strategy is a bilingual pay differential for staff certified through the County's Human Resource (HR) Department. Staff is encouraged to receive certification for the pay differential by streamlining the request process from MCDBHS to HR. MCDBHS has numerous bilingual staff members, who are a tremendous asset for our community by serving the Hispanic population 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 MCDBHS buildings, our posters, signage, and beneficiary handbooks inform clients of policies, procedures, and practices regarding their right to receive services in their preferred 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. Telephonic interpretation services are only utilized when other options are unavailable through a contract with CyraCom, LLC. A contract is also established with Centro Binacional

Para El Desarrollo Indígena Oaxaqueño (CBDIO) to help provide translation in Spanish and other indigenous Oaxacan languages and dialects. 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 Zapoteco 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 the public of their rights to receive language assistance services free of charge in their primary language. The beneficiary handbook also provides this information.

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

MCDBHS 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 and supported when the staff was polled and 73% of bilingual staff stated they would like a language identifier. CY 2021 was the first full year the language identifier was displayed.

We are working with our Human Resources Department to ensure that staff that identifies as bilingual and wish to provide interpreting services is certified and receives a stipend.

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

Since MCDBHS uses both bilingual staff and/or an interpreter service to accommodate clients who have Limited English Proficiency, some notable lessons are to increase interpreter training and ensure that bilingual staff is properly trained.

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.)*

No technical assistance needed at this time.

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.

MCDBHS 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 informing the public of this right. 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 to ensure ongoing services in their language are arranged for ahead of time.

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 (MCDBHS threshold language) is utilized during operating hours and contracted interpretation services through CyraCom, LLC and 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).

Staff who is identified as providers of interpreting services completes an interpreter training through our training portal Relias. The course titled, "The Role of the

Behavioral Health Interpreter" is assigned to staff and after the online completion they are assessed to ensure understanding which they must pass to complete the training and move forward in providing interpreter services.

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 who do not meet the threshold language criteria 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.

MCDBHS 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 services via the services brochures in our lobbies, the beneficiary handbook, posters, and flyers displayed at our provider sites.

Upon a beneficiary request, MCDBHS 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 available, 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 MCDBHS staff interpreter was offered free of charge, but they opted to use someone else against MCDBHS' advisement. The practice will be discouraged whenever possible and minor children will not be utilized as interpreters. If Spanish speaking staff is not available, CyraCom telephonic interpreting 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, √
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.

MCBHS has different programs for consumers which welcome everyone from different racial, ethnic, linguistic, and cultural background, they are:

- Community Outreach & Wellness Centers. MCDBHS partners with Turning Point Community Program which has two "drop-in-centers" called Hope House and Mountain Wellness Center. 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 and Mountain Wellness Center 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 awareness
        - 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 to 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 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.

- Paternal Mental Health Pilot Project, Project D.A.D, MCDBH is in the beginnings of its MHSA Innovation Plan partnership with Project D.A.D (Dads, Anxiety, & Depression). The services provided target the underserved populations with a preeminence on the barriers that males face when becoming a father. This unique model targets the mental health of new fathers to correlate with the mental health of an infant and mother to ensure the future success of the family component.
    - Some of the services and information provided include:
        - Meeting the needs of men, women, and infants
        - Supporting perinatal care for mothers/fathers
        - Focus on child support, DSS involvement and high schools
        - Assistance with impact of fatherhood
        - Trainings focused on fatherhood engagements strategies
        - Services available in Spanish
        - Communication skills

A strategy for 2023, included the tracking of how Cultural Competency is being

implemented within the Community Partners Programs. This will be tracked through quarterly progress meetings and progress reports for accountability.

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).

MCDBHS has two alternatives of cultural/linguistic services that are provided to the clients upon request. These 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. MCDBHS 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 MCDBHS 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: Brochures & Beneficiary Handbooks 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, MCDBHS 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 MCDBHS 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

MCDBHS 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 and substance abuse 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 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 MCDBHS Quality Assurance and Performance Improvement (QAPI) process, the Quality Improvement Committee (QIC) conducts regular monitoring activities regarding 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.

MCDBHS 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 Quality Improvement (QI) staff and presented to the QIC 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.