



**YOLO COUNTY
HEALTH & HUMAN SERVICES AGENCY**

CULTURAL COMPETENCE PLAN UPDATE



JANUARY 2018

Department of Health Care Services, Mental Health and Substance Use Disorder
Division (MHSUDS), Quality Assurance Section
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CRITERION 1

COUNTY MENTAL HEALTH SYSTEM

COMMITMENT TO CULTURAL COMPETENCE

I. County Mental Health System commitment to cultural competence

The county shall include the following in the Cultural Competence Plan Requirement (CCPR):

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

Yolo County Health and Human Services Agency (HHSA) and the County of Yolo are committed to a culturally competent and proficient system of care. The county's values statement encompasses this commitment of ongoing progress and excellence:

As Yolo County employees, we recognize this is a great place to live and work. We are committed to doing right by others through public service and maintaining the trust of our residents and peers. Together, we will continue to foster a healthy, supportive and professional environment, striving always for excellence.

HHSA's 2017-2018 Strategic Plan Goals reflect the commitment to cultural competence and addressing, recognizing and valuing racial, ethnic and cultural diversity. Strategic Plan Goals include objectives to reduce stigma and increase access to culturally responsive services.

- Goal 1: Improve Outcomes for Clients and Community
- Increase community-based access points for outpatient specialty mental health services.
- Goal 2: Ensure Fiscal Health
- Use mental health funding more efficiently by increasing use of community-based treatment options instead of hospitalizations.
- Goal 3: Strengthen Integration
- Develop and provide training on core topics, including eligibility for safety net programs, trauma-informed practices, mental health first aid, social determinants of health, fiscal issues, human resources and leadership.

- Goal 4: Make Data Informed-Decision and Create a Culture of Quality
- Advance “culture of quality” through implementation of quality improvement projects in all branches.

Yolo County HHSA has long-standing policies related to Cultural Competency. The Cultural Competence Committee and Quality Management program have focused recent activities on revising and creating new policies and procedures to better reflect and define the practices of cultural competence within the HHSA system.

The county shall have the following available on site during the compliance review:

- B. Copies of the following documents to ensure the commitment to cultural and linguistic competence services are reflected throughout the entire system:
1. Mission Statement;
 2. Statements of Philosophy;
 3. Strategic Plans;
 4. Policy and Procedure Manuals;
 5. Human Resource Training and Recruitment Policies;
 6. Contract Requirements; and
 7. Other Key Documents (Counties may choose to include additional documents to show system-wide commitment to cultural and linguistic competence).

Yolo County Health and Human Services Agency will have items available on-site during compliance review.

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

The CCPR shall be completed by the County Mental Health Department. The county will hold contractors accountable for reporting the information to be inserted into the CCPR.

The county shall include the following in the CCPR:

- A. A description, not to exceed two pages, of practices and activities that demonstrate community outreach, engagement, and involvement efforts with identified racial, ethnic, cultural, and linguistic communities with mental health disparities; including, recognition and value of racial, ethnic, cultural, and linguistic diversity within the system. That may include the solicitation of diverse input to local mental health planning processes and services development.

Yolo County Health and Human Services Agency (HHSA) is committed to ongoing activities to address the involvement and reduction of mental health disparities for underserved communities. These activities include:

Community Outreach

HHSA's Outreach/Benefits Specialists and staff members from a variety of other programs participate in community-based cultural events to build trust, provide resources and develop relationships with diverse populations within Yolo County. Community Outreach activities during 2017, followed by the racial/ethnic breakdown of participants, included:

1. Food Bank Outreach, West Sacramento – 11/21/17, 64 total (16 Hispanic/Latino, 13 Russian, 9 Black/African American, 19 Caucasian, 5 Asian/Pacific Islander, 2 Other).
2. Binacional Health Council, Woodland – 10/15/17, 120 total (120 Hispanic/Latino);
3. Senior Center, Woodland – 10/12/17, 311 total (89 Hispanic, 12 Black/African American, 201 Caucasian, 2 Alaskan Native/American Indian, 7 Asian/Pacific Islander);
4. Yolo County Fair, Woodland – 9/30/17, 260 total (99 Hispanic, 45 Black/African American, 80 Caucasian, 36 Asian/Pacific Islander); and
5. Special Needs Family Day, West Sacramento – 5/6/17, 130 total (106 Russian, 4 Hispanic/Latino, 1 Other and 19 Caucasian);
6. Senior Resource Faire, West Sacramento – 5/5/17, 140 total (86 Caucasian, 13 Black/African American, 6 Hispanic/Latino, 11 Alaskan Native/American Indian, 18 Asian/Pacific Islander, 1 Other and 5 Russian);
7. Health Faire, Madison Migrant Center – 4/30/17, 43 total (43 Hispanic/Latino);
8. Health Faire, Davis Migrant Center – 4/23/17, 153 total (153 Hispanic/Latino);
9. Health Faire, Empower Yolo, Woodland – 4/20/17, 147 total (88 Hispanic/Latino, 8 African American, 45 Caucasian, 6 Asian/Pacific Islander);
10. Spring Fling Event, Housing Authority, Woodland – 4/10/17, 94 total (71 Hispanic/Latino, 3 Caucasian, 5 Alaskan Native/American Indian, 2 Asian/Pacific Islander, 13 – Other/Unknown);
11. Food Bank Outreach, West Sacramento- 2/8/17, 106 total (22 Hispanic/Latino, 17 Russian, 10 Black/African American, 45 White, 5 Alaskan Native/American Indian, 7 Asian/Pacific Islander);

Engagement and Involvement Efforts

Quality Improvement Committee (QIC) provides an important forum for input to the local mental health planning process. Within the last year, QIC has employed efforts to increase participation from clients, family members and community members from underserved populations. Increased participation from provider agencies has also assisted in providing diverse input and feedback from staff members, including perspectives from clients served in community-based settings.

The Mental Health Services Act (MHSA) Community Stakeholder Process continues to offer open opportunities for individuals of all racial, cultural and ethnic communities to participate in planning processes and services development. Community Planning Activities for the current MHSA Three Year Program included input and review from the following forums:

1. Local Mental Health Board;
2. Community Corrections Partnership;
3. Board of Supervisors;
4. Focus Groups – Homeless, Community-Based Organization (CBO) Adult, CBO Youth/Children, National Alliance for the Mentally Ill (NAMI) Family Members, Latino-Esparto, Lesbian Gay Bisexual Transgender Queer (LGBTQ), Peer Support Worker and Latino-West Sacramento;
5. Planning Summits - System of Care Summits, MHSA Component Planning Summit, MHSA Annual Updates; and
6. Stakeholder Surveys – Russian Intercept Survey, Consumers and Family Module and Parents with Minor Children Module.

- B. A narrative description, not to exceed two pages, addressing the county's current relationship with, engagement with, and involvement of, racial, ethnic, cultural, and linguistically diverse clients, family members, advisory committees, local mental health boards and commissions, and community organizations in the mental health system's planning process for services.

Local Mental Health Board

The Yolo County Local Mental Health Board meets monthly and is a critical entity in the behavioral health system's planning process. The Local Mental Health Board has dedicated members, including peers, family members of people with mental illness, mental health professionals, and individuals from a variety of other backgrounds. The Board provides guidance to HHS on issues regarding mental health, substance use disorders, and public guardianship. Activities include public forums and site visits throughout the county to residences and facilities where peers live and receive services.

Provider Stakeholder Workgroup

The Provider Stakeholder Workgroup (PSWG) has scheduled monthly meetings and is attended by behavioral health services contract providers

and HHS staff. The goal of PSWG is to collaborate on the efficient and appropriate use of resources, to maintain communication and transparency and, to promote high quality services to Yolo's vulnerable populations served and supported by HHS and its providers.

Cultural Competence Committee

The Cultural Competence Committee (CCC) and the CCC's LGBTQ+ Workgroup provide important feedback and guidance for behavioral health service delivery. The Committee and Workgroup have dedicated energy and resources to engage culturally diverse membership and perspectives during the past year. Meetings, extended discussions and hosted trainings/events have assisted in the goals of reducing stigma and increasing access for diverse populations and identifying program and service recommendations and concerns.

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

HHS has continued to provide activities to help ensure the skill development and strengthening of community organizations. The monthly PSWG meeting and PSWG communications (emails, etc.) provide a forum for information sharing, planning and discussion. Also, the Early Periodic Screening, Diagnostic, and Treatment (EPSDT) Provider meetings and System Utilization Review (SUR) meetings help ensure clinically sound, culturally appropriate and responsive services through triage, planning and resource coordination.

Trainings to community organizations have included:

1. Serving Spanish-Speaking Populations (12/7/17);
2. Serving Individuals with Military Experience (11/2/17);
3. Communicating Effectively with Diverse Populations; Serving the LGBTQ+ Communities (10/10/17);
4. Serving the LGBTQ+ Populations (9/7/17, 4/21/17 and 3/31/17);
5. Understanding the Diversity and Needs of Russian-Speaking Immigrants and Communities (6/1/17, 4/21/17, 3/30/17 and 2/10/17);
6. Law and Ethics for Behavioral Health Care Providers (5/10/17);
7. Client Culture: Recovery, Resiliency and Wellness (5/4/17); and
8. The DSM 5: A Dimensional and Holistic Framework for Diagnosing (3/7/17);

CCC meetings, activities and monthly email updates provide other important skill development and strengthening of community organizations. Email updates provide information regarding local training and cultural competence activities. Special CCC Workgroup and/or Extended Discussions have included:

1. Mental Health and Spirituality;
2. Cultural Competent Policies and Procedures;
3. LGBTQ+ Workgroup Meetings with extended discussions:
 - a. foster care youth and families; and
 - b. training and supervision needs for professional staff.

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

While numerous programs, services and efforts were implemented or initiated during this past year, several lessons learned will guide goals and activities for 2018. These include:

1. Gaining trust and rapport with diverse cultural groups will continue to require more non-traditional and community-based strategies; and
2. Despite the desire and willingness of staff and stakeholders to participate in Cultural Competence activities, there is an ongoing dilemma of prioritizing time to participate and fulfill other important work responsibilities, including direct service activities with clients.

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

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

The county shall include the following in the CCPR:

- A. Evidence that the County Mental Health System has a designated CC/ESM who is responsible for cultural competence and who promotes the development of appropriate mental health services that will meet the diverse needs of the county's racial, ethnic, cultural, and linguistic populations.

Theresa Smith, LCSW has been the designated CC/ESM since October 1, 2016. She has been a Manager with Yolo County since 2006 and has continued her ongoing participation on the Behavioral Health Management Team. She chairs the CCC and facilitates Cultural Competence trainings and activities for staff, providers and other stakeholders. She also serves as the MHS Workforce, Education and Training (WET) Coordinator.

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

The cultural competence responsibilities of the CC/ESM include:

1. Development of the state-mandated Cultural Competence Plan Requirement (CCPR), as well as yearly updates;
2. Oversee, coordinate and chair the Cultural Competence Committee;
3. Provide Cultural Competence Committee updates to the Quality Improvement Committee (QIC);
4. Provide leadership and consultation through ongoing policy identification and analysis, advocacy, and collaboration with federal, state, and local, and community based organizations to ensure delivery of culturally and linguistically appropriate services;
5. Attend trainings that inform, educate, and develop the unique skills necessary to enhance the understanding and promotion of cultural competence in the behavioral health system;
6. Ensure compliance with the California Mental Health Plan Cultural Competence requirements and identify and facilitate implementation of cultural competence best practices;
7. Identify resources available, and funding opportunities for culturally competent services;
8. Participate in the development of criteria and guidelines that ensure the infusion of cultural competency in all trainings;
9. Participate and advise in planning, policy, and quality improvement recommendations to county leaders to ensure that diverse groups have access to appropriate services;
10. Interface with Language Line Services, and contracted interpreter services to make sure HHSa is using the service appropriately, and to obtain products and services that will augment the cross-cultural resources of HHSa; and
11. Provide cultural competency information, technical assistance, training and consultation as requested.

IV. Identify budget resources targeted for culturally competent activities
The county shall include the following in the CCPR:

A. Evidence of a budget dedicated to cultural competence activities.

Several budget line items are targeted for cultural competent activities. The following positions are examples and evidence of staff dedicated to the implementation of culturally competent activities:

1. Cultural Competence/Ethnic Services Manager (.50 FTE)

2. LGBTQ Initiative (.25 FTE);
3. Outreach/Benefits Specialists (2.5 FTE);
 - a. Spanish Bilingual;
 - b. Russian Bilingual;
 - c. Family Partner; and
4. Bilingual staff pay differential.

Additional budget targeted to cultural competence activities include:

Interpreter Services: Language Line (fee for service)	\$1,561.34
MH Services for Deaf and Hard of Hearing (NorCal Services)	\$35,000
TAY Wellness Center Services	\$280,000
TAY Speaker Bureau	\$25,000
Early Childhood Mental Health Access and Linkage Program	\$225,000
School-Based Access and Linkage Program – Rural Districts	\$120,000
School-Based Access and Linkage Program – Urban Districts	\$200,000
Peer and Family Led Support Services	\$100,000
Integrated Behavioral Health Services for Latino Community and Families	\$257,500
Senior Peer Counselor Volunteers	\$50,000
LGBTQ+ Cultural Competency Initiative	\$50,000
Clinical Internship Program	\$80,000

- B. A discussion of funding allocations included in the identified budget above in Section A., also including, but not limited to, the following:

Interpreter and translation services;
 Reduction of racial, ethnic, cultural, and linguistic mental health disparities;
 Outreach to racial and ethnic county-identified target populations;
 Culturally appropriate mental health services; and
 If applicable, financial incentives for culturally and linguistically competent providers, non-traditional providers, and/or natural healers

Interpreter and translation services

Staff members are paid bilingual pay supplement which allows direct service and administrative support staff to provide linguistically appropriate services. Level 1/Interpreter staff members are paid an additional 55 cents per hour and Level 2/Translation staff members are paid an additional 70 cents per hour.

Language Line Services are utilized when bilingual staff members are not available. Language Line Services are provided at a rate of .90 per minute for all languages. From January 2016 through October 2017, a cost of \$1,561.34 was incurred for utilization of the services. Behavioral health staff members utilized Language Line Services for the provision of services in the following languages:

1. Spanish
2. Russian
3. Punjabi
4. Cantonese
5. Cambodian
6. Vietnamese
7. Amharic
8. Korean
9. Tagalog
10. Romanian

Outreach to racial and ethnic county-identified target populations

Two Outreach/Benefits Specialists, who are bilingual/bicultural (Spanish-speaking and Russian-speaking), assist the un-served, un-insured and/or low income consumers with mental health conditions to access benefits and services, thereby removing barriers to mental health treatment. The Family Partner/Outreach Specialist has been instrumental in providing assistance to families accessing mental health services and to multi-cultural and diverse populations including children and youth, TAY, rural, and foster youth.

Reduction of racial, ethnic, cultural, and linguistic mental health disparities/Culturally appropriate mental health services

A multitude of programs have been implemented to address the mental health disparities that exist for a variety of racial, ethnic, cultural and linguistic communities. The programs identified in Section A provide outreach and engagement activities and services to improve access and/or provide services for persons who are Latino, LGBTQ+, 0-5, Children, TAY and Older Adults. Please see program descriptions in Criterion 3 section.

CRITERION 2
COUNTY MENTAL HEALTH SYSTEM
UPDATED ASSESSMENT OF SERVICE 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.

I. General Population

The county shall include the following in the CCPR:

Summarize the county's general population by race, ethnicity, age, and gender. 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).

Population	
Population estimates, July 1, 2016, (V2016)	215,802
Age and Sex	
Persons under 5 years, percent, July 1, 2016, (V2016)	5.8%
Persons under 18 years, percent, July 1, 2016, (V2016)	21.3%
Persons 65 years and over, percent, July 1, 2016, (V2016)	12.1%
Female persons, percent, July 1, 2016, (V2016)	51.3%
Race and Hispanic Origin	
White alone, percent, July 1, 2016, (V2016)(a)	75.0%
Black or African American alone, percent, July 1, 2016, (V2016)(a)	2.9%
American Indian and Alaska Native alone, percent, July 1, 2016, (V2016)(a)	1.8%
Asian alone, percent, July 1, 2016, (V2016)(a)	14.6%
Native Hawaiian and Other Pacific Islander alone, percent, July 1, 2016, (V2016)(a)	0.6%
Two or More Races, percent, July 1, 2016, (V2016)	5.2%
Hispanic or Latino, percent, July 1, 2016, (V2016)(b)	31.5%
White alone, not Hispanic or Latino, percent, July 1, 2016, (V2016)	47.3%
Population Characteristics	
Veterans, 2012-2016	8,827
Foreign born persons, percent, 2012-2016	22.2%
Income & Poverty	
Persons in poverty, percent	19.0%

II. Medi-Cal population service needs (Use current CAEQRO data if available.)

The county shall include the following in the CCPR:

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

Please see Calendar Year 2015 data by Age, Gender and Race/Ethnicity based on Medi-Cal Approved Claims Data. Data on language not included on CAEQRO report.

	YOLO					MEDIUM		STATEWIDE	
	Average Number of Eligibles per Month (4)	Number of Beneficiaries Served per Year	Approved Claims	Penetration Rate	Approved Claims per Beneficiary Served per Year	Penetration Rate	Approved Claims per Beneficiary Served per Year	Penetration Rate	Approved Claims per Beneficiary Served per Year
TOTAL									
	44,080	1,511	\$6,470,006	3.43%	\$4,282	4.31%	\$5,943	4.82%	\$5,522
AGE GROUP									
0-5	7,502	40	\$92,461	0.53%	\$2,312	1.56%	\$4,248	2.12%	\$4,129
6-17	14,207	444	\$1,813,825	3.13%	\$4,085	5.07%	\$6,388	6.14%	\$6,490
18-59	16,721	845	\$4,020,513	5.05%	\$4,758	5.19%	\$5,824	5.55%	\$5,048
60 +	5,651	182	\$543,207	3.22%	\$2,985	3.38%	\$5,796	2.94%	\$4,395
GENDER									
Female	24,239	799	\$3,575,514	3.30%	\$4,475	4.00%	\$5,624	4.38%	\$5,079
Male	19,841	712	\$2,894,492	3.59%	\$4,065	4.69%	\$6,277	5.36%	\$5,971
RACE/ETHNICITY									
White	11,918	742	\$3,177,471	6.23%	\$4,282	6.51%	\$6,127	7.68%	\$5,698
Hispanic	19,725	336	\$1,094,014	1.70%	\$3,256	2.80%	\$5,287	3.49%	\$5,045
African-American	1,879	120	\$517,781	6.39%	\$4,315	7.16%	\$5,819	8.47%	\$5,839
Asian/Pacific Islander	4,702	72	\$228,220	1.53%	\$3,170	2.60%	\$5,057	2.57%	\$4,862
Native American	318	25	\$70,783	7.86%	\$2,831	6.71%	\$6,230	7.51%	\$5,804
Other	5,540	216	\$1,381,737	3.90%	\$6,397	6.24%	\$7,387	5.83%	\$6,434

- The overall penetration rate (3.64%) is approximately 45% lower than the medium-sized MHP average (6.60%) and the statewide average (6.56%)
 - The Yolo County penetration rate is lower than the medium-county and statewide averages for all race/ethnicity categories, except for Native American beneficiaries;
 - The penetration rate for Hispanic beneficiaries (1.70%) is 39.3% lower than the medium MHP average (2.8%) and less than half the statewide average (3.49%). This reflects the largest disparity in access across race/ethnic groups;
 - The penetration rates for youth ages 0-5 and 6-17 are disproportionately lower than other age groups (0-5: 0.53% and 6-17: 3.13%) when compared to medium MHP (0-5: 1.56% and 6-17: 5.07%) and statewide (0-5: 2.12% and 6-17: 6.14%) averages;
 - The penetration rate for Foster Care Youth (32.83%) is approximately two-thirds lower than medium sized counties (48.98%) and lower than the statewide average (47.19%); and
 - In Yolo County, penetration rates by for females (3.30%) are 8.80% lower than for males (3.59%), compared to 14.7% lower for medium-sized MHPs (4.00% vs. 4.69%) and 18.3% lower for statewide averages (4.38% vs. 5.36%);
- The overall approved claims per beneficiary served (\$4,282) is 27.9% lower than the medium-sized MHP average (\$5,943) and 22.4% lower than the statewide average (\$5,522)
 - The overall approved claims per beneficiary served in Yolo County is significantly lower than the medium-county and statewide averages for all race/ethnicity categories;
 - The approved claims per beneficiary served for Hispanic beneficiaries (\$3,256) is 38.4% lower than the medium MHP average (\$5,287) and (36%) less than the statewide average (\$5,045);
 - The approved claims per beneficiary served for youth ages 0-5 and 6-17 are disproportionately lower than other age groups (0-5: \$2,312 and 6-17: \$4,085) when compared to medium MHP (0-5: \$4,248 and 6-17: \$6,388) and statewide (0-5: \$4,129 and 6-17: \$6,490) averages;

- The approved claims per beneficiary served for Foster Care Youth (\$4,951) is approximately 40% lower than medium sized counties (\$8,324) and the statewide average (\$8,127); and
- In Yolo County, approved claims per female beneficiary served (\$4,475) are 10% higher than for males (\$4,065). Conversely, approved claims for female beneficiaries served are 10% lower in medium-sized MHPs (\$5,624 vs. \$6,277) and 14.9% lower for statewide averages (\$5,079 vs. \$5,971).

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

The county shall include the following in the CCPR:

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

Note: The following 2007 200% of poverty data were accessed at the DHCS website on the following page:

<http://www.dhcs.ca.gov/provgovpart/Documents/CaliforniaPrevalenceEstimates.pdf> within the link titled "Severe Mental Illness (SMI) Prevalence Rates"

County Estimates of Need for Mental Health Services for Yolo County – SMI Definition All Ages

Total Population				Household Population			Households below 200% poverty		
Total Pop	Cases	Pop	Percent	Cases	Pop	Percent	Cases	Pop	Percent
Total Population	10,199	199,407	5.11	9,567	190,831	5.01	5,360	70,111	7.64
Youth Age 0-17									
Youth total	3,780	50,914	7.42	3,721	50,419	7.38	1,798	20,291	8.86
AGE									
00-05	1,172	15,662	7.48	1,171	15,652	7.48	595	6,704	8.88
06-11	1,117	15,019	7.44	1,107	14,921	7.42	521	5,867	8.88
12-17	1,492	20,233	7.37	1,443	19,845	7.27	682	7,720	8.83
GENDER									
Male	1,918	25,821	7.43	1,886	25,580	7.37	914	10,343	8.84
Female	1,862	25,092	7.42	1,835	24,839	7.39	884	9,948	8.88

Total Pop	Cases	Pop	Percent	Cases	Pop	Percent	Cases	Pop	Percent
ETHNICITY									
White-NH	1,502	21,547	6.97	1,488	21,443	6.94	519	5,940	8.74
African Am-NH	122	1,415	8.61	116	1,358	8.55	78	844	9.2
Asian-NH	397	5,025	7.9	385	4,937	7.79	243	2,649	9.19
Pacific I-NH	27	327	8.27	26	318	8.18	15	159	9.18
Native-NH	20	269	7.34	19	267	7.27	8	90	8.83
Other-NH	0	0	0	0	0	0	0	0	0
Multi-NH	160	2,144	7.46	158	2,132	7.4	65	689	9.37
Hispanic	1,553	20,187	7.69	1,529	19,963	7.66	871	9,921	8.78
POVERTY LEVEL									
Below 100%	882	8,819	10	872	8,722	10	872	8,722	10
100%-199%	926	11,570	8	926	11,570	8	926	11,570	8
200%-299%	633	9,040	7	633	9,040	7	0	0	0
300%+ pov	1,228	20,458	6	1,228	20,458	6	0	0	0
Undefined	113	1,027	10.99	63	629	10	0	0	0
RESIDENCE									
Household	3,721	50,419	7.38	3,721	50,419	7.38	1,798	20,291	8.86
Institution	22	108	20	0	0	0	0	0	0
Group quarters	38	386	9.76	0	0	0	0	0	0
Adult 18+									
Adult Total	6,419	148,493	4.32	5,846	140,412	4.16	3,562	49,819	7.15
AGE									
18-20	355	14,556	2.44	265	11,274	2.35	220	7,323	3.01
21-24	1,323	24,112	5.49	1,200	22,083	5.43	1,028	15,329	6.71
25-34	1,242	22,391	5.54	1,155	21,825	5.29	700	7,698	9.1
35-44	1,490	24,216	6.15	1,397	23,655	5.91	776	6,734	11.52
45-54	1,056	24,715	4.27	1,007	24,365	4.13	398	3,939	10.11
55-64	586	18,918	3.1	552	18,647	2.96	289	4,056	7.12
65+	367	19,585	1.88	270	18,564	1.45	150	4,741	3.16
GENDER									
Male	2,531	72,090	3.51	2,282	67,942	3.36	1,316	22,660	5.81
Female	3,887	76,404	5.09	3,564	72,470	4.92	2,246	27,159	8.27
ETHNICITY									
White-NH	3,785	83,717	4.52	3,446	79,394	4.34	1,940	22,331	8.69
African Am-NH	287	3,963	7.23	214	3,436	6.22	149	1,543	9.63
Asian-NH	407	17,899	2.28	376	16,519	2.28	300	8,842	3.39
Pacific I-NH	16	757	2.15	16	732	2.12	8	211	3.88
Native-NH	71	1,114	6.39	59	1,034	5.71	27	281	9.49
Other-NH	0	0	0	0	0	0	0	0	0
Multi-NH	202	3,347	6.03	191	3,067	6.22	137	1,561	8.8
Hispanic	1,650	37,696	4.38	1,545	36,230	4.26	1,001	15,051	6.65

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

Youth Age 0-17

The 0-5 and 6-11 age groups show the highest percent (8.88) of households below the 200% poverty level. For the 12-17 age group, the percent rating reflected 8.83.

- Native American or Alaskan Native, African American, Asian and Pacific Islander reflect the highest percent of households below the 200% poverty level;
- Male (8.84) and Female (8.88) demonstrated close percent ratings.

The data continue to support the need to focus on outreach, linkage and services to address the mental health needs of children and youth in Yolo County. Culturally competent strategies and services are required to address varied cultural and ethnic groups.

Adult 18+

Adults 25-54 show the greatest disparity when comparing general household populations to households below the 200% poverty level (Ages 25-34, 5.29 vs. 9.1; Ages 35-44, 5.91 vs 11.52 and Ages 45-54, 4.13 vs 10.11).

- Females reflect the highest percent and need in both the general household population (4.92) and households below the 200% poverty level (8.27);
- African Americans reflected the highest need percent in households below the 200% poverty level;
- Native American or Alaskan Native cultural group reflected the second highest prevalence need for households below the 200% poverty level. Also this group demonstrated the greatest disparity between household population (5.71) and households below the 200% poverty level (9.49); and
- Whites also reflected a greater disparity between the general household populations (4.34) and households below the 200% poverty level (8.69).

An analysis of the data substantiates the mental health needs of the adult population who are low income and experience life situations impacting socio-economic status. Outreach and services for adults must include culturally responsive strategies for Native Americans or Alaskan Natives, Whites and African Americans.

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

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

The county shall include the following in the CCPR:

- A. From the county's approved CSS plan, extract a copy of the population assessment. If updates have been made to this assessment, please include the updates. Summarize population and client utilization data by race, ethnicity, language, age, and gender (other social/cultural groups may be addressed as data is available and collected locally).

Please see appendix for excerpts from county's approved CSS plan previously submitted.

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

Please see appendix for the most recent population assessment completed. Please note that updated assessment and service needs were identified during Community Program Planning (CPP) process for the MHSA Three-Year Program and Expenditure Plan 2017-2020 in September 2016.

A summary of 2016-2017 CSS implemented programs is noted below:

Program (Component)	Ages Served	Description	Provider	# served
Children's Mental Health Services (CSS)	0-15	Full Service Partnership (FSP): Services for children with the highest level of mental health need.	Turning Point	21
		System Development (SD): Selective services for severely mentally ill consumers.	HHSA	3
		Outreach and Engagement: Strategy to help identify and connect children and families in need of services.	HHSA	119
Pathways to Independence, Transition-Age-Youth (CSS)	16-25	Full Service Partnership (FSP): Services for TAY children with the highest level of mental health need.	HHSA/ Turning Point	19
		System Development (SD): Services for TAY with a mild to moderate mental health need.	HHSA	39
		Outreach and Engagement: Strategy to help identify and connect TAY and families in need of services.	HHSA	165

Program (Component)	Ages Served	Description	Provider	# served
Adult Wellness Alternatives (CSS)	25-59	Full Service Partnership (FSP): Services for adults and older adults with the highest level of mental health need.	HHSA/ Turning Point	105
		System Development (SD): Services for adult and older adults with a less intensive level of need.	HHSA	242
		Outreach and Engagement: Strategy to help identify adult and older consumers in need of services.	HHSA	1,018
Older Adult Outreach and Assessment (CSS)	60 +	Full Service Partnership (FSP): Services for older adults with the highest level of mental health need.	HHSA	27
		System Development (SD): Services for older adults with a mild to moderate mental health need.	HHSA	97
		Outreach and Engagement: Strategy to help identify and connect older adults to services.	HHSA	165
Access to Care for Homeless and Indigent (ACHIP) (CSS)	18 +	System Development and Outreach and Engagement: Services and outreach support for individuals who are uninsured/underinsured, homelessness, and/or have recently been released from the hospital or jail.	YCCC	52
Free to Choose (CSS)	18 +	System Development (SD): Harm reduction services for consumers with co-occurring disorders.	Turning Point	68

Note: Objectives will be identified in Criterion 3, Section III.

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

The county shall include the following in the CCPR:

- A. Which PEI priority population(s) did the county identify in their PEI plan? The county could choose from the following six PEI priority populations:
- Underserved cultural populations
 - Individuals experiencing onset of serious psychiatric illness
 - Children/youth in stressed families
 - Trauma-exposed
 - Children/youth at risk of school failure
 - Children/youth at risk or experiencing juvenile justice involvement
- B. Describe the process and rationale used by the county in selecting their PEI priority population(s) (e.g., assessment tools or method utilized).

Yolo County's identified PEI Priority populations are:

1. Children, Ages 0-5
2. Children, Ages 6-18
3. Transition Age Youth, Ages 16-25
4. Older Adults
5. Latino children, youth and families, especially in rural areas
6. Lesbian, Gay, Bisexual, Transgender and Queer/Questioning populations

The priority PEI populations were identified via the MHSA Community Planning Process and the resulting Community Needs Assessment Findings. Stakeholders provided input regarding community needs as well as suggestions for how Yolo might strengthen MHSA services for county residents.

CRITERION 3

COUNTY MENTAL HEALTH SYSTEM

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).

Note: As counties continue to use this CCPR as a logic model, counties will use their analyses from Criterion 2, to respond to the following:

I. Identified unserved/underserved target populations (with disparities):

The county shall include the following in the CCPR:

- Medi-Cal population
 - Community Services Support (CSS) population: Full Service Partnership population
 - Workforce, Education, and Training (WET) population: Targets to grow a multicultural workforce
 - Prevention and Early Intervention (PEI) priority populations: These populations are county identified from the six PEI priority populations
- A. List identified target populations, with disparities, within each of the above selected populations (Medi-Cal, CSS, WET, and PEI priority populations).

Medi-Cal

- Hispanic
- Children, 0-5
- Children/Youth, 6-17
- Other Category – Race/Ethnicity/Multi-Cultural
- Native American
- Asian/Pacific Islander
- African-American
- White
- Male

CSS

- Children/Youth, 0-17 with serious emotional disturbance
- Transition Age Youth, 16-25 with serious emotional disturbance and/or serious mental illness
- Adults, 26-59 at risk of incarceration, hospitalization and/or homelessness
- Older Adults, 60+ at risk of incarceration, hospitalization and/or homelessness

WET

- Psychiatrists
- Bilingual and Bicultural staff to address needs of diverse client populations including Latino/Hispanic and Russian-speaking populations
- Culturally competent trained staff for diverse cultural, racial and ethnic populations
- LGBTQ+ trained staff with expert supervision
- Career pathways, training and support for consumers/peers and family members
- Diverse staff to increase the availability of home and community based clinical services.

PEI

- Children, Ages 0-5
- Children, Ages 6-18
- Transition Age Youth, Ages 16-25
- Older Adults
- Latino children, youth and families, especially in rural areas
- Lesbian, Gay, Bisexual, Transgender and Queer/Questioning populations (LGBTQ+)

1. From the above identified PEI priority population(s) with disparities, describe the process and rationale the county used to identify and target the population(s) (with disparities).

The priority PEI populations were identified via the MHSA Community Planning Process and the resulting Community Needs Assessment Findings. Stakeholders provided input regarding community needs as well as suggestions for how Yolo might strengthen MHSA services for county residents.

II. Identified disparities (within the target populations)

The county shall include the following in the CCPR:

- A. List disparities from the above identified populations with disparities (within Medi-Cal, CSS, WET, and PEI's priority/targeted populations).

Medi-Cal

When compared to other medium sized counties and statewide penetration rates, disparities in access are seen among Hispanic, African American, White, Asian/Pacific Islander and Other/Multi-Racial cultural groups. While the penetration rate for Native American beneficiaries exceeds the medium-sized MHP and statewide averages, the actual numbers of beneficiaries served is too small to draw meaningful conclusions. Regarding age groups, greatest disparities existed for 0-5 and 6-17 age groups, but all other age groups were below the medium size county's penetration rates.

CSS

CSS programs and services have been expanded to address the identified disparities across all age group populations in related racial/ethnic, linguistic, socio-economic disparities. As previously reported, penetration rates for Yolo reflect overall lower penetration rates compared to other medium-sized counties as well as statewide averages.

WET

The greatest staff shortage exists for psychiatrists. While numbers have improved for other job classifications, there remains a need to increase bi-lingual and bi-cultural staff members and increase the cultural competency level of all staff members, peers/consumers and family members.

PEI

As reflected in Medi-Cal findings, Children, Transition Age Youth and Latino/Hispanic cultural groups demonstrate the greatest disparity in access and need for services. LGBTQ+ is another priority PEI population due to lack of trained staff, LGBTQ+ local services and current insufficient data collection mechanisms. Stakeholders also identify Older Adults as a priority PEI population.

III. Identified strategies/objectives/actions/timelines

The county shall include the following in the CCPR:

- A. List the strategies identified in CSS, WET, and PEI plans, for reducing the disparities identified.
- B. List the strategies identified for each targeted area as noted in Criterion 2 in the following sections:

- I. Medi-Cal population
- II. 200% of poverty population
- III. MHSA/CSS population
- IV. PEI priority population(s) selected by the county, from the six PEI priority populations

Medi-Cal/200% of Poverty Populations

Outreach and engagement strategies for these populations require non-traditional and culturally inclusive efforts. Increasing community based and co-located mental health services are access strategies targeted for implementation in the current MHSA Plan. In addition, there is a prioritized strategy to provide bilingual/bicultural outreach and mental health services. Enhancing the cultural competency of all staff members provides an important component to addressing disparities with this population, which also includes identifying and facilitating connections with healing alternatives and culture specific providers when needed.

CSS/MHSA CSS Population

The following CSS programs and strategies have been developed to reduce the disparities with identified target and underserved populations:

Children's Mental Health Services

The Children's Mental Health (CMH) Program provides Outreach and Engagement, System Development, and Full Service Partnership for children with serious emotional disturbance who meet medical necessity for county mental health services.

Goals and Objectives

Goal 1:

CMH Programs aim to provide Full Service Partnership, System Development, and Outreach and Engagement services to all children through age 17 in Yolo County who are experiencing serious emotional difficulties.

Goal 2: To expand and augment mental health services to enhance service access, delivery and recovery.

Objective 1: Increase the level of participation and involvement of ethnically diverse families in all aspects of the public mental health system;

Objective 2:

Reduce ethnic and cultural disparities in accessibility, availability and appropriateness of mental health services to more adequately reflect mental health prevalence estimates;

Objective 3: Increase the array of community supports for children and youth diagnosed with serious emotional disturbance and their families; and

Objective 4: Improve success in school and at home, and reduce institutionalization and out of home placements.

TAY Pathways to Independence

The Pathways to Independence Program provides Outreach and Engagement, System Development, and Full Service Partnership for youth with serious emotional disturbance and/or serious mental illness. This program will address needs including access to case management and psychiatry, upholding a continuum of services, and separating TAY Wellness Center services from adult services.

Goals and Objectives

Goal 1:

Pathways to Independence aims to provide Full Service Partnership, System Development, and Outreach and Engagement services to youth ages 16-24 in Yolo County who are experiencing serious mental illness while transitioning to adulthood.

Goal 2:

To expand and augment mental health services to enhance service access, delivery and recovery.

Objective 1:

Reduce ethnic and cultural disparities in accessibility, availability and appropriateness of mental health services and to more adequately reflect mental health prevalence estimates; and

Objective 2: Support successful transition from the foster care and juvenile justice systems.

Adult Wellness Alternatives

The Adult Wellness Alternatives Program provides Outreach and Engagement, System Development and Full Service Partnership to adults who are unlikely to maintain recovery in the absence of ongoing services. Across the County, the continuum of services includes psychiatry, case management and Wellness Centers.

Goals and Objectives

Goal 1:

The Adult Wellness Alternatives program aims to meet the mental health treatment needs of un-served, under-served, and inappropriately served adults in Yolo county with serious mental illness who may be experiencing homelessness or be at risk for homelessness, have criminal justice system involvement, have a co-occurring substance abuse disorder, or have a history of frequent use of hospital and emergency room utilization.

Goal 2: To expand and augment mental health services to enhance service access, delivery and recovery.

Objective 1: Provide treatment and care that promote wellness, recovery, and independent living;

Objective 2: Reduce the impact of living with serious mental illness (i.e. homelessness, incarceration, isolation); and

Objective 3: Promote the development of life skills and opportunities for meaningful daily activities.

Community Based Drop-In Navigation Centers

The Community Based Drop-In Navigation Centers will offer behavioral health and social support opportunities to adults at risk of incarceration, hospitalization, and/or homelessness, who are not yet connecting to services, or who are minimally linked and engaged. Staff will provide services such as assessment and linkage to mental health services, psychosocial/educational groups, assistance with housing or public benefit applications, and individual case management.

Goals and Objectives

Goal 1:

The Community Based Drop-in Navigation Centers provide support to consumers who may not yet be ready to engage in more intensive, clinic-based mental health services, with the goal of preventing mental health crises and/or connecting consumers to services when and if they desire those services.

Goal 2: To expand and augment mental health services to enhance service access, delivery and recovery.

Objective 1: Provide supportive, flexible, consumer-driven services to all consumers at their preferred level of engagement;

Objective 2: Assist consumers at risk of developing a mental health crisis to identify and access the supports they need to maintain their mental health;

Objective 3: Reduce the impact of living with mental health challenges through the provision of supports to address basic needs; and

Objective 4: Increase service access and service connectedness with adults experiencing mental health problems.

Peer and Family Led Support Services

Peer and Family Led Support Services assist peers and families to understand the signs and symptoms of mental health, promote awareness of mental health resources, develop ways to support an individual or loved

one to access needed services, and receive support to cope with the impact of mental health for an individual or within the family. Program services are peer/family led.

Goals and Objectives

Goal 1: The Peer and Family Led Support Services program aims to provide family and consumer-led support services and psychoeducation to caregivers and consumers.

Goal 2: To expand and augment mental health services to enhance service access, delivery and recovery.

Objective 1: Provide community-building activities for consumers and their families;

Objective 2: Develop knowledge base for consumers and their families; and

Objective 3: Develop self- advocacy skills for family members and peers.

WET

The following FY 2017-2020 WET programs address identified workforce targets and goals. Identified CSS transfer-in funds will support the WET programs for the latter two fiscal years after the sunset of WET funding.

Psychiatry Residency Program Development

This program serves the dual purpose of addressing the workforce shortage of psychiatrists and increasing the availability and quality of psychiatrists serving Yolo consumers. Yolo is partnering with UC medical schools for a Psychiatric Residency program to train psychiatric residents and encourage them to enter the public mental health workforce.

Psychiatry Residents receive training in psychiatric assessment and treatment, cultural competency and community mental health.

Goals and Objectives

Goal:

The Professional Development program aims to ensure a competent and trained workforce in alignment with MHSA values that is versed in relevant evidence based practices.

Objective 1: Ensure clinical staff are trained in relevant evidence based practices;

Objective 2: Provide support to front office staff to provide supportive and welcoming experiences; and

Objective 3: Ensure a culturally competent and informed workforce.

Peer Workforce Development Workgroup

The Peer Workforce program will provide peers with the evidence-based skill building, professional development opportunities, training, and internal HHS support they require to provide effective services to consumers, reduce stigma, and expand their own foundation of marketable skills. The workgroup will research best practices on supporting and maximizing peer staff.

Goals and Objectives

Goal:

The Peer Workforce Development Workgroup aims to create a program that will ensure that Peers are provided with the evidence-based skill building, professional development opportunities, training, and internal HHS support they require to provide effective services to consumers, reduce stigma, and expand their own foundation of marketable skills.

Objective 1: Strengthen the onboarding, training, and supervision available to peer support staff;

Objective 2: Consider evidence-based practices in the peer support model; and

Objective 3: Increase inclusion of peer workforce across the agency.

Mental Health Professional Development

The Mental Health Professional Development program provides training for mental health providers to serve a diverse consumer population. Professional development focuses on emerging and best practices. Examples of programs include: E-Learning, changes in DSM manual, Gallup's StrengthsFinder training, Perinatal Mental Health Services Training, and Cultural Competence/Mental Health Resources.

Goals and Objectives

Goal:

The Professional Development program aims to ensure a competent and trained workforce in alignment with MHSA values that is versed in relevant evidence based practices.

Objective 1: Ensure clinical staff are trained in relevant evidence based practices;

Objective 2: Provide support to front office staff to provide supportive and welcoming experiences; and

Objective 3: Ensure a culturally competent and informed workforce.

Clinical Internship Program

The program aims to increase the availability of home- and community-based clinical services while training new Social Workers in specialty mental health services. The Clinical Internship program connects Masters' level student interns with mental health consumers through rotation placements on various teams, including Older Adults, Access and Crisis, Forensic, Transition Age Youth, Homeless and Full Service Partnership . HHSA will ensure that interns receive the required level of clinical supervision and training ongoing.

Goals and Objectives

Goal:

This program aims to increase the availability of home- and community-based clinical services while training new Social Workers in specialty mental health services for individuals age 16 and older.

Objective 1: Increase the workforce competent to assess, diagnose, and treat individuals and families in the public mental health system; and

Objective 2: Provide psychotherapeutic supports to assess and treat individuals and families in the public mental health system.

PEI/PEI Priority Populations

Early Childhood Mental Health Access and Linkage Program

The Early Childhood Mental Health Program Access and Linkage program connects children to the appropriate prevention or mental health treatment service. By placing an Access & Referral Specialist in community settings, the program provides universal screenings to identify children who at risk of developing or showing emerging signs of mental health issues. The program then connects children to suitable services that prevent or intervene early to address mental health problems, regardless of funding source or service setting.

Goals and Objectives

Goal 1: The Early Childhood Mental Health Access and Linkage Program aims to connect children to the appropriate prevention or mental health treatment service.

Goal 2: To expand and augment mental health services to enhance service access, delivery and recovery.

Objective 1: Prevent the development of mental health challenges through early identification;

Objective 2: Address existing mental health challenges promptly with assessment and referral to the most effective service; and

Objective 3: Strengthen access to community services for children and their families.

Mentorship/Strengths-Building Program

The Mentorship/Strengths-Building Program provides outreach and engagement for at-risk youth to build their resiliency and help mitigate their mental health experiences. The program offers school and community based education programs about children's mental health; school and/or community based prevention groups for school-age children; and after-school mentorship to children and youth. Services are conducted in familiar settings for children and families, with bilingual/bicultural staff in areas with a high proportion of non-English speaking populations.

Goals and Objectives

Goal 1:

The Mentorship/Strengths-Building Program aims to engage underserved youth, in both rural and urban settings, in creative activities that build their resiliency and help to mitigate and/or support their mental health experiences.

Goal 2: To expand and augment mental health services to enhance service access, delivery and recovery.

Objective 1: Provide evidence based curricula to support the development of socially appropriate skills and behaviors;

Objective 2: Strengthen children and youth relationships with peers and supportive adults; and

Objective 3: Support the development of appropriate coping and problem-solving skills.

School-Based Access and Linkage Program

The School-Based Access and Linkage program places a specialist who offers identification and intervention for youth in need of mental health services, and who subsequently links them to suitable services, regardless of funding or service setting. Wellness Teams, including school administrators, counselors, teachers, and staff, meet monthly to review current participants and refer new youth. This program shifts the focus from brief treatment in the schools, to understanding needs and linking the child to the appropriate level of mental health service.

Goals and Objectives

Goal 1:

The School-Based Access and Linkage program aims to connect children and youth to the appropriate prevention or mental health treatment service in both rural and urban settings.

Goal 2: To expand and augment mental health services to enhance service access, delivery and recovery.

Objective 1: Prevent the development of mental health challenges through early identification;

Objective 2: Address existing mental health challenges promptly with assessment and referral to the most effective service; and

Objective 3: Strengthen access to community services for children, youth, and their families.

TAY Wellness Center Services

Yolo County HHSA is expanding available Wellness Center days and hours for TAY who are either at-risk of, or currently experiencing, mental health problems. The Center Peer and Professional staff will assist TAY to grow their skills in navigating the mental health system, while promoting recovery, resiliency, and connection to services. The Center services will include multiple levels of mental health services, from one-on-one support to interventions specific to severe mental illness. The Center will focus on providing a safe space through activities including sports, mentoring, college preparedness workshops, and group counseling.

Goals and Objectives

Goal 1: Provide a youth/ TAY meeting space focused on resiliency, socialization, peer-support, and mental health programs and services.

Objective 1: Provide TAY rehabilitative wellness programs, services, group support, and age-appropriate socialization activities at a Wellness Center; and

Objective 2: Increase number of TAY accessing and participating in mental health services.

TAY Speaker's Bureau

This program aims to reduce the stigma by replacing harmful misconceptions with stories of recovery and resiliency. The TAY Speaker's Bureau engages TAY to share their experiences with mental health to educate and inspire their communities. TAY will receive monthly training and stipends for developing their stories, public speaking practice, and community presentations.

Goals and Objectives

Goal:

Reduce the stigma and discrimination associated with having a mental health issues, by replacing misconceptions with stories of recovery.

Objective 1: Educate community members on the experience of mental health for TAY to better serve and/or support TAY;

Objective 2: Reduce stigma and discrimination thereby increasing access to services for TAY who otherwise may not seek help; and

Objective 3: Build TAY's resiliency and recovery through these leadership opportunities.

Early Intervention Program

The Early Intervention program focuses on youth who are demonstrating signs of developing a mood disorder (i.e., bipolar disorder, major depressive disorder). This program will include a variety of clinical and other supportive services at home, in the clinic, and in community based settings, and will provide evidence based interventions to address emerging symptoms and to support the youth to stay on track developmentally.

Goals and Objectives

Goal 1: Provide early intervention services for youth that are beginning to develop a mood or anxiety-related serious mental illness.

Goal 2: To expand and augment mental health services to enhance service access, delivery and recovery.

Objective 1: Support young adults to stay on track developmentally and emotionally; and

Objective 2: Mitigate the negative impacts that may result from an untreated mental illness.

Integrated Behavioral Health Services for Latino Community and Families

The Integrated Behavioral Health Services for the Latino Community Families program will provide culturally responsive services to Latino/Hispanic residents with health issues, mental health illnesses, and/or substance use issues. The program provides primary care and full-scope behavioral health services to consumers, focused on engaging the family system, while employing specific strategies for engaging male heads of household.

Goals and Objectives

Goal 1:

Integrated Behavioral Health Services for Latino Community and Families aims to provide comprehensive health services, including physical and behavioral health, to the Hispanic/Latino community.

Goal 2: To expand and augment mental health services to enhance service access, delivery and recovery.

Objective 1: Utilize culturally responsive approaches to engaging the Hispanic/Latino population;

Objective 2: Increase engagement in mental health and primary care services by Hispanic/Latino men; and

Objective 3: Improve health and behavioral health outcomes for the Hispanic/Latino population.

LGBTQ+ Cultural Competency Initiative

The LGBTQ+ Cultural Competency Initiative provides the Cultural Competency Committee with information needed to deepen cultural competency among all staff, providers, and other partners. The Initiative will train HHSA staff on cultural competency, deepen clinicians' specialization in specific practice areas, and support data infrastructure development specific to LGBT+ consumers. The initiative addresses needs of cultural competency among staff specific to serving the LGBT+ population; makes recommendations regarding culture-specific experts who will train and provide services to consumers when indicated; makes recommendations regarding supervisory support for clinicians providing services to LGBT+ consumers; and makes recommendations regarding data collection concerning the LGBT+ population.

Goals and Objectives

Goal:

The LGBTQ+ Cultural Competency Initiative aims to increase targeted support beyond the current training model to improve cultural competency across the system.

Objective 1: Provide a basic level of cultural competency to all staff;

Objective 2: Provide an expert level of cultural competency in specialty areas, including LGBTQ+, targeted to select staff; and

Objective 3: Develop mechanisms to electronically gather, organize, analyze and evaluate demographic data around LGBT+ consumers.

IV. Additional strategies/objectives/actions/timelines and lessons learned

The county shall include the following in the CCPR:

- A. List any new strategies not included in Medi-Cal, CSS, WET, and PEI.
Note: New strategies must be related to the analysis completed in Criterion 2.

1. 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, WET, and PEI.

Yolo County has been fortunate to see successes with increased outreach and engagement opportunities for several cultural groups including Russian-speaking immigrants and communities, Latino farmworkers and Transition Age Youth. During 2017, increased coordination efforts with Russian Information and Support Services resulted in four cultural awareness trainings, participation in a Community Networking Breakfast and a local Special Needs Family Community Event. A local CBO, Rural Innovations in Social Economics (RISE), Incorporated, provides a new component to the Latino Outreach efforts with the RISE Latino Farmworker Outreach Program. This program provides targeted outreach to Yolo County Latino/Hispanic farmworkers with health issues, mental health issues, and/or substance use issues and refers those in need of Integrated Behavioral Health Care Services to CommuniCare Health Centers. The December 2017 opening of the STAY WELL CENTER (STAY = Support for Transition Age Youth) at Woodland Community College now provides an additional wellness space for transition age youth. Yolo County HHS Peer Support Worker staff are a component of the program, with their efforts directed at increasing and improving engagement for TAY across the continuum of need and services.

HHS continually challenges staff and systems to think, serve and connect "outside of the box and office", allowing for needed improvements ongoing. While Yolo County continues to work to include the voices and involvement of underserved populations within the county mental health system at all points of service and planning processes, additional strategies must be developed to address the climate of fear, uncertainty and safety risks that exist for several cultural groups including Latinos/Hispanics, African Americans and LGBTQ+.

- V. **Planning and monitoring of identified strategies/objectives/actions/timelines to reduce mental health disparities** (Criterion 3, Section I through IV requires counties to identify strategies,

objectives, actions, and timelines to reduce disparities. This section asks counties to report processes, or plan to put in place, for monitoring progress.)

The county shall include the following in the CCPR:

- A. List the strategies/objectives/actions/timelines provided in Section III and IV above and provide the status of the county's implementation efforts (i.e. timelines, milestones, etc.).

Programs and services are in the first fiscal year of a three fiscal year plan. Many programs have been implemented during the first six months of the fiscal year, and are demonstrating increased services and/or outreach to target populations.

The following programs will be implemented or reach initial milestones within the remaining two quarters of the fiscal year:

- Peer Workforce Development Workgroup – Quarterly workgroup meetings will begin in Winter 2017. Peer Workforce activities have included recruitment, initial training and identification of additional supervisory support.
- Community Based Drop-In Navigation Centers – A new site location has been identified. Processes are underway with goals to complete training for staff members in April 2017 and open site in May 2017.

- B. 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 II of Criterion 3. Discuss what measures and activities the county uses to monitor the reduction or elimination of disparities.

The framework that has been adopted by Yolo County is Results Based Accountability (RBA). It involves three levels of performance measures:

PM 1: How much did we do?

PM 2: How well did we do it?

PM 3: Is anyone better off?

Staff members continue to participate in RBA trainings to enhance efforts to collect data that not only reflect effort and quantity, but also quality and effect. Consumer Perception Surveys continue to provide valuable insight regarding programs and services. With the increasing implementation of RBA, additional performance measures will be identified and data collected to

determine if clients are better off, specifically demonstrating changes in skills/knowledge, attitudes/opinions and behaviors/circumstances.

The Cultural Competence Committee has identified increased Program and Services Reviews during 2018, which will assist in ascertaining progress with collecting RBA performance measures during the first fiscal year of service and planned progress/milestones to accomplish during fiscal years two and three.

CRITERION 4

COUNTY MENTAL HEALTH SYSTEM

CLIENT/FAMILY MEMBER/COMMUNITY COMMITTEE: INTEGRATION OF THE COMMITTEE WITHIN 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 other group that addresses cultural issues and has participation from cultural groups, that is reflective of the community.**

The county shall include the following in the CCPR:

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

The Yolo County Cultural Competency Committee strives to ensure that Yolo County's commitment to cultural and linguistic competency are reflected throughout the Health & Human Services Agency (HHS) system, and that staff training and program policies reflect this commitment and manifest racial, ethnic, cultural, and linguistic diversity. The primary goal of the committee is to produce, implement and maintain a Cultural Competence Plan relating to a system-wide commitment to cultural and linguistic competence.

The Cultural Competence/Ethnic Services Manager serves as chair of the Cultural Competence Committee. During 2017, the Committee conducted monthly meetings which also included special outreach activities, training or extended discussions to assist in meeting the committee's goals. In addition, a LGBTQ+ Workgroup met monthly starting in March 2017. Please see appendix for Cultural Competence Committee and LGBTQ+ Workgroup schedule and topics.

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

The Cultural Competence Committee has established a practice of reviewing and inviting prospective new committee members to be reflective of Yolo's diverse community. A standing agenda item of "Who are we missing at the table? Who should we invite?" helps to identify and assure ongoing needed outreach efforts. Quarterly reviews will be instituted in 2018 and recorded in minutes regarding the status of committee membership and involvement being reflective of the community.

- C. Organizational chart
Please see appendix for organizational chart.
- D. Committee membership roster listing member affiliation if any.
Cultural Competence Committee roster and sign-in sheets will be available for on-site review.

II. The Cultural Competence Committee, or other group with responsibility for cultural competence, is integrated within the County Mental Health System. The county shall include the following in the CCPR:

- A. Evidence of policies, procedures, and practices that demonstrate the Cultural Competence Committee's activities including 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/Quality Improvement Program in the county;
 - 3. Participates in overall planning and implementation of services at the county;
 - 4. Reporting requirements include directly transmitting recommendations to executive level and transmitting concerns to the Mental Health Director
 - 5. Participates in and reviews county MHSA planning process;
 - 6. Participates in and reviews county MHSA stakeholder process;
 - 7. Participates in and reviews county MHSA plans for all MHSA components;
 - 8. Participates in and reviews client developed programs (wellness, recovery, and peer support programs); and
 - 9. Participates in revised CCPR (2010) development.

The Cultural Competence Committee has adopted practices to ensure that the Committee is integrated and involved in the County Mental Health System.

Program and Services Planning and Review

The Committee has taken initial steps this past year for Program and Services Planning and Review. The Committee conducted six workgroup and extended discussion meetings to understand current program and service needs and challenges. These special meetings included the following topics:

- 1) Data;
- 2) Policies and Procedures;
- 3) Mental Health and Spirituality; and
- 4) Foster Care Needs and Resources.

The Committee also identified the goal to include specific program reviews during 2018 meetings, including inviting program staff and participants to share successes, challenges and needs.

Reporting Requirements/Transmitting Recommendations and Concerns

The Committee includes a standing agenda of "Recommendations to County Programs and Services" during regular meetings to record and transmit recommendations. Feedback from executive level is providing during designated committee meetings. The recommendations and concerns recorded during the year included:

- 1) Ensure services, especially providers of residential services are LGBTQ+ affirming in their practices/services
- 2) Determine what gender neutral bathroom options are available in HHS buildings.
- 3) Establish ongoing workgroups in 2018 for
 - a) Spanish-speaking Communities and
 - b) Russian-speaking communities
- 4) Provide written and oral information regarding how demographic information is handled and reported when undocumented immigrants participate in HHS services.

Participates and Reviews County Mental Health MHS planning, stakeholder and plans

During each Cultural Competence Committee meeting, time is designated for MHS Updates and information sharing. Extended MHS Planning and Review time has also been scheduled during meetings to review and provide feedback for MHS planning process and plans. Additionally, Cultural Competence Committee members are engaged in specific MHS focus groups, planning summits and/or key informant interviews.

Participating in Cultural Competence Plan Development

The Committee played a critical role in the development of the Cultural Competence Plan. With the objective to develop a Cultural Competence Plan update based on medium-sized county criteria (versus the small county criteria previously utilized); the Committee engaged in special CCP review and planning activities from July to December 2017.

- B. Provide evidence that the Cultural Competence Committee participates in the above review process.

Please see appendix for Cultural Competence Committee topics and Cultural Competence/Ethnic Services Manager Quality Improvement Committee (QIC) updates.

- C. Annual Report of the Cultural Competence Committee's activities including:

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?

Goals/Objectives:

- a) Complete activities and tasks to ensure a revised Cultural Competence Plan update is completed by January 31, 2018 utilizing medium-size county CCP criteria.
This goal was met. The CC/ESM and committee members engaged in ongoing activities to establish a new plan update based on medium-size county criteria.
- b) Establish regular meeting schedule, agenda items and topics to ensure the committee's integration, involvement and influence within the county mental health system.
This goal was met with a publicized monthly meeting schedule which included special workgroups and extended discussions to understand and impact the county mental health system. The Committee will build upon this format and structure to address and meet 2018 goals and objectives.
- c) Provide opportunities to educate and reduce stigma via Cultural Competence Committee (CCC) sponsored/hosted activities.
This goal was met. The Cultural Competence Committee hosted two events:
- 1) March 2017 – Understanding the Needs and Diversity of Russian-speaking Immigrants and Communities
This event provided a training, cultural displays and information to increase awareness and needs specific to Russian-speaking Immigrants and Communities.
 - 2) May 2017 – Welcoming and CCC Mental Health Event
This event provided an opportunity to raise awareness of the existence and goals of the Cultural

Competence Committee. The event included cultural competence display boards, videos and discussion.

- d) Facilitate progress on addressing the needs of the LGBTQ+ communities of Yolo County.
The ongoing meetings and activities of the LGBTQ+ Workgroup helped to meet the goal of making progress with LGBTQ+ issues and initiative. The Workgroup participated in community outreach tabling and facilitated special meetings to gather information and identify next steps regarding 1) Developing LGBTQ+ expert staff and 2) understanding needs of LGBTQ+ foster care youth and families.
2. Reviews and recommendations to county programs and services; The Committee forwarded four Recommendations/Concerns to Executive level during the year. The Deputy Director of Mental Health will provide quarterly updates during 2018 regarding action taken and/or planned for each recommendation/concern.
3. Goals of Cultural Competence Plans
The Cultural Competence Committee goals for 2018 include:
 - A. Complete Program Reviews to identify current service delivery efforts for underserved target populations and to identify strategies to improve penetration rates.
 - B. Increase participation and feedback from diverse and prevalent cultural groups in Cultural Competence Committee meetings, workgroups and activities.
 - C. Continue LGBTQ+ Workgroup meetings to assist in meeting goals of the LGBTQ+ Cultural Competency Initiative.
 - D. Establish Workgroups to address disparities for
 - 1) Latino/Hispanic populations and
 - 2) Russian-Speaking Immigrants and Communities
 - E. Provide learning opportunities and activities to enhance cultural awareness and knowledge in Yolo County.
4. Human Resources Report;
The Staff and Provider Ethnicity and Language Proficiency Survey was conducted in Fall 2017. Additional demographic categories were added this year, and surveys were anonymous to help encourage completion of the survey. Additional and/or expanded demographic categories included gender, self-identified sexual orientation and veteran status. The CCC also expanded categories for ethnicity as well as ensuring "other: specify" options to many questions. A separate, non-anonymous survey was utilized to capture language proficiency and cultural training experience. The

information gathered will inform several goals and activities for the upcoming year. Please see appendix for surveys. Surveys will be tabulated and reviewed during the March 2018 Cultural Competence Committee meeting. Please note the following initial survey summary excerpts below.

HHSA Staff Member Surveys:

Sixty (60) staff members completed the survey. Of the 60,

- 15 staff members (25.42%) responded yes to being of Latino/Hispanic Origin
- 54 staff members (90%) indicated female gender, six staff members indicated male gender. Transgender female, transgender male were not endorsed.
- 56 staff members (93.33%) identified as heterosexual/straight; one individual identified as lesbian; one individual identified as queer; and one chose not to answer.
- 11 individuals (18.33%) self-identified as a person with a disability.

5. County organizational assessment;
An organizational self-assessment of cultural competence was completed in October 2017. The special meeting and discussion provided an important review of current organizational strengths and identified areas for improvement. Please see appendix for organizational assessment tool. Please note below overall ratings and summary.

	CC CRITERION	SCORE <i>Scale = 1 to 5</i>	COMMENTS
1	Agency Commitment to Cultural Competence	3	It was noted that agency has management level person and dedicated budget for CC activities, but is in process with revised written plan.
2	Assessment of Service Needs	2-	Group members noted scores of 2, 2- and 1.5. Identified need to have data on service user consistency across programs.
3	Cultural Input into Agency Activities	3	HHSA was noted for having established free-standing CC Committee, but needed data on most prevalent cultural groups to consider additional points.

	CC CRITERION	SCORE <i>Scale = 1 to 5</i>	COMMENTS
4	Integration of Cultural Competence Committee within Organization	3.5	Group members noted scores of 3, 3.5 and 4. The group noted full performance of two identified activities, but only initial steps taken for the other two indicators.
5	Cultural Competence Staff: Training and Activities	2	Group members noted that at least three hours of CC specific trainings were offered but there was no stated requirement for number of training hours to complete.
6A	Cultural Competence Staff: Recruitment, Hiring and Retention strategies for most prevalent cultural group	5	Group members based score for Spanish-speaking population (threshold language)
6B for second most prevalent cultural group	3	Group members based score for Russian-speaking population (threshold language)
6C for third most prevalent cultural group	0	No points credited. Members noted need to have data for 3 rd most prevalent cultural group.
7	Language Capacity: Interpreters	4	Limited points since members noted need to have data for 3 rd most prevalent cultural group.
8	Language Capacity: Bilingual Staff	5+	Group members noted having Spanish-speaking staff members at the direct service, supervisory and administrative level.
	Total Score	30.5	

6. Training plans;
The Committee has recommended that the 2018 training calendar include a training regarding Mental Health and Spirituality. Specifically, it has been recommended that a training is offered to practitioners to assist in their efforts to appropriately acknowledge and address spirituality and faith

impact their clients' recovery and resiliency, especially for clients who have experienced trauma, stigma and alienation from their faith based or spiritual experiences.

7. Other county activities, as necessary.
The Cultural Competence Committee provided oversight for the LGBTQ+ Workgroup during 2017. The Workgroup met monthly and hosted several extended discussions in order to provide feedback and recommendations to the LGBTQ+ Cultural Competence Initiative. The Workgroup also provided a forum to discuss and identify other prospective grassroots/community based efforts including a local LGBTQ+ Resource Center.

CRITERION 5

COUNTY MENTAL HEALTH SYSTEM

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 stakeholders to receive annual cultural competence training.

The county shall include the following in the CCPR:

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

1. The projected number of staff who need the required cultural competence training. This number shall be unduplicated.

A review of Human Resource records indicate that 106 unduplicated staff members will need to complete the required cultural competence training.

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

Yolo County HHSA monitors and provide opportunities to complete cultural competence training via several mechanisms including:

- A. Monthly All Behavioral Health Staff Meetings;
A minimum of three trainings per year are dedicated to Cultural Competency topics.
- B. Support Staff Trainings;
The Cultural Competence/Ethnic Services Manager provides a minimum of three CC trainings per year during regular Support Staff meetings.
- C. Relias/Elearning;
Relias accounts and training courses are made available to staff members. A minimum of three courses per calendar year will be identified as cultural competence training options for staff members.

- D. On-site, off site, livestream and webinars training opportunities;
The Cultural Competence/Ethnic Services Manager will publicize relevant cultural competence training opportunities available for staff members to attend.

Training sign-in sheets are retained to verify attendance for required cultural competence trainings. An enhanced training tracking system will be instituted in 2018 to document each staff members' number of training hours completed.

- 3. How cultural competence has been embedded into all trainings.
Increased planning and coordination activities have assisted in ensuring that cultural competence is embedded into all training. Responsibilities of the Cultural Competence/Ethnic Service Manager and Workforce, Education, and Training Coordinator include planning and coordination with speakers and trainers to ensure that training topics are culturally inclusive, relevant and responsive. Activities often include review of proposed materials for inclusion of cultural considerations and tailoring topics to address identified service populations needs. The Cultural Competence Committee and Behavioral Health Managers/Supervisors also participate in training planning and coordination meetings to identify culturally competent training needs, priorities and goals.

II. Annual cultural competence trainings
The county shall include the following in the CCPR:

- A. Please report on the cultural competence trainings for staff. Please list training, staff, and stakeholder attendance by function (If available, include if they are clients and/or family members):
 - 1. Administration/Management;
 - 2. Direct Services, County;
 - 3. Direct Services, Contractors;
 - 4. Support Services;
 - 5. Community Members/General Public;
 - 6. Community Event;
 - 7. Interpreters;
 - 8. Mental Health Board and Commissions; and
 - 9. Community-based Organizations/Agency Board of Directors

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;
5. Social/Cultural Diversity (Diverse groups, LGBTQ, SES, Elderly, Disabilities, etc.);
6. Mental Health Interpreter Training;
7. Training staff in the use of mental health interpreters; and
8. Training in the Use of Interpreters in the Mental Health Setting.

Please note below the 2017 Cultural Competence trainings.

Training Event	Description of Training	How long	Attendance by function	Total	Date of training	Name of Presenter
Cultural Awareness/Sensitivity	Communicating Effectively with the Hearing Impaired and Visually Impaired	20 minutes	<i>Support Services - 6</i>	6	1/23/17	Theresa Smith, LCSW
Social/Cultural Diversity	Understanding the Diversity and Needs of Russian-speaking Communities and Immigrants	60 minutes	<i>*Direct Services - 19</i> <i>*Direct Services Contractors - 3</i> <i>*Administration - 2</i> <i>*Local MHB - 1</i> <i>*Other Community - 14 Stakeholders</i>	39	2/10/17	Tatiana Shevchenko, Russian Information & Support Services
Social/Cultural Diversity	Understanding the Diversity and Needs of Russian-speaking Communities and Immigrants	60 minutes	<i>*Administration - 1</i> <i>*Other Community Stakeholders - 8</i>	9	3/30/17	Tatiana Shevchenko, Russian Information & Support Services
Social/Cultural Diversity	Serving the LGBTQ Populations	300 minutes	<i>*Direct Services - 3</i> <i>*Direct Services Contractors - 8</i> <i>*Administration - 1</i>	12	3/31/17	Poshi Walker, NorCal Mental Health America
Social/Cultural Diversity	Serving the LGBTQ Populations	390 minutes	<i>*Direct Services - 10</i> <i>*Direct Services Contractors - 18</i> <i>*Administration - 1</i>	29	4/21/17	Poshi Walker, NorCal Mental Health America
Social/Cultural Diversity	Understanding the Diversity and Needs of Russian-speaking Communities and Immigrants	60 minutes	<i>*Direct Services - 5</i> <i>*Administration - 1</i> <i>*Other Community Stakeholders - 4</i>	10	4/27/17	Tatiana Shevchenko, Russian Information & Support Services

Training Event	Description of Training	How long	Attendance by function	Total	Date of training	Name of Presenter
Cultural Sensitivity and Awareness	Client Culture: Recovery, Resilience and Wellness;	90 minutes	*Direct Services - 33 *Direct Services Contractors - 7 *Administration - 4 *Interpreters - 3 *Other Community Stakeholders - 5	52	5/4/17	Tessa Smith, Family Partner; Client Panel
Multi-Cultural Knowledge	CCC's Welcoming and Mental Health Event; Don't ask me where I am from, ask me where I am local	90 minutes	<ul style="list-style-type: none"> • Administration/Management; - 3 • Direct Services, Counties; • Direct Services, Contractors; 3- • Support Services; • Community Members/General Public; • Community Event; • Interpreters; and • Mental Health Board and Commissions - 2 • Community-based Organizations/Agency Board of Directors -1 • Client - 1 	26	5/12/17	James Glica-Hernandez
Social/Cultural Diversity	Understanding the Diversity and Mental Health Needs of Russian-speaking Communities and Immigrants	90 minutes	*Direct Services - 14 *Administration - 1 *Interpreters- 3	18	6/1/17	Tatiana Shevchenko, Russian Information & Support Services
Cultural Competence Communication	Training staff in the use of mental health interpreters;	20 minutes	#Support Staff - 5	5	7/24/17	Theresa Smith, LCSW
Cultural Competence Communication	Training staff in the use of mental health interpreters; Communicating Effectively with the Hearing Impaired and Visually Impaired	90 minutes	*Direct Services - 18 *Administration - 4 *Interpreters - 9	31	8/3/17	Theresa Smith, LCSW

Training Event	Description of Training	How long	Attendance by function	Total	Date of training	Name of Presenter
Social/ Cultural Diversity	Serving the LGBTQ+ Communities	90 minutes	<i>*Direct Services - 29</i> <i>*Direct Services</i> <i>Contractors - 2</i> <i>*Administration - 11</i> <i>*Interpreters - 2</i>	44	9/7/17	Theresa Smith, LCSW
Social/ Cultural Diversity; Cultural Competence Communication	Serving the LGBTQ+ Communities; Training staff in the use of mental health interpreters	30 minutes	<i>*Support Staff – 2</i> <i>*Administration - 1</i> <i>*Interpreters - 3</i>	6	9/25/17	Theresa Smith, LCSW
Social/ Cultural Diversity; Cultural Competence Communication (Fourth and Hope)	Communicating Effectively with Diverse Populations; Serving the LGBTQ+ Communities	90 minutes	<i>*Direct Services</i> <i>Contractors - 16</i>	16	10/10/17	Theresa Smith, LCSW
Social/ Cultural Diversity	Best Practices for Working with LGBTQ Victims	6 hours	<i>*Direct Services - 8</i> <i>*Administration - 2</i>	10	10/26/17	Al Killen- Harvey (Livestream)
Social/ Cultural Diversity	Serving Individuals with Military Experience (Veterans)	90 minutes	<i>*Direct Services - 26</i> <i>*Direct Services</i> <i>Contractors - 1</i> <i>*Administration - 11</i> <i>*Interpreters - 6</i> <i>*Other Community</i> <i>Stakeholders- 1</i>	45	11/2/17	Reed Walker, MSSE, USN (ret)
Mental Health Interpreter Training	Overview of Behavioral Health System for Behavioral Health Interpreters	60 minutes	<i>*Interpreters - 5</i>	5	By 12/26/17	Relias/E- learning
Mental Health Interpreter Training	The Role of the Behavioral Health Interpreter	60 minutes	<i>*Interpreters - 4</i>	4	By 12.26/17	Relias/E- learning
Social/ Cultural Diversity	Serving Spanish- speaking Communities	90 minutes	<i>*Direct Services - 20</i> <i>*Direct Services</i> <i>Contractors - 2</i> <i>*Administration - 6</i> <i>*Interpreters - 5</i>	33	12/7/17	Latino Outreach Program Providers; Theresa Smith, LCSW

III. Relevance and effectiveness of all cultural competence trainings

The county shall include the following in the CCPR:

A. Training Report on the relevance and effectiveness of all cultural competence trainings, including the following:

1. Rationale and need for the trainings: Describe how the training is relevant in addressing identified disparities.

Trainings provided help to ensure staff members' cultural awareness and sensitivity for the delivery of culturally and linguistically appropriate services. *Communicating with Diverse Individuals and Families* presented review of cultural differences and considerations when interacting with diverse populations. Strategies and tips for interacting with visually impaired and hearing impaired individuals were included topics. Additional trainings provided specific insights into cultural traditions for special populations including Spanish-speaking communities, Russian-speaking immigrants and communities, LGBTQ+ populations and individuals with military experience. All trainings had the goal of providing implementation strategies to assist with addressing disparities and providing equitable services.

2. Results of pre/post tests (Counties are encouraged to have a pre/post test for all trainings).

HSA training evaluation forms include questions to gauge if a training participants' knowledge has increased related to the training objectives. Training evaluations reflected that training participants had overall increased knowledge after attending a specific training.

3. Summary report of evaluations.

Training evaluations often reflected appreciation of the information presented and a desire for more training time on the topic. Suggestions included future presentations with trainers from diverse cultural backgrounds who can share a different perspective with knowledge gained from personal cultural experiences, upbringing and backgrounds.

4. Provide a narrative of current efforts that the county is taking to monitor advancing staff skills/post skills learned in trainings.

HSA is involved in several efforts to monitor and identify needed staff skills and awareness. The Fall 2017 Staff and Provider Language and Cultural Training Survey requested that staff

members identify cultural topics for which they have skills and experience; and identify cultural training topics and issues for which they would like to receive more training. This information will be utilized in developing training opportunities as well as identifying staff members with experience and skill sets to address specific cultural groups or issues. HSA evaluation forms will provide ongoing feedback regarding knowledge level of staff members regarding various cultural competencies.

The LGBTQ+ Cultural Competency Initiative will continue to identify the criteria and component for staff members to acquire, hone and demonstrate skills to provide culturally competent services to LGBTQ+ populations. In addition to the basic cultural competency training for all staff members; training and supervision will be provided to designated "expert staff". Initial recommendations include passing grade completion of a 5-hour online LGBTQ+ course and participation in ongoing training and supervision (at least 10 hours annually).

The Cultural Competence Committee (CCC) will continue to recommend training topics and expectations for staff members and providers. The Cultural Competence Coordinator/Ethnic Services Manager will continue to share and incorporate feedback and guidance from the Cultural Competence Committee for cultural competency trainings for staff and providers.

5. County methodology/protocol for following up and ensuring staff, over time and well after they complete the training, are utilizing the skills learned.

HSA will utilize the Staff and Provider Language Proficiency and Cultural Training annual surveys to monitor staff members training skills and needs. Additional surveys will be utilized to ascertain utilization of skills overtime. Increase use of training post-tests will also assist in gauging of retention and utilization of skills learned.

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

The county shall include the following in the CCPR:

- A. Evidence of an annual training on Client Culture that includes a client's personal experience inclusive of racial, ethnic, cultural, and linguistic communities. Topics for Client Culture training may include the following:
 - Culture-specific expressions of distress (e.g., nervios);

- Explanatory models and treatment pathways (e.g., indigenous healers);
- Relationship between client and mental health provider from a cultural perspective;
- Trauma;
- Economic impact;
- Housing;
- Diagnosis/labeling;
- Medication;
- Hospitalization;
- Societal/familial/personal;
- Discrimination/stigma;
- Effects of culturally and linguistically incompetent services;
- Involuntary treatment;
- Wellness; Recovery; and
- Culture of being a mental health client, including the experience of having a mental illness and of the mental health system.

Note: The following explanation is offered to assist counties in understanding the issue to be addressed here. Cultural competence incorporates a set of values, experiences, and skills that direct service providers are expected to attain to provide appropriate and effective specialty mental health services to clients in a culturally competent manner. Training efforts should be concentrated in providing direct service providers with cultural competence skills and an understanding of how the consumer, their mental illness, their experience with the mental health system, and the stigma of mental illness, has impacted the consumer. Clients bring a set of values, beliefs, and lifestyles that are molded as a result of their personal experiences with a mental illness, the mental health system, and their own ethnic culture. These personal experiences and beliefs can be used to empower clients to become involved in self-help programs, peer advocacy and support, education, collaboration and partnership in system change, alternative mental health services, and in seeking employment in the mental health system.

- 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.

Please note below the 2018 Training Plan.

Training Event	Description of Training	How long	Attendance by function	Date of training	Name of Presenter
Cultural Awareness/Sensitivity	Client Culture: Youth, TAY and Families Resiliency; Navigating Multiple Agencies	75 minutes	*Direct Services *Direct Services Contractors * Support Services *Administration *Interpreters *Other Community Stakeholders	May 3, 2018	Youth and/or family members
Social/Cultural Diversity	Mental Health and Spirituality	60 minutes	*Direct Services *Direct Services Contractors * Support Services *Administration *Interpreters *Other Community Stakeholders	August 2, 2018	Guest Trainer - TBD
Mental Health Interpreter Training	Understanding Culture, Ethnicity and Language Dynamics	60 minutes	*Interpreters	Spring/Summer 2018	E-learning or live training (TBD)
Working with Mental Health Interpreters	Best Practices; Understanding Culture, Ethnicity and Language Dynamics	30 minutes	*Direct Services *Direct Services Contractors * Support Services *Administration *Interpreters Stakeholders	Summer/Fall 2018	E-learning, webinar or live training
Social/Cultural Diversity	Communicating with Diverse Individuals and Families	60 minutes	*Direct Services *Direct Services Contractors * Support Services *Administration *Interpreters *Other Community Stakeholders-	November 1, 2018	Theresa Smith, LCSW or Guest Trainer

CRITERION 6:

COUNTY MENTAL HEALTH SYSTEM

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

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

The county shall include the following in the CCPR:

- A. Extract 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.

The following data was reflected in the 2011 Cultural Competence Plan:

	Race/Ethnicity Data			
	Yolo ADMH Staff	All Other CBO's etc.	Total Yolo County MH Workforce	
AK. Native/Am. Indian	4.9	7.3	12.2	1.3%
Asian/Pacific Islander	7.8	66.1	73.9	7.7%
Black/African American	4.1	84.0	88.1	9.2%
Hispanic	20.1	86.6	106.7	11.1%
White	54.2	580.9	635.1	66.1%
Other/Unknown/Multiracial	6.5	38.3	44.8	4.7%
Total	97.6	863.2	960.8	100.0%

- 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.

Alaska Native/American Indian:

Overall the Alaska Native/American Indian population is low with higher percentages in poverty households. Census data reflect 1.8% of the Yolo County population is American Indian and Alaska Native, the second lowest percentage of identified Race and Hispanic Origin. Yolo County exceeds the penetration rate of medium-sized counties and statewide average for the Alaska Native/American Indian cultural group, although

the total number of beneficiaries served is small. The Yolo County workforce, as set forth in the 2009 WET Plan, included 1.3% in this racial/ethnic group, indicating the group was adequately represented in the workforce. The Fall 2017 Staff Ethnicity survey reflected that 5.08% of respondents identified as American Indian/Alaska Native.

Asian/Pacific Islander:

It is noted that 15.2% of the Census population is identified as Asian (14.6%) and Native Hawaiian and Other Pacific Islander (0.6%). The WET plan identified that the population is underrepresented among the county's mental health workforce. Only 1.69% of Fall 2017 Staff Ethnicity Survey respondents identified as Asian Indian and 0% as Pacific Islander.

Black/African American:

The Black/African American population comprises 2.9% of the county's residents. The WET plan indicated that this cultural group was adequately represented in the mental health workforce, but the penetration rate is below the statewide and medium-sized county averages. The Fall 2017 Staff Ethnicity Survey reflected that 16.95% identified as Black/African American.

Hispanic:

The Hispanic population represents 31.5% % of Yolo's residents. WET Plan data noted that total mental health workforce was 11.1% Hispanic, while for Behavioral Health was significantly higher at 20.61%. However, 2015 Medi-Cal data documents the greatest disparity for penetration rate exists for the Hispanic cultural group. The Fall 2017 Staff Ethnicity Survey reflected 25.42% identifying of Latino/Hispanic Origin and the following ethnic identifications: Chicano – 1.69% and Mexican/Mexican American 18.64%.

White/Caucasian:

The White/Caucasian population represents 47.3% of the population. The WET Plan noted that White/Caucasian remain the majority population in both the workforce and service populations. Penetration rate for this cultural group is below the medium-sized county and statewide averages. Nearly 39% of Fall 2017 Staff Ethnicity Survey respondents identifies as White/Caucasian.

- C. If applicable, the county shall report in the CCPR, the specific actions taken in response to the cultural consultant technical assistance recommendations as reported to the county during the review of their WET Plan submission to the State.

Not applicable.

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

The WET Plan noted the need for more bilingual/bicultural Hispanic staff, as well as from Russian, Ukrainian, and Asian/Pacific Islander cultures. Yolo County has been able to make progress with increasing more bilingual/bicultural Hispanic/Latino staff members. Contributing factors include increase in workforce numbers, Spanish-bilingual position classification and recruitment efforts and more competitive salaries and benefits. Goals still exist to increase the number of staff members with Russian, Ukrainian and Asian/Pacific cultural backgrounds. Current workforce includes Russian and Russian-speaking Benefits Specialist and Mental Health Specialist (Case Manager).

- E. Share lessons learned on efforts in rolling out county WET planning and implementation efforts.

Historically, the biggest impact impeding expanded WET efforts has been the poor economy, along with Yolo's generally flat County general fund base, associated with being a highly rural County.

In recent years, the impact of the current political climate on recruitment and retention of diverse staff is one of the greatest influential factors in meeting WET goals. Fortunately, Yolo County has been able to rebuild its workforce after significant reductions in force during the Recession.

The positive impact of Integration into a Health & Human Services Agency, along with competitive salary and benefits packages, have assisted in improving recruitment efforts.

HHSA's increasing and ongoing prioritization regarding employee satisfaction is projected to address retention of staff members.

CRITERION 7:

COUNTY MENTAL HEALTH SYSTEM

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 language of the client 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

The county shall include the following in the CCPR:

A. Evidence of dedicated resources and strategies counties are undertaking to grow bilingual staff capacity, including the following:

1. Evidence in the Workforce Education and Training (WET) Plan on building bilingual staff capacity to address language needs.

Please see appendix for WET Plan Workforce Needs Assessment.

2. Updates from Mental Health Services Act (MHSA), Community Services and Supports (CSS), or WET Plans on bilingual staff members who speak the languages of the target populations.

Workforce, Education and Training recommendations in the MHSA 2017-2020 Plan note that HHSA should continue to develop ways to increase staff diversity, including bilingual and bicultural staff.

There are currently eighteen Behavioral Health staff members receiving a bilingual pay differential. These staff members provide bilingual services within their scope of duties and interpreter services for other staff members. Languages include:

- Spanish – 13 staff members
- Russian/Ukraine – 1 staff member
- American Sign Language – 1 staff member
- Khmer – 1 staff member
- Punjabi/Hindu – 1 staff member
- Mandarin/Cantonese – 1 staff member

In addition, several staff members provide bilingual services but are not currently receiving bilingual pay including the Medical Director (Spanish) and Access and Crisis Manager (Punjabi).

3. Total annual dedicated resources for interpreter services.

In addition to bilingual staff members, HHSa maintains interpreter services with Language Line and NorCal Services for Deaf and Hard of Hearing populations. The NorCal Services annual contract amount is \$35,000. HHSa pays for the Language Line as a fee for service at 94 cents per minute for all languages.

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

County shall include the following in the CCPR:

- A. Evidence of policies, procedures, and practices in place for meeting clients' language needs, including the following:
1. A 24-hour phone line with statewide toll-free access that has linguistic capability, including TDD or California Relay Service, shall be available for all individuals. **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. 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.
 4. Training for staff who may need to access the 24-hour phone line with statewide toll-free access so as to meet the client's linguistic capability.

Please see appendix for policies or information regarding

- a) Information Dissemination and Cultural Competency
- b) Cultural Competency and Training of Interpreters

For clients with Limited English Proficiency (LEP), HHSa continues to post language identification charts in every waiting room. The posted charts direct the client to point to the preferred language and informs the client that an interpreter will be secured.

Staff is reminded of the free language assistance availability during interpreter trainings and Cultural Competency trainings. Staff is

also reminded to provide language assistance information by the checkbox on the Acknowledgment of Receipt checklist.

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

Access, crisis and grievance materials are available in English and Yolo's two threshold languages, Spanish and Russian, in reception and waiting room areas. Clients whose primary language is one other than English, Spanish or Russian are assisted through the procedure listed in the previous section.

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

HHSa has established protocol to accommodate persons who have Limited English Proficiency. Upon initial contact with an individual who has limited proficiency in English, but who does not speak a designated threshold language (Spanish or Russian), office support staff may use a Language Identification Chart to assist in identifying the person's language needs and seeks an interpreter. If an interpreter for that language is not available, the language line is used. For return appointments, interpreters are scheduled in accordance with client appointments. The language line is used if no interpreters are available in the client's preferred language.

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

While interpreter services are offered, clients may often decline services for various reasons. Training efforts have focused on providing additional follow up and support to clients in encouraging the use of interpreter services and ascertaining if client prefers alternatives to initial interpreter secured.

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

HHSa continues to monitor and work to improve efforts related to after-hours calls, both crisis and non-crisis type. Ensuring timely, accurate and consistent information provision and follow up remain a prioritized area of attention. Developing phone scripts and regular communication with providers have been important strategies.

- F. Identify county technical assistance needs.

HHSa would appreciate receiving information regarding preferred or identified exemplary processes for monitoring language competency, proficiency and/or formal testing of interpreters.

- 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.

The county shall include the following in the CCPR:

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

Signs are posted in waiting areas informing of the availability of interpreters. A Bilingual Staff Roster is available to staff members via the HHSa intranet.

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

Electronic health record progress notes include required fields to indicate preferred language of client and if service was provided in client's preferred language.

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

HHSa's Bilingual roster reflect staff members who are linguistically proficient in threshold languages during regular day operating hours.

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

Currently Bilingual/Interpreter staff members are required to participate in interpreter training. The County of Yolo also currently utilizes Self-Certification Process for Bilingual Skills for All Languages. Staff members must certify that they are competent due to place of origin, culture or training to provide oral and written interpretations between English and the identified language(s) on the certification form for Level I. For Level II-Advanced Level staff members must also certify competency to provide oral and written interpretations, including the interpretation of technical documents. The certification form informs staff members that in the event

that the County develops or contracts for a formal testing program that the employee may be required to prove proficiency via the testing process in order to continue to receive bilingual pay compensation.

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

The county shall include the following in the CCPR:

- A. Policies, procedures, and practices the county uses that include the capability to refer, and otherwise link, clients who do not meet the threshold language criteria (e.g., LEP clients) who encounter the mental health system at all key points of contact, to culturally and linguistically appropriate services.
- 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.
- C. Policies, procedures, and practices that comply with the following Title VI of the Civil Rights Act of 1964 (see page 32) 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.

Please see appendix for Policy regarding Language and Special Communications Needs.

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

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

- A. Culturally and linguistically appropriate written information for threshold languages, including the following, at minimum:
 - 1. Member service handbook or brochure;
 - 2. General correspondence;
 - 3. Beneficiary problem, resolution, grievance, and fair hearing materials;
 - 4. Beneficiary satisfaction surveys;
 - 5. Informed Consent for Medication form;
 - 6. Confidentiality and Release of Information form;
 - 7. Service orientation for clients;
 - 8. Mental health education materials, and
 - 9. Evidence of appropriately distributed and utilized translated

materials.

- B. Documented evidence in the clinical chart, that clinical findings/reports are communicated in the clients' preferred language.
- C. Consumer satisfaction survey translated in threshold languages, including a summary report of the results (e.g., back translation and culturally appropriate field testing).
- D. Mechanism for ensuring accuracy of translated materials in terms of both language and culture (e.g., back translation and culturally appropriate field testing).
- E. Mechanism for ensuring translated materials is at an appropriate reading level (6th grade). Source: Department of Health Services and Managed Risk Medical Insurance Boards.

Documents and/or information will be made available for review during compliance visit.

CRITERION 8

COUNTY MENTAL HEALTH SYSTEM

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

The county shall include the following in the CCPR:

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

1. Evidence the county has alternatives and options available within the above programs that accommodate individual preference and racially, ethnically, culturally, and linguistically diverse differences.
2. Briefly describe, from the list in 'A' above, those client-driven/operated programs that are racially, ethnically, culturally, and linguistically specific.

The Wellness Centers offer a variety of rehabilitative services, skill-building groups and a computer lab with internet access. Clients are encouraged to engage in wellness and recovery activities at drop-in Wellness Centers located in Woodland and West Sacramento. The Wellness Centers, are designed for transition age youth (16-24), adults and older adults. There are currently two Wellness Centers at County locations, with a third projected to open mid-2018. The third Wellness Center will be located in Davis, and targeted to programs for Transition Age Youth.

At the Wellness Centers, clients of all cultures share practices, beliefs, and ethnic foods, as well as games and other activities. Cultural holidays, such as *Cinco de Mayo*, are celebrated through activities of the Wellness Center. Consumers often engage in art projects involving painting, drawing, textiles, sculpture, jewelry, poetry and short stories. These projects reflect the cultural and religious diversity of the clientele, as well as their talents and imagination. An annual Consumer Art Show allows opportunity for projects to be displayed.

The *STAY (STAY=Support for Transition Age Youth) Well Center*, located on the local community college campus, provides an additional wellness program for transition age youth. The purpose of the *STAY Well Center* is to provide a wellness space for transition age youth (16-25 years old) and Woodland Community College (WCC) students. The Center aims to provide ongoing support and intervention for students facing mental health, personal, and/or academic challenges, enhance connectivity with peers and mentors, reduce stress and increase student persistence and success rates at WCC. The center addresses sensitive topics regarding mental, social, and physical health in a stigma free environment.

Recovery-oriented vocational rehabilitation opportunities continue to be offered to Wellness Center clients by Turning Point Community Programs at Cool Beans Coffee & Eats, a consumer-supervised, consumer-operated coffee station located at the Woodland Bauer Site. There the consumers develop self-confidence, as well as experience with making espresso drinks, selling food and snacks, and cashiering.

II. Responsiveness of mental health services

The county shall include the following in the CCPR:

- 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).
- 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.

The HHS Provider List is made available to clients and has historically identified providers/vendors and information regarding populations served, Non-English Languages Spoken and Cultural Considerations, including their services specific to LGBTQ, Physically Impaired, Visually Impaired, Hearing Impaired, Socioeconomic Groups-Extreme, Female Issues, Male Issues and Older Adult/Aging populations.

Updates to the Provider Directory are collected monthly and include the following:

- 1) Specialty populations served and specific services offered;
- 2) Cultural and linguistic services and capabilities, including languages offered and alternatives and options for culturally appropriate services; and
- 3) Whether the provider's office/facility has accommodations for people with physical disabilities, including offices, exam room(s) and equipment.

- C. Counties have policies, procedures, and practices to inform all Medi-Cal beneficiaries of available services under consolidation of specialty mental health services. (*Outreach requirements as per Section 1810.310, 1A and 2B, Title 9*)

(Counties may include a.) Evidence of community information and education plans or policies that enable Medi-Cal beneficiaries to access specialty mental health services; or b.) Evidence of outreach for informing under-served populations of the availability of cultural and linguistic services and programs (e.g., number of community presentations and/or forums used to disseminate information about specialty mental health services, etc.)

Please see appendix for:

- Policy and Procedure: Information Dissemination and Cultural Competency
- Policy and Procedure: Availability of Translated Materials
- Yolo County Guide to Mental Health Services

- 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;
 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
 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. (The county may

include evidence of a study or analysis of the above factors, or evidence that the county program is adjusted based upon the findings of their study or analysis.)

HHSA offices are ADA-compliant and close to public transportation. Efforts are made to decorate offices with paintings, sculptures and other objects that include artwork and scenes from varied cultural groups, making the offices welcoming to clients and the community. Consumer artwork is prevalent, both in the hallways and in treatment rooms, reflecting the diversity of the clientele.

The contract provider CommuniCare Health Centers has co-located behavioral health treatment with physical health clinic offices, which may serve to reduce stigma.

HHSA staff and providers continually strive to increase community-based and/or home-based services to increase access and improve outcomes for clients.

III. Quality of Care: Contract Providers

The county shall include the following in the CCPR:

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

Contract providers are required to provide information during the Request For Proposal (RFP) process regarding the capabilities, history and plans to provide culturally competent services. RFP proposals are evaluated and scored on multiple criteria in the selection of contract providers.

IV. Quality Assurance

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

The county shall include the following in the CCPR:

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

HHSA utilizes Results Based Accountability (RBA) framework to identify relevant client outcome measures for programs and services. Programs identify specific outcome measures for three levels:

PM1: How much did we do?

PM2: How well did we do it?

PM3: Is anyone better off?

Child Adolescent Needs and Strengths (CANS) and Adult Needs and Strengths Assessment (ANSA) are also utilized by staff members; targeted training for expanded understanding and use of these tools is planned for 2018.

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

Training evaluation forms were utilized in 2017 to gather feedback and suggestions regarding providing culturally and linguistic competent services. Cultural competency trainings provided and feedback solicited for the following populations:

- 1) Russian-Speaking Immigrants and Communities
- 2) Spanish-Speaking Communities
- 3) LGBTQ+ Populations and Communities
- 4) Individuals with Military Experience (Veterans)

During 2018, the Cultural Competence Committee plans to conduct Program and Service Reviews during committee meetings to gain additional information regarding staff's experience and opinions regarding HHSA's ability to value cultural diversity in its workforce and provision of culturally and linguistically competent services. CCC will also review available HHSA staff satisfaction survey results.

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

Process

Upon receipt of a grievance from a consumer:

- Information is verified in the Electronic Health Management Information System, including Medical Record Number, Address, Phone number;
- If the grievance is related to service delivery, notes in the system are reviewed;
- Medi-Cal is checked/verified;
- Information is noted in a tracking log, with the grievance date;
- An acknowledgement of the grievance is mailed to the individual with contact information for Quality Management (QM); and
- A written response is sent within 60 days.

During the investigation phase, QM staff gathers information by talking with the grieving party regarding the circumstances surrounding the grievance, and learning what the party would like to have done to resolve the grievance. Other necessary parties (e.g., staff involved in the grievance, staff that might have information surrounding the circumstances) are interviewed. Finally, a plan to address the grievance is developed and implemented, with notification back to the party who filed the grievance.

Quality Improvement Committee (QIC) Reports
Grievance data is reviewed during QIC meetings.

APPENDIX LISTING

1. CSS Plan: Population Assessment
2. Organizational Chart
3. Cultural Competence Committee Meeting Topics
4. Cultural Competence/Ethnic Services Manager's QIC Updates
5. Staff and Provider Ethnicity and Proficiency Surveys
6. Agency Self-Assessment of Cultural Competence Tool
7. WET Plan Workforce Needs Assessment
8. Policy and Procedure: Information Dissemination and Cultural Competency
9. Policy and Procedure: Cultural Competency and Training of Interpreters
10. HHSA's Bilingual Staff Roster
11. Policy and Procedure: Language and Special Communications Needs
12. Policy and Procedure: Availability of Translated Materials
13. Yolo County Guide to Mental Health Services