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CHECKLIST OF THE

CULTURAL COMPETENCE PLAN REQUIREMENTS MODIFICATION (2010)

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Purpose

The Cultural Competence Plan Requirements (CCPR), as detailed in DMH Information Notice 10-02, establish new standards and criteria for the entire County Mental Health System, including Medi-Cal services, Mental Health Services Act (MHSA), and Realignment as part of working toward achieving cultural and linguistic competence. Each county must develop and submit a cultural competence plan consistent with these CCPR standards and criteria (per California Code of Regulations, Title 9, Section 1810.410). “CCPR” in this document shall mean the county’s completed cultural competence plan submission inclusive of all requirements. The original CCPR (2002), Department of Mental Health (DMH) Information Notice 02-03, addressed only Medi-Cal Specialty Mental Health Services, while the revised CCPR (2010) is designed to address all mental health services and programs throughout the County Mental Health System. The CCPR (2010) seeks to support full system planning and integration. The revised CCPR (2010) includes the most current resources and standards available in the field of cultural and linguistic competence and is intended to move toward the reduction of mental health service disparities identified in racial, ethnic, cultural, linguistic, and other unserved/underserved populations. The revised CCPR (2010) works toward the development of the most culturally and linguistically competent programs and services to meet the needs of California’s diverse racial, ethnic, and cultural communities in the mental health system of care.

CCPR Modification (2010)

In response to small county requests, DMH has worked closely with the California Mental Health Director’s Association Small Counties’ Committee to develop an abridged version of the full CCPR. The modified version of the full CCPR shall from herein be called the CCPR Modification (2010).

The California Department of Mental Health is using the California Code of Regulations, Title 9, Section 3200.260, for the definition of eligible “Small Counties”. Those "Small Counties" who are eligible, may complete and submit a CCPR Modification (2010) or elect to submit the full CCPR (2010) (DMH Information Notice 10-02). The submission deadline for small counties shall be March 15, 2011.

Background

The CCPR (2002) revised addendum indicated that “future CCP requirements will evolve as more experience through plan development and implementation progresses. While efforts are being made on an ongoing basis to achieve cultural competence, as our competence improves, our standards will need to improve.” The CCPR Modification (2010) serves as an outcome of these advances in the field of cultural competence. DMH seeks to keep the County Mental Health System updated with the latest studies and applications in the field of cultural and linguistic competence, so that the mental health system functions as a highly efficient organization with the ability to provide effective and integrated services to its ethnic/racial and cultural communities. The

CCPR Modification (2010) serves to operationalize cultural competence at both the organizational and contractor level.

The basis for the revised CCPR (2010) and the CCPR Modification (2010) criteria is the U.S. Department of Health and Human Services, Office of Minority Health (2001) *National Standards for Culturally and Linguistically Appropriate Services in Health Care: Executive Summary* (CLAS) [See Federal Standards, page 28 of this CCPR Modification (2010)]. The revised CCPR Modification (2010) criteria were developed from a compilation of the CCPR (2002), CLAS, and other current cultural competence organizational assessment tools (see attached references). Combined, these documents incorporate eight domains that cover a system in its entirety:

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

(Source: University of South Florida, 2006. *Organizational Cultural Competence: A Review of Assessment Protocols)*

Research on the above eight domains included review and analysis of 17 organizational level cultural competence assessment tools being used in the field today. The research yielded a compilation of the eight significant assessment domains as focus areas for assessing and integrating cultural competence into mental health programs. The domains work to create an organizational model for operationalizing cultural competence into systems. The inclusion of these eight domains is necessary for a County Mental Health System to effect change and progress towards a culturally competent mental health system of care in California.

From the above eight *domains*, eight *criteria* were developed to encompass the revised CCPR Modification (2010) and assist counties in identifying and addressing disparities across the entire mental health system. Those eight criteria are as follows:

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

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

The County Mental Health System in California has changed greatly with the passage of the MHSA. The MHSA has opened many doors for unserved/underserved individuals and works toward increasing the county workforce. As MHSA expands and increases services, DMH recognizes that county reporting requirements have also increased. The CCPR Modification (2010) takes this into consideration and has focused on omitting reporting redundancies by developing one, single plan that will be applied to all programs throughout the system. Where applicable, the CCPR Modification (2010) requires copies or updates of areas already addressed in other reports or plans. Some areas will apply to Medi-Cal only, while other areas will apply to the entire system; these are delineated throughout the CCPR Modification (2010).

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

This CCPR Modification (2010) includes listings of required Federal and State statutes, regulations, and DMH policy letters related to cultural and linguistic competence in the delivery of mental health services. These provisions are in addition to other Federal or State laws that prohibit discrimination based on race, color, or national origin (for more information see page 27).

Timeframes

The revised CCPR Modification (2010) shall be submitted by each small county to DMH on a staggered three-year cycle (a comprehensive CCPR Modification (2010) is submitted every three years and an Annual Update is submitted in the interim years). Annual updates will be required and DMH will select specific criteria for counties to report on for each update. The first revised CCPR Modification (2010) will be due in March 2011; subsequent CCPR Modifications will be due in 2014 and 2017. Annual updates will be due in 2012, 2013, 2015, and 2016. California Code of Regulations, Title 9, Chapter 11, Medi-Cal Specialty MHS, Article 4, Section 1810.410 (c)-(d) states each Mental Health Plan (MHP) shall submit an annual CCPR update consistent with the requirements of this revised CCPR document, consistent with the plan reporting requirements, including the population assessment and organizational and service provider assessments.

Counties may direct all inquiries about this CCPR Modification (2010) to the California Department of Mental Health, Office of Multicultural Services at 916-651-9524.

Directions for completing the CCPR Modification (2010)

The DMH expects this CCPR Modification (2010) to be completed by the county Department of Mental Health (referred in document as county). The county will provide the plan to all county contractor(s) providing mental health services and hold the contractor(s) accountable for reporting the information to be inserted into the CCPR Modification (2010). The CCPR Modification (2010) must reflect the activities of the MHP (county and contractor) and both county and contractor are required to adhere to the plan. NOTE: The DMH recognizes that "small counties" may not contract with any contractors.

The DMH will review the CCPR Modification (2010) submission and will provide a score and feedback to the counties.

An original, three copies, and a compact disc of this CCPR Modification (2010) saved in PDF format (preferred) or Microsoft Word format 1997-2003 is due by March 15, 2011.

The CCPR Modification's Cover Sheet shall be the first sheet of the submitted document. Submissions should follow the assigned format identifying each criterion by number, criterion title, and page numbers. Sections of the CCPR Modification (2010) should be complete; however, if a section is incomplete (such as data is unavailable), identify the section and briefly explain when the section will be submitted to DMH. Counties must meet the submission deadlines. If submission timelines cannot be met, counties shall notify DMH ahead of time. Please call the Office of Multicultural Services at 916-651-9524 to discuss CCPR Modification (2010) deadline submissions.

YOLO COUNTY

CULTURAL COMPETENCE

Plan 2023

"A diverse mix of voices leads to better discussions, decisions, and outcomes for everyone."
-Sundar Pichai

“Rarely, if ever, are any of us healed in isolation. Healing is an act of communion."
-Bell Hooks

CRITERION 1
COUNTY MENTAL HEALTH SYSTEM COMMITMENT TO CULTURAL COMPETENCE

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

I. County Mental Health System commitment to cultural competence

Yolo County Health and Human Services Agency (HHSA) continues demonstrating a commitment to cultural competence, culturally responsive services, and this includes an expanded vision and commitment to the principles and practice of diversity, equity, inclusion and belonging (DEIB) as part of our system programming.

HHSA seeks to improve all people's mental health and resilience, especially those negatively impacted by the social determinants of health (SDH) and Adverse Childhood Experiences (ACES), and to reduce disparities and disproportionate

engagement in systems, as these factors are detrimental to the mental health of vulnerable populations.

Yolo County and HHSA launched the Yolo County Basic Income (YOBI) Project, putting resources in the hands of those marginalized by circumstances and the systems working for their long-term health and financial stability.

Our Adult and Aging Forensics teamwork with the county criminal justice system to increase access to Mental Health Court, Addiction Intervention Court, and other diversion programs offered by the District Attorney's office. This year the DA wrote new policy designed to increase access for Black, Indigenous, and people of color to these diversion programs by expanding eligibility guidelines. These guidelines benefitted all eligible residents, and increased access by 18%.

The Children's Mental Health Department secured a federal Families First Prevention Services Act grant to support youth and caregivers, prevent, or reduce entries into the Child Welfare system, and to address the disproportionate engagement of Black, Indigenous, and LatinX families in the CWS system. Prevention Planning is in progress.

Further, HHSA and Yolo County overall operate multiple organizations to further cultural competency, including:

- HHSA Cultural Competence Committee
- Team Equity! The internal facing CCC workgroup addressing systemic inequities
- District Attorney's Multi-Cultural Community Council

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

Throughout 2021, HHSA engaged in various virtual and in-person activities to demonstrate the ongoing commitment to community outreach, engagement, and inclusion efforts with identified racial, ethnic, cultural, and linguistic communities with mental health disparities.

Community Outreach activities and partnerships to communicate the organization's progress in implementing Culturally and Linguistically Appropriate Services (CLAS) to all stakeholders, constituents, and the public, and to foster and sustain trust and relationship between the community and the service setting (CLAS Stand. 15) include several new partnerships, including:

- Yolo County Public Defenders' Office joined our Cultural Competence Committee (CCC) to offer two Expungement Clinics to the community.

- NorCal Resist, partnered with the CCC to offer two Free Brake Light Repair and Community Tables to the community.
- Unite Us, is a person-centered care coordination platform, which securely standardizes how health and social care providers securely communicate and track outcomes together. More than 40 Yolo County primary care and behavioral health providers, including HHSA have joined this platform to streamline referral processes and share data results.

Our work continues with these long-standing partners as well:

- Yolo County Library outreach and education
- MHSA Integrated Behavioral Health Services Rise Promotores Program-Latino Outreach focused on reducing stigma and increasing knowledge and access to behavioral health resources among Latinx farmworkers.
- CREO Outreach, programming addressing the needs of the migrant and/or monolingual community. CREO Program outreach offering behavioral health education/counseling and case management from a bilingual/bicultural perspective.
- CREO program hosting weekly Community "Platicas" in Spanish, on a virtual platform with relevant topics such as Public Charge, DACA Information, and Connecting Culture and Wellness to promote healthy outcomes.
- CREO Program hosted a Dia de los Muertos community event to honor the rich and culturally relevant experiences of the Latino Community in Yolo County. The event included an interactive altar, health education, music and dance, and was held in a Community Garden.
- Empower Yolo, offers outreach, engagement and assistance to domestic violence, assault, molestation, and trafficking victims and education to the community and professionals.
- Yolo Food Bank
- Health Education Council assists in outreach to the Russian speaking community and collaboration with the Mexican Consulate.
- Yolo Children's Alliance advances the work of the Yolo County Child Abuse Prevention Council and organizes food, coat and toy giveaways for the community.
- Resilient Yolo is a partnership with dedicated non-profit and CBO providers offering ACEs screening and trainings to educational and health systems. Partnership with UCD Perinatal Origins of Disparities/ACEs Aware Project.
- Cool Davis, an organization dedicated to climate change issues with a racial equity lens

- UC Davis Pow Wow, participation in this annual event communicates support and relationship with First Nations community members.
- District Attorneys' Multi-Cultural Community Council, partnership on criminal justice Community Transparency Dashboard, and Race Blind charging Project became Assembly Bills codified into statewide laws this year; sponsors annual Youth Leadership Academy 3-day event; presents monthly virtual Commons Town Hall videos on a variety of topics related to racial equity and social justice.
- Woodland Ecumenical Multi-Faith Ministries
- Collaboration with City of Davis Climate Action and Adaptation Plan as member of the Technical Advisory Committee offering racial equity and cultural considerations to inform the Plan.
- YoloCares completed a three-year health equity project, Life Transitions. Supported by the Yocha Dehe Wintun Nation and Sutter Health, Life Transitions is a community health needs assessment (CHNA) designed to identify and address barriers to end-of-life care for Native American and rural communities. The CHNA was compiled into a final report which was distributed to health systems, providers, and the public, including to over 50 hospices nationwide.

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

The DEI Coordinator plans, coordinates, implements, communicates, and evaluates cultural and linguistic healthcare and outreach services and programs offered by the Health and Human Services Agency (HHSA); coordinates and promotes quality and equitable care to racial and ethnic populations; develops, coordinates, and facilitates the implementation of the Cultural Competence Plan including training and education programming; and improves staff needs or support by addressing systemic inequities and developing racial equity programming as directed in the Health and Human Services Agency Strategic Plan. The DEI coordinator is responsible for administering, implementing, maintaining, and evaluating all direct services for the HHSA Cultural Competence Program and leading, monitoring, and training program staff.

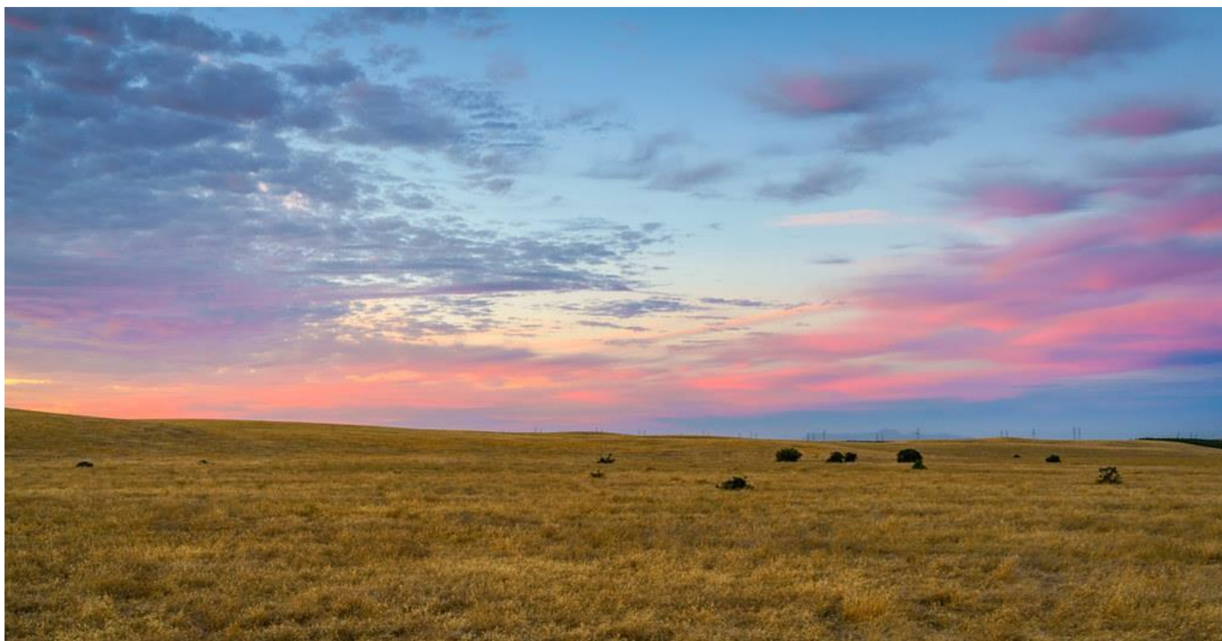
DEI Coordinator, Tessa Smith, serves as the HHSA Cultural Competence/Ethnic Services Manager, participating in the CBHDA Cultural Competence, Equity, and Social Justice Committee and the Central Region Ethnic Services Manager workgroup, and managing HHSA Cultural Competence Committee activities.

III. Identify budget resources targeted for culturally competent activities

Several budget line items were targeted for culturally competent activities in 2022 including:

- Trainings:
  - LGBTQ+/Cultural Competency Initiative trainings
    - LGBTQ+ Youth resilience activities

        - Appropriate use of Pronouns
    - Interpreter Services and Language Line Training--Use of cross-cultural interpretation services
    - Cultural Considerations when engaging special populations including:
        - Russian Speaking population
        - Indigenous population
        - Asian/Pacific Islander
        - LatinX
        - Africa Diaspora
        - Faith-Based communities
        - Other special subject matter as identified, i.e.,Neuro-diversity, etc.
- Bilingual staff pay differential
- MH Services for Deaf and Hard of Hearing (NorCal Services)
- Integrated Behavioral Health Services for Latino Community and Families
- MHSA Programs to address needs of PEI priority populations and CSS unserved/underserved.
- Membership in the Government Alliance for Racial Equity (GARE) for all county staff
- Cultural Competence Plan funding allocations for 2022 and continuing in 2023 include:
- Agency wide training and education on health and racial equity; disparities and disproportionality in systems of care.
- Update artwork and photos throughout the HHSA buildings to celebrate our diverse community.
- Staff Wellness Spaces
- Heritage Fair & training in cultural appreciation and humility.
- Community Resource and Healing Space for African American Families
- The development and implementation of programming to reduce disparities and promote resilience in underserved populations through culturally responsive outreach, engagement, and education to both the community and the staff that serves that community.
- Youth Programming-



“We need to create new opportunities for the world to understand what visions we have for the future, how we see ourselves, our people, and our communities.”
– Xiuhtezcatl Martinez

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.

Note: All counties may access 2007 200% of poverty data at the DMH website on the following page: http://www.dmh.ca.gov/News/Reports_and_Data/default.asp within the link titled “Severe Mental Illness (SMI) Prevalence Rates”. Counties shall utilize the most current data offered by DMH.

Note: This Criterion includes significantly more data from our MHSA plan and CAEQRO. This is intentional, as we will do an in-depth examination of this data using a trauma-informed, racial equity lens to develop our 3-year CCP in 2023.

I. **General Population Data-NOTE:** The data on this page contains inaccuracies, most notably regarding the Black/African American population in Yolo County. According to the latest U.S. Census Bureau Report, Black/African Americans

represent 3.2% of Yolo County population.
https://www.census.gov/quickfacts/yolocountycalifornia

Community Characteristics of Yolo County

Yolo County spans 1,015 square miles and is home to 216,986 people as of the July 2021 estimates by the U.S. Census Bureau.[1] Yolo County has four incorporated cities - Davis, West Sacramento, Winters, and Woodland—and several census designated places and unincorporated communities-Brooks, Clarksburg, Dunnigan, El Macero, Esparto, Guinda, Knights Landing, Madison, Monument Hills, Rumsey, Tancred, University of California-Davis, Yolo, Capay, El Rio Villa, Fremont, Jacobs Corner, Kiesel, Merritt, Mikon, Norton, Plainfield. Riverview, Sugarfield, Valdez, Vin, and Zamora.[2] The Patwin people are native to this region, and they comprise the federally recognized tribes of Cachil DeHe Band of Wintun Indians of the Colusa Indian Community, Kletsel Dehe Wintun Nation, and Yocha Dehe Wintun Nations.[3]

Yolo County has always been an agricultural area. UC Davis, the largest employer in the county, began as a research farm site for UC Berkeley. Currently, UC Davis is number one in the nation for agriculture and veterinary medicine studies. The demographics and health outcomes of the county can fluctuate regionally and seasonally with the influx and outflux of UC Davis affiliates. UC Davis has 38,347 enrolled students this year.

Demographics[4,5]

In Yolo County, 52% of the population is female and 48% is male (Table 1). Age distributions in Yolo County are similar to California, however a greater portion of Yolo County's population are young adults than California's young adult population (15 to 24 years old). Disproportionate to the rest of the county, Davis has more 15- to 24-year-olds (41%) than Yolo County and California. This is likely due to UC Davis enrollment.

Overall, in Yolo County, persons 14 years and younger comprise 17% of the population, 24% are 15 to 24 years, 41% are 25 to 59 years, and 18% are 60 years and older (Table 2). Clarksburg (27%) and Knights Landing's (30%) population skews older, with more people 60 and older.

Table 1. Sex Demographics, 2020 American Community Survey 5-Year Estimates

	Male	Female
Clarksburg	55%	45%
Davis	47%	53%
Esparto	45%	55%
Knights Landing	52%	48%
West Sacramento	49%	51%
Winters	53%	47%
Woodland	50%	50%
Yolo County	**48%**	**52%**
California	**50%**	**50%**

Table 2. Age Demographics, 2020 American Community Survey 5-Year Estimates

	0–14 years	15–24	25–59	≥60
Clarksburg	26%	0%	45%	27%
Davis	11%	41%	33%	16%
Esparto	30%	13%	41%	16%
Knights Landing	20%	9%	40%	30%
West Sacramento	23%	14%	47%	17%
Winters	18%	15%	51%	15%
Woodland	20%	14%	47%	19%
Yolo County	**17%**	**24%**	**41%**	**18%**
California	**19%**	**13%**	**48%**	**20%**

County-wide, the largest groups are White, non-Hispanic/Latino (46%) followed by White, Hispanic/Latino (21%), and Asian (14%). Clarksburg (66%), Davis (51%), and Winters (51%) have greater portions of White, non-Hispanic/Latinos that exceeded Yolo and California's White, non-Hispanic/Latino population (37%). The Black/African American and American Indian/Alaska Native population hovers between 0% to 3% in most Yolo communities, and the Hawaiian/Pacific Islander population is less than 1% in every community (Table 3).

Table 3. Race and Ethnicity, 2020 American Community Survey 5-Year Estimates

	Clarksburg	Davis	Esparto	Knights Landing	West Sacramento	Winters	Woodland	Yolo County	California
White–Not Hispanic or Latino	66%	51%	48%	40%	44%	51%	37%	46%	37%
White–Hispanic or Latino	16%	9%	40%	38%	19%	28%	33%	21%	20%
Black or African American	0%	3%	0%	2%	5%	0%	2%	3%	6%
American Indian and Alaska Native	0%	0%	0%	1%	1%	0%	1%	1%	1%
Asian	2%	25%	2%	1%	12%	0%	8%	14%	15%
Native Hawaiian & Other Pacific Islander	0%	0%	0%	0%	1%	0%	0%	0%	0%
Some other race	0%	3%	4%	7%	7%	9%	8%	6%	14%
Two or more races	16%	8%	6%	12%	12%	11%	11%	10%	8%

Most households in Yolo County speak English only at home (64%) (Table 4). Other languages spoken in Yolo households are Spanish (21%), Other Indo-European languages (7%) which include Russian, and Asian/Pacific Islander languages (8%). The Department of Health Care Services has identified English, Spanish, and Russian as threshold languages in Yolo County. A threshold language is defined as a primary language: (a) in a service area with 3,000 people or 5% of the population (whichever is lower) or (b) 1,000 individuals in a ZIP code or 1,500 in two contiguous ZIP codes.

Knights Landing has the lowest percentage of households speaking only English at home (54%), and Clarksburg has the highest percentage of English only speaking households (100%). In Esparto and Knights Landing, over 40% of households speak Spanish. Davis has the highest percentage of Asian speaking households (15%) in Yolo County.

Table 4. Language Spoken At Home, 2020 American Community Survey 5-Year Estimates

	Clarksburg	Davis	Esparto	Knights Landing	West Sacramento	Winters	Woodland	Yolo County	California
English only	100%	70%	56%	54%	60%	63%	58%	64%	56%
Spanish	0%	8%	42%	45%	21%	37%	34%	21%	28%
Other Indo-European languages (including Russian)	0%	6%	1%	0%	12%	1%	4%	7%	5%
Asian and Pacific Islander languages	0%	15%	2%	1%	6%	0%	4%	8%	10%
Other languages	0%	1%	0%	0%	1%	0%	0%	1%	1%

Following state trends, Yolo County's civilian veteran population rate ranges from 2% to 6%. Esparto (6%) and West Sacramento (6%) have the highest percentage of veterans, and Clarksburg (2%) has the lowest percentage of veterans in their population.

Table 5. Veteran Status, 2020 American Community Survey 5-Year Estimates

	Clarksburg	Davis	Esparto	Knights Landing	West Sacramento	Winters	Woodland	Yolo County	California
Civilian veterans	2%	3%	6%	3%	6%	4%	5%	4%	5%

Health Factors[1,2,3,4]

In addition to a person's individual lifestyle, socioeconomic (income, education, employment) and environmental (community safety, accessible services) factors can influence a person's health outcomes. Sometimes these factors can be so impactful that they supersede an individual's efforts to maintain physical and mental wellness or reach optimum health across the lifespan. In Yolo County, environmental and socioeconomic health disparities seem to exist between regions of the county and between racial and ethnic groups of Yolo County. Although most outcomes are comparable to state or national outcomes, some indicators showed that Yolo County is faring better (Table 6).

Yolo County's Racial Disparity in Poverty Score (0.12) showed that that were slightly higher gaps in poverty rates between racial and ethnic groups in Yolo County than poverty disparities by race/ethnic groups in California as a whole (0.10). For this measure, zero indicates no gaps in poverty rates by racial/ethnic groups, and a score of 1 represents great differences in poverty rates by racial/ethnic groups.

When looking at the Segregation Index score, Yolo County had a better score (0.19) than California (0.32) and the United States (0.39). A lower score indicates that a community is more racially and ethnically integrated.

The Gini Index, a smmary measure of income inquality, Score for Yolo County (0.49) was the same as California's score and higher than the United States score (0.44). Unfortunately, a score closer to 0 is more favorable and indicates less income inequality across the population.

Table 6. Disparity Scores, US News and World Report, 2022

	Racial Disparity in Poverty	Segregation Index Score	Gini Index Score
Yolo County	0.12	0.19	0.49
California	0.10	0.32	0.49
United States	0.13	0.39	0.44

In Yolo County, life expectancy at birth varies from 69.5 years to 89.4 years by census tract (Table 7). An average of all census tracts shows a Yolo citizen's life expectancy to be 82.3 years. On average by location, Clarksburg (84.4 years), Davis (86.7 years), Esparto (80.9 years), Woodland (80.1), and Zamora/Knights Landing (82.2 years) have life expectancies that exceed 80 years. The remaining locations, West Sacramento (77.9 years) and Winters (79 years), have life expectancies below 80 years.

If there were equity by location, there would be consistent life expectancies by location and census tract, which we do not see in this region. For example, on average those in West Sacramento have a shorter life expectancy (77.9 years) compared to those living in Davis (84.3 years). Across census tracts with the lowest (69.5 years) and highest (89.4) life expectancies there is a disparity of 19.9 years.

Table 7. Life Expectancy by Census Tract, Yolo County, 2020

Census Tract	Location	Life Expectancy
101.01	West Sacramento	75.6
101.02	West Sacramento	76.2
102.01	West Sacramento	76.3
102.03	West Sacramento	69.5
102.04	West Sacramento	77.7
103.02	West Sacramento	76.1
103.1	West Sacramento	80.2
103.12	West Sacramento	82.5
104.01	Clarksburg	84.4
104.02	West Sacramento	86.8
105.01	Davis	N/A
105.05	Davis	89.4
105.08	Davis	87.7
105.09	Davis	87.2
105.1	Davis	88.6
105.11	Davis	83
105.12	Davis	88.6
105.13	Davis	85.4
106.02	Davis	77.8
106.05	Davis	78.7
106.06	Davis	79.8
106.07	Davis	84.4
106.08	Davis	84.3
107.01	Davis	82.1
107.03	Davis	84.3
107.04	Davis	83.9
108	Woodland	73.4
109.01	Woodland	77.5
109.02	Woodland	74.5
110.01	Woodland	81.6
110.02	Woodland	82.2
111.01	Woodland	78.4
111.02	Woodland	77.8
111.03	Woodland	86.6
112.03	Woodland	87.7
112.04	Woodland	80.2
112.05	Woodland	81.9
112.06	Woodland	79.5
113	Winters	79
114	Zamora/Knights Landing	82.2
115	Esparto	80.9

Life expectancy by race in Yolo varied by group but followed state and national trends (Table 8). In Yolo County, Asian/Pacific Islanders (86.66 years) and Hispanic/Latino (82.65 years) have the longest life expectancy. The White, Non-Hispanic population's life

Table 12. Percent Below the Poverty Level by Age Group, 2020 American Community Survey 5-Year Estimates

	Overall	Under 18 years	18–64 years	65 years and over
Clarksburg	0%	0%	0%	0%
Davis	30%	9%	38%	5%
Esparto	13%	19%	8%	15%
Knights Landing	16%	32%	14%	4%
West Sacramento	16%	22%	14%	14%
Winters	9%	7%	9%	19%
Woodland	11%	13%	10%	9%
Yolo County	**19%**	**15%**	**22%**	**9%**
California	**13%**	**17%**	**12%**	**10%**

By race, Black/African American (35%), Asian (34%), and American Indian/Alaska Natives (24%) had the greatest percent population under the poverty level in Yolo County. In Davis, the same three groups had the greatest percent population under the poverty level, however these groups had poverty rates that exceeded California rates for the same groups by 2 to 4 times. Clarksburg did not have any groups that were below the poverty level.

Yolo County's homelessness count has increased 15% from 2019 to 2022. At a point-in-time survey administered on February 22, 2022, there were 33.7 individuals experiencing homelessness per 10,000 residents. West Sacramento had the highest rates of homelessness (53.8), and Winters and rural communities had the lowest rates (3.2).

Among those experiencing homelessness, 12% were children under 17 years, 3% were young adults 18 to 24 years, 53% were adults over 24 years, and 32% had unknown ages. A small portion of those experiencing homelessness had post-traumatic stress disorder (14%), serious mental illness (16%), substance use disorder (13%), or had co-occurring mental health and substance use disorders (6%). Three percent were veterans. During this survey, 29% were female, 53% were male, and the remaining had unknown gender identities (17%).

Table 14. Individuals Experiencing Homelessness per 10,000 Residents

	2017	2019	2022
Davis	21.4	27.2	27.9
West Sacramento	32.8	35.6	53.8
Woodland	22.8	39.5	44.4
Winters and Rural Communities	2.3	9.06	3.2
Total County	**21.4**	**29.4**	**33.7**

Table 15. Age Demographics of Those Experiencing Homelessness, February 2022

	%
Children (0–17 years)	12%
Young Adults (18–24 years)	3%
Adults (25+ years)	53%
Unknown Age	32%
Total County	**21.4**

Table 19. Educational Attainment, 2020 American Community Survey 5-Year Estimates

	Clarksburg	Davis	Esparto	Knights Landing	West Sacramento	Winters	Woodland	Yolo County	California
Less than 9th grade	0%	1%	7%	19%	7%	13%	10%	7%	9%
9th to 12th grade, no diploma	0%	1%	11%	14%	8%	5%	8%	6%	7%
High school graduate (includes equivalency)	26%	7%	22%	23%	21%	21%	25%	18%	20%
Some college, no degree	26%	12%	35%	15%	25%	23%	22%	20%	21%
Associate's degree	27%	5%	5%	7%	10%	13%	8%	7%	8%
Bachelor's degree	19%	32%	16%	15%	19%	12%	17%	22%	22%
Graduate or professional degree	2%	43%	4%	8%	12%	13%	11%	21%	13%

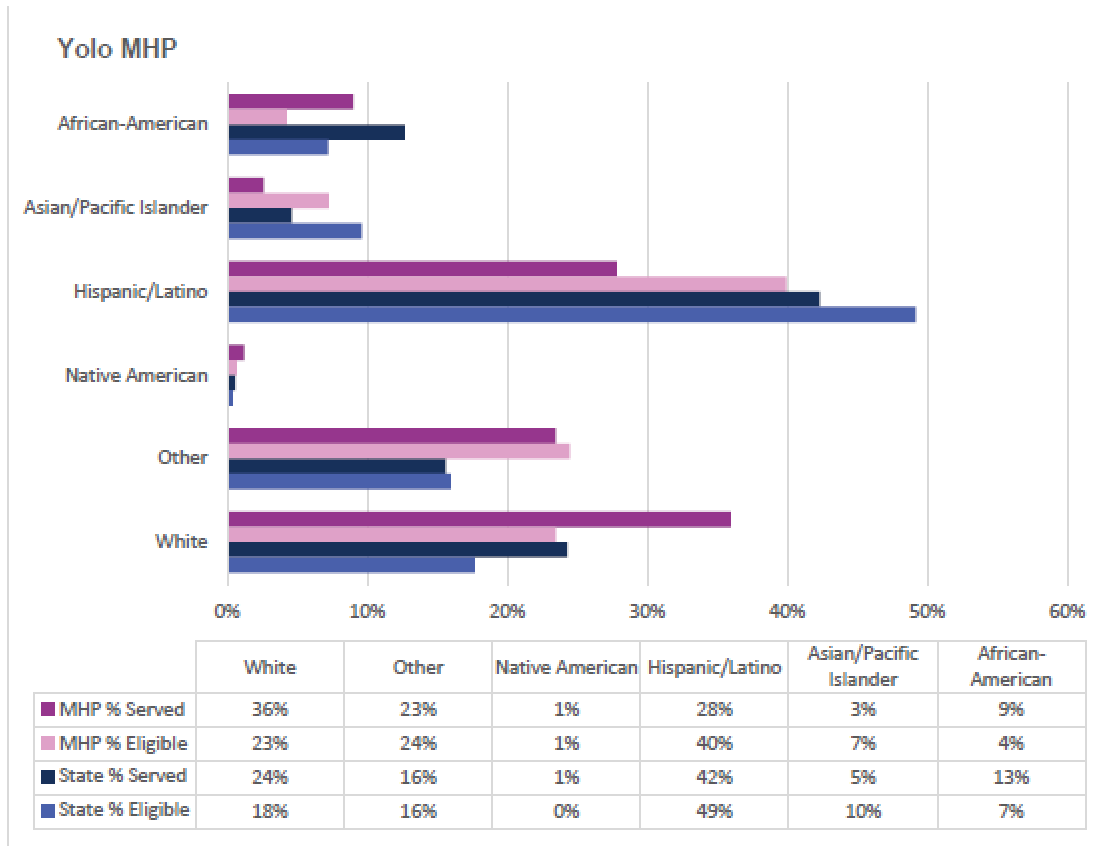
II. Medi-Cal population service needs (Use current CAEQRO data if available)

Section A: Summary by race/ethnicity, language, age, gender, and other relevant small county cultural populations:

Table A-1: County Medi-Cal Eligible Population and Beneficiaries Served by the MHP in CY 2021, by Race/Ethnicity

Race/Ethnicity	Annual Eligibles	Beneficiaries Served	PR MHP	PR State
African-American	2,547	174	6.83%	7.64%
Asian/Pacific Islander	4,366	50	1.15%	2.08%
Hispanic/Latino	24,056	540	2.24%	3.74%
Native American	403	23	5.71%	6.33%
Other	14,730	455	3.09%	4.25%
White	14,121	698	4.94%	5.96%
Total	**60,223**	**1,940**	**3.22%**	**4.34%**

Fig. A-2: Percentage of Eligibles and Beneficiaries Served by Race/Ethnicity, CY2021



	White	Other	Native American	Hispanic/Latino	Asian/Pacific Islander	African-American
MHP % Served	36%	23%	1%	28%	3%	9%
MHP % Eligible	23%	24%	1%	40%	7%	4%
State % Served	24%	16%	1%	42%	5%	13%
State % Eligible	18%	16%	0%	49%	10%	7%

Table A-2: Beneficiaries Served by the MHP in CY 2021, by Threshold Language

Threshold Language	Unduplicated Annual Count of Medi-Cal Beneficiaries Served by the MHP	Percentage of Medi-Cal Beneficiaries Served by the MHP
Spanish	192	9.90%
Threshold language source: Open Data per BHIN 20-070		

Figure 1: Overall Penetration Rates CY 2019-21

Yolo MHP

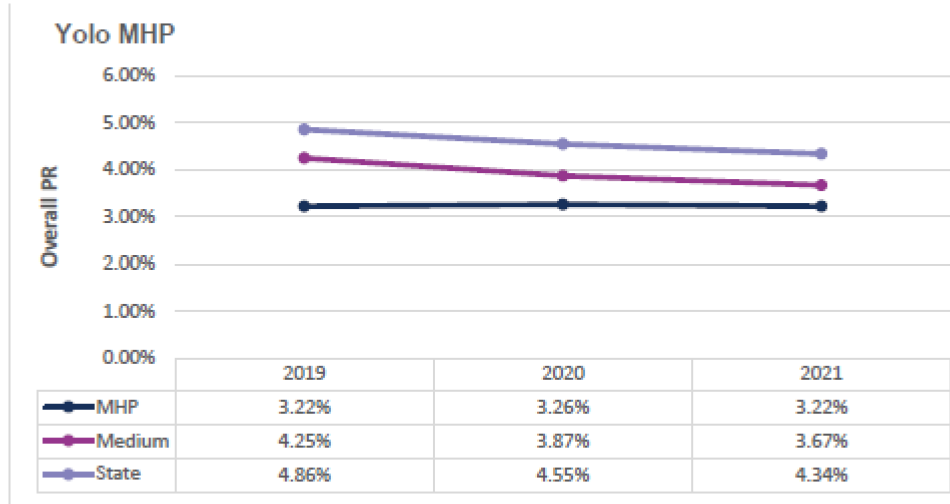


Figure 2: Overall ACB CY 2019-21

Yolo MHP

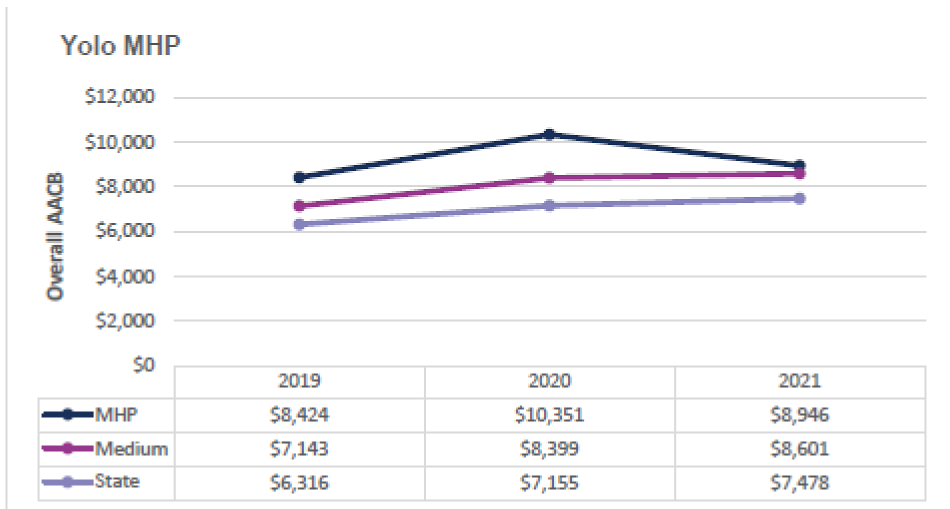
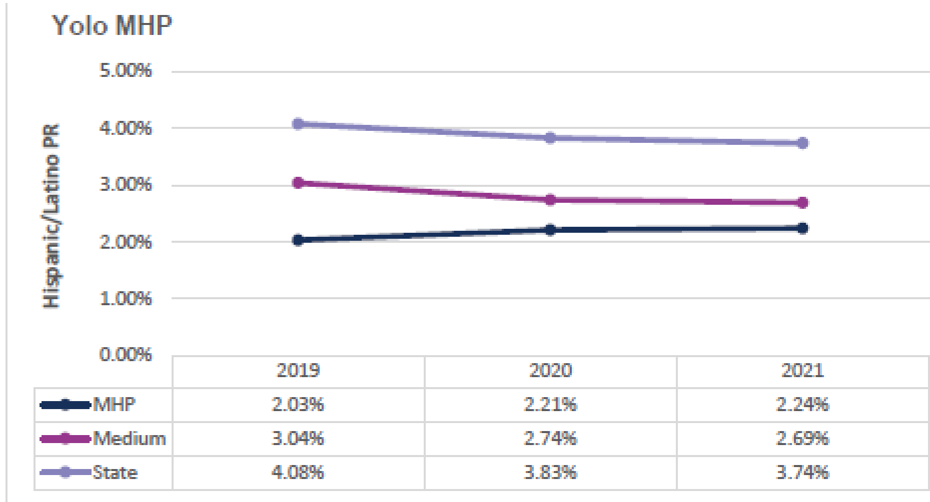


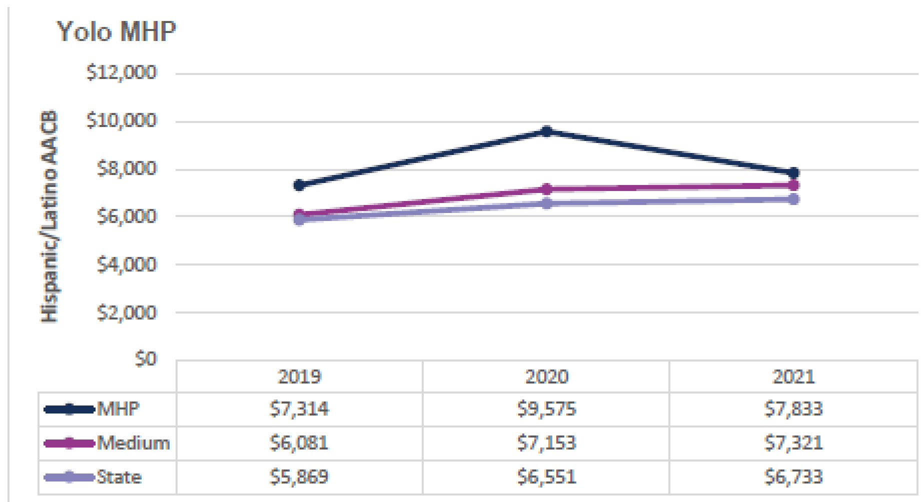
Figure 3: Latino/Hispanic Penetration Rates CY 2019-21

Yolo MHP



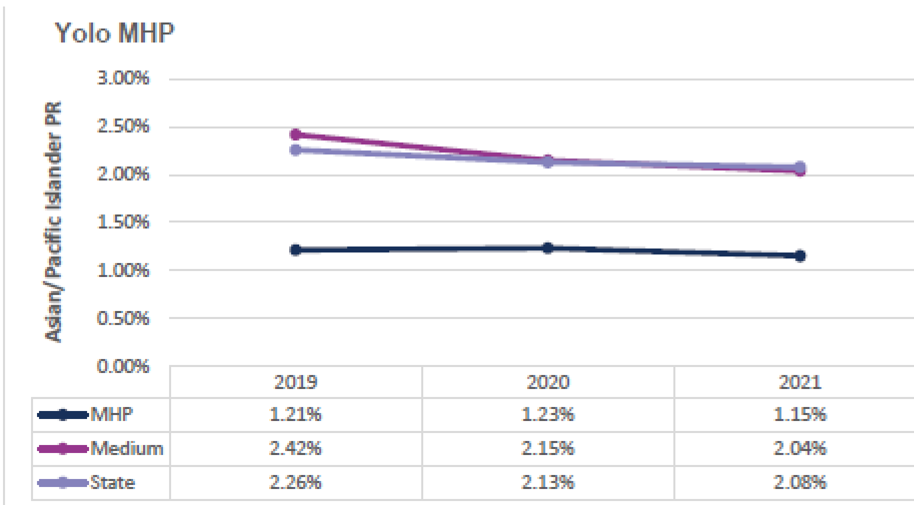
	2019	2020	2021
MHP	2.03%	2.21%	2.24%
Medium	3.04%	2.74%	2.69%
State	4.08%	3.83%	3.74%

Figure 4: Latino/Hispanic ACB CY 2019-21



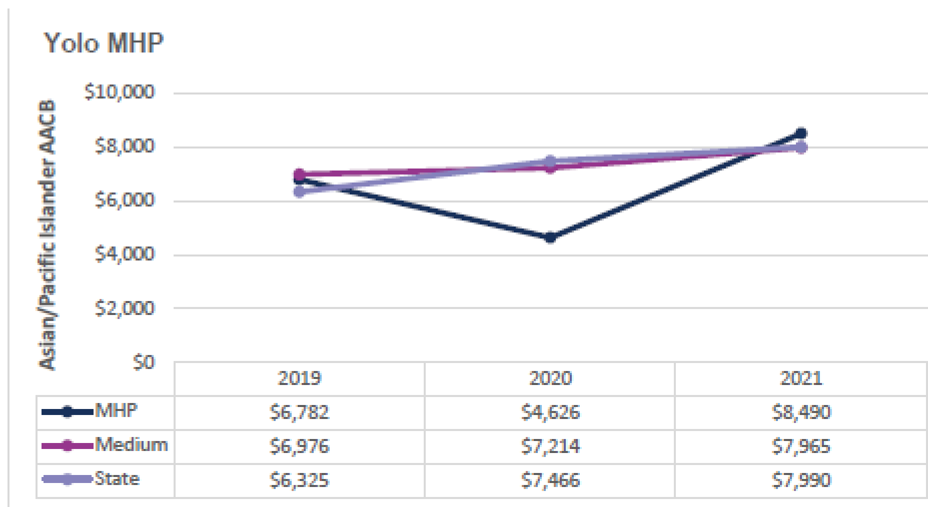
	2019	2020	2021
MHP	$7,314	$9,575	$7,833
Medium	$6,081	$7,153	$7,321
State	$5,869	$6,551	$6,733

Figure 5: Asian/Pacific Islander Penetration Rates CY 2019-21



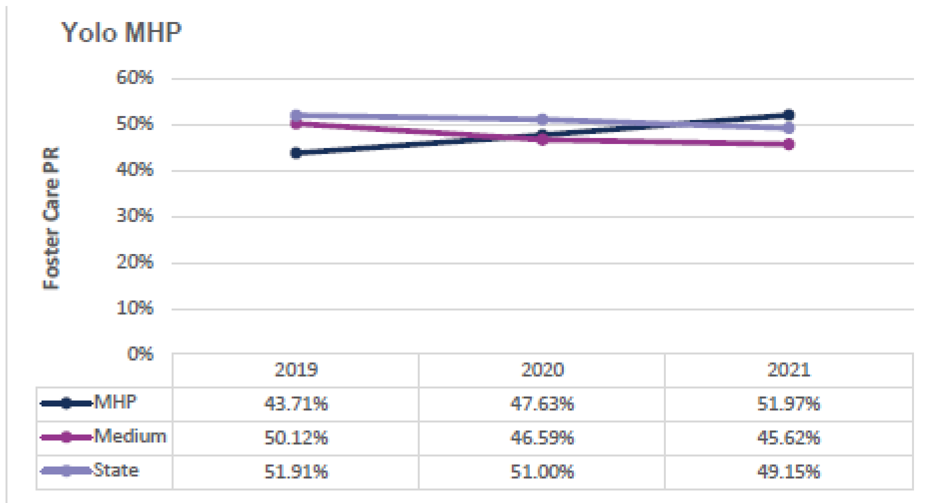
	2019	2020	2021
MHP	1.21%	1.23%	1.15%
Medium	2.42%	2.15%	2.04%
State	2.26%	2.13%	2.08%

Figure 6: Asian/Pacific Islander ACB CY 2019-21



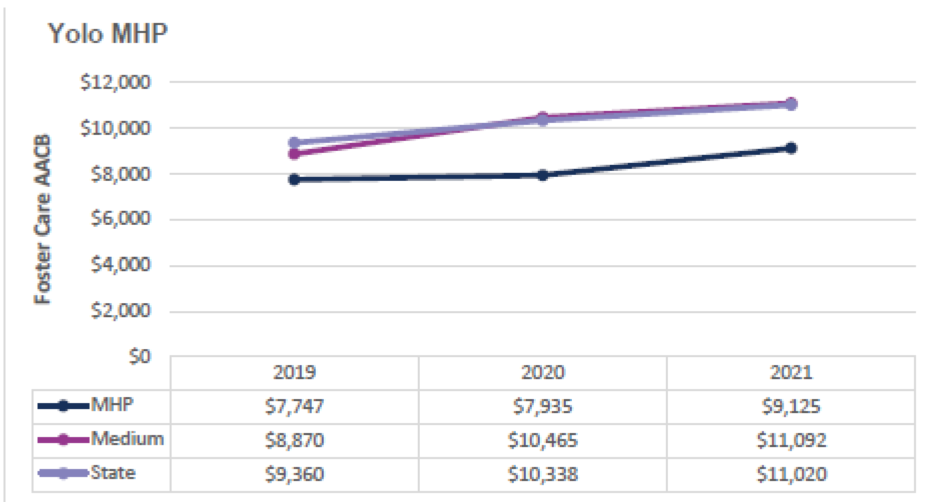
	2019	2020	2021
MHP	$6,782	$4,626	$8,490
Medium	$6,976	$7,214	$7,965
State	$6,325	$7,466	$7,990

Figure 7: FC Penetration Rates CY 2019-21



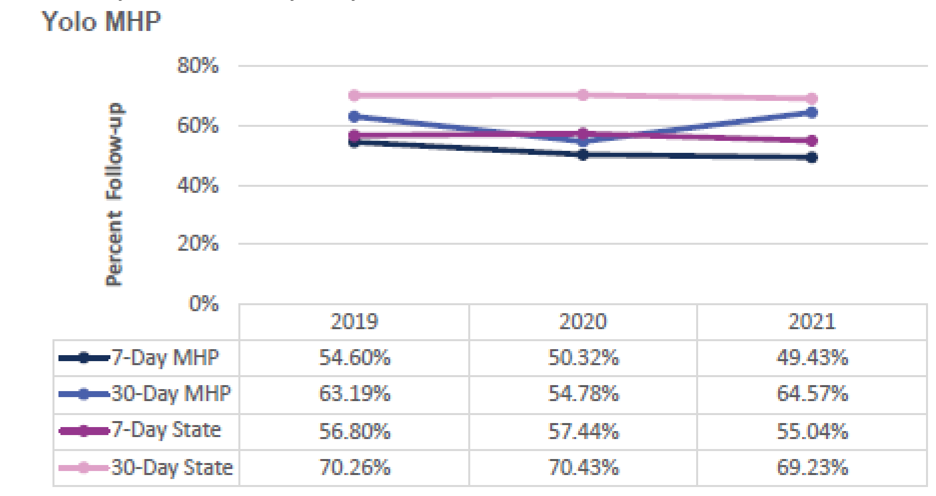
	2019	2020	2021
MHP	43.71%	47.63%	51.97%
Medium	50.12%	46.59%	45.62%
State	51.91%	51.00%	49.15%

Figure 8: FC ACB CY 2019-21



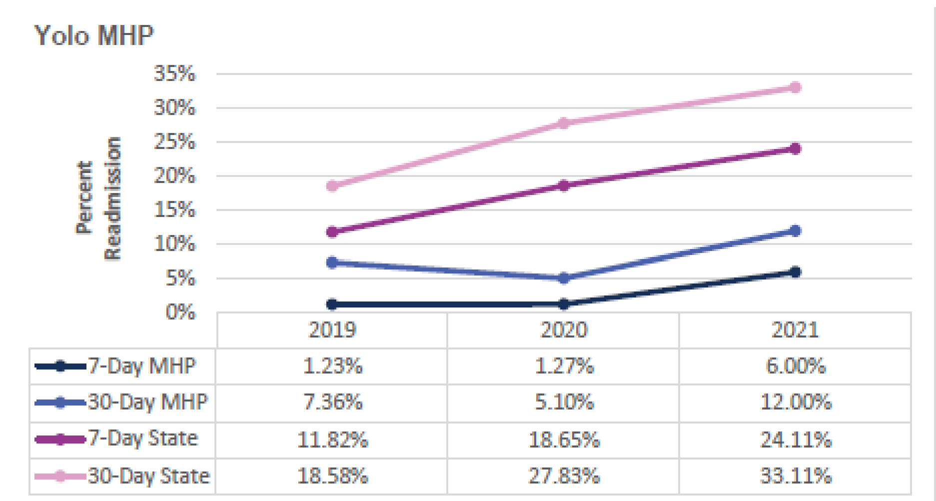
	2019	2020	2021
MHP	$7,747	$7,935	$9,125
Medium	$8,870	$10,465	$11,092
State	$9,360	$10,338	$11,020

Figure 10: 7-Day and 30-Day Psychiatric Readmission Rates CY 2019-21



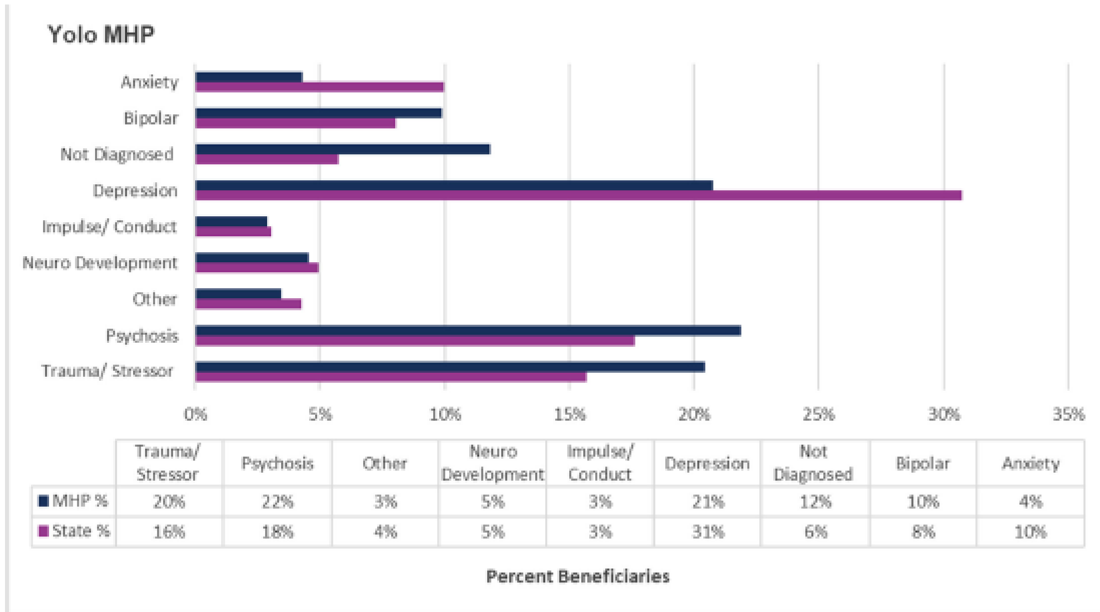
	2019	2020	2021
7-Day MHP	54.60%	50.32%	49.43%
30-Day MHP	63.19%	54.78%	64.57%
7-Day State	56.80%	57.44%	55.04%
30-Day State	70.26%	70.43%	69.23%

Figure 11: 7-Day and 30-Day Psychiatric Readmission Rates CY 2019-21



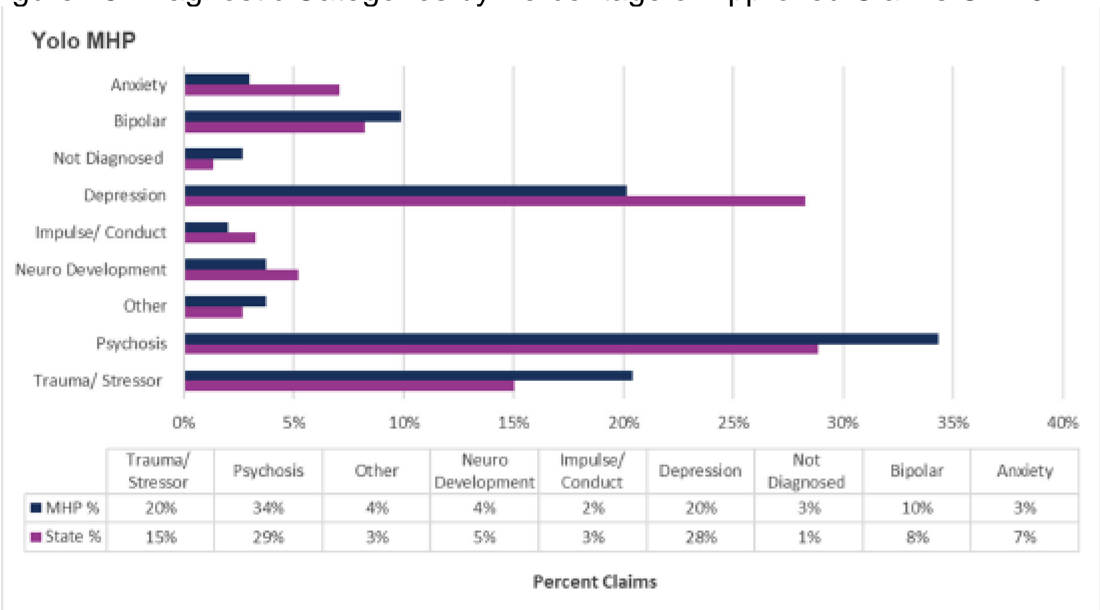
	2019	2020	2021
7-Day MHP	1.23%	1.27%	6.00%
30-Day MHP	7.36%	5.10%	12.00%
7-Day State	11.82%	18.65%	24.11%
30-Day State	18.58%	27.83%	33.11%

Figure 12: Diagnostic Categories by Percentage of Beneficiaries CY 2021



	Trauma/ Stressor	Psychosis	Other	Neuro Development	Impulse/ Conduct	Depression	Not Diagnosed	Bipolar	Anxiety
MHP %	20%	22%	3%	5%	3%	21%	12%	10%	4%
State %	16%	18%	4%	5%	3%	31%	6%	8%	10%

Figure 13: Diagnostic Categories by Percentage of Approved Claims CY 2021



	Trauma/ Stressor	Psychosis	Other	Neuro Development	Impulse/ Conduct	Depression	Not Diagnosed	Bipolar	Anxiety
MHP %	20%	34%	4%	4%	2%	20%	3%	10%	3%
State %	15%	29%	3%	5%	3%	28%	1%	8%	7%

Figure 14: Psychiatric Inpatient Utilization CY 2019-21

Year	Unique Medi-Cal Beneficiary Count	Total Medi-Cal Inpatient Admissions	MHP Average LOS in Days	Statewide Average LOS in Days	MHP AACB	Statewide AACB	Total Approved Claims
CY 2021	297	532	11.61	8.86	$15,630	$12,052	$4,642,110
CY 2020	266	467	12.63	8.67	$16,940	$11,814	$4,505,917
CY 2019	263	473	10.16	7.80	$13,351	$10,535	$3,511,193

Figure 15: HCB CY 2019-21

Entity	Year	HCB Count	% of Beneficiaries Served	% of Claims	HCB Approved Claims	Average Approved Claims per HCB	Median Approved Claims per HCB
Statewide	CY 2021	27,729	4.50%	33.45%	$1,539,601,175	$55,523	$44,255
MHP	CY 2021	122	6.29%	37.62%	$6,528,691	$53,514	$42,137
	CY 2020	144	7.89%	42.79%	$8,078,517	$56,101	$45,367
	CY 2019	117	6.51%	38.81%	$5,874,509	$50,209	$43,414

Figure 16: Retention of Beneficiaries

	YOLO			STATEWIDE			
Number of Services Approved per Beneficiary Served	**# of beneficiaries**	**%**	**Cumulative %**	**%**	**Cumulative %**	**Minimum %**	**Maximum %**
1 Service	156	8.04	8.04	10.25	10.25	6.09	26.63
2 Services	132	6.80	14.85	6.20	16.45	4.14	20.82
3 Services	143	7.37	22.22	4.88	21.33	0.00	11.01
4 Services	69	3.56	25.77	4.47	25.80	2.20	10.34
5-15 Services	522	26.91	52.68	30.41	56.22	19.65	38.46
>15 Services	918	47.32	100.00	43.78	100.00	12.31	57.09

Figure 17: CY 2020 Medi-Cal Expansion (ACA) Penetration Rate and ACB

Entity	Annual ACA Eligibles	Total ACA Beneficiaries Served	Penetration Rate	Total Approved Claims	AACB
MHP	18,740	420	2.24%	$3,656,520	$8,706
Medium	613,796	20,261	3.30%	$151,430,714	$7,474
Statewide	4,385,188	167,026	3.81%	$1,066,126,958	$6,383

Figure 18: CY 2021 Distribution of Beneficiaries by ACB Range

Claims Range	Beneficiary Count	% of Beneficiaries Served	% of Total Approved Claims	Total Approved Claims	Average Approved Claims per Beneficiary	Median Approved Claims per Beneficiary
Medium Cost ($20K to $30K)	112	5.77%	15.59%	$2,704,974	$24,152	$23,649
Low Cost (Less than $20K)	1,706	87.94%	46.80%	$8,122,200	$4,761	$3,146

Figure 19: Summary of CY 2021 Short-Doyle/Medi-Cal Claims

Month	# Claim Lines	Billed Amount	Denied Claims	% Denied Claims	Approved Claims
Jan	5,107	$1,234,822	$0	0.00%	$1,189,131
Feb	4,873	$1,217,275	$15,255	1.25%	$1,148,711
Mar	5,471	$1,375,801	$6,150	0.45%	$1,284,430
April	4,909	$1,243,533	$3,138	0.25%	$1,168,670
May	4,921	$1,314,031	$451	0.03%	$1,258,304
June	4,997	$1,384,031	$18,978	1.37%	$1,319,545
July	5,242	$1,430,063	$23,423	1.64%	$1,368,156
Aug	5,060	$1,427,848	$16,963	1.19%	$1,368,844
Sept	4,748	$1,236,768	$7,476	0.60%	$1,179,467
Oct	4,820	$1,262,612	$26,973	2.14%	$1,146,697
Nov	4,122	$1,129,796	$41,408	3.67%	$1,036,286
Dec	4,173	$1,082,233	$9,557	0.88%	$1,053,002
Total	**58,443**	**$15,338,813**	**$169,772**	**1.11%**	**$14,521,243**

Figure 20: Summary of CY 2021 Top Five Reasons for Claim Denial

Denial Code Description	Number Denied	Dollars Denied	Percentage of Total Denied
Service line is a duplicate and a repeat service procedure code modifier not present	197	$55,022	32.41%
Medicare Part B must be billed before submission of claim	135	$34,721	20.45%
Beneficiary not eligible or non-covered charges	47	$22,262	13.11%
Other	142	$18,751	11.05%
Other healthcare coverage must be billed before submission of claim	42	$15,486	9.12%
Deactivated NPI	30	$13,234	7.80%
Late claim	51	$9,880	5.82%
Service location NPI issue	1	$413	0.24%
Total Denied Claims	**645**	**$169,769**	**100.00%**
Overall Denied Claims Rate	**1.11%**		
Statewide Overall Denied Claims Rate	**1.43%**		

Medi-Cal Approved Claims data for YOLO County MHP Calendar Year 2021

	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											
	60,221	1,940	$17,355,865	3.22%	$8,946		3.67%	$8,601		4.34%	$7,478
AGE GROUP											
0-5	6,323	115	$416,665	1.82%	$3,623		1.08%	$5,014		1.96%	$5,427
6-17	14,215	651	$6,186,809	4.58%	$9,504		4.41%	$8,835		5.93%	$8,668
18-59	31,535	1,023	$9,575,110	3.24%	$9,360		4.05%	$8,632		4.52%	$7,181
60 +	8,150	151	$1,177,281	1.85%	$7,797		2.95%	$8,911		2.83%	$6,176
GENDER											
Female	32,328	962	$8,854,934	2.98%	$9,205		3.58%	$8,371		4.22%	$7,139
Male	27,894	978	$8,500,931	3.51%	$8,692		3.77%	$8,850		4.49%	$7,844
RACE/ETHNICITY											
White	14,121	698	$6,509,354	4.94%	$9,326		5.43%	$9,069		5.96%	$7,599
Hispanic/Latino	24,056	540	$4,230,017	2.24%	$7,833		2.69%	$7,321		3.74%	$6,733
African-American	2,547	174	$1,290,779	6.83%	$7,418		5.92%	$8,487		7.64%	$7,786
Asian/Pacific Islander	4,366	50	$424,518	1.15%	$8,490		2.04%	$7,965		2.08%	$7,990
Native American	403	23	$295,917	5.71%	$12,866		5.90%	$9,576		6.33%	$7,891
Other	14,730	455	$4,605,280	3.09%	$10,121		4.17%	$10,336		4.25%	$8,894
ELIGIBILITY CATEGORIES											
Disabled	5,466	585	$5,703,068	10.70%	$9,749		13.77%	$10,847		14.46%	$8,588
Foster Care	483	251	$2,290,337	51.97%	$9,125		45.62%	$11,092		49.15%	$11,020
Other Child	13,730	493	$3,550,138	3.59%	$7,201		3.26%	$7,190		4.43%	$6,892
Family Adult	9,143	149	$1,076,795	1.63%	$7,227		2.62%	$5,325		3.16%	$4,717
Other Adult	6,698	35	$153,612	0.52%	$4,389		0.87%	$7,642		0.82%	$5,196
MCHIP	6,444	139	$925,255	2.16%	$6,657		2.70%	$7,063		3.86%	$6,682
ACA	18,740	420	$3,656,659	2.24%	$8,706		3.30%	$7,473		3.81%	$6,383
SERVICE CATEGORIES											
Inpatient Services	60,221	297	$4,642,110	0.49%	$15,630		0.37%	$14,175		0.38%	$13,059
Residential Services	60,221	84	$920,654	0.14%	$10,960		0.10%	$13,140		0.07%	$11,650
Crisis Stabilization	60,221	55	$171,519	0.09%	$3,119		0.26%	$5,150		0.44%	$3,238
Day Treatment	60,221	3	$3,795	0.00%	$1,265		0.00%	$15,571		0.00%	$10,321
Case Management	60,221	941	$2,419,507	1.56%	$2,571		2.04%	$1,430		1.63%	$1,283
Mental Health Services	60,221	1,497	$6,082,085	2.49%	$4,063		2.76%	$4,387		3.48%	$4,328
Medication Support	60,221	958	$1,858,695	1.59%	$1,940		1.88%	$3,212		2.16%	$2,385
Crisis Intervention	60,221	176	$189,278	0.29%	$1,075		0.79%	$1,467		0.52%	$1,653
TBS	60,221	38	$244,323	0.06%	$6,430		0.04%	$8,039		0.04%	$10,612
Look-A-Like	60,221	19	$0	0.03%	$0		0.00%	$3,197		0.00%	$3,063

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

Yolo County HHSA demonstrates the need to improve efforts to address disparities with all identified groups. Yolo County reflects a lower penetration rate than other medium-sized counties across most populations. The Hispanic and Asian/Pacific Islander penetration rates continue to fall behind the statewide and medium-sized counties averages. Further investigation regarding these rates relative to Yolo County's Hispanic and Asian/Pacific Islander populations could inform a measurable QI and/or CC goal and help the MHP understand the level and type of effort required to achieve it.

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

Program Summary Table

Program Name	Status	Target Age	Access	Navigation	Integrated Services	Respite	Crisis Response	Clinical Services	Education	Support Group	Training	Stigma & Cultural Competency	Youth	Persons Experiencing Homelessness	Increase Funding	More Providers	Flexible Funding	Evaluation/Data	Formerly or Currently Incarcerated Individuals	1-Year Budget 23/24	3-Year Budget 23/26
Community Services & Supports (CSS) Plan																					
Adult Wellness Services	C	26–59	•	•			•	•						•		•	•	•	•	$8,915,199	$27,812,217
Children's Mental Health Services- FSP	C	0–20						•					•	•				•		$540,000	$1,702,350
Children's Mental Health Services-Non-FSP	C	0–20	•	•				•					•	•				•		$1,303,269	$4,078,367
Co-Occurring Disorder Assessment and Intake-AB2265	C	18+	•	•										•					•	$ 557,470	$1,723,244
Community-Based Drop-In Navigation Center	C	18+	•	•			•	•										•	•	$1,111,928	$3,122,960
Mental Health Crisis Service & Crisis Intervention Team Training	M	16+	•	•			•	•	•		•		•	•	•			•	•	$2,843,659	$10,344,089
Older Adult Outreach Assessment Program	C	60+	•	•			•	•						•		•	•	•	•	$1,620,804	$4,493,268
Pathways to Independence	C	16–25	•	•			•	•			•	•	•	•		•		•		$1,494,984	$4,694,051
Peer- and Family-Led Support Services	C	18–59		•					•	•								•		$170,000	$510,000
Public Guardian Case Managers	C	18+	•	•																$258,300	$790,501
Supportive Housing and Social Service Coordination	C	18+		•						•										$105,000	$331,013
Tele-Mental Health Services	C	18+	•					•										•		$1,925,611	$5,981,373

Program Name	Status	Target Age	Access	Navigation	Integrated Services	Respite	Crisis Response	Clinical Services	Education	Support Group	Training	Stigma & Cultural Competency	Youth	Persons Experiencing Homelessness	Increase Funding	More Providers	Flexible Funding	Evaluation/Data	Formerly or Currently Incarcerated Individuals	1-Year Budget 23/24	3-Year Budget 23/26
Prevention and Early Intervention (PEI) Plan																					
College Partnership	C	16-25	•	•	•			•	•			•	•		•			•		$315,000	$945,000
Cultural Competence	C	0+	•						•	•	•	•					•	•	•	$708,333	$2,124,999
Early Childhood Mental Health Access & Linkage Program	C	0-5	•	•				•				•	•		•	•		•		$650,000	$1,950,000
Early Signs Training and Assistance	C	16+		•					•	•	•	•						•		$590,334	$1,517,092
K-12 School Partnerships	C	5-18	•		•			•	•			•	•		•			•		$3,507,733	$10,547,615
Latinx Outreach/Mental Health Promotores Program	C	16+	•	•	•			•		•		•	•	•				•		$582,500	$1,782,500
Mobile Hair Professionals to Support Mental Wellness and Connections	C	16+							•											$7,750	$7,750
Senior Peer Support Program	C	60+								•								•		$100,000	$300,000
CSS;PEI:INN:WET																					
Evaluation	C	0+																•			$236,858
Innovation (INN) Plan																					
Crisis Now	P	18+				•	•	•												$5,973,930	$5,973,930
Planning and Stakeholder Input Process for Crisis System Re-Design and Implementation	C	18+									•							•		$344,587	
Workforce Education & Training (WET) Plan																					
Central Regional WET Partnership	C	16+							•		•				•			•		$10,000	
Mental Health Professional Development	C	16+							•		•	•						•		$180,997	$551,823
Capital Facilities & Technological (CFTN) Plan																					
IT Hardware/Software/Subscription Services	C	N/A									•							•		$1,403,304	$4,290,164

Program Summary Table (cont.)

Full Extract and Analysis on Pages 104 -113 of the Yolo County MHSA 2022-
2022 Annual Update and Expenditure Plan

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

Full Extract and Analysis on Pages 81-95 of the Yolo County MHSA 2021-
2022 Annual Update and Expenditure Plan

“Without community, there is no liberation.”
- Audre Lorde

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).

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

- *Medi-Cal* – Identified from Yolo County Medi-Cal Approved Claims Data for Calendar Year 2019. (Lower penetration rate than Medium-Sized County Average. Reference: Data in Criterion 2 section). Population to include:
    - Children, 0-5

  - Children/Youth, 6-17
  - Adults, 18-59
  - Older Adults, 60+
  - Female
  - Male
  - White
  - Hispanic/Latino
  - African American
  - Asian/Pacific Islander
  - Native American
  - Another Race/Ethnicity Category

- *Community Services and Supports (CSS)* – Identified from Community Planning Process for 2023-2026 MHSA Plan:

  - Children/Youth, 0-20 with serious emotional disturbance and/or experiencing or at risk for substance abuse, homelessness, foster placement, incarceration, school expulsion or violent behavior
  - Transitional- Age Youth, 16-25 with serious emotional disturbance, substance abuse disorder, serious mental illness or experiencing/at risk for incarceration, homelessness, emancipation, or high-risk behavior
  - Adults, 26-59 at risk of incarceration, hospitalization and/or homelessness
  - Older Adults, 60+ at risk of social isolation, incarceration, hospitalization and/or homelessness

- *WET (Workforce Education and Training)* - Identified from Workforce Needs Assessment and Community Planning Process for 2020-2023 MHSA Plan.
  - Transitional Age Youth, 16-25
  - Adult age 26-59
  - Older Adult 60+

- *Prevention and Early Intervention (PEI)* - Identified from Community Planning Process for 2020-2023 MHSA Plan.
  - Children, Ages 0-5 (includes related services to caregivers)
  - Children, Ages 6-18
  - Transition Age Youth, Ages 16-25
  - Older Adults age 60+
  - Adults age 26-59
  - Latino children, youth and families, especially in rural areas
  - Lesbian, Gay, Bisexual, Transgender and Queer/Questioning populations (LGBTQ+)

II. Identified disparities (within the target populations)

Medi-Cal
Lower penetration rates are reflected among Hispanic, African American, White, Asian/Pacific Islander, and Other/Multi-Racial cultural groups when comparing rates to other medium-sized counties. This presents an opportunity for increased service to all populations.

CSS
CSS programs and services have continued to address the identified disparities across all age group populations and related racial/ethnic, linguistic, socio- economic disparities. Contracted providers participate in Yolo County MHP cultural competence efforts and have high praise for the resources and trainings that Yolo HHSA provides to enhance services for diverse populations.

PEI
Yolo County Medi-Cal data reflected a need to bridge barriers to access and services across children, youth, and adult age groups. Program efforts focus on improving timely access to services for underserved populations, along with linkages to treatment.

Adult & Aging (A&A)
The A&A Branch is focused on identifying and supporting underserved or marginalized populations within Yolo County. An emphasis on reducing stigma, overcoming access concerns, and conducting outreach throughout the more vulnerable and rural communities; in addition to ensuring care in threshold languages.

Child Welfare Services (CWS)

African American children are overrepresented among children in foster care nationwide and in Yolo County it was identified as a problem with increasing disparity during the 2020 County Self Assessment (CSA). There were also disparities identified in Hispanic/Latino and Native American youth at all points in the system, from the allegations received to the permanency outcomes. Child Welfare Services conducted listening sessions with staff which resulted in the development of a Racial Equity Workgroup, consisting of staff across the agency to address disparity and disproportionality in the Child Welfare System as well as diversity, equity

and inclusion in the workplace. CWS also integrated R.E.D. (Review, Evaluate, Direct) teams which are a multi-staff approach to screening calls and collectively determining a response.

As a result of the County Self Assessment and resulting Racial Equity Workgroup, Child Welfare Services identified the implementation of an Alternative Response (AR) program as a goal for the current 5-year System Improvement Plan (SIP). Guided by the historic data trend (increased numbers of African American children entering foster care), the agency focused the procurement with an identified target population of African American children and families, especially those 0-5 years old. Incorporated in the AR implementation is group decision making on all referrals to reduce bias in decision making. The Alternative Response program is set to go live in early 2024. While navigating the procurement and contracting process, the agency has already implemented group decision making as well as agency-wide trainings on anti-racist practice. In 2022-2023 CWS data has shown a decrease in the number of African American and Hispanic/Latino children with substantiations of child abuse or neglect as well as a reduction in entries to foster care. The reducing racial disparity is positive and the hope is that the implementation of the AR program will continue this trend.

Criminal Justice
Yolo County has several new diversion programs that help to reduce disparities across the continuum of the Criminal Justice system. The HHSA Forensics Team partners with the District Attorney, Public Defender, Probation, jails/juvenile hall staff, local community-based organizations, the court system, and judges, along with our quality management and admin/analyst teams to ensure that if a crime was committed due to a mental illness or related to substance use that residents have a chance to participate in a diversion program.

Yolo County Health and Human Services Agency's (HHSA) service delivery approach promotes practices that are culturally responsive, such as ongoing cultural humility training; recognition of the disproportionate impact of trauma, discrimination, and justice system involvement on marginalized communities in case plan development; recognition of cultural variations in the subjective perception of trauma and traumatic stress responses; Helping to restore a sense of safety through trust- building; Attending to the distress of the person in the way that they define it; and recognition of the autonomy and expertise of participants in their own lives through co-developed case plans. Culture includes race/ethnicity, but also faith/religion, sexual orientation, gender identity, region of residence, level of acculturation, literacy level and socioeconomic

status. HHSA's approach is based on trauma-informed practices including:
(1) Motivational Interviewing,
(2) Cognitive Behavioral Therapies and trauma-informed assessment and intervention,
(3) Strengths-based language,
(4) Harm Reduction,
(5) Peer Support Advocacy/Intervention.

We collect annual outcome data on our programs and use that data to inform where we might be falling short in terms of what populations we are serving, how can we do more to address disparities, and how do we identify those who are suffering due to increased community issues that impact daily life.

HHSA in partnership with the criminal justice system added 20 units to the Little House program on East Beamer to accommodate diversion program participants.

III. Identified strategies/objectives/actions/timelines

Medi-Cal

To meet cultural and linguistic needs of beneficiaries entering services, Yolo County routinely tests the Access Line during business hours, after hours and in non-English languages. Yolo HHSA has made great strides in this area as completed test calls have increased over the past year. An area for improvement continues to be the logging of the calls in the Access Log. Wait times and dropped calls were not addressed in the plan.

Most wellness center resources, activities and groups are available to anyone who wants to participate, not just to those who are receiving specialty mental health service through Yolo HHSA.

Beneficiary focus group participants reported positive perceptions overall but did report they would like increased activities such as field trips, social outings, and cooking classes. They also felt that Staff appeared stretched thin and would benefit from reduced caseloads. Hispanic/Latino beneficiaries shared insight on low utilization and indicated that how to access services was challenging. In addition, they indicated that physical health needs tend to take priority over mental health needs.

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 Services program at Yolo County HHSA provides mental health services county wide to youth 0-20 to address their unmet mental health need. The HHSA Children's Mental Health team provides services to children who are Latinx or English language learners, which are delivered by bilingual-bicultural clinicians. In addition, the HHSA Children's Mental Health team responds to all mental health service requests and links youth to appropriate mental health providers. This team provides a variety of group therapy programs that are open to all youth in the county, regardless of insurance. Lastly, the team provides trainings to partner and community agencies including trauma focused parenting and small groups to resource families.

Goals:
1. Provide valuable community-based mental health services to Yolo County youth and families aged 0–20 to address their unmet mental health needs. (FY 23/24)

2. Expand on our partnerships with other community-based agencies and LEA'S in Yolo County to collaborate in the delivery of mental health treatment such as group therapies and offering community-based trainings for caregivers.

Objectives:

1. Increase families' access to meaningful and appropriate mental health services. (New FY 23/24)
2. Increase group therapy programs and community-based trainings. (New FY23/24)

3. Reduce mental health symptoms and improve impairments in all life domains. (New FY 23/24)
4. Reduce out of home placements. (New FY 23/24)

The children and youth FSP program provide outreach and engagement, systems development, and FSP services for children and youth aged 0–20 with severe emotional disturbance who meet medical necessity for specialty mental health services. The FSP specifically provides case management and individual and family services to Yolo County children and youth up to age 20 with unmet or under met mental health treatment needs. Services are available to children countywide and include specific outreach into rural portions of the county, where a is proportionate

number of Yolo County residents are English learners and experience poverty.

GOALS
Goal 1: Provide FSP, system development, and outreach and engagement services to children & youth up to age 20 in Yolo County who are experiencing serious emotional difficulties.
Goal 2: Provide high-quality, community-based mental health services to Yolo County youth and families aged 0–20 who are experiencing serious emotional disturbances.
Goal 3 (NEW FOR 2023-2024): Expand on our partnerships with other mental health agencies in Yolo County to collaborate in the delivery of specialized treatment.

OBJECTIVES
Objective 1: Increase the level of participation and involvement of ethnically diverse families in all aspects of the public mental health system, by reducing ethnic and cultural disparities in accessibility, availability and appropriateness of mental health services to more adequately reflect mental health prevalence estimates.
Objective 2: Increase the array of community supports for children and youth diagnosed with serious emotional disturbance and their families.
Objective 3: Improve success in school and at home and reduce out of home placements.
Objective 4 (NEW FOR 2023-2024): Ensure families have access to meaningful and necessary services that do not create additional financial hardship.

2023 Actions and Strategies

(NEW FOR 2023-2024) Participate in community outreach events throughout the year both live and virtual.

Adult Wellness Services Program

Adult Wellness Services Program includes the HHSA Wellness Centers, contracted Adult FSP program, and the HHSA Forensics FSP Team, that focus on meeting the behavioral health treatment needs of unserved, underserved, and inappropriately served adults in Yolo County with the highest levels of behavioral health needs. This program serves adults aged 26-59 who are unlikely to maintain health or recovery and maximal independence in the absence of ongoing intensive services.
FSP programs provide comprehensive and intensive mental health services and employ a “whatever it takes” community-based approach, using innovative interventions to help people reach their recovery goals. The adult FSP programs have been contracted to HOPE Cooperative.

Adult Wellness services also include an HHSA Forensics FSP Team that have clients across the age spectrum, including TAY, adults, and older adults who participate in the Mental Health Court program. The FSP program uses an outreach and engagement strategy that is relevant to the situational and cultural needs of clients, with engagement "where they are" with respect to their community location, need for clinical and nonclinical services and supports, and stage in the recovery process.
YCCC Safe Harbor Crisis House provides crisis residential services for SMI adults to reduce psychiatric hospital stays, reduce the risk of homelessness, and serve as a step-down facility for clients transitioning back to the community. Safe Harbor also serves as an alternative to acute inpatient hospitalizations if a client does not meet criteria for an involuntary hold. YCCC's Farmhouse is a residential treatment program for SMI adults requiring intensive support. Their program offers a wide range of therapeutic and rehabilitative services to reduce or avoid long-term hospitalization or institutionalization.
All YCCC staff are trained at hire and annually on culturally appropriate services.

Additionally, culturally and linguistically appropriate services are delivered to individual clients. YCCC forms are continually being updated and improved to serve clients with unique cultural and linguistic needs. Free language assistance services are available to individuals with limited knowledge of the English language. YCCC employs multilingual staff and use of the language line is available for those who have various communication needs.

With all staff members having at least a basic level of respect for consumers, each staff member will be provided with training on how to best handle situations and apply their knowledge.

Agency-wide trainings develop the following skills:

- communication
- group facilitation
- client treatment plans
- crisis intervention
- medication knowledge
- effective interventions

YCCC is committed to fostering a diverse workforce, and maintaining a workplace that is equitable, inclusive, and safe for all employees. From recruiting practices, to pay and benefits, promotions, and all other aspects of employment with us, an environment of equity is of the utmost importance.

We not only recognize that the staff comprise a wide range of backgrounds and characteristics, but we believe those differences should be celebrated and valued. Whether it's race, religion, gender, national origin, ancestry, color, language, age, marital status, sexual orientation, gender identity, gender expression, physical or mental disability, medical condition, genetic information/characteristics, veteran status, political affiliation or any other characteristic, these are parts of each staff that contribute to human experiences, and ultimately to the knowledge and expertise that make staff a valuable asset to YCCC.

YCCC is committed and determined that there is access, opportunity, and advancement for all individuals. We are always looking for ways in which we can cultivate an inclusive work environment, strengthen our cultural competency, and train our managers and employees to provide opportunities for growth and development. Training is provided at hire and annually.

> It is our intention that all our employees, regardless of any background or characteristic, are always treated with respect and dignity.
>
> Also included in Adult Wellness Services is dedicated case management services for non-FSP clients in both Pine Tree Gardens (PTG) homes. NVBH's trauma-informed and strengths-based case management services include activities and support that help new PTG clients acclimate to their new homes through frequent connections to support their needs, ensure they get settled, and build a plan around their needs, which may include activities of daily living, financial literacy, how to care for the space and home, scheduling and time management, and medication management.

Additional supportive services are delivered in the two Adult wellness centers operated by Yolo County HHSA. The HHSA Wellness Centers, located in the Woodland Clinic and the West Sacramento Clinic, offers rehabilitative activities and services on a drop-in basis for approximately 200 behavioral health consumers each year. The Wellness Centers offer skill building groups, computers with internet access, recreational programming and weekly food distribution to supplement groceries for residents experiencing food insecurity. Not only are these a valued place of respite, the Wellness Centers also provide access to case management, psychiatry, and the continuum of services across the county.

Goals and Objectives

GOALS

Goal 1: Meet the mental health treatment needs of unserved, underserved, and inappropriately served adults in Yolo County with serious mental illness who may be experiencing or at risk of homelessness, have criminal justice system involvement, have a cooccurring substance abuse disorder, or have a history of frequent use of hospital and emergency rooms.
Goal 2: Expand and augment mental health services to enhance service access, delivery, and recovery

OBJECTIVES

Objective 1: Provide treatment and care that promote wellness, recovery, and independent living.
Objective 2: Reduce the impact of living with serious mental illness (e.g., homelessness, incarceration, isolation).
Objective 3: Promote the development of life skills and opportunities for meaningful daily activities

Actions and Strategies:

- Conducting strengths-based integrated assessments that comprehensively examine mental health, social, and physical health needs, focusing on consumer and family member engagement.
- Providing intensive support services and casement to unhoused and impoverished adults identified as FSP.
- Conducting outreach services to persons who are unhoused or at risk for homelessness with persistent and nonthreatening outreach and engagement services.
- Providing AOT to court-mandated consumers unable to accept voluntary treatment or who accept voluntary treatment but need an AOT level of care and who are at continued risk of harm.
- Providing adults with appropriate benefits assistance, including Social Security Disability Insurance, Supplemental Security Income, Medi-Cal, or Medicare applications, and referrals to advocacy services
- Assisting homeless adults and adults without stable housing by locating appropriate, safe, and affordable housing in the community.
- Operating a 24-hour crisis phone line and referring callers to crisis services and supports.
- Providing navigation and linkages to adults in need of resources in the county or community for mental health services through a peer support worker or outreach specialist.
- Delivering mobile services, including assessment and treatment, to reach adults who cannot access Yolo HHSA or other services as a result

of barriers to access (rural, transportation difficulties, etc.) or other disabilities.

Tele-mental Health

Yolo County mental health clinics currently use telepsychiatry to expand consumer access to a prescriber. These appointments are supported by an in-clinic medical assistance and nursing staff.
These services support outcomes by reducing barriers and expand the reach of the county's psychiatric and therapeutic services to underserved populations.
Additionally, tablets are being distributed to these populations to support increased tele-mental health services use.

Goals and Objectives

GOALS

Goal 1: Enhance access to psychiatric appointments for current clients in Yolo County.

Goal 2: Provide access to a psychiatric medication provider to community members in crisis throughout Yolo County.

OBJECTIVES

Objective 1: Secure and implement the necessary technology for two county clinics to provide prescriber telehealth consultations.

Objective 2: Continue current use of telepsychiatry for existing Yolo County clients.

A. Pathway to Independence

While in-house FSP services were capped at serving 25 Transitional Aged Youth (TAY) clients, through HHSA's contract with Telecare and their program INSPIRE as of 2021, HHSA expected to serve up to 50 Yolo County beneficiaries ages 16-25 in need of this level of care. However, 2022 data showed only a total of 17 TAY clients were served at the FSP level of care by this vendor. Also, as a part of the TAY program transition in 2021, HHSA created a dedicated TAY case manager for youth aged 16-25 who are in need of County mental health service but fall below the FSP level of care need. This new staff position served 44 clients at the 'moderate' level of care, many of whom had stepped down from FSP services.

In the last year, HHSA has not effectively met the program goal of providing FSP, system development, and outreach and engagement services to youth aged 16–24 in Yolo County who are experiencing serious mental illness while transitioning to adulthood. As a result of the low number of TAY FSP client served, HHSA is now transitioning the TAY FSP program to a new FSP vendor, Hope Cooperative, and ensuring 50 of the transferred slots remain earmarked for this population. Further, HHSA is planning to invest in the development of an entire continuum of care for TAY youth, ranging from prevention, outreach, and early engagement to FSP and Assistance Outpatient Treatment, as necessary. Relatedly, HHSA has not effectively expanded and augmented mental health services to enhance service access, delivery, and recovery for TAY in our community. As such, both goals will remain in place for the next year. The three detailed objectives from last year were not accomplished. TAY client ethnic and cultural disparities, improved assessment and referral processes, and more successful transitions for TAY from the foster and juvenile justice systems were not achieved due to lack of staffing resources for both internal teams and some specific TAY programs, such as EDAPT were noted. These objectives will also remain in place.

Goals and Objectives

GOAL

Goal 1: Provide FSP, system development, and outreach and engagement services to youth aged 16–24 in Yolo County who are experiencing serious mental illness while transitioning to adulthood.

Goal 2: Effectively expand and augmented mental health services to enhance service access, delivery, and recovery for TAY in our community.

OBJECTIVES

Objective 1: Reduce ethnic and cultural disparities in accessibility, availability, and appropriateness of mental health services and to reflect mental health prevalence estimates more adequately.
Objective 2: Address existing mental health challenges promptly with assessment and referral to the most effective services.
Objective 3: Support successful transition from the foster care and juvenile justice systems.

Community-Based Drop-In Navigation Center

The Navigation Center provides behavioral health triage, specialty mental health assessments, and short-term case management and peer support to adults in Yolo County. The program effectively expands specialty mental healthcare services for individuals who are not currently receiving services, or who are receiving services at an inadequate level for their needs. In addition, the program assists with reduction of homelessness, involvement in criminal justice systems, and psychiatric hospitalizations by linking clients with appropriate care, and serves people disproportionately impacted by social determinants of health. The Navigation Center also operates the drop-in Wellness Center four days a week, facilitated by a Peer Advocate.

In the last reporting period (Q1 of the 23-24 fiscal year), 108 unduplicated clients received services from the Navigation Center, many more than once. 65 unduplicated SMHS assessments were completed and, of clients referred to HHSA for psychiatric care, 91% linked. Staff transported 22 unduplicated clients, and provided direct subsidy assistance to 30. The Navigation Center was fully staffed in this quarter, which is reflected in increased client contact. Clinicians continued to offer drop-in crisis or screening support during all open hours, and began offering six assessment slots each weekly. Clinicians also began providing assessments at Monroe Detention Center. Case management was offered to all clients – providing basic needs supplies, transportation to appointments, and establishing health insurance and other benefits. With our Peer Support Advocate, many clients have become daily attendees of the Wellness Center – participating in art, meditation, and independent living skills.

CommuniCareOLE has done or is working with the following:

- The employment of a full-time Health Equity, Diversity, and Inclusion (HEDI) Manager. With the merger of CommuniCare Health Centers and Ole Health, this Manager now oversees DEI work in Yolo, Napa, and Solano counties.

- The implementation of a quarterly speaker series on DEI topics open to all staff.
- Language proficiency testing for staff providing clinical services in a language other than English, and bonus pay for these multilingual staff. All clinical staff will have completed testing by 12/1/23.

- All-Staff training on recognizing and responding to microaggressions
- All-Staff training on LGBTQ-competent services, psychosis, and a series on “eliminating inequities in behavioral health.”
- Numerous DEI initiatives, including coalition for People of Color, LGBTQ+ Sub-Committee, Racial Justice Book Clubs for Staff and White-Identified Managers, Specialized Consultation Group for staff providing services in Spanish.
- Events including collaboration on county Juneteenth celebration, tabling at Davis Pride, a Black Maternal Health event with the Perinatal Department, and the annual Dia De Los Muertos event open to the community.
- Worked with an external agency for review of DEI efforts. A strategic plan, the Equity Work Plan, is undergoing final edits and will be released in the new year.
- CCHC is involved in TIROH – Trauma-Informed, Resilience-Oriented Health efforts – which include themes related to human diversity.

Goals and Objectives

GOALS

Goal 1: 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 connecting consumers to services when and if they desire them.
Goal 2: Expand and augment mental health services to enhance service access, delivery, and recovery.

OBJECTIVES

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 with identifying and accessing the supports they need to maintain their mental health.

Objective 3: Reduce the impact of living with mental health challenges through the provision of basic needs.

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

Cultural Competence Updates: CommuniCare + OLE has done or is working with the following:

B. The employment of a full-time Health Equity, Diversity, and Inclusion (HEDI) Manager. With the merger of CommuniCare Health Centers and Ole Health, this Manager now oversees DEI work in Yolo, Napa, and Solano counties.

C. The implementation of a quarterly speaker series on DEI topics open to all staff.

D. Language proficiency testing for staff providing clinical services in a language other than English, and bonus pay for these multilingual staff. All clinical staff will have completed testing by 12/1/23.

E. All-Staff training on recognizing and responding to microaggressions

F. All-Staff training on LGBTQ-competent services, psychosis, and a series on "eliminating inequities in behavioral health."

G. Numerous DEI initiatives, including coalition for People of Color, LGBTQ+ Sub-Committee, Racial Justice Book Clubs for Staff and White-Identified Managers, Specialized Consultation Group for staff providing services in Spanish.

H. Events including collaboration on county Juneteenth celebration, tabling at Davis Pride, a Black Maternal Health event with the Perinatal Department, and the annual Dia De Los Muertos event open to the community.

I. Worked with an external agency for review of DEI efforts. A strategic plan, the Equity Work Plan, is undergoing final edits and will be released in the new year.

J. CCHC is involved in TIROH – Trauma-Informed, Resilience-Oriented Health efforts – which include themes related to human diversity.

K. Mental Health Crisis Services and Crisis Intervention Team (CIT) Training

Yolo County's comprehensive mental health crisis services program provides existing Yolo County clients and the larger county community with access to crisis interventions, crisis assessments, urgent and routine service referrals and linkages, and appropriate crisis residential or inpatient psychiatric facility or psychiatric health facility placement, as needed.

Mental health crisis services include walk-in crisis services access, in Davis, West Sacramento, and Woodland during regular business hours. Further, at any day or time, when a Yolo County Medi-Cal beneficiary, indigent individual, or existing Yolo County client is placed on an involuntary psychiatric hold by the local hospital staff, law enforcement, or certified county or provider clinicians, the crisis navigation staff secures placement at the appropriate crisis residential facility, psychiatric health facility, or acute psychiatric inpatient facility.

County crisis clinicians have been embedded with local law enforcement to form a co-responder team to intervene in mental health-related police calls to de-escalate situations that have historically resulted in arrest and assess whether the person should be referred for immediate behavioral health intervention. Currently, six crisis clinicians are embedded with the cites of Davis, Woodland, and West Sacramento and the Yolo County probation and Sheriff's Department. This plan includes the addition of two co-responder clinicians in collaboration with the Davis and West Sacramento Police Departments, for a total of eight co-responder positions. Staff members provide phone and in-person responses to the community, when available, when a family member or loved one reports an individual in crisis. Postcrisis, a staff member follow up with any people known to the county to have recently been in crisis to ensure effective service access and referral linkages. Additionally, a total of five part time Peer Support Worker

(PSW) positions have been added to create co-responder teams that include a person with lived experience.

Actions and Strategies:

- Reducing unnecessary local emergency room visits and involuntary psychiatric holds of individuals in crisis.
- Reducing crisis reoccurrence and repeat acute inpatient facility placement.
- Reducing unnecessary arrests of individuals in crisis.
- Preventing crisis escalation, which may result in serious injury or consequences to clients, their loved ones, and the community at large.
- Ensuring appropriate mental health service to anyone in need in advance of a crisis.
- Ensuring linkage to city and county homeless program resources for those in need of housing or shelter.

The Yolo County crisis staff delivers CIT training, modeled after a nationally recognized, evidence-based program known as the CIT Memphis Model, which focuses on training law enforcement personnel and other first responders to recognize the signs of mental illness when responding to a person experiencing a mental health crisis. The course curriculum is approved by the local Peace Officers Standards and Training agency, providing materials and 40 hours of training at no cost to the participating law enforcement agency or individual. The course trains participants on the signs and symptoms of mental illness and how to respond appropriately and compassionately to individuals or families in crisis. Further program modifications include the development and county delivery of an annual 8-hour CIT refresher training for all county law enforcement personnel who have previously completed the initial 40-hour curriculum. This refresher course curriculum was developed in concert with local enforcement agencies to ensure it includes relevant and updated topics that further attendees' intervention tools and understanding with diverse populations.

Actions and Strategies:

- Helping law enforcement personnel and first responders recognize the signs of mental illness when responding to mental health calls.
- Helping law enforcement and first responders work with people in crisis and noncrisis situations to receive the necessary intervention to promote wellness, recovery, and resilience.
- Training law enforcement personnel and first responders to have adequate understanding of the needs of culturally diverse populations.
- Raising awareness of the community needs among law enforcement and first responders.

Goals and Objectives

GOALS

Goal 1: De-escalate clients and community members in crisis by

providing appropriate mental health interventions and support.

Goal 2: Implement a community-oriented and evidence-based policing model for responding to psychiatric emergencies.

OBJECTIVES

Objective 1: Reduce the number of arrests and incarcerations among people with mental illness.

Objective 2: Strengthen the relationship among law enforcement, consumers and their families, and the public mental health system.

Objective 3: Reduce the trauma associated with law enforcement intervention and hospital stays during psychiatric emergencies.

H. Peer and Family Led Support Services

Peer- and Family-Led Support Services are psychoeducation groups and other support groups targeting peers and families. The services help consumers: (a) understand the signs and symptoms of mental health and resources, (b) promote awareness of mental health resources and develop ways to support and advocate for an individual or loved one to access needed services, and (c) receive support to cope with the impact of mental health for an individual or family. Services are exclusively led by peers and family members and provided outside of HHSA clinics and throughout the community, as appropriate, to best serve consumers and families.

The family member component of this program features an evidence-based psychoeducational curriculum that covers the knowledge and skills that family members need to know about mental illnesses and how best to support their loved one in their recovery. The peer component of the program features an evidence based psychoeducational curriculum that includes information about medications and related issues; evidence-based treatments that promote recovery and prevention; strategies for avoiding crisis or relapse; improving understanding of lived experience; problem solving; listening and communication techniques; coping with worry, stress, and emotional flooding; supporting your caregiver; and making connections to local services and advocacy initiatives.

Actions and Strategies

- Providing a safe, collaborative space for consumers and family members to share experiences.
- Providing accurate, up-to-date information about mental illnesses and evidence-based treatments.

- Providing an environment conducive to self-disclosure and the dismissal of judgment, for both self and others.
- Providing services where they are appropriate and needed, including but not limited to community centers, wellness centers, libraries, adult education locations, inpatient hospitals, and board-and-care facilities.
- Facilitating groups in a supportive way that models appropriate prosocial behavior.
- Providing one-on-one support when appropriate.
- Making referrals to other services as appropriate.

Goals and Objectives

GOALS
Goal 1: Provide family- and consumer-led support services and psychoeducation to caregivers and consumers.

Goal 2: Expand and augment mental health services to enhance service access, delivery, and recovery

OBJECTIVES
Objective 1: Provide community-building activities for consumers and their families.
Objective 2: Develop a knowledge base for consumers and their families.
Objective 3: Develop self-advocacy skills for family members and peers.

H. NAMI Yolo County
Provides peer and family led support services intended to assist peers and families of those with a mental health condition to 1) increase understanding of

the signs and symptoms of mental health conditions, 2) promote awareness of mental health resources and develop ways to support and advocate for an individual or loved one to access needed services, and 3) receive support to cope with the impact of mental health for an individual or within the family. The program serves adults age 18+ with evidenced-based curriculum including educational classes, support groups, and a resource helpline. The program serves transition age youth through NAMI Ending the Silence presentations to middle and high school students as well as various teen and TAY groups that help audience members learn about the warning signs of mental health conditions and what steps to take if you or a loved one are showing symptoms of a mental health condition. NAMI Yolo County offers support groups, educational classes, and community presentations in English and Spanish.

NAMI believes a diverse, inclusive and equitable organization is one where all employees, volunteers and members — regardless of gender, race, gender identity, ethnicity, national origin, age, sexual orientation, education, disability, veteran status or other dimension of diversity — feel valued and respected.

2023 Highlights:

- Increased racial/ethnic and linguistic diversity amongst staff and Board of Directors.
- Increased outreach to the Latinx/Hispanic community through the NAMI Compartiendo Esperanza program, designed to initiate culturally relevant community conversations within the Hispanic/Latinx community to learn more about mental health education and destigmatize mental illness.
- Provided simultaneous Spanish-language translation for all virtual presentations.
- Expanded programs to include in-person peer support groups in West Sacramento.
- Staff participated in NAMI National's Town Hall series that focused on: expanding workforce diversity strategies with an emphasis on hiring and retention; embedding justice, equity, diversity, and inclusion principles into NAMI's everyday life and actively enhancing culturally and linguistically appropriate services; and building capacity and capabilities for community outreach and engagement to diverse communities.
- All staff attended the 2023 "Building a Resilient Yolo Summit."
- Offered in-person educational course for parents of youth experiencing mental health symptoms (NAMI Basics) for the first-time post-pandemic.
- Offered support groups through virtual platforms and in-person.

Areas for Improvement in 2024:

- Implement mandatory cultural competency training and annual continuing education for all new volunteers.
- Expand outreach to minority and low-income communities, including Black, Indigenous, and People of Color (BIPOC), about NAMI Yolo County programs through culturally and linguistically appropriate presentations, support groups, and classes.

- Expand programs to include support groups centered around sharing some affinity, including but not limited to lived experience, racial/ethnic identity, or primary language.
- Continued recruitment of bilingual staff, Board members, and volunteers.
- Expand outreach to the more rural areas of Yolo County.
- Increase NAMI Yolo County's pool of paid staff in order to rebalance its reliance on a volunteer-heavy model that can be non-inclusive as it tends to attract people who have the means to serve as a volunteer.

Goals and Objectives

GOALS

Goal 1: Provide resources related to mental health services for adults living with mental illness and their families.

Goal 2: Support improved outcomes for mental health wellness, family stability, and psychoeducation.

OBJECTIVES

Objective 1: Provide a safe, collaborative space for consumers and family members to share experiences.

Objective 2: Provide accurate, up-to-date information about mental illnesses and evidence-based treatments

Objective 3: Provide an environment conducive to self-disclosure and the dismissal of judgment, both for self and others.

Objective 4: Expand outreach to minority and low-income communities, including Black, Indigenous, and People of Color (BIPOC), about NAMI Yolo County programs through culturally and linguistically appropriate presentations, support groups, and classes.

Objective 5: Expand outreach to youth and seniors about NAMI Yolo County programs.

PEI/PEI Priority Populations

Early Childhood Mental Health Access and Linkage Program First 5 Yolo FY 23-24 Cultural Competente Plan Updates

First 5 Yolo uses Friedman RBA per the principles of equity of the First 5 CA Commission to track demographic and performance metrics information to help improve services and to better match the needs of families. Language and health literacy are top barriers that we are currently focusing on addressing. While we have staffing to serve English and Spanish-speaking populations, East Asian and other non-English languages are not served to the same extent due to limitations in staffing availability. The cultural appropriateness or quality of language services needs to be reviewed as recent research highlights a need to make information more user-friendly across all languages, including English (plain language and health literacy efforts) to ensure citizens can access the services they need, self-manage, and make more informed decisions about their health.

Future work will continue to look more closely at health literacy and language access through HMG's increasing collaboration with healthcare providers and home visiting programs.

What's working in HMG: Key highlights:

1. The resource library used and developed by Help Me Grow Yolo (HMG) staff is regularly updated and expanded, which allows Help Me Grow Yolo staff to provide culturally appropriate resources more effectively.
2. In FY 2022-2023, In-home therapy for moms continued with expanded eligibility criteria. It removed treatment modality restrictions (previously CBT only), increasing access to fathers and caregivers and allowing clinicians to offer any treatment modality best matched to the client's mental health needs.

3. A partnership with the Yolo Trauma Informed Network of Care (an ACEs Aware grant and Resilient Yolo collaboration) has helped increase medical provider outreach and positioned HMG as a hub for prenatal-5 care coordination and navigation and development/capacity-building for trauma-informed, culturally appropriate services that both providers and families can benefit from. During the partnership in 22-23, HMG discussed barriers to the Early Intervention system and discussed shared advocacy messaging and referral workflows to support medical providers and families struggling through insurance barriers.

Key insight: Medical providers should in tandem/simultaneously refer child to specialists if needed and go through the family's existing insurance benefits. If the family does not have insurance or has received a denial to cover services from their insurance, medical providers should notify the Regional Center so the Regional Center can pay for the medical/therapy services for the family if needed

(as payor of last resort). As a result, HMG reported *more* children getting connected to Regional center services because medical providers have been making concurrent referrals to insurance and specialists.

- HMG and home visiting partner agencies have been sharing the below referral guide from the AAP to further support this messaging and help families and providers navigate the early intervention system. Additionally, HMG is sharing LTSAE brochures customized with the HMG webpage and call center phone number in multiple languages and multi-lingual evidence-based health literate books and planners from *Baby Basics* thanks to MHSA funding for language access supports.
- HMG also had some LTSAE brochures professionally translated into local languages as the CDC did not have these languages available (Farsi, Dari, Urdu, Russian).

LTSAE_FamilyFriendlyGuide_English.pdf (aap.org)

LTSAE_FamilyFriendlyGuide_Spanish.pdf (aap.org)

4. Completed Assistance Request Form for HMG posted and being piloted on HMG website (both F5Y and NCTC have a webform on their agency websites). HMG worked with UniteUS, Welcome Baby (WB) and F5Y to develop the free assistance request form helping families self-navigate and helping providers with or without a UniteUS account to refer into services. HMG continues to be a top user in UniteUS while uptake barriers remain high for other organizations. There is a need for greater coordination and TA support to navigate technology, data access/governance, and financing issues.
5. HMG Family Resource Centers (RISE Inc, YCCA) developing referral workflows with F5Y and CTC to better identify early childhood mental health needs and connect families to HMG supports such as screening, playgroups, and in home therapy for caregivers.
6. F5 Yolo and HMG leveraged MHSA funds to design a new family-facing webpage to help families access HMG and WB Home Visiting services. The webpage better captures what HMG is and who is involved and how "Help Me Grow Connects the Dots." A marketing consultant was hired for branding and marketing strategy for the webpage to make accessing HMG services easier. Webpage is now live on both F5Y and CTC's websites:
   Help Me Grow Yolo - First 5 Yolo
   Help Me Grow Yolo County

7. HMG Yolo facilitated a Russian translation of the CDC's Milestone Checklists in partnership with the Cultural Competence Committee. This included local review by a Mental health clinician who is fluent in Russian and whose input was invaluable in making the tools more family centered. This collaborative effort allowed Yolo County to add the Russian translation to the CDC's partner translations box website for others in the country to use while the CDC *does not* have a translation on their main site. This success story was celebrated by HHSA's cultural competency committee as an example of CLAS standards in action, calling it a *CLAS act*.

8. The partnership with R2R and Welcome Baby, based at a Federally Qualified Health Center, has allowed HMG to strengthen its prenatal and early postpartum outreach to help connect more families to timely interventions as needed.
9. HMG strengthened its partnership with ALTA Regional by joining the local Early Start State Systemic Improvement Plan implementation committee. This will allow First 5 Yolo and HMG to better advocate for systems change in partnership with ALTA Regional Center and better

align on goals and objectives that benefit the early childhood prevention and early intervention system. See the link for more details. Alta California Regional Center Implementation Assessment

A. K-12 School Partnerships Program

The K-12 School Partnerships Program is a collaboration between the five school districts, the Yolo County Office of Education, and community-based organizations to embed clinical staff members at schools throughout the county to provide an array of services including universal screening, assessment, referral, and treatment for children and youth aged 6–18. The K-12 School Partnerships Program aligns with the school districts use of the Multi-Tiered Systems of Support (MTSS) model of tiered based interventions. Services and supports are available at Tier I, Tier II and Tier III. Tier I services are those that everyone receives, Tier II services are typically small group interventions for youth who need additional support beyond what is available to all, and Tier III are the individualized therapy services for students who will benefit from one-on-one individualized counseling. The K-12 School Partnerships program provides evidence-based, culturally responsive services, as well as promising practices in outreach and engagement for at-risk children and youth to build their resilience and help mitigate and support their mental health experiences. The K-12 School Partnerships Program uses the Interconnected Systems Framework which employs a whole child approach by supporting students academically, behaviorally and in their social/emotional development.

GOALS

Goal 1: Increase access to a continuum of mental health services in locations that are easily accessible to students and their families.

Goal 2: Expand and augment mental health services to enhance service access, delivery, and recovery, through increased recruitment and retention of the mental health workforce.

Goal 3: Increase Medi-Cal beneficiaries' access to the K-12 services.

OBJECTIVES

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

Objective 2: Address existing mental health challenges promptly with assessment, referral to the most effective service, and short-term treatment.

B. Youth Early Intervention Program

The Youth Early Intervention Program is focused primarily on the early detection and identification of possible early psychosis and symptoms of psychosis. This program will be delivered by UC Davis EDAPT program and EDAPT staff will provide those services out of their Sacramento office and by telehealth. This program includes clinical and other supportive services at home, clinic, and community-based settings and provides evidence-based interventions to address emerging symptoms and support youth to stay on track developmentally. Services address and promote recovery and related outcomes for a mental

illness early in emergence and include services and support to parents and other natural supports.

GOALS

Goal 1: Provide early intervention services and early identification of early psychosis or emerging symptoms of psychosis.

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

OBJECTIVES

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

Objective 2: Utilize culturally responsive interventions to engage young people and their families

C. Latinx Outreach/Mental Health Promotores Program

The Latinx Outreach/Mental Health Promotores Program provides culturally responsive services to Yolo County Latinx residents (aged 18 or older) with health issues, mental health illnesses, or substance use issues. The program serves the entire Latinx community and seeks to develop relationships between providers and consumers, including their supporters, families, and community. This program addresses several needs, including:

- Integrating behavioral health services (to decrease costs to the county and providers for uninsured individuals).
- Reducing mental health hospitalizations for patients receiving services. • Increasing the quality of life and independence for individuals with health, mental health, and substance use issues.
- Expanding participatory input on program activities.
- Reducing stigma in the Latinx community with a resulting increase in service penetration rates in that community

By utilizing promotores (Latinx community members who receive training to provide basic health and mental health education in the community), information can be disseminated to the community in culturally appropriate ways. Promotores address the engagement challenges that arise due to stigma related to mental illness, the transient nature of seasonal harvest workers, long working hours for the population, and geographical barriers (e.g., rural or isolated settings) that make traveling to and from behavioral health service locations difficult. To ensure accessibility, the program’s outreach strategy follows a “meet individuals where they are” approach that includes a mobile component. Promotores can visits local farms and worksites to provide information and resources to the target population. Additionally, the program offers extended hours beyond traditional work hours each month, including events during the weekend.

Actions and Strategies

- Providing training in culturally competent and evidence-based practices for staff members.
- Providing counseling services in accessible locations at convenient times.
- Providing culturally competent services in English and Spanish.
- Using evidence-based practices and implementing quality assurance practices.
- Increasing access to primary care, mental health, and substance abuse treatment services for Latinx residents of Yolo County, including weekly outreach activities and whole-person health screenings.
- Connecting Latinx residents to entitlement supports as needed.
- Providing screening, assessment, short-term solution-focused therapy, and access to psychiatric support for medication assistance to address mental health concerns.
- Reducing stigma and behavioral health underutilization in Latinx communities.

The CREO Program by CommuniCare+Ole

The CREO Program is by design a program that supports the culture and traditions of its participants. The underlying belief is that "each individual and family possess critical strengths and protective characteristics that if identified, supported and reinforced can build resiliency and reduce risk.
Their focus is on improving health outcomes by addressing health inequities, reducing stigma regarding mental health and substance use with an additional expanded focus on creating opportunities for outreach and education. Providing direct mental health services, case management and resource acquisition to a largely underserved population of monolingual Spanish speaking immigrants and agricultural workers who are uninsured or underinsured in Yolo County. All services are provided in the participants preferred language by staff who are bilingual and bi-cultural. Most staff are either themselves immigrants or have parents who were for a connection that is based through lived experience. Additionally, CREO includes trusted individuals from the community known as Promotoras who attend numerous community health fairs, schools, local farms and migrant centers providing education on important topics that are currently impacting the community. Weekly virtual meetings called "Platicas" were developed to create an extended reach to the community providing topics such as mindfulness practices, substance use/misuse, parenting, legal and financial information, diabetes and health education. Bi-monthly advisory panels are conducted with volunteers who have participated in services and are willing to give input on relevant issues and needs of the community as well as feedback on their own experiences in the program. Satisfaction surveys are sent to clients asking for feedback on services and are reviewed and discussed by staff to inform new practices, procedures and topics of interest.

CREO's foundation is built on relationship and trust with the community that has been built over 8 years of providing culturally relevant services. Addressing stigma by providing accurate information and providing opportunities to engage

in more in-depth open discussions and conversations with the community provides a space to help build knowledge and support self-efficacy and community empowerment. Being responsive to immediate stressors that impact participants is important to creating a safe and trusting environment that offers solutions to reduce toxic stress. We partner with several organizations to provide a bridge to necessary resources that enable people who may not necessarily ask for or who may be afraid to ask.
Taking pride in traditional practices and reminding participants that their histories are important and are valuable contributions to the community in which they live is another way we promote hope and nurture resilience.

The RISE Inc. Latino Promotore Program's accomplishments include:

- RISE Inc. Has 2 Latino Promotores employed providing services to the targeted community in their language.
- The Latino promotores are culturally relatable staff members and provide resources and services that are culturally relevant to the farm working population.
- The Promotores have conducted consistent outreach to local farms in the rural areas of Esparto, Capay Valley, Madison and Winters CA.
- The Promotores have coordinated Farmworker Appreciation events, allowing for farmworkers to attend and become informed on support services.
- Advocacy and building relationships with farmworkers and services providers has had a positive outcome.
- Promotores are providing Mental Health resources to farmworkers in the areas they serve.
- Drop in opportunities in the form of Focus Group sessions have begun to support farmworkers.
- Promotores have completed training opportunities to better serve the farm working population.
- Bonds have been created between promotores and farm workers where needs are met in a more confident manner.

Anticipated plans for the future, include:

- Promotores will continue outreach efforts in providing services.
- More Farmworker appreciation events/health fairs will be held.
- Focus group sessions will continue as have.
- Continuing to establish relationships with farmworkers to serve their needs.
- Continue breaking stigmatizing views on Mental Health services.
- Carry on with culturally relevant approach methods.
- Establish more partnerships with service providers and work collaboratively.

Goals and Objectives

GOALS

Goal 1: Begin a social media campaign to develop, and distribute educational and culturally responsive Spanish materials on mental health and SUD issues including opioid overdose prevention and how to access services with or without insurance

Goal 2: Continue to collaborate with Benefits Advocates and Primary Care to provide linkages to medical services

OBJECTIVES

Objective 1: CCHC has a tracking system that pulls data from the electronic health record system on encounters and details of the encounters. Referrals/linkages to services can be tracked

Objective 2: Tracking for outreach materials would be counted by number of views on social media, counts for hand-outs

The CREO Program Team has worked diligently to analyze our services for cultural relevancy. We have reviewed and adapted EBP's to consider language, culture, and context so that the forms, assessments, and tools we use are compatible with our client's cultural values. We adapted a screening tool that assesses the level of stressors being experienced for immigrants. We incorporated a spiritual and resiliency component to support what our clients are doing that would be considered "protective factors" that are actually cultural resiliency factors. This allow us to respond in a sensitive way that supports what they have been doing and feel connected to without judgement. We have build strong trust within the community by staying aware of what the community is asking for and providing it through our weekly Platicas. We also celebrated our Annual Dia de los Muertos event with a successful Community Health Fair targeting Spanish speakers for resources and celebrating the culture and history in a respectful way that the family can enjoy.

A. College Partnership Program

The College Partnership Program aims to collaborate with local colleges and community-based organizations to provide engagement, access, and linkage services for college students who are either at risk of, beginning to, or currently experiencing mental health problems with the goal of promoting recovery, resilience, and connection to mental health services for those in need. The program intends to promote health and well-being for college students through the provision of physical and behavioral health services. This program builds on the successes of the college-based wellness center program developed in the previous MHSA three-year plan and expands to a more robust college-based

behavioral health program, providing a broad array of engagement, prevention, early intervention, and both physical and behavioral health intervention services. The focus of the College Partnership Program will leverage MHSA and Medi-Cal funds and funds from the local community college district to expand the array of mental health services and supports available on college campuses.

GOALS

Goal 1: Increase access to a continuum of mental health services in locations that are easily accessible to students and their families.

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

Goal 3: Ensure access to physical and mental health services for undocumented and Two Spirit and LGBTQ+ students.

OBJECTIVES

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

Objective 2: Address existing mental health challenges promptly with assessment, referral to the most effective service, and short-term treatment.

Objective 3: Increase capacity to support wellness on school campuses by expanding access to mental health services and supports for children, youth, and their families.

Objective 4: Increase outreach efforts for undocumented students by coordinating with college departments.

2023 Actions and Strategies

Continue to formally coordinate with the Woodland Community College to organize outreach efforts for undocumented and Two Spirit and LGBTQ+ student that provide information about physical/mental health services and other social services.

G. Mobile Hair Professionals to Support Mental Wellness and Connections

COVID-19 disproportionately affected people living with a mental illness, a substance use disorder, or both, especially people of color, which highlights that health equity is still not a reality in many communities in Yolo County. The mental wellness effects of living with a mental illness, such as low-self-esteem, anger management issues, relationship struggles, difficulty balancing work and life, anxiety about death, and stress of competition, have all increased dramatically due to the pandemic and especially among those living with serious mental illness and serious emotional disturbance.

The ClipDart Giveback program improves the mental wellness of members of the Yolo County community by providing free haircuts and connections to social services for adults living with

mental illness and other disabilities in Yolo County by working with nonprofit partners. This talented team of mobile hair care professionals give free haircuts for 6 hours every 21 days for 1 year to residents living at numerous housing locations serving people with serious mental illness throughout Yolo County. ClipDart also hosts five mental wellness giveback events across Yolo County, at which free haircuts, showers, vaccinations, HIV and hepatitis C testing, clothes, food, toys, hygiene products, and information regarding mental health and social services in coordination with the county and nonprofit partners the project also helps an important segment of the community—both hair care professionals, who often are a source of advice, counseling, and friendship for their clients, and individuals who receive haircuts or participate in the mental wellness giveback events. Giveback provides hair care professionals with an incredible opportunity to earn additional income while helping people in need by providing guaranteed appointments on specific days and improving the mental wellness of those who need it most through free haircuts and genuine conversation. In addition, the Giveback mental wellness giveback events connect people living with mental illness to goods and services and provide an opportunity for meaningful social interaction.
The interactions helps both hair care professionals and the people served increase their confidence, decrease anxiety, foster community, and simply enjoy social interactions during and after the unpredictable, economically unstable, and protracted pandemic.

Goals and Objectives

GOALS

Goal 1: Improve the self-esteem, anger management abilities, relationship struggles, work-life balance, and confidence of people living with a serious mental illness in various housing settings throughout the county through haircuts, shared connection, and support.

OBJECTIVES

Objective 1: Provide on-demand haircuts to support every 21 days with a different nonprofit housing partner throughout Yolo County, serving the MHSA target population of TAY, adults, and older adults.

Objective 2: Organize and host five mental wellness giveback events throughout Yolo County, connecting clients with their community, organizations, and partners.

H. Yolo Cares – Senior Peer Support Program

The Senior Peer Support Program mobilizes volunteers from the community to provide free, supportive counseling and visiting services for adults aged 60 or older in Yolo County who are troubled by loneliness, depression, loss of spouse, illness, or other concerns of aging. Services are voluntary, consumer directed, and strengths based. By providing psychosocial supports and identifying possible signs and symptoms of mental illness early and with ongoing assistance, senior peer counselors help older adults live independently in the community for as long as reasonably possible. Senior Peer Support volunteers coordinate with existing HHSA and community-based older adult services to provide opportunities for earlier intervention to avoid crises for older adults and create more opportunities for support through companionship and counseling. Volunteers and staff members employ wellness and recovery principles,

addressing both immediate and long-term needs of program members and delivering services in a timely manner with sensitivity to the cultural needs of those served.

YoloCares promoted the *Life Transitions* project coordinator to the new position of Community Educator, charged with leading the effort to implement agency-wide changes to address the identified barriers for these underserved populations.

The Community Educator gave a presentation to over 50 hospices nationwide through the National Partnership for Health and Hospice Innovation, outlining the CHNA findings and helping our sister organizations across the county begin to implement best practices around cultural inequities in end-of-life care. As part of YoloCares' internal implementation plan, the agency hosted Jan Murray-Garcia, founding faculty member and clinical professor at the Betty Irene Moore School of Nursing at UC Davis and a recognized expert in healthcare inequities, to give the first of a series of presentations to YoloCares staff, board members and volunteers. The presentation focused on bias and internal considerations to create a culture of diversity, equity, and inclusion.

In addition to the above, a bilingual (Spanish/English) Care Transition Specialist was hired to help serve Spanish speakers across the agency, including Senior Peer Companions. A Healthcare Navigator was hired to assist Native and rural communities with care access and resource navigation. A Community Champions program was launched to create a team of part-time community ambassadors to work within our diverse service area to inform community members about the services available through YoloCares and to help forge partnerships and connections.

Actions and Strategies

- Recruiting, screening and coordinating all peer counselor volunteers
- Training peer counselors in mental health resources, signs of mental illness, and how to work with older adults experiencing mental illness.
- Visiting older adults in the home or community to provide companionship and social support.
- Coordinating with the Friendship Line, a warmline and hotline that operates out of the San Francisco Institute on Aging.
- Referring and linking consumers to other community-based providers for other needed social services and primary care.

Goals and Objectives

GOALS

Goal 1: Support older adults to live independently in the community for as long as reasonably possible while ensuring their mental and physical well-being.

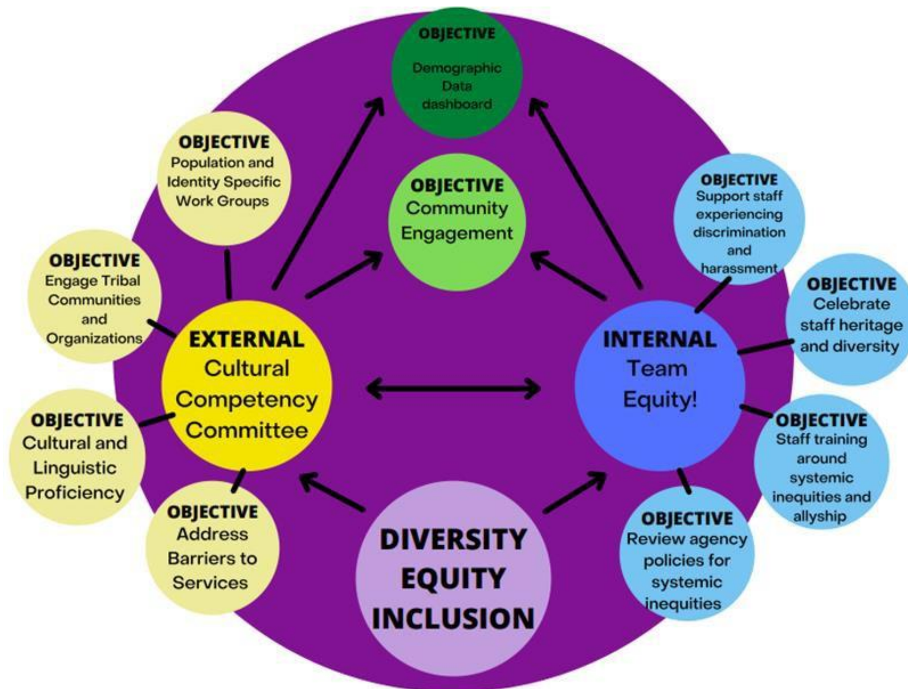
OBJECTIVES
Objective 1: Recruit, train, and support volunteers to provide peer counselling services.
Objective 2: Support independent living and reduce social isolation for older adults.
Objective 3: Promote the early identification of mental health symptoms in older adult

“In a time of destruction, create something: a poem, a parade, a community, a school, a vow, a moral principle; one peaceful moment.”
-- Maxine Hong Kingston

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 (CCC), or other groups that address cultural issues and has participation from cultural groups, that is reflective of the community.



The Cultural Competence Committee maintains a vibrant and diverse membership, with organizations sending alternates if a regular representative cannot attend the monthly meeting. CCC averages 18 – 24 regular attendees. The CCC list serves 225 members who receive and share our CCC newsletters and announcements throughout our community and support our events and partners. CCC demographic data, agendas, and messaging can be found in Appendix ___A___

The CCC focuses on increasing attention, activities, outreach, and training to incorporate the recognition and value of racial, ethnic, cultural, and linguistic diversity in the county mental health system while also seeking to address broader health disparities and the roots of their existence. The Cultural Competence Committee operates workgroups to provide targeted support to demographics historically underrepresented in government decision-making: Umoja (African Diaspora), LGBTQ+, Spanish-speaking, Russian-speaking, and Older Adults. Here is a list of activities supported by the CCC, its workgroups, members, and in collaboration with our community partners:

- Early Juneteenth celebration event planning. The annual event is in partnership with Mary L Stephen's Library and UCD. CCC's Umoja workgroup facilitated a Healing Space offering meditation/mindfulness exercises throughout the day of the celebration and shared 48 copies of Resmaa Menakem's book on healing racialized trauma entitled "My Grandmother's Hands" to interested attendees.

- West Sacramento Community Advisory Board presentation by CC/DEI Coordinator on the benefits of CABs in developing a data transparency portal and building trust with the community while addressing disparities in policing and arrest rates.

- Promoted Roadmap to the Future listening sessions arranged by the Yolo County Office of Education and Yolo County Board of Supervisors to map and assess the needs of children and families by district.

- Kifalme Youth Gathering (formerly the African American Student Leadership Conference). CCC supported all students attending with book purchases.

- Woodland Pride Parade: CCC LGBTQ+ workgroup partnered with CommunicareOLE to plan this event, joined by other HHSA staff members who built a float and others who volunteered on the parade day.
- Woodland PD officer Dallas Hyde presented Safe Space training to the CCC before the Pride parade.

- CCC Spanish-speaking workgroup collaborated with CommuniCareOLE to hold its annual Dia De Los Muertos event: attended planning meetings, contributed raffle prizes, and tabled the event, offering mental health resource information.

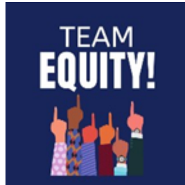
- Spanish-speaking workgroup members will also work with community leaders and the DA's office to address increased DUI arrests in the Hispanic/Latino community.

- Resilient Yolo Summit Steering Committee planning and presentation of the 9/19/23 Building a Resilient Yolo Summit.

- CCC members participated in planning and presenting the 3-day Youth Justice Leadership Academy offered by the Yolo County District Attorney's Multi-Cultural Community Council.

- CCC partnered with First 5 Yolo to increase access to the new evidence-informed CDC Milestone checklists (updated in 2022) by translating them and making the tool accessible to the Russian-speaking community. These health communication tools are intended to help families make more informed decisions, have the language to partner with their primary care providers in shared decision-making, and prepare for every well-child visit to help our littlest ones access the support they need when needed.
  The checklist has been uploaded to the CDC's Partner Translations folder in Box, where you may find additional languages that are not currently available on the CDC's website: https://app.box.com/s/zeg9i7ruh51hbm0icknatgz68ehn9z3h

Many of these community engagement activities were prefaced with months or weeks of event planning. More information on these activities can be found in Appendix _B_____



Team Equity! The workgroup is the CCC internal facing workgroup. Team Equity! addresses the HHSA Work Plan Goal to be a High-Performing Agency by supporting and engaging our staff. This internal workgroup identifies systemic inequities and develops racial equity programming across the agency. Additionally, Team Equity! seeks to break down existing departmental silos, improve workplace culture, and advance the practice of diversity, equity, inclusion, and belonging.

- HHSA Internal Candidate Feedback Policy was approved in May of this year, and the subsequent training of all supervisors and managers on its usage was completed by HR presentations over eight weeks and six trainings. **Status: Completed**

- HHSA's 3rd-party conflict resolution/mediation contract with Yolo Conflict Resolution Center was completed on December 21st, 2023. Rollout will begin in January 2024 and will include YCRC introducing the confidential process during all staff, departmental, and Team meetings, as well as the HHSA newsletter and Information emails. **Status: Ongoing**

- Offering identity-based Affinity Groups to staff and leadership was considerably delayed due to staff capacity and short staffing. Group facilitation trainings were presented in October for 10 Affinity group facilitators. The first Affinity group sessions were held in November. Sessions were offered to Hispanic/LatinX, LGBTQ+, African Diaspora, Men, and Christian staff. More groups will be added, more facilitators trained as interests and needs are identified, and capacity is built. **Status: Completed**

- Our last staff Diversity, Equity, Inclusion, and Belonging training was held on December 7th, 2023. HHSA leadership, supervisors, and Managers participated in nine monthly mandatory trainings, and all staff participated in three compulsory extended sessions. NOTE: We captured unprecedented (and confidential) staff and leadership demographic information, giving us an in-depth look at our diverse workforce. More on this initiative is discussed in Criterion 5. **Status: Completed**

- 23 DEIB Challenge messages were published bi-monthly in our HHSA newsletters, providing bite-sized information for staff to review on their time and capacity to absorb. Team Equity curated the info provided! Members. **Status: Completed**

- CCC/DEI members participated in the Community Health Assessment (CHA) and Improvement Plan (CHIP) community engagement/focus group process. CC/DEI Coordinator contributed a narrative to the Public Health Accreditation Board application. **Status: Completed**

New and Ongoing Collaborations

- **The Office of Emergency Services Cultural Diversity workgroup's** mission is to guide the Office of Emergency Services in providing a forum for community engagement in geographically diverse locations to engage with culturally diverse communities within the county. We know that research shows that cultural minority groups suffer disproportionately during every phase of a

disaster. This working group will provide us with feedback and assist in strategic planning, analyzing barriers and enablers to meet our community needs, evaluating the effectiveness of language access services provided, outreach/education, and addressing gaps in our emergency planning.

- **The Restorative Justice Partnership JAG Steering Committee** is meeting to develop an Evaluation Plan for its mental health, substance use, and Neighborhood Court diversion programs.

- **Connections to CARE (Community, Assistance, Recovery, and Engagement) (C2C)** is a significant expansion to Yolo County's existing continuum of criminal justice diversion programs. C2C's MOU with the District Attorney states HHSA's Cultural Competence Committee (CCC) will also participate in the Local Advisory Committee (LAC) to ensure equitable and respectful quality of care is embedded in C2C's design and routinely reduce disparities in C2C's service delivery by promoting culturally and gender appropriate sober living activities; monitoring cultural competence in diversion and SUD programming; offering cultural competency training on diverse cultural and gender-specific health beliefs and practices, preferred languages, and health literacy levels; and creating additional performance measures as needed.

- **The Children's Defense Fund Freedom School program** is coming to Yolo County in the summer of 2024. HHSA Cultural Competence is collaborating with YCOE, UCD, and Washington Unified School District to provide a six-week summer program for **80** elementary school youth to strengthen their education and learning, celebrate their identity and culture, use art to improve mental health, and increase resilience. This program especially hopes to reduce the isolation experienced by Black, Indigenous, and youth of color in a county where they represent the smallest demographic and have few opportunities to commune with other youth of color.

More on these programs can be found in Appendix _____B____

"Every moment is an organizing opportunity, every person a potential activist, every minute a chance to change the world."
– Dolores Huerta

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).

- **Culturally and Linguistically Appropriate Services training** on standards and application was offered in May 2023, with 60+ attendees consisting of staff, providers, and interested stakeholders. It is important to note that registration was low in the weeks before this training. It was a message to staff and contractors reminding them of CLAS standards and an expectation of CLAS delivery as meeting contractual obligations. It prompted a sharp increase in staff and subcontractor registrations and attendance. This identified a knowledge drain of standard practices due to high HHSA and subcontractor staff turnover. A second CLAS training was canceled due to the trainer's illness. We will offer this training several times in 2024.

- **Cultural Considerations when engaging the Russian/Ukrainian community** were presented to all staff, providers, and interested stakeholders.

- **Cultural Considerations to partner and understand the culture of our Sikh community** was offered during a regularly scheduled CCC meeting.

  We will resume and increase the Cultural Considerations training series in 2024. In the interim, as we concentrated on the needs of staff and their education, we consistently promoted culturally responsive and appropriate training by our state partners, i.e., the Lotus Project on Intergenerational trauma in the Asian American and Asian Immigrant/Pacific Islander community, and CiBHS LGBTQ+/Transgender awareness training.
- **Crisis Intervention Training:** CC/DEI Coordinator presented the Stigma Reduction/Family Storytelling session as part of CIT refreshers and the 40-hour training sessions. **14 sessions** were presented to more than 225 law enforcement officers this year.

For more information, see Appendix C ____

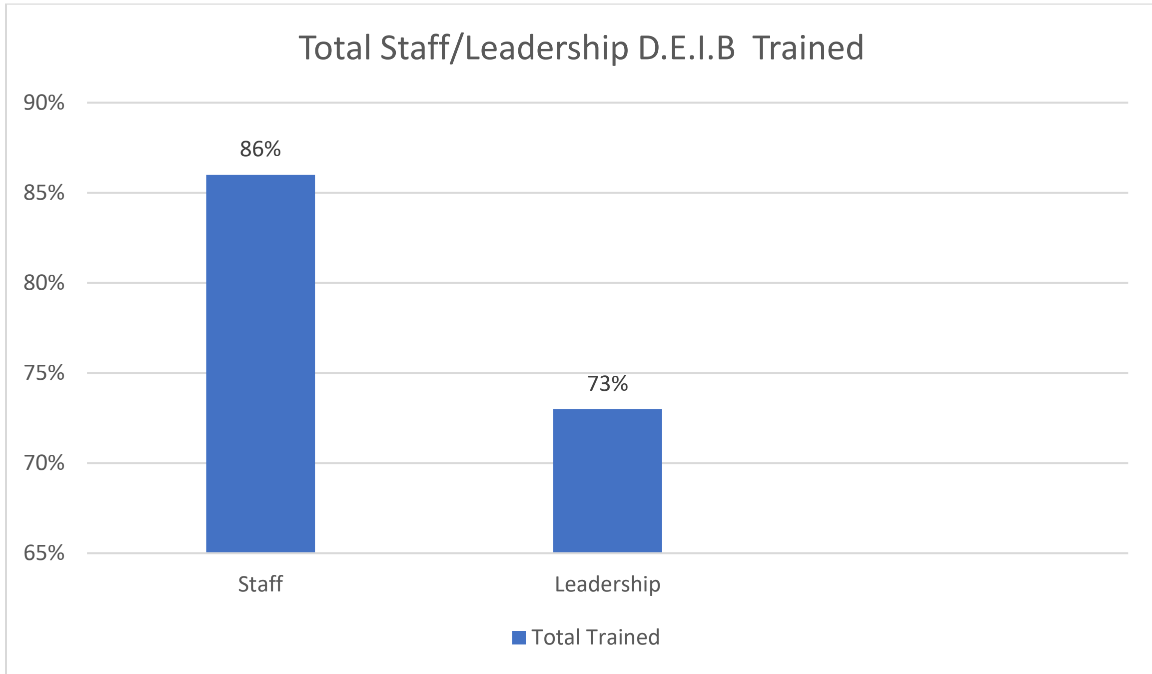
2023 has been a year for HHSA to address systemic issues of inequity, racism, classism, and all the isms that impact the way we interact with each other and the community we serve. To this end, a concentrated effort was made to inform, train, and engage all HHSA in self-reflection and organizational exposure to issues that impact workplace satisfaction and feelings of belongingness and service delivery.

MANDATORY DIVERSITY, EQUITY, INCLUSION, AND BELONGING (DEIB) TRAINING FOR ALL STAFF: 2023

Date	Training
January	**Psychological Safety**
February	**Historical Trauma Part I**
March	**Historical Trauma Part II**
April	**DEIB Part I**
May	**DEIB Part II**
June	**Trauma Informed Care for the Workforce Part I**
July	**Trauma Informed Care for the Workforce Part II**
August	**Leadership Values &Commitment Part I**
September	**Leadership Values & Commitment Part II**

Date	Training
March	**Trauma-informed Care & Psychological Safety in the Workplace**
May	**Historical & Intergenerational Trauma**
July	**Anti-bias & Cultural Responsiveness**

For more information, see Appendix C _& D___



The Calm app was made available in 2023, and addressing insomnia is the most used app. In prior years, offering the Calm app was part of planned staff Wellness Spaces in our agency. At this time, our agency is engaged in Project Refresh with General Services. This has precluded staff Wellness Spaces

“Never doubt that a small group of thoughtful, committed citizens can change the world; indeed, it's the only thing that ever has.”
-Margaret Mead

CRITERION 6
COUNTY MENTAL HEALTH SYSTEM
COUNTY’S COMMITMENT TO GROWING A MULTICULTURAL WORKFORCE: HIRING AND RETAINING CULTURALLY AND LINGUISTICALLY COMPETENT STAFF

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

I. **Recruiting a Diverse Workforce**

It is a goal of Team Equity! to work with Human Resources to establish Recruiting a Diverse Workforce Pilot Program for HHSA. This entails widening the number of sites where HHSA job openings are posted to websites that may include: Pink Jobs; iHispano; HBCU Connect; and PDN Recruits which is one of seven culturally distinct websites in The Professional Diversity Network. PDN provides a professional network for diverse talent

that is far more engaging and welcoming than a typical job board. Includes access to media and minority job boards. Reaches candidates everywhere from Ebony Magazine, the NAACP JobFinder.com, to VetJobs.com and disABLEDperson, Inc. This project has been delayed due to HR and staff capacity to monitor pilot effectiveness.

II. Consumer Perception Analysis: most current available data

Yolo County Health and Human Services Agency (HHSA) conducted the annual Consumer Perception (CP) Surveys to offer consumers and family members an opportunity to provide input/feedback on mental health services for quality improvement purposes. Surveys were conducted during the week of May 15-19, 2023 in partnership with UCLA Integrated Substance Abuse Programs (ISAP) and the MHP's contracted providers. This report includes an analysis of data collected from adults and youth receiving services in Yolo County behavioral health programs. There were 160 surveys returned across our programs, 9 of which were incomplete (i.e., blank) and 151 were complete (i.e., had at least one response that could be used for data analysis; missing and N/A responses were not included).
Survey forms were available in twelve languages (English, Arabic, Armenian, Spanish, Chinese, Farsi, Khmer, Korean, Russian, Vietnamese, Tagalog and Hmong).

Table 1A: Surveys Received vs. Surveys Completed - Yolo County

	Received	Completed	Not Completed	% Completed	% Not Completed	Statewide % Completed	Statewide % Not Completed
Family	37	34	3	91.89%	8.11%	78.92%	21.08%
Youth	22	21	1	95.45%	4.55%	76.34%	23.66%
Adult	84	79	5	94.05%	5.95%	73.63%	26.37%
Older Adult	17	17	0	100.00%	0.00%	76.31%	23.69%
Total	160	151	9	94.38%	5.63%	75.92%	24.1%

Table 1B: Reasons for not completing the survey by Form Type - Yolo County

	Reason for not completing survey					County %	Statewide %
	Refused	Impairment	Language	Other	Total		
Family	0	0	0	3	3	33.33%	25.23%
Youth	0	0	0	1	1	11.11%	21.46%
Adult	5	0	0	0	5	55.56%	46.78%
Older Adult	0	0	0	0	0	0.00%	6.53%
Total	5	0	0	4	9	100.00%	100.00%

Language Accessibility

Table 1D: Surveys Received by Language and Form Type - Yolo County

	Family		Youth		Adult		Older Adult	
	N	%	N	%	N	%	N	%
Arabic								
Armenian								
Chinese								
English	35	94.59%	22	100.00%	82	97.62%	16	94.12%
Farsi								
Hmong								
Khmer								
Korean								
Russian								
Spanish								
Tagalog								
Vietnamese								
Total	37	100.00%	22	100.00%	84	100.00%	17	100.00%

Surveys < 11 nor shown in Table 1D.

Satisfaction with Services

Table 3A: Satisfaction Score by Domain: Family and Youth - Yolo County

	Family					Youth				
	Mean Score	CI	Percent Agree 3.5+	SW* Mean Score	SW % Agree 3.5+	Mean Score	CI	Percent Agree 3.5+	SW* Mean Score	SW % Agree 3.5+
Access	4.63	4.45-4.80	100.0%	4.44	95.0%	4	3.50-4.50	84.2%	4.21	91.3%
General satisfaction	4.38	4.17-4.59	90.6%	4.38	93.0%	3.92	3.53-4.31	73.7%	4.21	89.8%
Outcome	3.87	3.59-4.15	71.0%	3.94	78.2%	3.52	3.12-3.91	57.9%	3.82	74.0%
Participation in Treatment Planning	4.2	3.99-4.41	90.6%	4.32	92.2%	3.59	3.21-3.96	63.2%	4.08	84.1%
Cultural Appropriateness	4.6	4.44-4.77	100.0%	4.58	98.0%	4.21	3.87-4.55	94.7%	4.38	95.3%
Social Connectedness	4.27	4.02-4.53	93.6%	4.27	92.9%	4.17	3.93-4.41	94.7%	4.10	89.1%
Functioning	3.94	3.68-4.20	71.0%	3.96	77.7%	3.54	3.14-3.95	57.9%	3.87	74.3%

Table 3B: Satisfaction Score by Domain: Adult and Older Adult - Yolo County

	Adult					Older Adults				
	Mean Score	CI	Percent Agree 3.5+	SW* Mean Score	SW % Agree 3.5+	Mean Score	CI	Percent Agree 3.5+	SW* Mean Score	SW % Agree 3.5+
Access	4.26	4.10-4.41	86.3%	4.33	91.0%	4.22	3.90-4.53	94.1%	4.31	90.6%
General satisfaction	4.38	4.23-4.53	90.0%	4.42	91.1%	4.41	4.12-4.70	100.0%	4.48	93.1%
Outcome	4.07	3.89-4.24	77.5%	4.00	77.4%	4.09	3.75-4.43	88.2%	4.02	79.5%
Participation in Treatment Planning	4.22	4.05-4.38	86.3%	4.33	91.5%	4.29	3.91-4.68	94.1%	4.32	91.5%
Quality	4.33	4.19-4.47	91.3%	4.34	90.6%	4.3	3.99-4.62	88.2%	4.33	91.1%
Social Connectedness	4.05	3.88-4.21	81.6%	3.98	77.1%	4.09	3.68-4.51	75.0%	3.97	79.2%
Functioning	4.05	3.87-4.23	77.6%	3.98	74.5%	3.98	3.62-4.33	76.5%	3.97	75.8%

CI = 95% Confidence Interval
* Statewide

“Language is the road map of a culture. It tells you where its people come from and where they are going.”
-Rita Mae Brown

CRITERION 7
COUNTY MENTAL HEALTH SYSTEM LANGUAGE CAPACITY (Reach out to Mario)

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

This work is ongoing. . .

Yolo HHSA
2023 What worked and what was learned
Yolo HHSA Adult and Aging plans to engage in additional tracking around the following:

- Identify county technical assistance needs
- Evidence of availability of interpreter (e.g. posters/bulletins) and/or bilingual staff for the languages spoken by community.
- Documented evidence that interpreter services are offered and provided to clients and the response to the offer is recorded.
- Evidence of providing contract or agency staff that are linguistically proficient in threshold languages during regular day operating hours.

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

Yolo HHSA Adult and Aging plans for the following changes and updates to policy:

- Policies, procedures, and practices that include the capability to refer, and otherwise link, clients who do not meet the threshold language criteria (e.g., LEP clients) who encounter the mental health system at all key points of contact,
- to culturally and linguistically appropriate services.
- 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.)
- Policies, procedures, and practices that comply with the following Title VI of the Civil Rights Act of 1964 (see page 27) requirements:
    - Prohibiting the expectation that family members provide interpreter services;
    - 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
    - Minor children should not be used as interpreters.

“Diversity is about creating an environment where a person can bring their whole self to work.”
-Laura Miller

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 (CLASFinal Report).

NOTE: This section is unchanged from the previous year. These our goals and intentions. Due to an early 2022 resurgence of the Covid, Omicron virus, site monitoring could not be safely undertaken. However, as updates in prior Criterion verify, contracted providers are embracing cultural competence in numerous, and exciting ways, and we will continue to ensure that culturally competent, linguistically appropriate services are exemplified in service delivery across our agency and contracted providers.

Yolo County HHSA prioritizes and maintains cultural competency on the part of contractors via clear contract language requiring respectful care. Standard contract language is as follows:

CULTURAL COMPETENCY

A. Cultural competence is defined as a set of congruent practice behaviors, attitudes, and policies that come together in a system, agency, or among consumer providers and

professionals which enable that system, agency, or those professional and consumer providers to work effectively in cross-cultural situations.

B. Contractor recognizes that cultural competence is a goal toward which professionals, agencies, and systems should strive. Becoming culturally competent is a developmental process and incorporates at all levels the importance of culture, the assessment of cross-cultural differences, the expansion of cultural knowledge, and the adaptation of services to meet culturally unique needs. Providing medically necessary specialty behavioral health, substance abuse, and co-occurring disorder services in a culturally competent manner is fundamental in any effort to ensure success of high quality and cost-effective services. Offering those services in a manner that fails to achieve its intended result due to cultural and linguistic barriers is not cost effective.

C. Contractor shall assess the demographic make-up and population trends of its service area to identify the cultural and linguistic needs of the eligible beneficiary population. Such studies are critical to designing and planning for providing appropriate and effective behavioral health, substance abuse, and co-occurring disorder services.

D. Contractor shall implement practices and protocols that are inclusive and responsive to the needs of diverse cultural populations, including Lesbian, Gay, Bisexual, Transgender and Queer/Questioning (LGBTQ) individuals, families and communities.

E. Contractor shall adopt the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care to improve health care quality and advance health equity. Refer to http://minorityhealth.hhs.gov (US Department of Health and Human Services Office of Minority Health).

F. Language Access and Translation Requirements

1. "Threshold Language" pursuant to the Dymally-Alatorre Bilingual Services Act and "Prevalent Language" pursuant to State contracts and 42 CFR. §438.10(a), means a language that has been identified as the primary language, as indicated on the Medi-Cal Eligibility System (MEDS), of 3,000 beneficiaries or five percent of the beneficiary population, whichever is lower, in County's Medi-Cal service area. (Cal. Govt. Code §7290-7299.8; 42 CFR. §438.10(a); 9 CCR §1810.410(a)(3).)

2. Contractor shall comply with the linguistic requirements included herein.

a. The Contractor shall provide all written materials for potential clients and clients in a font size no smaller than 12 point. (42 CFR. 438.10(d)(6)(ii).)

b. The Contractor shall ensure its written materials are available in alternative formats, including large print, upon request of the potential client or client at no cost. Large print means printed in a font size no smaller than 18 point. (42 C.F.R. § 438.10(d)(3).)

c. The Contractor shall make its written materials that are critical to obtaining services, including, at a minimum, provider directories, beneficiary handbooks, appeal and grievance notices, denial and termination notices, and Contractor's

behavioral health education materials, available in the prevalent non-English languages in the county. (42 CFR. § 438.10(d)(3).)

d. The Contractor shall notify clients that written translation is available in prevalent languages free of cost and shall notify clients how to access those materials. (See 42 CFR § 438.10(d)(5)(i) & (iii); 9 CCR § 1810.410(e)(4).)

i. The Contractor shall include taglines in the prevalent non-English languages in the State of California, as well as large print, explaining the availability of written translation or oral interpretation to understand the information provided. (42 CFR. § 438.10(d)(2).)

ii. The Contractor shall include taglines in the prevalent non-English languages in the State of California, as well as large print, explaining the availability of the toll-free and Teletypewriter Telephone/Text Telephone (TTY/TDY) telephone number of the Contractor's member/customer service unit. (42 CFR § 438.10(d)(3).)

iii. The Contractor shall notify clients that written translation is available in prevalent languages free of cost and shall notify clients how to access those materials. (42 C.F.R. § 438.10(d)(5)(i), (iii); Cal. Code Regs., tit. 9, § 1810.410, subd. (e), para. (4).)

e. The Contractor shall make oral interpretation and auxiliary aids and services, such as TTY/TDY and American Sign Language (ASL), available and free of charge for any language. Contractor shall notify clients that the service is available and how to access those services. (42 CFR. § 438.10(d).

CULTURAL COMPETENCY

A. Cultural competence is defined as a set of congruent practice behaviors, attitudes, and policies that come together in a system, agency, or among consumer providers and professionals which enable that system, agency, or those professional and consumer providers to work effectively in cross-cultural situations.

B. Contractor recognizes that cultural competence is a goal toward which professionals, agencies, and systems should strive. Becoming culturally competent is a developmental process and incorporates at all levels the importance of culture, the assessment of cross-cultural differences, the expansion of cultural knowledge, and the adaptation of services to meet culturally unique needs. Providing medically necessary specialty behavioral health, substance abuse, and co-occurring disorder services in a culturally competent manner is fundamental in any effort to ensure success of high quality and cost-effective services. Offering those services in a manner that fails to achieve its intended result due to cultural and linguistic barriers is not cost effective.

C. Contractor shall assess the demographic make-up and population trends of its service area to identify the cultural and linguistic needs of the eligible beneficiary population. Such studies are critical to designing and planning for providing appropriate and effective behavioral health, substance abuse, and co-occurring disorder services.

D. Contractor shall implement practices and protocols that are inclusive and responsive to the needs of diverse cultural populations, including Lesbian, Gay, Bisexual, Transgender and Queer/Questioning (LGBTQ) individuals, families and communities.

E. Contractor shall adopt the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care to improve health care quality and advance health equity. Refer to http://minorityhealth.hhs.gov (US Department of Health and Human Services Office of Minority Health).

2022 What worked and what was learned

Moving forward contracted organizations should provide the following:

- 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

- Evidence that the county informs clients of the availability of the above listing in their member services brochure.
- Evidence counties have policies, procedures, and practices to inform all Medi-Cal beneficiaries of available services under consolidation of specialty mental health services.
- 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:
  - Location
  - Transportation
  - Hours of operation, or other relevant areas;
  - 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)

“Not everything that is faced can be changed, but nothing can be changed until it is faced.”
— James Baldwin

California State Statute

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

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

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

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

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

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

WIC, Section 5807. – relates to Human Resources, Education, and Training Programs.Requires counties to work in an interagency collaboration (and public

and private collaborative programs) to effectively serve target populations to assure service effectiveness and continuity and help set priorities for services.

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

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

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

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

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

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

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

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

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

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

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

WIC, Section 5855. (f) -- relates to Children's Mental Health System of Care. "Culturalcompetence. Service effectiveness is dependent upon both culturally relevant and competent service delivery."

WIC. Section 5865. (b) -- relates to the county System of Care Requirement in place with qualified mental health personnel within three years of funding by the state. "(b) A method to screen and identify children in the target population including persons from ethnic minority cultures which may require outreach for identification. (e) A defined mechanism to ensure that services are culturally competent."

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

culturally competent, and individualized to the strengths and needs of each child and their family."

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

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

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

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

California Code of Regulations

California Code of Regulations (CCR), Title 9, Rehabilitative and Developmental Services. Division 1, Department of Mental Health, Chapter 10, Medi-Cal Psychiatric Inpatient Hospital Services, Article 1, Section 1704 "Culturally Competent Services means a set of congruent behaviors, attitudes and policies in a system or agency to enable effective service provision in cross-cultural settings."

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

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

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

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

California State Statute Cont.

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

CCR, Title 9, Rehabilitative and Developmental Services, Division 1, Department of Mental Health, Chapter 14. Mental Health Services Act, Article 2, Definitions, Section 3200.260. "'Small County' means a county in California with a total population of less than 200,000, according to the most recent projection by the California State Department of Finance."

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

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

MHSA Component Guidelines

Prevention and Early Intervention: Cultural Competence
"Improving access to mental health programs and interventions for unserved and underserved communities and the amelioration of disparities in mental health across racial/ethnic and socioeconomic groups are priorities of the MHSA. Therefore cultural competence must be emphasized in PEI programs."
Cultural Competence means incorporating and working to achieve cultural competence goals into all aspects of policy-making, program design, and administration and service delivery. (Source: PEI, 2007, p. 2).

Workforce Education and Training: Cultural Competence
Guides counties for the "development and implementation of recruitment, retention and promotion strategies for providing equal employment opportunities to administrators, service providers, and others involved in service delivery who share the diverse racial/ethnic cultural and linguistic characteristics of individuals with severe mental illness/emotional disturbance in the community." "Staff, contractors and other individuals who deliver services are trained to understand and effectively address the needs and values of the particular racial/ethnic, cultural, and /or linguistic population or community they serve." (Source: WET, 2007, p.4-5)

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

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

Federal Statute

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

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

Federal Statute Cont.

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

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

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

Federal Standards/Guidelines

U. S. Department of Health and Human Services, Office of Minority Health (OMH), National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care. These national standards were to respond to: 1) the need to ensure that all people entering the health care system receive equitable and effective treatment in a culturally and linguistically appropriate manner, and 2) a means to correct inequities that currently exist in the provision of health service and to make these services more responsive to the individual needs of all consumers. CLAS mandates (Standards 4, 5, 6, and 7) are current federal requirements for all recipients of Federal funds. Standards 1,2,3,8,9,10,11,12, and 13 are CLAS guidelines and are recommended by OMH for adoption as mandates for Federal, State, and national accrediting agencies. OMH recommends CLAS Standard 14 for adoption by healthcare organizations.

Center for Mental Health Services (CMHS), Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, Cultural Competence Standards in Managed Care Mental Health Services: Four Underserved/underrepresented Racial/Ethnic Groups –Final report from working groups on cultural competence in managed Mental Health Care Services.
Prepared by Western
Interstate Commission for Higher Education. (These standards have not been mandated by CMHS.)

DMH Letter

DMH Information Notice: 94-17 issued on December 7, 1994 -- requests all counties applying to become a Mental Health Plan to submit a written Implementation Plan for Psychiatric Inpatient Hospital Services Consolidation by January 1, 1995. Counties were required to describe the process they would implement to improve cultural competence and age-appropriate services to Medi-Cal beneficiaries.

Federal Waiver Request

DMH Waiver Request Submission to Health Care Financing Administration (HCFA) states: MHPs will be required to develop and implement a plan for the provision of culturally competent and age appropriate services to beneficiaries. At a minimum this plan must include maintaining a statewide 800 number with linguistic capability that is available 24 hours a day, and must include goals for improving cultural competence. DMH will establish a task force to address linguistic and cultural competence issues and may set additional statewide requirements for MHPs as a result of task force findings and recommendations.

DEFINITIONS

BILINGUAL STAFF

Bilingual staff members have language capacity in both English and the specific non-English languages used by cultural groups in the target community.

CLIENT/CONSUMER

Client/consumer is a person with lived experience of mental health issues. (*Source: California Network of Mental Health Clients*, 2002).

COMMUNITY-DEFINED EVIDENCE

"Community-defined evidence" means practices that have a community-defined evidence base for effectiveness in achieving mental health outcomes for underservedcommunities. It also defines a process underway that will develop specific criteria by which effectiveness may be documented using community-defined evidence that will eventually give the procedure equal standing with current evidence-based practices.

COMMUNITY ENGAGEMENT

Community engagement has been defined over the last two decades in multiple, evolving ways (1). One definition of community engagement is "the process of workingcollaboratively with relevant partners who share common goals and interests" (2). It involves "building authentic partnerships, including mutual respect and active, inclusiveparticipation; power sharing and equity; mutual benefit or finding the 'win-win' possibility" in the collaborative project (3). The emphasis on community engagement promotes a focus on common ground and recognizes that communities have importantknowledge and valuable experience to add to the public stakeholder input debate.

CULTURAL BROKERS

Cultural brokers may be State and county officials working within county Mental HealthDepartments (such as Cultural Competence/Ethnic Service Managers) or outside county Mental Health Departments (such as public health, social services, and education) who have prior knowledge and trusting relationships with particular communities. In addition, cultural brokers may be community activists, advocates working at the State or county level, as well as county or State level non-governmentalorganizations (with established trust and credibility in particular communities). For Native American communities in particular, contact with appropriate tribal organizationleaders is a critical first-step (*Source:* University of California, Davis, Center for Reducing Health Disparities and CA Department of Mental Health (2007). *Building Partnerships: Key Considerations When Engaging Underserved Communities Under the MHSA, UC Davis CRHD and DMH,* Page 3).

CULTURAL COMPETENCE
Cultural competence is a set of congruent practice skills, knowledge, behaviors, attitudes, and policies that come together in a system, agency, or among consumer providers and professionals that enables that system, agency, or those professionals and consumer providers to work effectively in cross-cultural situations (Adapted from Cross et al, 1989). (See CCR, Title 9, Rehabilitative and Developmental Services, Division 1, Department of Mental Health, Chapter 14, Mental Health Services Act, Article 2, Definitions, Section 3200.100, Cultural Competence)

ENGLISH PROFICIENCY
Level at which a person can understand English and respond in English to explain their behavioral healthcare problems, express their treatment preferences and understand the treatment plan.

ETHNIC DISPARITY
The mental health system has not kept pace with the diverse needs of racial and ethnic minorities, often underserving or inappropriately serving them. Specifically, the system has neglected to incorporate respect or understanding of the histories, traditions, beliefs, languages, and value systems of culturally diverse groups. (Source: California Department of Mental Health (2002) *Community Services and Supports Three-Year Program and Expenditure Plan Requirements).*

EVIDENCE BASED PRACTICE
Evidence based practice is a prevention or treatment practice, regimen, or service that is grounded in consistent scientific evidence showing that it improves client/participant outcomes in both scientifically controlled and routine care settings. The practice is sufficiently documented through research to permit the assessment of fidelity. This means elements of the practice are standardized, replicable, and effective within a given setting and for particular populations. As a result, the degree of successful implementation of the service can be measured by the use of a fidelity tool that operationally defines the essential elements of the practice. (Source: California Department of Mental Health (2002) *Community Services and Supports Three-Year Program and Expenditure Plan Requirements).*

FAMILY MEMBER
A family member is a parent or caretaker of a child, youth, adult, or older adult, who is currently utilizing, or has previously, utilized mental health services. (Source: California Department of Mental Health (2002) *Community Services and Supports Three-Year Program and Expenditure Plan Requirements).*

GATEKEEPER
“Gatekeeper” means those individuals in a community who have face-to-face contact with large numbers of community members as part of their usual routine; they may be trained to identify persons at risk for mental health problems or suicide and refer them to treatment or supporting services as appropriate.

HISTORICAL DISPARITIES
Historical disparities have been consistently found in and continue to exist among California's racial-ethnic populations including African Americans, Latinos, Asian Pacific Islanders (API), and Native American. Any other population group(s) targeted in a county plan must be clearly defined with demonstrated evidence and supporting data to target them as having historical disparities in unserved, underserved and inappropriately served in mental health services. (Source: MHSOAC, (2008). *Cultural & Linguistic Competence Technical Resource Group Workplan*.)

INTERPRETERS
Interpreters are individuals with specific language skills and knowledge of health care terminology who are trained to communicate effectively with persons with limited proficiency with the English language.

INTERPRETER SERVICES
Interpreter services are methods in place to assist persons with limited English proficiency. This includes telephone interpreter services ("language lines"), interpreters obtained from a central listing maintained by agency or other source, trained volunteers from a target community with identified language skills.

KEY POINTS OF CONTACT (MANDATED/NON-MANDATED)
"Common points of access to Specialty Mental Health Services from the MHP, including, but not limited to, the MHP's beneficiary problem resolution process, county owned or operated or contract hospitals, and any other central access locations established by the MHP." (Source: CCR, Title 9, Rehabilitative and Developmental Services. Division 1, Department of Mental Health, Chapter 11, Medi-Cal Specialty Mental Health Services, Article 4, Section 1810.410, Cultural and Linguistic Requirements)

LIMITED ENGLISH PROFICIENT (LEP)
A diminished level of English language skills that calls into question the person's ability to understand and respond to issues related to their treatment.

LINGUISTIC COMPETENCE
The capacity of an organization and individuals working within the system are able to communicate effectively and convey information in a manner that is easily understood by diverse audiences including persons of LEP, those who have few literacy skills or are not literate; and individuals with disabilities that impair communication. It also means that the structures, policies, procedures and dedicated resources are in place that enables organizations and individuals to effectively respond to the literacy and language needs of the population being served. *(*See CCR, Title 9, Rehabilitative and Developmental Services, Division 1, Department of Mental Health, Chapter 14, Mental Health Services Act, Article 2, Definitions, Section 3200.210, Linguistic Competence.)

LINGUISTICALLY PROFICIENT
A linguistically proficient person is a person who meets the level of proficiency in the threshold languages as determined by the MHP.

MEDI-CAL BENEFICIARIES
Any person certified as eligible under the Medi-Cal program according to Title 22, Section 51001.

NON-TRADITIONAL MENTAL HEALTH SETTINGS
"Non-traditional mental health settings" means systems and organizations not traditionally defined as mental health; i.e., school and early childhood settings, primary health care systems including community clinics and health centers, and community settings with demonstrated track records of effectively serving ethnically diverse and unserved or underserved populations.

PENETRATION RATE
The total number of persons served divided by the number of persons eligible.

PREVALENCE
The number of cases of the condition present in a defined population at a specified time or in a specified time interval (e.g., the total number of cases with a specific disease or condition, such as ischemic heart disease, at a given time divided by the total population at that time) (Source: California Department of Mental Health (2002) *Community Services and Supports Three-Year Program and Expenditure Plan Requirements).*

PRIMARY LANGUAGE
That language, including sign language, which must be used by the beneficiary to communicate effectively, and which is so identified by the beneficiary.

PROMISING PRACTICE
"Promising Practice" means programs and strategies that have some quantitative data showing positive outcomes over a period of time, but do not have enough research or replication to support generalized outcomes. It has an evaluation design in place to move towards demonstration of effectiveness; however, it does not yet have evaluation data available to demonstrate positive outcomes.

RECOVERY
Recovery refers to the process in which people who are diagnosed with a mental illness are able to live, work, learn, and participate fully in their communities. For some individuals, recovery means recovering certain aspects of their lives and the ability to live a fulfilling and productive life despite a disability. For others, recovery implies the reduction or elimination of symptoms. Focusing on recovery in service planning encourages and supports hope. (Source: California Department of Mental Health (2002) *Community Services and Supports Three-Year Program and Expenditure Plan Requirements).*

RESILIENCE
Resilience means the personal qualities of optimism and hope, and the personal traits of good problem-solving skills that lead individuals to live, work and learn with a sense of mastery and competence. Research has shown that resilience is fostered by positive experiences in childhood at home, in school and in the community. When children encounter negative experiences at home, at school, and in the community, mental health programs, and interventions that teach good problem-solving skills, optimism, and hope can build and enhance resilience in children. *(Source: California Family Partnership Association, (2005).* (Source: California Department of Mental Health (2002) *Community Services and Supports Three-Year Program and Expenditure Plan Requirements).*

RETENTION RATE
A retention rate is the percent of new clients who receive 2, 3, 4, etc. follow-up day or outpatient services following an initial non-crisis contact with the mental health system. This measures the rate at which new clients in general are retained in the system for treatment.

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

SPECIALTY MENTAL HEALTH SERVICES
Includes the following: rehabilitative mental health services, psychiatric inpatient hospital services, targeted case management, psychiatrist services, psychologist services, and Early and Periodic Screening, Diagnosis and Treatment (EPSDT) supplemental services.

STAFF DIVERSITY
Staff who are representative of the diverse demographic population of the service area and including the leadership of the organization as well as its governing boards, clinicians, and administrative personnel. (*Source: CLAS, Final Report, Page 8*).

TARGET POPULATION
That part of the general population designated as the population to be served by the administrative or service delivery entity. (*Source: Chambers, Final Report: 2008: Cultural Competency Methodological and Data Strategies to Assess the Quality of Services in Mental Health Systems of Care, Page 42)* **Note**: DMH recognizes each MHSA component has its own identified target population(s).

THRESHOLD LANGUAGE
The annual numeric identification on a countywide basis, of 3,000 beneficiaries or five (5) percent of the Medi-Cal beneficiary population, whichever is lower, whose primary language is other than English, for whom information and services shall be provided in their primary language.

TRANSLATION SERVICES
Translation services are those services that require "The conversion of a written text into a written text in a second language corresponding to and equivalent in meaning to the text in the first language". **Note:** Translation refers to written conversions from one language into a second language, while interpreting refers to the conversion of spoken or verbal communication from one language into a second language. (Source: California Healthcare Interpreters Association, 2002)

UNDERSERVED
Individuals who have been diagnosed with serious mental illness and children who have been diagnosed with serious emotional disorders, and their families, who are getting some service, but whose services do not provide the necessary opportunities to participate and move forward and pursue their wellness/recovery goals. This category would also include individuals who are so poorly served that they are at risk of situational characteristics such as homelessness, institutionalization, incarceration, out-of-home placement or other serious consequences (Source: Department of Mental Health *(2002) Community Services and Supports Three-Year Program and Expenditure Plan Requirements).*

UNSERVED
Persons who may have serious mental illness and children who may have serious emotional disorders, and their families, who are not receiving mental health services. Examples of underserved populations described in the MHSA include older adults with frequent, avoidable emergency room and hospital admissions, adults who are homeless or incarcerated or at risk of homelessness or incarceration, transition age youth existing the juvenile justice or child welfare systems or experiencing their first episode of major mental illness, children and youth in the juvenile justice system or who are uninsured, and individuals with co-occurring substance use disorders. Frequently, unserved individuals/families are part of racial ethnic populations that have not had access to mental health programs due to barriers such as poor identification of their needs, provider barriers lacking ethno-culturally competent services, poor engagement and outreach, limited language access, limited access in rural areas and American Indian Rancherias or reservations and lack of culturally competent services and programs within existing mental health programs. (*Source: Community Services and Supports Three-Year Program and Expenditure Plan Requirements).*

WELLNESS
A dynamic state of physical, mental, and social well-being; a way of life which equips the individual to realize the full potential of his/her capabilities and to overcome and compensate for weaknesses; a lifestyle which recognizes the importance of nutrition, physical fitness, stress reduction, and self-responsibility. Wellness has been viewed as the result of four key factors over which an individual has varying degrees of control: human biology, environment, health care organization (system), and lifestyle. (*Source: Community Services and Supports Three-Year Program and Expenditure Plan Requirements).*

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Appendix A

This appendix consists of the Cultural Competency agenda and demographics. Follow these steps click to open zip file, click Document Cloud, click Cultural Competency

Appendix B

Cultural Competency Activities and Events

This appendix consists of the Cultural Competency activities and events that were held. Follow these steps click to open zip file, click Document Cloud, click Activities and Events

Appendix C

Cultural Competency Trainings

This Appendix consists of all the Cultural Competency Diversity Equity & Inclusion trainings C.L.A.S and other trainings that were held. Follow these steps click to open zip file, click Document Cloud, click Trainings

Appendix D

DEIB Training PowerPoints

This Appendix consists of all the Cultural Competency Diversity Equity & Inclusion trainings PowerPoints. Follow these steps click to open zip file, click Document Cloud, click Trainings

Participant Handouts for DEIB Training All Staff Group - Google Drive
Participant Handouts for DEIB Training Leadership Group - Google Drive