Behavioral Health Services

Cultural Competence Plan Update
Fiscal Year 2024/2025

Orange County Health Care Agency Behavioral Health Services
Multicultural Development Program

Table of Contents

DIRECTOR'S MESSAGE

Greetings Department of Health Care Services,

We are pleased to submit the annual Cultural Competency Plan Update for Orange County's Behavioral Health Services (BHS). Our vision remains steadfast: to provide high-quality, equitable behavioral health services that meet the diverse needs of our communities. This update reflects our ongoing efforts to ensure that services are accessible, culturally responsive, and centered around the individuals and families who rely on us the most.

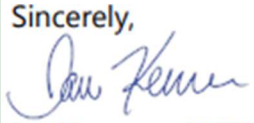
As we move through another year of transformation and opportunity, we remain committed to meeting change with resilience, flexibility, and compassion—keeping our most vulnerable community members at the core of every decision. Our Behavioral Health Equity Committee (BHEC) continues to serve as a vital platform for county and community collaboration, working to advance equity across our system and in our service delivery.

The goals set forth in our previous Cultural Competency Plan Update continue to guide and evolve our work. These include:

- Embedding equity as foundational elements of our behavioral health system.
- Strengthening the work of the Behavioral Health Equity Committee and its workgroups to deepen trust and relationships with the communities we serve.
- Recruiting and retaining a highly qualified, diverse, bilingual, and bicultural workforce.
- Operationalizing the Cultural Competency Plan by ensuring that Culturally and Linguistically Appropriate Services (CLAS) standards are upheld in every client, participant, and family interaction.

Looking ahead, we are committed to refining and building upon these goals through continued engagement with community voices. We firmly believe that a culturally responsive and equitable behavioral health system is not only possible—it is essential and achievable through shared vision, intentional collaboration, and dedication.

Sincerely,



Ian Kemmer, LMFT
Director of Behavioral Health Services

INTRODUCTION

The Orange County Health Care Agency Behavioral Health Services is responsible for delivering mental health and substance use services to Orange County residents who are experiencing major mental illness or substance use issues. Behavioral Health Services provides the following services:

- Navigational Help
- Crisis Services
- Alcohol & Substance Use Services
- Children & Youth Services
- Adult (18+) Services
- Older Adult (60+) Services
- Wellness Promotion & Prevention

Behavioral Health Services (BHS) consists of the following service areas:

- Children and Youth Services (CYS)
- Adult and Older Adult Behavioral Health (AOABH)
- Navigation
- Forensics
- Crisis & Acute Care Services (CAACS)
- Substance Use Disorder (SUD)
- Mental Health Services Act (MHSA)
- Quality Management Services

The vision, mission, and goals of the Orange County Health Care Agency are as follows:

VISION
Quality health for all.
MISSION
In partnership with the community, deliver sustainable and responsive services that promote population health and equity.
GOALS
Promote quality, equity, and value. Ensure the HCA's sustainability. Offer relevant services to the community.

According to the Substance Abuse Mental Health Services Administration's (SAMHSA) Office of Behavioral Health Equity, behavioral health equity is "the right to access high-quality and affordable health care services and supports for all populations, including Black, Latino, and Indigenous and Native American persons, Asian Americans and Pacific Islander and other persons of color; members of religious minorities; lesbian, gay, bisexual, transgender, and queer (LGBTQ+) persons; persons with disabilities; persons who live in rural areas; and persons otherwise adversely affected by persistent poverty or inequality." The need to respond to changes in populations demographics prompted the Orange County Health Care Agency to establish the Office of Population and Health Equity 2021 and implement the Equity in OC initiative. This initiative brings together over 200 community-based organizations and stakeholders to address the social determinants of health and collaboratively work towards eliminating health (including mental health and substance use) disparities across the populations of Orange County. Over the next decade, adolescents and older adults will become the fastest growing sub-group populations of Orange County.

Within Behavioral Health Services, the goals continue to be to:

1. Ensure the CLAS Standards are implemented across programs and clinic levels.
2. Support the Behavioral Health Equity Committee (BHEC) and its workgroups, which are formed in equitable and balanced partnership with members of the community, which includes leveraging the workgroups to promote community engagement meetings, especially in conjunction with the MHSA Office and the OPHE.
3. Develop equity a as core components of the County's work in service to the community through the following activities:
    a. Review all County Policies, Procedures, and Operating Practices to ensure behavioral health equity is supported.
    b. Recruit and retaining highly qualified bi-lingual and bi-cultural staff across all levels within BHS.
4. Support the implementation of Anti-Racism Resolution (Resolution No. 21-028) of the Board of Supervisors, which reads:

> *"NOW, THEREFORE, BE IT RESOLVED THAT THE ORANGE COUNTY BOARD OF SUPERVISORS declares out commitment to protect and improve the lives of Orange County residents in acknowledging the grave harms of racism, repudiate those who perpetrate acts of racism, and commit to work in our role as a county government to eradicate racism."*

On Tuesday, December 6, 2022, the Board of Supervisors declared racism "with its resultant social and health inequities" a public health crisis. The latest report on hate crimes indicated a 165% increase in 2021, with Asian Americans and Pacific Islanders as the populations most affected. In the resolution, the board vowed to "work to promote an inclusive, well-informed, and racial equity justice-oriented governmental organization that is conscious of injustice and unfairness through robust trainings and continuing education to expand the understanding of how racial discrimination affects individuals and communities most impacted by inequities." This declaration reinforces the work of BHS in addressing equity in our services.

These goals are being implemented in collaboration with the Behavioral Health Equity Committee, and the progress to date has been:

- Promote community engagement meetings to provide information on mental health and recovery services available through the County and contracted agencies.
- Distribute information in threshold languages.
- Raise awareness around CLAS Standards and their implementation.
- Continue to address cultural humility and cultural responsiveness through self-paced trainings.

Notes:

- The term Client and Consumer are used interchangeably throughout the plan. All terms are used to describe individuals receiving services from Behavioral Health Services.

CRITERION 1: COMMITMENT TO CULTURAL COMPETENCE

National Standards for Culturally and Linguistically Appropriate Services (CLAS Standard) 2, 3, 4, 9 & 15.

1-I: County Mental Health System Commitment to Cultural Competence.

The County shall include the following in the Cultural Competence Plan Requirements (CCPR): Policies, procedures, or practices that reflect steps taken to institutionalize the recognition and value of racial, ethnic, and cultural diversity within the County Mental Health System.

The commitment to the principles of Cultural Competence is reflected in the broad categories of Policies, Procedures and Practices; Program Oversight and Compliance; Community Engagement and Involvement Efforts; and current budgetary allotments which have been set aside for further expansion of our programs. The entire Cultural Competence Plan will address each of these constructs in detail to provide guidance to Mental Health & Recovery Services (BHS) in meeting the complex behavioral health needs of our communities in an equitable manner. Each section of this criterion will provide an overview of principles, practices, policies, documents, and official structures used throughout BHS.

Policies, Procedures, or Practices

The focus on cultural competence is documented in several BHS written policies and procedures. These include, but are not limited to:

*Table 1.1 BHS Policies and Procedures (Updated 2023)***

Policy Number	*Policy Details*
BHS Policy 02.01.01.	All of Mental Health and Recovery Services (BHS) County and County Contracted providers shall be culturally competent.
BHS Policy 02.01.02.	All Mental Health and Recovery Services (BHS) beneficiary/clients shall have access to linguistically appropriate services.
BHS Policy 02.01.03.	Mental Health and Recovery Services (BHS) is committed to providing beneficiaries/clients with culturally/linguistically appropriate written materials in all threshold languages or in alternate formats.
BHS Policy 02.01.04.	All beneficiaries receiving behavioral health services from the County of Orange Health Care Agency (HCA) Mental Health and Recovery Services (BHS) will receive and/or have access to a copy of the appropriate Provider Directory.

*Table 1.1 BHS Policies and Procedures (Updated 2023)** continued*	
Policy Number	*Policy Details*
BHS Policy 02.01.05.	Written materials provided to consumers, family members or significant others of the BHS MHP shall be field tested in the threshold languages to ensure comprehension. Written materials include, but are not limited to: · MHP Consumer Handbook · MHP Provider List · General Correspondence · Beneficiary grievance and fair hearing materials · Confidentiality and release of private health information · MHP orientation materials · SMHS education materials
BHS Policy 02.01.06.	It is the policy of BHS to seek and incorporate input from the service providers and community representatives, consumers and families representing the diverse ethnic and cultural groups of Orange County into service design and implementation.
BHS Policy 02.01.07	Meeting Deaf and Hard of Hearing Language Needs at Key Points of Contact. To ensure that all Deaf and Hard of Hearing Medi-Cal beneficiaries receiving services in Orange County Mental Health and Recovery Services (BHS) within the Mental Health Plan (hereby referred to as Orange MHP) and Drug Medi-Cal Organized Delivery System (DMC-ODS) have access to linguistically appropriate services through staff or interpreters proficient in beneficiary's primary language, e.g., American Sign Language (ASL). This policy also applies to non-MediCal clients receiving services within BHS.
BHS Policy 02.06.02.	Required distribution of informing materials shall be documented so as to be easily audited. The Advance Directives shall be documented as required in CFR 42, Chapter 4.
BHS Policy 03.01.03.	BHS trainings that address cultural issues shall be of the highest possible quality. Toward this end, the Multicultural Development Program shall provide review, feedback and consultation on all trainings that address cultural issues prior to the training date.

***Copies of all the Policies and Procedures listed above is in Appendix I.*

Program Oversight and Compliance

BHS utilizes policies and procedures to provide oversight and governance for workforce expectations, client care, and to establish strategic goals. The following is a brief sample of policies and procedures, strategic plans, and documents that establish accountability. BHS continues to develop strategic plans as needs arise and reviews its governance policies regularly.

Table 1.2 Program Oversight and Compliance Supporting Documents

Title	*Description*	*Source*
BHS Policies and Procedures	List of policies and procedures for operations and client care	https://www.ochealthinfo.com/about-hca/behavioral-health-services/bh-services/policies-and-procedures
Drug Medi-Cal Organized Delivery System	Levels of care, services, and resources	https://www.ochealthinfo.com/providers-partners/authority-quality-improvement-services-division-aqis/quality-assurance-18
HCA Organizational Chart	Leadership within organization	https://sharepoint.ochca.com/sites/HCAOrgCharts/_layouts/15/WopiFrame2.aspx?sourcedoc=%7B02480F63-AFDA-4707-B704-8E4B9FC9E19C%7D&file=11.2023%20OC%20HCA%20EXECUTIVE%20ORG%20CHART%20(EXTERNAL).pdf&action=default
Compliance Orientation, Education and Training	HCA Human Resources policies	https://www.ochealthinfo.com/sites/healthcare/files/2023-02/03.01.02_2023_Compliance_Orientation_Education_and_Training.pdf
Informing Materials for Mental Health Plan Consumers	Accountability policies and procedures	https://www.ochealthinfo.com/sites/hca/files/import/data/files/50869.pdf
Medi-Cal Consumer Rights Under the Orange County Mental Health Plan	Client care and rights	https://www.ochealthinfo.com/sites/hca/files/import/data/files/50870.pdf

Notes:

- Mental Health & Recovery Services is now Behavioral Health Services (BHS). The policies remain the same.
- The Office of Equity will continue to monitor and update the aforementioned policies and procedures to ensure they are current, up to date, and in compliance with current state and federal policies and procedures as needed in FY24/25.

1-II: The County shall show Recognition, Value, and Inclusion of Racial, Ethnic, Cultural, and Linguistic Diversity within the System.

The Cultural Competency Plan Requirements (CCPR) shall be completed by the county Mental Health Department. The county will hold contractors accountable for reporting the information to be inserted into the CCPR. The county shall include the following in the CCPR:

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

The Orange County Health Care Agency, Behavioral Health Services (BHS) is dedicated to including diverse consumers, family members, stakeholders, and community members from throughout the county in the planning and implementation of Mental Health Services Act (MHSA) programs and services. BHS's Community Program Planning (CPP) process is being updated. This enhancement encompasses a vision that encourages community participation with the goal of empowering the community for the purpose of generating ideas, providing input that contributes to decision making, and creating a county/community partnership dedicated to improving public behavioral health outcomes for Orange County residents. These efforts include engaging stakeholders in discussion topics related to public behavioral health policy, pending legislation, program planning, implementation, evaluation, and financial resources affiliated with public behavioral health programs, as well as obtaining feedback that is factored into decision-making.

MHSA Community Program Planning (CPP) consists of planned meetings with diverse stakeholders from all regions of the County in which HCA reviews MHSA related information and seeks input from community. The CPP process emphasizes the importance of consumer and family member involvement and allows for continuous communication between HCA and stakeholders to allow for implementation of real time program adjustments and quality improvement.

MHSA has been integral in supporting the transformation of the public behavioral health system. Through the MHSA, County agencies ensure that key community stakeholders can provide input into program development, implementation, evaluation, and policy for MHSA funded programs. This approach assists County safety net organization in integrating the needs of diverse individuals, families, and communities in its programming.

CULTURALLY AND LINGUISTICALLY CONGRUENT APPROACHES

BHS has a commitment to cultural competency and ensuring that this value is incorporated into all aspects of BHS policy, programming, and services, including planning, implementing, and evaluating programs and services. To ensure culturally sensitive approaches in each of these areas, BHS is proposing a re-organization and will establish the Office of Equity (OE), which reports to the Chief of BHS. The Office of Equity works with the Behavioral Health Equity Committee (BHEC), which currently consists of diverse, equitable representation from county and community and entails various population specific subcommittees. Currently, the subcommittees include Spirituality, Deaf and Hard of Hearing (DHH), Asian/Pacific Islander (API, LatinX, Black/African-American Group, and LGBTQ+, with the intent of increasing and expanding these subcommittees to include Veterans, Homelessness, and additional populations over time. The Office of Equity is to be led by an Ethnic Services Manager (ESM), who reports directly to the Chief of BHS. The ESM oversees the BHEC Steering Committee and works closely in conjunction with the MHSA program leads to ensure compliance with Culturally and Linguistically Appropriate Services (CLAS) standards to ensure that the services provided address cultural and linguistic needs. The ESM or OE staff will regularly sit on boards or committees to provide input or effect change regarding program planning and implementation.

OE will also provide support by translating documents for the department, as well as coordinating interpretation services for stakeholder outreach, meetings, and training events. Language regarding cultural competence is included in all agency contracts with community-based organizations and individual providers to ensure contract services are provided through a framework of cultural humility. Behavioral

Health Trainings are also reviewed to ensure they address cultural congruence and responsiveness.

BHS is highly committed to including consumers, family members, and other stakeholders within all levels of our organizational structure. It continues to be our mission to include consumers and family members into an active system of stakeholders. BHS intends to establish the Office of Consumer and Family Affairs that reports to the ESM. Outreach to consumers and family members performed through the Office of Consumer and Family Affairs, MHSA Program Support and Administration, Prevention and Intervention office, Innovations team, community partners and contracted provider agencies, to encourage regular participation in MHSA activities. Consumer engagement occurs through regularly scheduled Community Program Planning process meetings, community events, department activities, and committee meetings. Consumer input is always considered when making MHSA related system decisions in BHS.

The MHSA Manager and Component Leads, in conjunction with the Office of Equity, and the HCA Communications Team, have shared responsibility for coordination and management of the Community Program Planning (CPP) process. This process is built upon existing stakeholder engagement practices and collaborative networks within the behavioral health system and continues to evolve through a quality improvement framework.

COMMUNITY PLANNING PROCESS - MHSA

In prior years, Orange County had utilized a 51-member Steering Committee as part of a formal group to support the community planning process. In June 2021, the Steering Committee was dissolved, and a new process was to be established. During this time of re-organization, the MHSA Program Planning and Administration office continued to engage with the community for the development of the last Annual Update through informational meetings to maintain communication and sharing information while the new structure was in development. The meetings focus on Mental Health and Recovery Services information, community Behavioral Health issues and needs, and presentations by MHSA funded programs.

During the 2022/23 fiscal year, an updated Community Program Planning (CPP) process began to emerge. BHS continued to host monthly virtual Community Engagement Meetings (CEM) and began to build on this infrastructure through hosting population specific meetings, focus groups, and community meetings. As a kick-off to this reimagining, on November 10, 2022, BHS hosted an MHSA

Summit. Approximately 170 people attended this full day event which was held at the Behavioral Health Training Center in the City of Orange. The overarching goal of the Summit was to strategically advance MHSA communication and future planning with system partners, County residents, and key stakeholders. Translation and transportation services were offered to support participation from diverse community stakeholders, consumers, and family members.

The day began with a land acknowledgment from the Native community and each transition incorporated a brief cultural activity or personal recovery testimony. Breakfast and lunch were provided to attendees and each participant received incentive items to thank them for their attendance. Consistent with CPP standards, self-identified consumer and family members were provided a gift card in appreciation for their participation.

The morning session of the Summit focused on providing an overview and educational session for stakeholder and staff attendees about Mental Health Services Act policies, requirements, finance, and opportunities for partnership. Following a break, attendees enjoyed a panel discussion comprised of both stakeholders and staff as they discussed and described the transformational power of MHSA programs and practices.

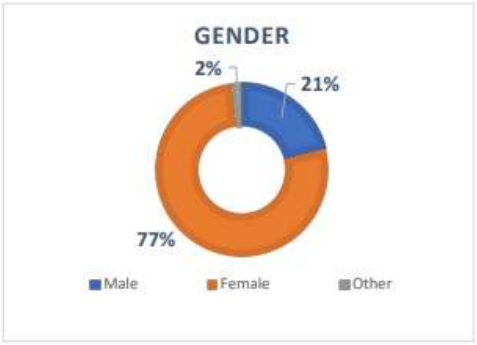
Panelist described first-hand accounts of how the system transformed to meet community needs, provided testimony of their journey into recovery via MHSA programs, and the ability to provide needed behavioral health supports and services beyond the standard insurance benefits allowable through Medi-Cal.

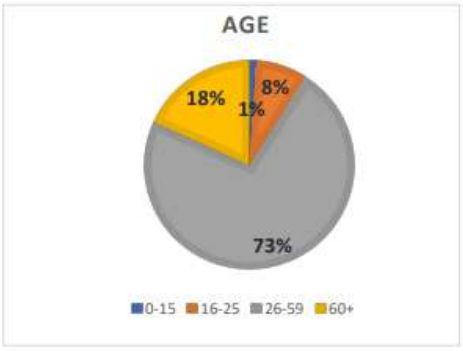
The afternoon session was a focused discussion and prioritization exercise for the development of proposed Innovation project concepts. Attendees participated in a World Café style planning session where four different Innovation Project Concepts were discussed.

Attendees broke out into four different groups, having the opportunity to listen to an overview of proposed concepts and weigh in with insights and recommendations. After participating in each group, attendees then prioritized which concepts should be considered for future development.

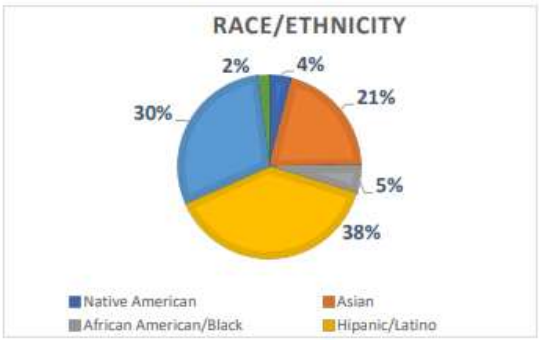
All attendees were encouraged to complete online stakeholder surveys. For individuals without internet access or electing not to use their electronic devices, iPads were provided by BHS so they could access the survey. In addition, hard copies were made available upon request.

The demographic breakdown of participants who attended the Summit and completed a stakeholder survey is illustrated below. It is important to note that not every respondent answered every question. In addition, for the Groups Represented question, individuals could select more than one category. The majority of MHSA Summit attendees identified as adults between the ages of 26-59 and 77% of attendees identified as female.

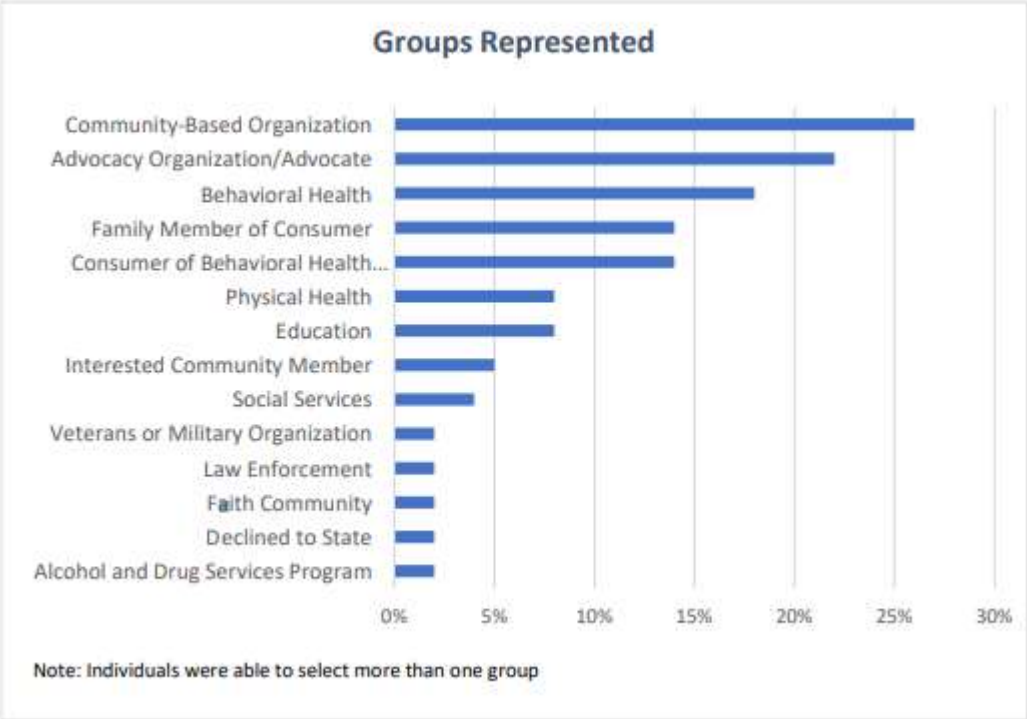




The majority of MHSA Summit attendees identified as Hispanic/Latino (38%) with the second largest group identifying as Caucasian/White (30%).



The graph below illustrates the survey respondent groups represented at the MHSA Summit.



After the MHSA Summit, in addition to the regularly scheduled Community Engagement Meetings, a series of ten (10) stakeholder focus groups were conducted with consumers of MHSA funded programs and services throughout December and January. In addition, population specific planning meetings for older adults, veterans, very young children, and school-aged children and youth were hosted by system partners or hosted by BHS for community input.

Sharing Information with Our MHSA Stakeholders

Materials and Reports

In an effort to communicate information to our stakeholders, materials have been created to better disseminate the information that is being presented on or discussed. For example, in response to stakeholder feedback and to highlight the stakeholder comments BHS receives during functions such as trainings and stakeholder meetings, simplified reports that summarize stakeholder feedback are created and shared at subsequent meetings. These snapshot reports can include stakeholder demographics, a summary of the feedback in the form of text, charts, and infographics that are incorporated into presentations to communicate this information. This process has been incorporated into monthly Community Engagement Meetings (CEMs). At the beginning of each meeting,

an overview of the analysis from the previous meeting is presented that allows for additional conversation or feedback. This change has allowed BHS to better communicate information and its services to the community and has allowed stakeholders to see how their involvement and suggestions shape and influence program planning and the services the agency provides.

In addition, BHS has improved the collection and tracking of stakeholder demographics related to Community Program Planning. A set of questions has been developed and are requested of each participant at each stakeholder meeting. The demographics are collected via live polls launched during virtual meetings, a link to an online survey that can be accessed directly from the link or through a Quick Response (QR) code, and/or paper copies of the survey. All data is combined into a centralized data set.

Approaches to Extended Education and Information Sharing

To better advertise, communicate, and educate our diverse stakeholders and staff to the agencies' activities, events, goals, resources, and programs, the HCA incorporates multiple approaches to information sharing which will include, but are not limited to, enhanced use of social media platforms, distribution of newsletters and information to the community and partners, and hosting information sessions.

The "Your Health Matters OC" livestreamed talk show on health hosted by HCA Director, Dr. Clayton Chau, and County Health Officer, Dr. Regina Chinsio-Kwong, is a prime example of these efforts. The live, bi-weekly talk show on YouTube and Facebook features healthcare professionals within the HCA and expert guests from within the OC community. Each Episode features a variety of relevant health topics that impact health and the Orange County community. Members of the public and media are encouraged to view the webcast live or at their convenience by clicking on the link https://youtu.be/_Jm9WW599D4.

"The HUB" monthly newsletter is developed by the Community Networking Project team as part of BHS's collaboration with the education system. The HUB is specially designed to serve our community and connect to the rich array of K-12 school-based mental health events, activities, services, resources, webinars, trainings, policy, and funding opportunities, and more. This monthly newsletter provides information directly to education and community partners.

Three monthly meetings, the HCA Townhall, the BHS Townhall, and the BHS Contract Provide Monthly updates are part of an internal strategy that serves to inform HCA staff and stakeholders of changes, updates, and happenings across the agency, including MHSA processes.

- The HCA Townhall meetings provide an opportunity for the HCA Director to discuss agencywide happenings, communicate with and educate staff about changes, and acknowledge the achievements of staff and the agency.

- The BHS Townhall provides focused updates specific to BHS, addressing updates and changes happening within the agency, across the state and/or county, and with the broader behavioral health initiative context.

The BHS Contract Provider Monthly updates meeting provides the medium for regular information sharing, dialogue, and discussion of changes in policies, legislation, and procedures within and across the extended mental health plan.

In addition to community education, BHS makes certain staff are aware of MHSA requirements and programming. As an example, at a Behavioral Health Operations Meeting, the MHSA Manager provided a comprehensive training concerning the Mental Health Services Act regulations and Community Program Planning requirements.

Community Program Planning Process for the MHSA Three Year Program and Expenditure Plan for FY's 2023-24 through 2025-26 (Three-Year Plan)

BHS is fully committed to a year-round stakeholder engagement process. Preparation and development of this MHSA Three-Year Plan included meetings hosted in multiple venues in each region of the County, interactive countywide webinars, sessions hosted in collaboration with Wellness Centers, and a collaborative event hosted with Community Voices, a citizen group invested in supporting MHSA CPP activities. Scheduled meetings will be held throughout Orange County during the Three-Year Plan posting period. Different from previous years, BHS posted the Three-Year Plan for 30-day public comment and posting while concurrently hosting the additional CPP meetings. This will allow stakeholders the opportunity to access the "live" Plan and comment forms in real time versus waiting until the meetings to review the plan had ended. The information contained below, provides a detailed overview of the intended CPP process for the Three-Year Plan. This section will be updated and finalized as part of the final Plan.

To meet the requirements of the MHSA, extensive outreach will be conducted to promote the MHSA Three Year Plan Community Program Planning (CPP) process. A variety of methods were used at multiple levels to give stakeholders, including consumers, family members, community members, and partner agencies the opportunity to have their feedback included and their voice heard. This included press releases to local media outlets, including culturally specific media and posting on the HCA website, distribution of emails and flyers to community partners, community and contracted organizations, other county agencies, cultural committees, and regularly scheduled stakeholder

meetings, such as the Orange County Behavioral Health Advisory Board. These materials were distributed to representatives of our diverse populations. Social media sites, such as Instagram, were also used to extend the reach of the agency in connecting interested community members with the stakeholder process. Finally, a zoom recording of the Three-Year Plan overview was posted for easy access for individuals who were unable to join a live session. You can access this recording at Orange County MHSA Three Year Program and Expenditure Plan Overview for FY 2023-24 through 2025-26. - YouTube.

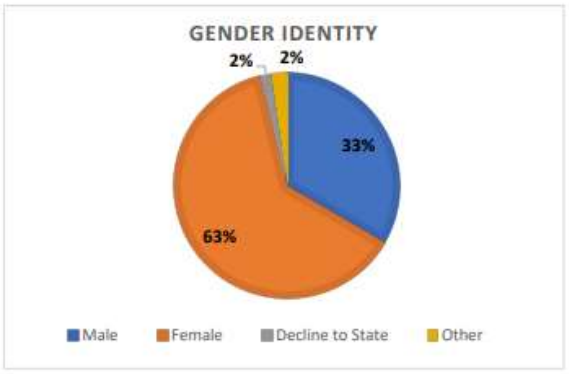
The MHSA Manager and Component Leads, in conjunction with the Office of Equity (OE), and HCA Communications have responsibility for coordination and management of the Community Program Planning (CPP) process. This process was built upon existing stakeholder engagement components, mechanisms, and collaborative networks within the behavioral health system. In many cases, meetings were held in the community at sites where consumers were already comfortable attending services, events, and meetings.

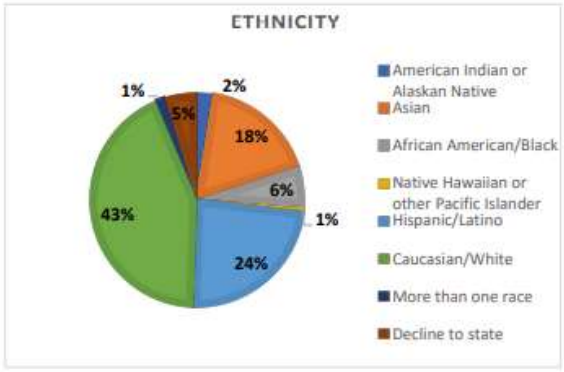
Congruent with WIC § 5848(a), participation by key groups of stakeholders included, but were not limited to:

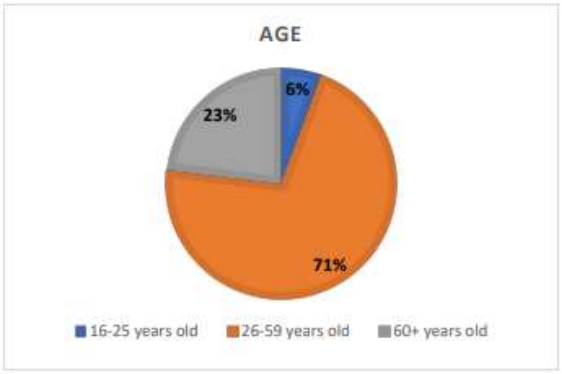
- Individuals with serious behavioral health illness and/or serious emotional disturbance and/or their families.
- Providers of behavioral health and/or related services such as physical health care and/or social services.
- Representatives from the education system.
- Representatives from local hospitals, hospital associations, and healthcare groups.
- Representatives of law enforcement and the justice system.
- Veteran/military population of services organizations.
- Other organizations that represent the interests of individuals with serious a behavioral health illness and/or serious emotional disturbance and/or their families.

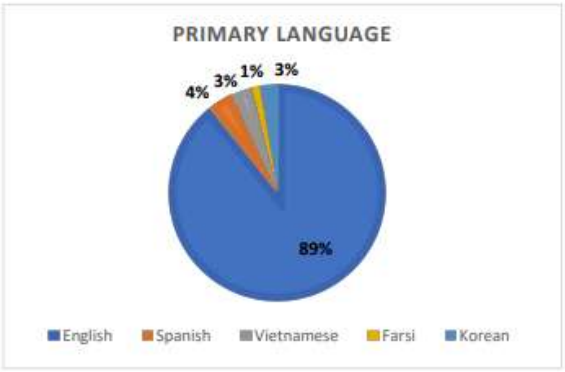
From October 2022 through January 2023, BHS collected demographic information of CPP participants via in-person and online surveys and polls. The following is an overview of CPP participants who completed a survey during that timeframe. This demographic information will be updated to include data from the meetings during the 30-day public comment and posting period and will be included in the final version of the Three-Year Plan.

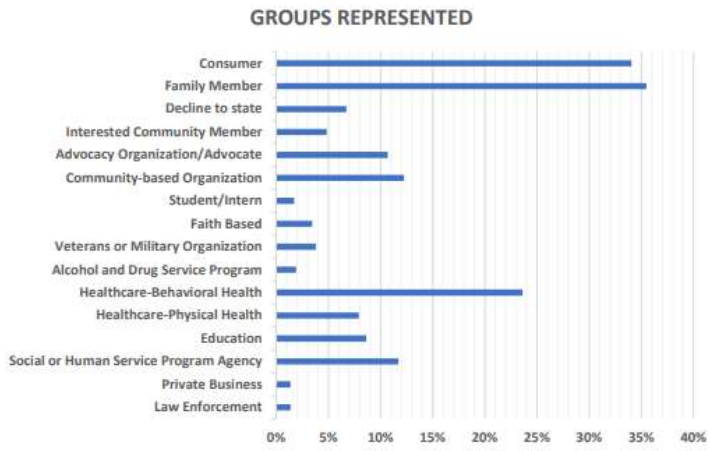
CPP Demographics October 2022 through January 2023

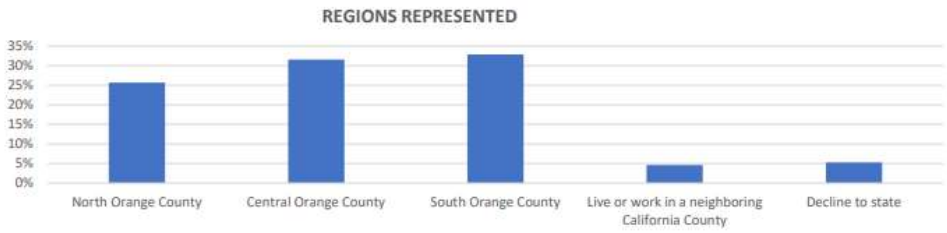












As listed in the schedule included in this report, a CPP session was held by the OC Behavioral Health Advisory Board on March 8, 2023, additional meetings will be hosted to reach each geographic region of the county, and special sessions were offered to members of the Equity in OC committee on February 22, 2023.

To ensure participation of unserved, underserved, or inappropriately served cultural groups, the Office of Equity will offer stakeholder engagement meetings for the MHSA Three Year Plan for each of their BHEC subcommittees. To further include community involvement, sessions will be held in collaboration with Wellness Centers, Community Centers, and virtually across the County. BHS staff will host a discussion with diverse attendees about the background and intent of the MHSA, the MHSA Three Year Plan, and proposed updates, as well as obtain feedback and recommendations for system improvement.

To ensure that stakeholders can fully benefit from the community meetings, BHS staff arrange for Spanish, American Sign Language, and Vietnamese interpretation, and other languages, upon request, at each meeting. At the end of each presentation, the facilitator will open the presentation to encourage discussion, allow stakeholders to have questions answered, and provide input. Once the question-and-answer session concludes, participants will be advised about additional opportunities to provide feedback. The link to the survey is provided in the presentation and participants were also provided information for alternative methods to provide input and feedback including the email address, phone number for the MHSA Coordinator, and a link to the community surveys.

To further support this Community Planning Process (CPP) effort, a special session of the regular MHSA Community Engagement Meeting was hosted by MHSA Program Planning and Administration on March 20, 2023. The session followed the format that had been established as a standard practice for all CEM meetings. Attendees participated in a group virtual session and were then moved into small break out groups, to allow for comfortable discussion opportunities. A special session of the Behavioral Health Equity Committee (BHEC) was hosted by Ethnic Services Manager in collaboration with the MHSA Manager to ensure additional opportunities for stakeholders to interact with decision making staff. Attendees at all stakeholder engagement meetings were afforded the opportunity to provide feedback and input into the MHSA Three Year Plan via verbal comment and discussion, live polls, and a post meeting survey in which stakeholders had the opportunity to provide written comments. Surveys were available in threshold languages, in hard copy, as well as provided a QR code or a link that directly connected to the electronic survey. Participants were also provided a handout that provided instruction for multiple ways to submit comments.

Additionally, BHS partnered with multiple organizations to promote OC Navigator and other resources at different community events. Some events that BHS participated in during 2023 included:

- Black History Parade and Unity Festival
- Juneteenth Celebration
- Chicano Heritage Festival
- Sanando Juntos Event
- Various Health Fairs, including ones with Abrazar and with Norooz Clinic
- Fentanyl Forums in each of the five supervisory districts
- South Coast Chinese Chinese Cultural Center Moon Festival
- Second Baptist Church Suicide Awareness/Prevention Event
- Latino Health Access: Self-Care for Men
- Naloxone Training/Distrubution
- NAMI CARE Act Presentation
- Garden Grove Unified School District Community Resource and Health Fair
- Khmer Water Blessing Ceremony
- AFSP Out of Darkness Walk
- Asian American Senior Citizens Center Mid-Autumn Festival
- South Asian Network Bollywood Film Night
- OC Older Adults Needs Assessment – in conjunction with various Supervisor Offices
- Korean Community Services Arirang Festival
- APAIT Soulful Skills: Journaling Workshop
- Latino Health Access: Hispanic Heritage Month
- Wellness Center Pop-Up Mental Health Events
- Second Baptist Church Men's Health Awareness Event
- Healthy Halloween: D3 Health Fair
- Latino Health Access: Noche Familiar de Tradiciones Hispano-Americans
- U.S. Vets Hometown Heroes
- Place of Safe Care Summit
- Vanguard University Wellness Fair
- OCAPICA Kababayan Mixer
- South Coast Chinese Cultural Center – Various Workshops
- OC Sherriff's Interfaith Forum
- Soka University Senior Summit Wellness Fair
- Shanti OC Community Ofrenda Night
- Veteran Health and Wellness Summit
- Southland Integrated Services Food Trolley and Gratitude Event
- Cambodian Family Community Services – Thanksgiving Potluck

- Latino Health Access – Cafecito en Santa Ana High School
- OMID Mental Health Event – Farsi
- U.S. Vets: Pets for Vets
- Council on Aging – Older Adult Mental Health Training
- LGBTQ Center OC Queer Joy
- CSUF Mental Health Resource Fair
- Meeting of the Minds
- Saddleback College Annual Health Fair
- Irvine Valley College Pride
- Laguna Playhouse: Our Stories Program Celebration
- OCAPICA's Palengke: A Night Market Celebrating Philippine Independence
- Cypress Senior Center Community Resource Fair
- 2nd Annual Cruising for Higher Education
- Kids Fishing Derby Event
- Directing Change- Red Carpet Event
- State Senator Umberg & Councilmember Leon Health and Resources Fair
- ADEPT Family Day
- Addressing the Opioid Crisis
- Healthcare Everywhere Conference
- Orange County Substance Abuse Prevention Network (OCSAPN) Conference
- 17th Annual Community First Conference

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

BHS actively seeks opportunities to collaborate with communities and to increase its impact and reach with diverse communities. Prevention and Early Intervention Services contract with a variety of community-based organizations that provide services in various languages and address equity gaps in the system. These organizations provide an array of diverse culturally and linguistically appropriate services and cater to specific needs of the community and populations they serve. Behavioral Health Equity Committee (BHEC) consists of several workgroups, including Deaf & Hard of Hearing, Spirituality, Outreach to Black/African-American Community, LGBTQ+, with two additional workgroups in development which include the LatinX and the Asian/Pacific Islander (API) Communities. This list is in the process of expanding, to ensure we are able to identify and build relationships

with additional population groups. The BHEC steering committee consists of both county and community members, with one of the seats designated for the liaison with the Behavioral Health Advisory Board (BHAB). Additionally, several seats on the BHEC steering committee are held by peers and family members.

As BHS developed and implemented the Community Assistance Recovery and Empowerment (CARE) Act, multiple community forums and townhalls were organized where information was shared with diverse communities, including peers. BHS worked with NAMI-OC to host these forums.

The Behavioral Health Training Services (BHTS) oversees the contract for Crisis Intervention Trainings (CIT) for law enforcement and first responders to train them on how to effectively work with diverse individuals and who may be experiencing a mental health crisis, and how to provide them with resources for appropriate behavioral health services.

The acting ESM participates in the OC Sherriff's Interfaith Advisory Council and collaborates on ways to reduce stigma and address mental health challenges in various faith/spiritual communities.

The BHEC is expanding its efforts in meeting with community leaders, community-based organizations, clients, and family members, and will be working more closely with the Behavioral Health Advisory Board to address concerns in the community and ensure that we are planning and implementing responsive services to our diverse communities. Additionally, BHEC is conducting outreach at various community events to raise awareness about the different workgroups and share opportunities to get involved.

1-II-C: A narrative discussing how the county is working on skills development and strengthening of community organizations involved in providing essential services.

Currently, the county provides an annual cultural competence training that supports providers in delivery culturally appropriate services to our diverse communities. In addition to the annual training, the ESM reviews trainings provided to county staff and contracted providers to ensure cultural considerations are addressed. A list of trainings that qualified as "cultural development" trainings are included in Criterion 5.

In addition to the aforementioned, BHTS, in collaboration with the contracted Behavioral Health Training Collaborative (BHTC), provides an array of community trainings related to:

- Suicide prevention
- Anger Management
- Seasonal Anxiety and Depression
- Resilience and Hope
- Motivation & Goal Setting
- Mental Health First Aid (MHFA)
    - Adult
    - Youth
- Trauma-Informed Care
- Understanding Adverse Childhood Experiences (ACEs)
- Self-Care for Professionals
- The Power of Self-Compassion
- Recognizing and Responding to Client Needs
- LGBTQ+
- Improving Family Communications
- Multi-Cultural Mental Health Training
- Building Trauma-Informed School Communities
- Evidence-Based Clinical Trainings
- Multi-Part Trainings Supporting families and Individuals Living with Mental Illness.

BHTS and BHTC have formed an Orange County Cohort for Mental Health First Aid Trainers, and collectively provide MHFA trainings to community agencies, programs, and the public. Mental Health First Aid, offered through the National Council on Mental Wellbeing, is an 8-hour training course designed to provide community members key skills to help them identify signs and symptoms pertaining to substance use and mental health challenges, as well as equip them with skills to assist someone experiencing a mental health concern or crisis. MHFA was designed to reduce stigma around mental health, as well as raise awareness about resources available for support. Several populations find it difficult to openly discuss mental health or mental illness due to wide range of factors. Community members often find there to be stigma, barriers to service, lack of trust due to historical and communication issues, and spiritual beliefs. Offering MHFA to the community has served as an opportunity to openly discuss mental health (wellness and illness), as well as provide tangible resources to access support, along with skills to have a conversation in a culturally attuned manner. The revised curriculum has placed greater emphasis on culture, with a focus on diversity and

representation in their curriculum and scenarios. During FY22/23 there were a total of 61 MHFA trainings offered (Adult and Youth Curricula).

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

While we attempted to build up the Threshold Language Workgroup, there were challenges. We have identified various individuals who are interested in serving on this workgroup and will be expanding it to include both language and ethnic group. We were able to identify leads for the API and LatinX, with plans to expand to the South Asian/Middle Eastern/North African (SAMENA) group.

Additionally, we have encountered challenges with the participation in some of the subcommittees and will be implementing a new approach in the upcoming year to utilize time in the quarterly public meetings to allow for participation and contribution towards the goals of the subcommittees.

Finally, we will be creating a workgroup to address various topics pertaining to cultural competency content development, which will be rolled out to our county and contracted providers. Additionally, we are exploring trainings in Spanish for clinicians who conduct services in Spanish.

1-II-E: Identify county technical assistance needs.

There are no areas requiring technical assistance at this time.

1-III: Each County has a Designated Cultural Competence/Ethnic Services Manager (CC/ESM) Person Responsible for Cultural Competence.

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

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

BHS has a designated Ethnic Services Manager/Cultural Competency who is responsible for ensuring cultural competence tenets are embedded throughout the system of care and promotes the development of culturally appropriate behavioral health services to meet the diverse needs of our racial, ethnic, cultural and linguistic populations in an equitable manner. The Ethnic Services

Manager/Cultural Competency Officer retired in March 2022, and while the position is in recruitment (pending a reorganization), there is an Acting Ethnic Services Manager who is filling this position and reporting directly to the Chief of BHS. (See Appendix VII – Mental Health and Recovery Services Re-organization Chart)

1-III-B: Written description of the cultural competence responsibilities of the designated CC/ESM.

The Ethnic Services Manager at OC HCA/BHS is also in charge of the Multicultural Development Program. The ESM tasks and responsibilities are:

- Participate in the development and implementation of the Cultural Competence Plan, and coordination of the Cultural Competence Committee (CCC). In December of 2020 CCC members approved to change its name to Behavioral Health Equity Committee (BHEC).

    - Develop, implement, and ensure accuracy of verbal interpretation and written translation (transliteration) services and materials into the threshold languages as well as American Sign Language (ASL).
    - Participate in all aspects of Mental Health Service Act (MHSA) program implementation strategies as well as performing required system evaluation and reports to the state Department of Health Care Services (DHCS).
    - Develop, coordinate, and facilitate the implementation of the state Department of Health Care Services required Cultural Competency Plan.
    - Provide cultural competence consultation, evaluation, and training/education for the entire behavioral health system of care, including County and service contractors, to ensure service deliveries are culturally and linguistically appropriate to the needs of the populations served and in compliance with local and state mandates.
    - Identify local and regional cultural behavioral health needs of ethnically and culturally diverse populations as they influence County systems of care; make recommendations to department management.
    - Maintain an on-going relationship with community organizations, planning agencies, and the community at large.
    - Review and approve all staff trainings for culturally competent content.
    - Oversee the Multicultural Development Program (MDP), which aims to promote behavioral health equity by enhancing culturally and

linguistically appropriate, responsive, and inclusive behavioral health services for all ethnic and cultural groups through supportive services, training, education, research, and advocacy. The program provides and coordinates language services and cultural trainings. Additionally, it addresses mental health needs of the Deaf and Hard of Hearing community through consultation and training. In addition, consumer/peer supervision, culturally responsive and inclusive clinical consultation, culturally responsive and inclusive community research and advocacy are provided while identifying local and regional behavioral health needs of linguistically and culturally diverse populations as they impact County systems of care. MDP also assists in:

- Developing, coordinating, and facilitating the implementation of a culturally responsive and inclusive plan for Orange County.
- Developing, implementing, and ensuring the accuracy of verbal interpretation and written translation services and materials in all threshold languages.
- Planning and organizing cultural diversity events at an organizational and community level, and;
- Supporting strategies and efforts for reducing racial, ethnic, cultural, and linguistic disparities.

1-IV: Identify Budget Resources Targeted for Culturally Competent Activities.

1-IV-A: Evidence of a budget dedicated to cultural competence activities.

Within HCA BHS, the Multicultural Development Program, highlighted above, is the unit dedicated to cultural competence activities. This unit coordinates requests for document translation, interpretation services, and leverages existing bilingual/bicultural staff across BHS. There are more than 350 bilingual staff available to provide interpretation services as needed. The MDP program currently consists of 2 positions dedicated to interpretation and translation in Spanish and Vietnamese. Within the Behavioral Health Training Services (BHTS) team, MDP has access to additional staff who are able to assist with translation and interpretation services in Spanish, Arabic, Farsi, and Korean as part of their job responsibilities. The total budget for the MDP program for FY22/23 was set for $617,000. The Office of Equity is still in development, and the budget will be updated to reflect the changes to the office.

In addition to translations and interpretation, the Multicultural Development Program also ensures cultural considerations are addressed in each of the trainings provided. Also, MDP staff participate in community outreach efforts to support language and cultural needs.

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

As mentioned above, the current MDP budget allocated includes 3 Mental Health Professionals (1 coordinating the interpretation and translations services, 1 designated for Spanish interpretation and translations, 1 designated for Vietnamese interpretation and translation). Additionally, a part-time office support staff assists in the operations, a Deaf Services Coordinator, and an ESM oversees the department.

1. **Interpreter and translation services;**
   MDP utilizes both internal staff members for translation and interpretation services, along with external vendors: $300,00 (for ASL services) and $200,000 (for multiple languages).

2. **Reduction of racial, ethnic, cultural, and linguistic mental health disparities;**
   MDP staff are heavily involved in the Behavioral Health Equity Committee (BHEC) (by participating in various workgroups). The BHEC seeks to gain community participation and involvement in directly informing the Cultural Competence Plan (and update). The current workgroups are expanding to include additional groups that cater to various identified population groups, such as Native/Indigenous, Women, People with Disabilities, Veterans, to name a few.

   Additionally, the Prevention and Early Intervention (PEI) program funded several events centered around reducing stigma and discrimination related to mental health, especially within the unserved and underserved communities. These programs will be discussed in more detail in Criterion 3.

3. **Outreach to racial and ethnic county-identified target populations;**
   The various workgroups under the BHEC have reached out to their respective communities and populations to engage in discussions and collaborations. Additionally, Prevention and Early Intervention funds the Outreach for Increasing Recognition of Early Signs of Mental Illness. These

programs are intended to reach "potential responders," i.e., community members who are working with or likely to encounter individuals who are experiencing, or at elevated risk of experiencing, a mental health challenge. At-risk individuals can include, but are not limited to, PEI Priority Populations such as unserved and underserved racial/ethnic communities; immigrants and refugees; children and youth who are at risk of school failure and/or juvenile justice involvement; foster youth and non-minor dependents; individuals who have been exposed to trauma or are experiencing the onset of serious mental illness; the LGBTQ community; and those experiencing homelessness.

These programs will be discussed in further detail in Criterion 3.

4. **Culturally appropriate mental health services;**

Bicultural and bilingual staff are hired to provide services and support in, at minimum, the six threshold languages. In addition to language proficiency and usage, BHS also seeks to hire representatives of underserved cultural groups, such as veterans, LGBTQ+, Deaf and Hard of Hearing, to name a few.

The Behavioral Health Referral Line (OC-LINKS) consists of staff who are bi-cultural and bi-lingual in the threshold languages, ensuring access to community members with someone who can help them navigate the system in their preferred language. Calls are available in 6 languages other than English, and chat is available in Spanish.

Additionally, the OC Navigator website provides information in the following 9 languages: English, Arabic, Simplified Chinese Farsi, Khmer, Korean, Spanish, Tagalog, and Vietnamese.

Promising practices and culturally defined practices provided throughout our system of care include the use of Promotoras and community health workers, the affirmative model for working with the LGBTQ+ clients, and trauma-informed approaches to care are utilized with a multitude of our linguistic and cultural populations.

An extensive list of community programs will be discussed in Criterion 3.

5. **If applicable, financial incentives for culturally and linguistically competent providers, non-traditional providers, and/or natural healers.**

   A bilingual pay differential (up to $0.90/hour) is paid to certified (tested) bilingual employees. 478 employees were paid a bilingual pay differential (as of November, 2023).

Number of Bilingual Staff, by Position, November 2023

	SPANISH	VIETNAMESE	KOREAN	FARSI	ARABIC	OTHER LANGUAGE	GRAND TOTAL
BEHAVIORAL HEALTH CLINICIAN I	68	13	1	1	3	3	89
BEHAVIORAL HEALTH CLINICIAN II	71	13	9	4	2	1	100
BEHAVIORAL HEALTH NURSE	3	0	0	0	0	0	3
CLINICAL PSYCHOLOGIST I	4	0	0	1	1	0	6
CLINICAL PSYCHOLOGIST II	8	2	2	1	0	0	13
COMMUNITY HEALTH ASSISTANT II	2	0	0	0	0	0	2
COMMUNITY WORKER II	3	0	1	0	0	0	4
COMPREHENSIVE CARE NURSE II	3	0	1	0	0	1	5
CONTRACT EMPLOYEE	1	2	0	0	0	0	3
DATA ENTRY TECHNICIAN	0	1	0	0	0	0	1
HCA PROGRAM SUPERVISOR I	2	0	0	1	0	0	3
HCA SERVICE CHIEF I	9	2	0	1	1	0	13
HCA SERVICE CHIEF II	13	2	0	0	0	1	16
HEALTH PROGRAM SPECIALIST	3	0	2	0	0	1	6
INFORMATION PROCESSING SPECIALIST	1	0	0	0	0	0	1
INFORMATION PROCESSING TECHNICIAN	9	0	0	0	0	0	9
MENTAL HEALTH SPECIALIST	48	11	0	0	0	2	61
MENTAL HEALTH WORKER II	19	1	0	0	0	0	20
MENTAL HEALTH WORKER III	2	0	0	0	0	0	2
NURSING ASSISTANT	0	0	0	0	0	1	1
OFFICE ASSISTANT	5	1	0	0	0	0	6
OFFICE SPECIALIST	58	4	1	1	0	0	64
OFFICE SUPERVISOR C	2	0	0	0	0	0	2
OFFICE SUPERVISOR D	3	0	0	0	0	0	3
OFFICE TECHNICIAN	15	2	0	0	0	0	17

Number of Bilingual Staff, by Position, November 2023 - continued

	SPANISH	VIETNAMESE	KOREAN	FARSI	ARABIC	OTHER LANGUAGE	GRAND TOTAL
PSYCHIATRIST	2	3	1	1	0	0	7
RESEARCH ANALYST III	1	0	0	0	0	0	1
RESEARCH ANALYST IV	1	0	1	0	0	0	2
SECRETARY III	1	0	0	0	0	0	1
SR. COMPREHENSIVE CARE NURSE	0	1	0	0	0	0	1
SR. OFFICE SUPERVISOR (C/D)	1	0	0	0	0	0	1
STAFF ASSISTANT	4	2	0	0	0	0	6
STAFF SPECIALIST	5	2	1	0	0	0	8
SUPVG COMPREHENSIVE CARE NURSE	0	1	0	0	0	0	1
Total	**367**	**63**	**20**	**11**	**7**	**10**	**478**

CRITERION 2: UPDATED ASSESSMENT OF SERVICES NEEDS

@CLAS Standard: 2

2-I: General Population

2-1-A: Summarize the county's general population, race, ethnicity, age, and gender. The summary may be a narrative or a display of data.

Table 1: Orange County's General Population Summary 2023

Demographic Characteristics of Orange County		
	Population	*Percent of Total Population*
Gender		
Male	1,552,028	49.5%
Female	1,583,727	50.5%
Other/Not Listed	---	<1%
Ethnicity		
American Indian/Alaska Native	3,720	0.1%
Asian/Pacific Islander	714,973	23.0%
Black/African American	49,450	1.6%
Hispanic/Latino	1,073,055	34.2%
White/Caucasian	1,140,831	36.4%
More than one race	129,611	4.1%
Age		
0-Less than 5 years	156,412	5%
5-9 years	164,795	5.3%
10-14 years	201,295	6.4%
15-19 years	207,561	6.6%
20-24 years	196,575	6.3%
25-34 years	438,989	14%
35-44 years	415,081	13.2%
45-54 years	412,987	13.2%
55-59 years	213,164	6.8%
60-64 years	199,064	6.3%
65 and older	529,832	16.9%
Total Population	*3,135,755*	

Source: American Community Survey (ACS) 2023, US Census

*The ACS groups ages differently than how reported to the state

2-II: Medi-Cal Population Service Needs

2-II-A: Summarize Medi-Cal population and client utilization data by race, ethnicity, language, age, and gender

Table 2A: Medi-Cal Indicators for Calendar Year 2023 by Plan Type and Member Demographics

Jan 2023- Dec 2023	Mental Health Plan (MHP)					Drug Medi-Cal-Organized Delivery System (DMC-ODS)				
	Average Number of Members per Month[1]		*Members Receiving a Service*[2]		*Penetration Rate*	*Average Number of Members per Month*[1]		*Members Receiving a Service*[2]		*Penetration Rate*
Total[3]	***1,019,974***		***24,827***		***2.4%***	***635,670***		***5,976***		***0.9%***
Age	***N***	***%***	***N***	***%***	***%***	***N***	***%***	***N***[6]	***%***	***%***
0-5 years	83,119	8.1%	247	1.0%	0.3%	82,809	13.0%	-	-	-
6-11 years	89,309	8.8%	1,222	4.9%	1.4%	89,221	14.0%	-	-	-
12-17 years	101,621	10.0%	2,927	11.8%	2.9%	101,609	15.9%	82	1.4%	0.1%
18-20 years	52,850	5.2%	692	2.8%	1.3%	28,964	4.5%	44	0.7%	0.2%
21-64 years	564,363	55.3%	4,563	18.4%	0.8%	216,905	34.0%	2,238	37.4%	1.0%
65+ years	128,712	12.6%	233	0.9%	0.2%	118,118	18.5%	52	0.9%	0.0%
Gender	***N***	***%***	***N***	***%***	***%***	***N***	***%***	***N***	***%***	***%***
Male	470,756	46.2%	11,859	47.8%	2.5%	281,757	44.2%	3,917	65.5%	1.4%
Female	549,219	53.8%	12,865	51.8%	2.3%	355,868	55.8%	2,046	34.2%	0.6%
Other/Not Listed			103	0.4%	N/A			13	0.2%	
Race/Ethnicity	***N***	***%***	***N***	***%***	***%***	***N***	***%***	***N***	***%***	***%***
American Indian/Alaska Native	1,349	0.1%	152	0.6%	11.3%	613	0.1%	34	0.6%	5.5%
Asian/Pacific Islander	187,869	18.4%	1,885	7.6%	1.0%	109,702	17.2%	211	3.5%	0.2%
Black/African American	17,658	1.7%	1,155	4.7%	6.5%	10,256	1.6%	188	3.1%	1.8%
Hispanic/Latino	478,317	46.9%	10,896	43.9%	2.3%	334,211	52.4%	2,377	39.8%	0.7%
White/Caucasian	152,266	14.9%	5,270	21.2%	3.5%	79,206	12.4%	2,545	42.6%	3.2%
More than one Race/Another[4]	182,332	17.9%	5,201	5.6%	2.9%	103,538	16.2%	761	3.0%	0.7%

Table 2A: Medi-Cal Indicators for Calendar Year 2023 by Plan Type and Member Demographics, continued

Jan 2023- Dec 2023	Mental Health Plan (MHP)					Drug Medi-Cal-Organized Delivery System (DMC-ODS)				
	Average Members per Month[1]		Total Members Receiving a Service[2]		Penetration Rate	Average Members per Month[1]		Total Members Receiving a Service[2]		Penetration Rate
Primary Language	**N**	**%**	**N**	**%**	**%**	**N**	**%**	**N**	**%**	**%**
English	624,356	61.2%	17,227	69.4%	2.8%	353,361	55.4%	5,198	87.0%	1.5%
Arabic	4,726	0.5%	39	0.2%	0.8%	3,524	0.6%	< 11	0.1%	0.1%
Farsi	9,394	0.9%	69	0.3%	0.7%	6,706	1.1%	< 11	0.2%	0.1%
Korean	11,656	1.1%	60	0.2%	0.5%	8,015	0.0%	< 11	0.0%	0.0%
Mandarin	5,028	0.5%	27	0.1%	0.5%	3,659	0.6%	-	0.0%	0.0%
Russian[5]	3,015	0.3%	< 11	0.0%	0.3%	2,540	0.4%	< 11	0.0%	0.1%
Spanish	269,776	26.4%	3,003	12.1%	1.1%	200,313	31.4%	254	4.3%	0.1%
Vietnamese	82,211	8.1%	360	1.5%	0.4%	51,318	8.0%	14	0.2%	0.0%

Percentages that fall below the overall penetration rate (PR) are noted in red font.

[1] *Average Members per Month is the average of monthly totals using Orange County member enrollment/eligibility data (i.e., 834 or MMEF).*

[2] *Total Members Receiving a Service is the unduplicated count of clients receiving at least one service during CY 2023 using claims data (i.e., 837 files).*

[3] *The total count may differ from the sum of the total counts presented in each demographic category due to rounding calculations and/or unknown/missing information from members at the time of enrollment. Percentages presented in each demographic category may not total to 100% due to rounding.*

[4] *More than one/Another race/ethnicity includes those who identified with more than one race/ethnicity or as Middle Eastern/North African (MENA).*

[5] *Russian became a threshold language during the year. Counts may not be complete.*

[6] *Residents aged 0-11 years were not included in the DMC-ODS analysis of penetration rates.*

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

Total Medi-Cal Members and Members Served in the Mental Health Plan and Drug Medi-Cal Organized Delivery System – Calendar Year 2023

Mental Health Plan (MHP)			***Drug Medi-Cal-Organized Delivery System (DMC-ODS)***		
Average Members per Month[1]	*Total Members Receiving a Service*[2]	*PR*	*Average Members per Month*[1]	*Total Members Receiving a Service*[2]	*PR*
1,019,974	***24,827***	***2.4%***	***635,670***	***5,976***	***0.9%***

PR = Penetration Rate

[1] *Average Members per Month is the average of monthly totals using Orange County member enrollment/eligibility data (i.e., 834 or MMEF).*

[2] *Total Members Receiving a Service is the unduplicated count of clients receiving at least one service during CY 2023 using claims data (i.e., 837 files).*

Mental Health: In calendar year (CY) 2023, the average number of people eligible for Specialty Mental Health Services per month was just over one million, and the overall penetration rate (PR) was 2.4%.

Substance Use: In CY 2023, the average number of people eligible for Drug Medi-Cal Organized Delivery System (DMC-ODS) services per month was 635,670, and the overall PR was 0.9%.

Disparities Analysis: Disparities in service utilization by age, gender, race/ethnicity, and primary language are described below. Disparities were defined as a subpopulation penetration rate that fell below the overall MHP penetration rate of 2.4% or the overall DMC-ODS penetration rate of 0.9% and reflect the need to increase and/or improve outreach and engagement for underserved populations.

Age

Mental Health: To better understand the extent of MHP services provided to Medi-Cal members across the life span, penetration rates were examined for six different age groups: 1) 0-5 years, 2) 6-11 years, 3) 12-17 years, 4) 18-20 years, 5) 21-64 years, and 6) 65+ years. All age groups except adolescents (12-17 years) were underserved in CY 2023, with PRs ranging from 0.3% to 1.4%.

Substance Use: For DMC-ODS, four age groups were examined: 1) 12-17 years, 2) 18-20 years, 3) 21-64 years and 4) 65+ years. All age groups except adults (21-64 years) were underserved in CY 2023, with PRs less than 0.2%.

CY 2023	Mental Health Plan (MHP)					Drug Medi-Cal-Organized Delivery System (DMC-ODS)				
	Average Members per Month[1]		*Total Members Receiving a Service*[2]		*PR*	*Average Members per Month*[1]		*Total Members Receiving a Service*[2]		*PR*
Total[3]	***1,019,974***		***24,827***		***2.4%***	***635,670***		***5,976***		***0.9%***
Age[4] in years	***N***	***%***	***N***	***%***	***%***	***N***	***%***	***N***	***%***	***%***
0-5	83,119	8.1%	247	1.0%	0.3%	82,809	13.0%	-	-	-
6-11	89,309	8.8%	1,222	4.9%	1.4%	89,221	14.0%	-	-	-
12-17	101,621	10.0%	2,927	11.8%	2.9%	101,609	15.9%	82	1.4%	0.1%
18-20	52,850	5.2%	692	2.8%	1.3%	28,964	4.5%	44	0.7%	0.2%
21-64	564,363	55.3%	4,563	18.4%	0.8%	216,905	34.0%	2,238	37.4%	1.0%
65+	128,712	12.6%	233	0.9%	0.2%	118,118	18.5%	52	0.9%	0.0%

PR = Penetration Rate. Percentages that fall below the overall PR are noted in red font.

[1] *Average Members per Month is the average of monthly totals using Orange County member enrollment/eligibility data (i.e., 834 or MMEF).*

[2] *Total Members Receiving a Service is the unduplicated count of clients receiving at least one service during CY 2023 using claims data (i.e., 837 files).*

[3] *The total count may differ from the sum of counts by age group due to rounding and/or unknown/missing information from members at the time of enrollment.*

[4] *Residents ages 0-11 were not included in the DMC-ODS analysis of penetration rates.*

Gender

Mental Health: Penetration rates by gender were not notably different from the overall MHP PR of 2.4%. The data did not capture non-binary identities.

Substance Use: Females were less likely to have received services than males (i.e., PRs= 0.6% and 1.4%, respectively). The data did not capture non-binary identities.

CY 2023	Mental Health Plan (MHP)					Drug Medi-Cal-Organized Delivery System (DMC-ODS)				
	Average Members per Month[1]		*Total Members Receiving a Service*[2]		*PR*	*Average Members per Month*[1]		*Total Members Receiving a Service*[2]		*PR*
Total[3]	***1,019,974***		***24,827***		***2.4%***	***635,670***		***5,976***		***0.9%***
Gender	***N***	***%***	***N***	***%***	***%***	***N***	***%***	***N***	***%***	***%***
Male	470,756	46.2%	11,859	47.8%	2.5%	281,757	44.2%	3,917	65.5%	1.4%
Female	549,219	53.8%	12,865	51.8%	2.3%	355,868	55.8%	2,046	34.2%	0.6%
Another/ Not Listed			103	0.4%				13	0.2%	

PR = Penetration Rate. Percentages that fall below the overall PR are noted in red font.

[1] *Average Members per Month is the average of monthly totals using Orange County member enrollment/eligibility data (i.e., 834 or MMEF).*

[2] *Total Members Receiving a Service is the unduplicated count of clients receiving at least one service during CY 2023 using claims data (i.e., 837 files).*

[3] *The total count may differ from the sum of counts by gender due to rounding and/or unknown/missing information from members at the time of enrollment.*

Race/Ethnicity

Mental Health: Hispanic/Latinos (46.9%) represented the largest group of Medi-Cal eligibles, followed by Asian/Pacific Islanders (18.4%) and those identifying with more than one or another race (17.9%). Although Asian/Pacific Islanders represented the second largest group of Medi-Cal eligibles, they had the lowest penetration rate (1%).

Substance Use: Those identifying as Asian/Pacific Islander, Hispanic/Latino, or with more than one/another race represented over 85% of people eligible for DMC-ODS services yet had the lowest penetration rates (0.2% to 0.7%).

CY 2023	Mental Health Plan (MHP)					Drug Medi-Cal-Organized Delivery System (DMC-ODS)				
	Average Members per Month[1]		Total Members Receiving a Service[2]		PR	Average Members per Month[1]		Total Members Receiving a Service[2]		PR
Total[3]	***1,019,974***		***24,827***		***2.4%***	***635,670***		***5,976***		***0.9%***
Race/ Ethnicity	***N***	***%***	***N***	***%***	***%***	***N***	***%***	***N***	***%***	***%***
American Indian/ Alaska Native	1,349	0.1%	152	0.6%	11.3%	613	0.1%	34	0.6%	5.5%
Asian/Pacific Islander	187,869	18.4%	1,885	7.6%	1.0%	109,702	17.2%	211	3.5%	0.2%
Black/African American	17,658	1.7%	1,155	4.7%	6.5%	10,256	1.6%	188	3.1%	1.8%
Hispanic/ Latino	478,317	46.9%	10,896	43.9%	2.3%	334,211	52.4%	2,377	39.8%	0.7%
White/ Caucasian	152,266	14.9%	5,270	21.2%	3.5%	79,206	12.4%	2,545	42.6%	3.2%
More than one Race/ Another[4]	182,332	17.9%	5,201	5.6%	2.9%	103,538	16.2%	761	3.0%	0.7%

PR = Penetration Rate. Percentages that fall below the overall PR are noted in red font.

[1] *Average Members per Month is the average of monthly totals using Orange County member enrollment/eligibility data (i.e., 834 or MMEF).*

[2] *Total Members Receiving a Service is the unduplicated count of clients receiving at least one service during CY 2023 using claims data (i.e., 837 files).*

[3] *The total count may differ from the sum of counts by race/ethnicity due to rounding and/or unknown/missing information from members at the time of enrollment.*

[4] *More than one/Another race/ethnicity includes those who identified with more than one race/ethnicity or as Middle Eastern/North African (MENA).*

Primary Language

Mental Health: Eight primary language groups were examined. The majority of Medi-Cal members (61.2%) and members served (69.4%) reported English as their primary language. Non-English speakers continued to be underserved. While Spanish-speakers represented 26% of Medi-Cal members, they only represented 12.1% of all clients served in CY 2023, with a PR of 1.1%. Those who spoke Arabic, Korean, Mandarin, Vietnamese, Russian or Farsi had penetration rates below 1%.

Substance Use: Similar patterns were seen in the DMC-ODS. Over half (55.4%) of Medi-Cal members and most of the members served (87%) reported English as their primary language. Penetration rates for Arabic, Farsi, Korean, Mandarin, Spanish, Vietnamese and Russian-speaking individuals were at or below 0.1%.

CY 2023	Mental Health Plan (MHP)					Drug Medi-Cal-Organized Delivery System (DMC-ODS)				
	Average Members per Month[1]		Total Members Receiving a Service[2]		PR	Average Members per Month[1]		Total Members Receiving a Service[2]		PR
Total[3]	***1,019,974***		***24,827***		***2.4%***	***635,670***		***5,976***		***0.9%***
Primary Language	***N***	***%***	***N***	***%***	***%***	***N***	***%***	***N***	***%***	***%***
Arabic	4,726	0.5%	39	0.2%	0.8%	3,524	0.6%	< 11	0.1%	0.1%
English	624,356	61.2%	17,227	69.4%	2.8%	353,361	55.4%	5,198	87.0%	1.5%
Farsi	9,394	0.9%	69	0.3%	0.7%	6,706	1.1%	< 11	0.2%	0.1%
Korean	11,656	1.1%	60	0.2%	0.5%	8,015	0.0%	< 11	0.0%	0.0%
Mandarin	5,028	0.5%	27	0.1%	0.5%	3,659	0.6%	-	0.0%	0.0%
Spanish	269,776	26.4%	3,003	12.1%	1.1%	200,313	31.4%	254	4.3%	0.1%
Vietnamese	82,211	8.1%	360	1.5%	0.4%	51,318	8.0%	14	0.2%	0.0%
Russian[4]	3,015	0.3%	< 11	0.0%	0.3%	2,540	0.4%	< 11	0.0%	0.1%

PR = Penetration Rate. Percentages that fall below the overall PR are noted in red font.

[1] *Average Members per Month is the average of monthly totals using Orange County member enrollment/eligibility data (i.e., 834 or MMEF).*

[2] *Total Members Receiving a Service is the unduplicated count of clients receiving at least one service during CY 2023 using claims data (i.e., 837 files).*

[3] *The total count may differ from the sum of counts by language due to rounding and/or unknown/missing information from members at the time of enrollment.*

[4] *Russian became a threshold language during the year. Counts may not be complete.*

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

2-III-A: Summarize the 200% of poverty (minus Medi-Cal population) and client utilization data by race, ethnicity, language, age, and gender.

The table below compares Medi-Cal members served in the MHP to the total number of Orange County residents living at or below the 200% FPL, separated by whether or not they were enrolled in Medi-Cal. Results indicate that nearly one-quarter of Orange County residents are living at or below 200% of the FPL (692,000 compared to 3,209,272).

Table 4: Orange County Population and Clients Under 200% of the Federal Poverty Line

CY 2023	*Average Members per Month*[1]		*Members Receiving a Service*[2]		*County-Wide Estimated Population Living at or Below 200% FPL*[3]			
					Medi-Cal		*Non-Medi-Cal*	
	N	*%*	*N*	*%*	*N*	*%*	*N*	*%*
Gender								
Male	470,756	46.2%	11,859	47.8%	201,000	39.4%	128,000	49.8%
Female	549,219	53.8%	12,865	51.8%	309,000	60.6%	129,000	50.2%
Other/Not Listed			103	0.4%	0	0%	0	0%
Race/Ethnicity								
American Indian/Alaska Native	1,349	0.1%	152	0.6%	*	*	*	*
Asian/Pacific Islander	187,869	18.4%	1,885	7.6%	156,000	30.6%	67,000	26.1%
Black/African American	17,658	1.7%	1,155	4.7%	12,000**	2.4%**	*	*
Hispanic/Latino	478,317	46.9%	10,896	43.9%	268,000	52.5%	124,000	48.2%
White/Caucasian	152,266	14.9%	5,270	21.2%	60,000	11.8%	62,000	24.1%
More than one/Another	182,332	17.9%	5,201	5.6%	18,000**	3.5%**	3,000**	1.2%**
Age								
0-5 years	83,119	8.1%	247	1.0%	16,000**	3.1%**	7,000**	2.7%**
6-17 years	3,682	15.7%	4,149	16.7%	101,000**	19.8%**	17,000**	6.6%**
18-64 years	3,974	17.0%	5,255	21.2%	301,000	59.0%	168,000	65.4%
65+ years	128,712	12.6%	233	0.9%	92,000	18.0%	65,000	25.3%
Total	1,019,974		24,827		510,000		257,000	

PR = Penetration Rate. Percentages that fall below the overall PR are noted in red font.

** No data available; ** Statistically unstable*

Sums by subcategory may not equal total population estimates.

[1] *Average Members per Month is the average of monthly totals using Orange County member enrollment/ eligibility data (i.e., 834 or MMEF).*

[2] *Total Members Receiving a Service is the unduplicated count of clients receiving at least one service during CY 2023 using claims data (i.e., 837 files).*

[3] *California Health Interview Survey (2023). Counts are estimates.*

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

Description of the 2023 County Population with and without Medi-Cal Living at or Below 200% of the FPL:

Medi-Cal Members: In 2023, an estimated 510,000 residents with Medi-Cal were living in Orange County at or below 200% of the FPL (see Table 4). About half of these residents were Hispanic/Latino, and about 60% were either between the ages of 18-64 years or were female.

Disparities were identified by comparing the percentage of Medi-Cal members who identified with a specific demographic characteristic (i.e., male or female, a particular race/ethnicity, etc.), to the percentage each population received services in the MHP. This analysis is described below.

Non-Medi-Cal Members: In 2023, an estimated 257,000 residents without Medi-Cal were living in Orange County at or below 200% of the FPL in 2023 (see Table 4). About half were Hispanic/Latino, about two-thirds were between the ages of 18-64 years, and they were nearly evenly split between male and female.

These data were reviewed to identify whether certain populations were disproportionately represented among those living at or below 200% of the FPL.

Analysis of the 2023 County Population Living at or Below 200% of the FPL:

Gender

Medi-Cal Members: Among Medi-Cal members, females (60.6%) were more likely than males (39.4%) to be living at or below 200% FLP. Although females were slightly more likely than males to receive MHP services (51.8% and 47.8%, respectively), the MHP was less likely to have reached females living at or below 200% of the FLP.

Non-Medi-Cal Members: The percent of OC residents living at or below 200% of the FPL was equally represented across female and male residents.

Race/Ethnicity

Medi-Cal Members: Among Medi-Cal members, Hispanic/Latinos and Asian/Pacific Islanders (API) were disproportionately represented among those living at or below 200% of the FPL (52.5% and 30.6%, respectively). In addition, only 7.6% of clients who received MHP services in 2023 were Asian/Pacific Islander, indicating this population is particularly underserved among Medi-Cal members generally, as well

as among members living at or below 200% of the FPL. While Hispanic/Latinos represented the largest proportion of clients served in the MHP (43.9%), this rate was slightly below the overall percent of Medi-Cal members who identified as Hispanic/Latino (46.9%) or Medi-Cal members who were living at or below 200% of the FPL (52.5%).

Non-Medi-Cal Members: Among OC residents living at or below 200% of the FPL nearly half identified as Hispanic/Latino (48.2%) and about one-quarter identified as Asian/Pacific Islander (26.1%) or as White/Caucasian (24.1%).

Age

Medi-Cal Members: Among Medi-Cal members, adults aged 18-64 years were disproportionately represented among those living at or below 200% of the FPL (59.0%). Of clients who received MHP services in 2023, 21.2% were in this age group, indicating that adult Medi-Cal members living at or below 200% of the FPL were particularly underserved. Similarly, while older adults aged 65 years or older represented 18% of Medi-Cal members living at or below 200% of the FPL, they were only 0.9% of Medi-Cal members who received MHP services.

Non-Medi-Cal Members: When looking at the age groups of OC residents living at or below 200% of the FPL, nearly two-thirds were adults (65.4%) and one-quarter were older adults (25.3%).

2-IV: MHSA Community Services and Supports (CSS) Population Assessment and Service Needs.

2-IV-A: From the CSS component of the county's approved Three-Year Program and Expenditure Plan, extract a copy of the population assessment. If updates have been made to this assessment, please include the updates. Summarize population and client utilization data by race, ethnicity, language, age, and gender.

Tables 5 and 6 below were pulled from the most recent Mental Health Services Act (MHSA) Three Year Expenditure Plan Update (FY 2024 – 2025). Information presented discusses Orange County Population statistics, actual and proposed budgets for MHSA funded programs (e.g., CSS and PEI), and estimated demographics of clients served by age, gender, and race/ethnicity.[1]

[1] Orange County Health Care Agency, Mental Health Services Act Three-Year Program Expenditure Plan, Fiscal Years 2024-25. Published Spring 2024. [https://www.ochealthinfo.com/sites/healthcare/files/2023-06/MHSA_2023-26_Plan_Low_Res_v02.pdf]

Table 5: Orange County Population Statistics

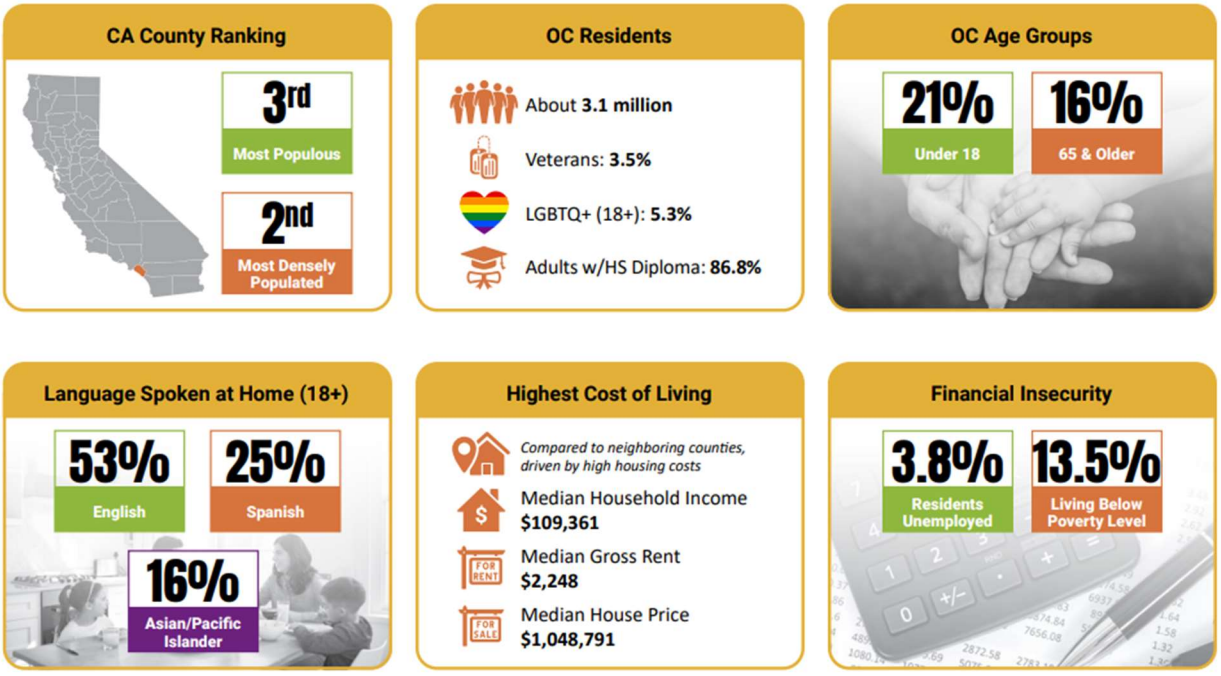


Table 6: MHSA CSS Fiscal Year 2022/2023

OC CENSUS

ORANGE COUNTY RESIDENTS BY DEMOGRAPHIC CHARACTERISTIC					
Age	**2022 ACS**	**Gender**	**2022 ACS**	**Race/Ethnicity**	**2022 ACS**
0-9 yrs	12%	Female	51%	African American/Black	2.3%
10-19 yrs	14%	Male	48%	American Indian/Alaskan Native	1%
20-29 yrs	13%	Transgender	>1%	Asian/Pacific Islander	23%
30-39 yrs	13%	Genderqueer	>1%	Caucasian/White	38%
40-49 yrs	12%	Questioning/Unsure	>1%	Latino/Hispanic	34%
50-59 yrs	14%	Another	>1%	Two or More Races	4%
60+ yrs	22%				

2022 Population: 3,151,184 **Source: American Community Survey (ACS) 2022**

CSS/MHSA

DEMOGRPAHIC CHARACTERISTICS OF PEOPLE SERVED IN FY 2022-23					
Age	**Estimated**	**Gender Identity**	**Estimated**	**Race/Ethnicity**	**Estimated**
0-15 yrs	16%	Female	49%	African American/Black	5%
16-25 yrs	24%	Male	50%	Asian/Pacific Islander	10%
26-59 yrs	50%			Caucasian/White	32%
60+ yrs	10%			Latino/Hispanic	38%
				Middle Eastern/North African	1%
				Other	2%
				Unknown	11%

Estimated demographic breakdown for FY 2024-25 Three-Year Plan based on individuals entered into Electronic Health Record in fiscal year 2021-2022. Those served only in Supportive Services not included.

PEI/MHSA

INDIVIDUALS SERVED IN PEI PROGRAMS BY DEMOGRAPHIC CHARACTERISTIC					
Age	**Estimated**	**Gender Identity**	**Estimated**	**Race/Ethnicity**	**Estimated**
0-15 yrs	53%	Female	65%	African American/Black	4%
16-25 yrs	6%	Male	34%	American Indian/Alaskan Native	4%
26-59 yrs	25%	Other	1%	Asian/Pacific Islander	21
60+ yrs	16%			Caucasian/White	18%
				Latino/Hispanic	51%
				Native Hawaiian/Pacific Islander	1%
Served: 223,331				Other	>1%

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

Age

The percentage of children (0-15 years old) in the CSS program at 16% is lower than what is reported in the Census, which is approximately 18%. The percentage of Transitional Age Youth (16-25) in the CSS programs at 24% is higher than the 13% reported in the Census. Adults (26-59) served in the CSS were at 50%, which is comparable to the approximately 43% listed in the Census. As for the Older

Adults (60+ years), they are greatly underrepresented in the CSS programs at 10%, compared to the 22% listed in the Census.

Gender

The proportion of females and males in the MHSA-CSS Unduplicated Clients Served vary from the county population. The county female population is at 50.5%, and accounts for 51% of the actual, unduplicated clients served so it is fairly comparable. The male population, at 49.5% is comparable to the actual, unduplicated clients served, which was 50%. The number of transgender, genderqueer, questioning/unsure, and other is similar between reported population in the Census and the clients served, which is <1% – however, this number is very low.

Race/Ethnicity

The percentage of Black/African Americans in the CSS programs is higher compared to their proportion of the county population (5.0% vs. 2.3%). The proportion of Asian/Pacific Islanders in CSS programs is lower compared to the Census (10% vs. 23%). The percentage of Latinos in CSS programs is also lower when compared to their proportion of the population 38.0% vs. 34.0%. The percentage of Caucasian is similar in CSS programs compared to their proportion of the county population (32% vs. 38.0%). Similarly, American Indian/Alaska Native is similar in CCS programs compared to the proportions reported in the Census (1%).

2-V: Prevention and early Intervention (PEI) Plan: The Process Used to Identify the PEI Priority Populations

2-V-A: Which PEI Priority Population(s) did the county identify in the PEI component of its Plan?

The State defines six specific Prevention and Early Intervention Programs, which are:

1. Early Intervention
2. Outreach for Increasing Recognition of Signs of Mental Illness
3. Stigma and Discrimination Reduction
4. Prevention
5. Suicide Prevention
6. Access and Linkage to Treatment

The identified priorities include:

1. Childhood trauma prevention and early intervention to deal with early origins of mental health needs.
2. Early Psychosis and mood disorder detection and intervention; and mood disorder and suicide prevention programming that occurs across the lifespan.
3. Youth outreach and engagement strategies that target secondary school and transitional age youth, with priority on partnership with college and mental health programs.
4. Culturally competent and linguistically appropriate prevention and intervention.
5. Strategies targeting the mental health needs of older adults.
6. Early identification programming of mental health symptoms and disorders, including but not limited to, anxiety, depression, and psychosis.

Each of these priorities outlined above are integrated into the OC MHSA Plan and aligned with the programs and strategies.

PEI STATE PROGRAM CATEGORY	LOCAL PROGRAM	SB 1004 IDENTIFIED PRIORITY					
		CHILD TRAUMA	EARLY PSYCHOSIS/ MOOD	YOUTH OUTREACH	CULTURE COMP	OLDER ADULTS	EARLY ID
Stigma and Discrimination Reduction	MH Community Education Events for Reducing Stigma & Discrimination	X		X	X	X	
Outreach for Increasing Recognition of Early Signs of Mental Illness	Behavioral Health Training Services	X			X	X	
	Early Childhood Mental Health Providers Training	X			X		
	MH & Well-Being Promotion for Diverse Communities			X	X	X	
	Services for TAY and Young Adults			X	X		
	K-12 School-Based MH Services			X	X		
	Statewide Projects			X	X		
Prevention	Prevention Services and Supports for Families	X			X		
	Prevention Services and Supports for Youth	X		X	X		X
Early Intervention	Community Counseling & Supportive Services	X	X		X	X	X
	School-Based Mental Health Services		X		X		X
	Early Intervention Services for Older Adults				X	X	X
	OC Parent Wellness Program	X	X		X		X
	Thrive Together OC		X		X		
	OC CREW		X		X		
	OC4Vets	X	X	X	X	X	X
Suicide Prevention	Suicide Prevention Services	X	X	X	X	X	X
Access and Linkage to Treatment	OC Links	X	X	X	X	X	X
	OC Outreach and Engagement for Homeless				X	X	X
	Integrated Justice Involved Services				X		

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

CLAS Standards: 1, 10 &14

3-I: List the Target Populations with Disparities your County Identified in Medi-Cal and all MHSA Components (Medi-Cal, CSS, WET, and PEI Priority Populations)

The information and data provided throughout this Criterion comes from the MHSA Three-Year Program and Expenditure Plan Update (FY24/25)

(https://www.ochealthinfo.com/services-programs/mental-health-crisis-recovery/quality-services-compliance/mental-health-20)

Medi-Cal Target Population(s) with Disparities:

The Orange County Medi-Cal population for Calendar Year 2023 includes 1,029,294 beneficiaries.

Disparities can be identified in all Racial/Ethnic Populations for Mental Health.

To begin, the population of White/Caucasian in Orange County is 36.4%. The population of Hispanic/Latino in Orange County is 34.2%. Yet, the Average Number of Medi-Cal Eligible members per Month for White/Caucasian is reported at only 14.9% whereas Hispanic/Latino is reported at 46.9%. Black/African American (1.6%) and Native American Average Number of Medi-Cal Eligibles per Month were close to comparable to the population in Orange County. For Asian Pacific American the population is 23% compared to Medi-Cal Eligible members per Month were 18.4%. More than One Race/Other represents 27% of Average Number of Medi-Cal Eligibles per Month compared to 17.9% of the general population. We are unable to identify which target populations are served.

Asian and Pacific Islanders are underutilizing Medi-Cal services in Orange County. On average, 18.4% of Asian or Pacific Islander residents were eligible for Medi-Cal services, yet only 7.6% received an approved service, constituting a 1.0% penetration rate. Caucasians (3.5%) and Native Americans (11.3%) populations were served at higher percentages when compared to the Asian Pacific Islanders (1.0%) Medi-Cal eligible populations.

In terms of age, residents over 65 years of age are underutilizing services. Residents over 60 comprised 12.6% of the Medi-Cal eligible population, yet only 0.9% had an approved service. Older Adults (65+) had the lowest penetration rate of all age populations groups (0.8%). Children ages 0-5 had the second lowest penetration rate of all age populations groups (0.3%).

Spanish speakers comprised almost one-third of the Medi-Cal population (26.4%), but only 12.1% had an approved service. Similarly, those who spoke an Asian or Pacific Islander language made up 9.7% of the Medi-Cal population and only 2.8% had an approved service.

CSS Population with Disparities:

Disparities can be observed in the population served by CSS, especially in the Older Adults (60+) demographic and the Asian Pacific Islander demographic, as both were served at lower percentages when compared to their percentage in the county overall population. In contrast, the African American and the Young Adults (16-25 years old) populations, were served at higher percentages when compared to their percentages in the county overall population.

WET Population with Disparities:

BHS employed 1,004 employees as of November 2023 (noting there is currently a 24% vacancy rate). Disparities exist in the workforce with regards to gender and languages spoken. Of the 1,004 filled positions, 478 qualify for bilingual pay (48% of the current staff). The lowest penetration rates exist for the Spanish-Speaking and API communities.

A workforce analysis and needs assessment will be completed in conjunction with the Southern California Regional Partnerships (SCRP) partners. The needs assessment will determine workforce patterns and trends to assist in informing the development of a new five-year plan which can be used to increase recruitment and retention strategies, ensure the hiring of a culturally responsive workforce, and build interest in the public mental health field. The new WET five-year plan will include data on the utilization rates of the five new WET focus areas. These areas include:

- Recruitment and Retention
- Pipeline Development
- Scholarships
- Stipends
- Loan Assumption Programs

Target Populations within MHSA Components:

Californians living with serious mental illness and/or addiction can face many obstacles to receiving both behavioral health and medical care. As a result, these individuals may die decades earlier than the general population. The factors that can contribute to the challenge include barriers to transportation, age and cultural factors, beneficiaries

needing to navigate separate delivery systems to access care, and, limitations in data sharing/care coordination.

To address some of these factors, the state of California, under the direction of the Department of HealthCare Services (DHCS), is implementing the California Advancing and Innovating Medi-Cal (CalAIM) initiative. CalAIM is the state's long-term commitment to transform Medi-Cal, with the intention of making the program more equitable, coordinated, and person-centered to help Medi-Cal beneficiaries maximize their health and life trajectory. The intention of this multi-component initiative is a more integrated and flexible behavioral health system that is currently being implemented through improvements to behavioral health policy and payment reform. In addition to CalAIM, many other policy changes are being implemented, pushing changes in the delivery of behavioral health care for a system that has been in place for decades with in a relatively short period of time. A summary of some of the most recent changes include:

BHSA:

The most impactful policy initiative is the anticipated passage of Proposition 1. Proposition 1 combines portions of SB-326 and AB-531 as in a singular proposition that is trending as approved based on preliminary results of a California ballot measure on March 5, 2024. The proposition repurposes the Mental Health Services Act (MHSA), changing the name to the Behavioral Health Services Act (BHSA) and updates the priority populations to include Substance Use Disorders (SUD) and use of the funding.

The BHSA Eliminates the MHSA component funding for Community Services and Supports, (76% of the fund that includes the ability to set aside funds for Workforce Education and Training and Capital Facilities and Technological Needs), Prevention and Early Intervention (19%), and Innovation (5%). Instead, BHSA requires 35% of funds to be directed toward Full Service Partnerships (FSP), 30% of funding for Housing Interventions, and 35% for Behavioral Health Services and Supports (BHSS).

The BHSA expands the priority population by including individuals with substance use disorders and prioritizes individuals at risk of or experiencing homelessness, justice involvement, child welfare involvement, and/or institutionalization/conservatorship. The BHSA is set to be enacted January 1, 2025, to begin the updated community program planning process. The MHSA is anticipated to sunset June 30, 2026, and require all counties have approved BHSA Integrated Plans approved by local Boards before July 1, 2026. The BHSA does not include a specific component for Innovation. Based on current language included in SB-326, approved Innovation Component projects can continue to be implemented past the July 1, 2026, start date.

Many MHSA programs contained within the Annual Update are proposed for "right-sizing." Right sizing is a process that adjusts program budgets based on the actual amount of MHSA funding that was used to support a program over the last year. Right-sizing can help identify unspent MHSA funds that can then be invested to expand existing programs or develop new programs within the same component. The process can also allow program budgets to be reduced when state revenues are lower than anticipated. The Annual Update reflects reductions based on rightsizing. Should revenue continue to be received at lesser values than anticipated, further component program reductions or eliminations may take place through an amendment to the Plan.

The only component reflecting an increase in the Innovation component. Innovation funds may only be used according to their categorical use as described above and may not be used to backfill shortfalls for other component programs.

Highlights of Innovation projects contained in the plan include a newly proposed project to support the ability to respond to intensive legislative mandates and changes, expansion of existing projects and possibly investing in the second part of the statewide Psychiatric Advanced Directives project.

Progressive Improvements for Valued Outpatient Treatment (PIVOT) project- The current multitude of state initiatives will have unknown impacts across the public Behavioral Health system. The current system of care is not currently designed to easily integrate these changes. Therefore, the need to modify how OC BHS conducts business and delivers services must be updated.

The multiple initiatives make is clear that the state is envisioning an updated paradigm for public behavioral health services, especially those services provided through the specialty mental health plan (MHP). County specialty mental health plans need to respond and reimagine their systems of care in order to meet the requirements. The "re-imagining" of the overall system, along with the testing of new processes is proposed under the Progressive Improvements for Valued Outpatient Treatment (PIVOT) project.

The overall Innovation, the Progressive Improvements for Valued Outpatient Treatment (PIVOT) project, proposes to redesign the OCBHS system and create and test service models where the delivery, care coordination, and payment for care is aligned to make a seamless and integrated experience for behavioral health clients that result in improved client outcomes. The project also intends to test innovative approaches to workforce recruitment and retention that have worked in other systems to strengthen the pathways to becoming a clinical service provider and provide incentives for retention of highly qualified staff.

This multi-component project will result in an overall system redesign while simultaneously addressing key areas in the current BH system of care and allows pilot projects intended to identify and develop successful behavioral health approaches that can be integrated across the system of care. The pilots, or components, include:

- Innovative approaches to Delivery of Care - The FSP Re-Boot concept will focus primarily on Program Performance and Performance Management that is implemented through real-time technical assistance with County staff and contracted providers.
- Full Service Partnership Re-Boot: Testing a Social Finance Approach to Improve Client Outcomes - The FSP Re-Boot concept will focus primarily on Program Performance and Performance Management that is implemented through real-time technical assistance with County staff and contracted providers.
- Integrated Complex Care Management: Testing Whole Person Approaches for Care in the Older Adult Population - the purpose of this proposed component is to begin to develop and plan a system of care for older adults living with both behavioral health and physical/neurocognitive conditions which may include individuals who are homeless or at risk of homelessness.
- Developing Capacity for the Delivery of Specialty Mental Health Plan Services in Diverse Communities - This component seeks to evaluate the minimum capacity of a community-based organization to be able to become a specialty mental health plan contracted provider, review the amount of technical assistance needed to support development and implementation, and determine if embedding culturally based approaches for specialty mental health care improve both penetration rates and client outcomes.
- Innovative, Countywide Workforce Initiative - The BHS Innovative Workforce Initiative will take successful strategies from both internship programs and apprenticeship programs and may utilize a third party vendor as the "employer of record" to support payment of incentives for participating in the internship program.

SUD Medi-Cal (DMC-ODS) Population with Disparities:

BHS served 5,976 Medi-Cal Substance Use Disorder clients in Calendar Year 2023.

Of this population, disparities can be seen in the Youth/Young Adults and Older Adults. These populations were served at lower percentages when compared to their percentages as Medi-Cal beneficiaries. In contrast, the Caucasians and Adult (18+) populations were served at significantly higher percentages than their percentage of Medi-Cal beneficiaries.

Fewer Medi-Cal beneficiaries served were female compared to those who were Medi-Cal eligible (34.2% versus 55.8%). In contrast, 65.5% of Medi-Cal beneficiaries served were male, which was greater than their percentage of the Medi-Cal eligible population of 44.2%.

3-I-A: From the above identified PEI Priority Population(s) with disparities, describe the process and rationale the county used to identify the target population(s) (with disparities).

As noted in Criterion 2, the County of Orange, Orange County Health Care Agency (OCHCA), Behavioral Health Services (BHS) and community stakeholders embarked on an extensive community planning process to identify priority populations, strategic priorities and to develop concepts to be included in the PEI Strategic Plan for approval by the State.

Prevention and Early Intervention (PEI) Statewide Projects are intended to support PEI strategies and messaging across the state as well as locally via the California Mental Health Services Authority (CalMHSA), a joint powers authority (JPA), working on behalf of California Public Behavioral Health plans. The PEI Statewide effort was jointly initiated with other California counties for the purpose of making both a statewide and local impact. Orange County is a member of the JPA and a contributor to statewide PEI Projects. BHS intends to assign $500,000/fiscal year of local PEI funding to the JPA the last two years of this plan.

The PEI Statewide Project is a collection of campaigns which seek to expand the awareness of mental health needs and supports, reduce stigma, prevent suicides, and teach individuals how to achieve mental wellness. All initiatives implemented under the Statewide PEI Project are collectively known as "Take Action for Mental Health/Toma Accion Para Las Salud." The initiative is marketed as the campaign for California's ongoing mental health movement. It builds upon established approaches and provides resources to support Californians' mental health needs.

Currently, MHSA funded programs support school-aged children and youth through a comprehensive continuum of programs providing prevention, early intervention, outpatient, and intensive services. Implementation of *Student Behavioral Health Incentive Program (SBHIP), in response to Assembly Bill 133 effective January 1, 2024,* shifts responsibility for many of the services and programs provided under the prevention and early intervention component to be managed by CalOptima. Higher levels of care continue to be managed by BHS, but the shift in the law requires a change at the local level, as well.

To ensure that access to school-based services and supports continues, BHS is committed to maintaining current level of services and programming while the system responds to these legislative changes and partners continue to build the capacity of both the school system and the managed care plan (CalOptima) to meet the January 2024 mandate. While SBHIP provides a payment mechanism for the provision of medically necessary school-based behavioral health services, there is not a mechanism for paying for coordination of behavioral health services at the systems level. Under the MHSSA, a network of regional coordinators has been successfully working to facilitate collaborative meetings between districts and community partners, host regional and countywide meetings between districts, BHS and community providers, and coordinating services for school districts with other k-12 service providers and BHS. The MHSSA funding that supports this coordination is set to end in 2024. BHS intends to continue to fund the coordination of services and support the development of the capacity of the education system to work in partnership with both the Managed Care Plan (CalOptima) and the Mental Health Plan (BHS) beginning in year two of the three-year plan.

The collaborative planning for the shift will continue, with proposed MHSA changes being reflected in future MHSA Plans and Updates. As such, the current funding directed toward services for school aged children and youth may be re-directed to support coordination and partnership, in lieu of direct services as the managed care plan, CalOptima establishes access to necessary services through their mandate. This change establishes an update to the multi-tiered system of supports framework that has been largely adopted across the state, revising it at the local level to reflect the addition of CalOptima as a systems partner, including an additional "tier" to clarify levels of care, supports, and allowing systems to better define and align roles and responsibilities.

3-II: Identified Disparities (Within the Target Populations)

3-II-A: List disparities in each of the populations (Medi-Cal, CSS, WET, and PEI).

Medi-Cal:

As previously described above, disparities exist in Orange County for specific populations. For the Medi-Cal population, disparities can be seen in access to services for all racial/ethnic groups.

Asian/Pacific Islanders (API) represent 18.4% of the Medi-Cal Eligible population yet the API Medi-Cal population served is 7.6%, therefore the API penetration rate is 1.0%.

For Latinos, there is a lack of access and service utilization in general, having a penetration rate at 2.3% and being the largest Medi-Cal beneficiary population at 43.9%.

Caucasians represented 14.9% of Medi-Cal beneficiaries and 21.2% of beneficiaries served by BHS. Caucasians have a penetration rate of 3.5%.

African Americans represented 1.7% of Medi-Cal beneficiaries and 4.7% of beneficiaries served by BHS. African Americans have a penetration rate of 6.5%.

Native Americans represented 0.1% of Medi-Cal beneficiaries and 0.6% of beneficiaries served by BHS. Native Americans have a penetration rate of 11.3%.

When examining the Medi-Cal population by age, Older Adults (65+) have the lowest penetration rate at 0.2%, followed by Children 0-5 at 0.3%, Adults (21 – 64) at 0.8%. Youth (12-17) have the highest penetration rate at 2.9%.

When examining the Medi-Cal population by preferred language, the penetration rate for the preferred Spanish language group was 1.1% and for API 1.4%.

CSS Population:

(API) beneficiaries were the most disproportionately underrepresented.

OC penetration rates were lower than those seen statewide across all racial/ethnic groups and all age groups. The lowest penetration rates were among adults over the age of 65 (0.2 percent), children from birth to five (0.3 percent), and API (1.00 percent). On average, 18.4% of Asian or Pacific Islander residents were eligible for Medi-Cal services, yet only 7.6% received an approved service. Residents over 65 years of age comprised 12.6% of the Medi-Cal eligible population, yet only 0.9% had an approved service. There was also a noticeable difference for those who speak a language other than English at home. Spanish speakers comprised almost one-fourth of the Medi-Cal population (26.4%), but only 12.1% had an approved service. Similarly, those who spoke an Asian or Pacific Islander language made up 9.7% of the Medi-Cal population and only 3.1% had an approved service. Based on the number of Medi-Cal eligible residents in CY 2023 and the number of beneficiaries with an approved service, the following groups were identified as underrepresented:

- Asian or Pacific Islanders
- Youth 5 years of age and under
- Native Americans
- Black or African Americans
- Adults over the age of 65
- Residents who spoke a language other than English

WET Population:

As of November 2023, BHS had 478 staff who were paid bi-lingual pay differential. This represents about 47% of the BHS active workforce. Spanish speakers comprised almost one-fourth of the Medi-Cal population (26.4%) and 31.4% of the DMC-ODS, yet represent 77% of the workforce who receive bi-lingual pay. BHS is working with HR to actively recruit bilingual staff in more threshold languages to better meet the needs of our beneficiaries.

PEI Population:

70% of our funding in PEI is allocated to prevention and early intervention strategies for children and youth (0-17 years old). 14% of the funding is allocated to strategies targeting the mental health needs of Older Adults who make up 23.2% of the population in Orange County.

3-III: Identified Strategies/Objectives/Actions/Timelines

3-III-A: List the strategies identified for the Medi-Cal population as well as those strategies identified in the MHSA plan for CSS, WET, and PEI components for reducing the disparities identified.

Medi-Cal:

Providers are contractually required to participate in cultural competency trainings and provide culturally and linguistically appropriate services. Programs are subject to test calls to assess the effectiveness of information delivery, customer services, and language access services.

The programs listed below in the MHSA components also cater to Medi-Cal beneficiaries and aim to reduce disparities and increase access to services.

To address opioid related substance abuse disparities in Orange County, BHS began a pilot program at the Santa Ana Substance Abuse Disorder outpatient clinic to provide Medication Assisted Treatment (MAT) for Medi-Cal beneficiaries.

CSS Plan:

Under the Mental Health Services Act (MHSA), 76% of MHSA funding is directed toward the Community Services and Supports (CSS) component. The CSS component provides access to an expanded continuum of care for persons living with a serious mental illness (SMI) or serious emotional disturbance (SED). The CSS section is organized according to programs that operate with similar service responsibilities but may serve different target populations. Programs intended to provide interventions or supports during a mental health crisis are described in the Crisis System of Care section. CSS programs are comprised of twenty-two programs designed to support a continuum of services that support the mental health need of all. The goal of all CSS programs is providing the necessary services and supports that help consumers achieve mental health and wellness and recovery goals.

MHSA Community Planning identified trends in stakeholder feedback that included expanded access for culturally specific programs include veterans, LBGTQI+, API, and disabilities as well as expanded services for older adults and very young children. As a result of this feedback, BHS established a Vietnamese FSP to cater specifically to the monolingual Vietnamese-speaking community. Further, the community stakeholder process shared a community need to expand access to mental health and recovery services during weekends as well as offer evening clinical services. In addition to expanded access, stakeholder feedback also identified trends within the system development/coordination to enhance TAY specific programming, enhance continuum of services for very young children and to invest in coordination across multiple service systems (including enhanced coordination for high acuity populations).

CSS also provides the following programs to reduce the disparities:

- The Mobile **Crisis Assessment Team** (CAT) program serves individuals of all ages who are experiencing a behavioral health crisis. Clinicians respond to calls from anyone in the community 24 hours a day, 7 days a week year-round and dispatch to locations throughout Orange County other than inpatient psychiatric or skilled nursing facilities which are staffed to conduct such evaluations. The CAT also includes the Psychiatric Emergency Response Teams

(PERTs), which consist of CAT clinicians who are stationed at police departments or ride along with assigned law enforcement officers to address behavioral health-related calls in their assigned cities or regionally.

- The **In-Home Crisis Stabilization (IHCS)** program operates a 24-hour, 7-day a week, year-round service which consists of family stabilization teams that provide short term, intensive in-home services to individuals who have been assessed to be at imminent risk of psychiatric hospitalization or out-of-home placement but are capable of remaining safely in the community and out of the hospital with appropriate support. The teams include clinicians, case managers and peers with lived experience, with one set of teams serving youth under age 18 and another serving TAY, adults and older adults ages 18 and older. Individuals are referred by County behavioral health clinicians, County and County-contracted CSUs, our CAT teams and emergency department personnel.

- **Crisis Stabilization Units** (CSUs) provide the community with 24-hour, 7-day a week, year-round service for individuals who are experiencing a behavioral health crisis requiring emergent stabilization that cannot wait until a regularly scheduled appointment. One of the units serves Orange County residents ages 13 and older, the majority of whom may be on a 72-hour civil detention for psychiatric evaluation due to danger to self, others or grave disability resulting from a behavioral health disorder (i.e., Welfare and Institutions Code 5150/5585). The CSUs can be accessed directly by individuals experiencing a crisis, as well as by family members, law enforcement and others in the community who believe an individual has an emergent behavioral health need.

- The **WarmLine** provides toll-free, non-emergency, non-crisis phone support, text, and internet chat service available to any Orange County resident needing support for behavioral health issues for themselves or family members. The program also serves family members. Beginning July 2020, the WarmLine began providing services 24 hours a day, seven days a week, year-round. This program is supported by a new Office of Suicide Prevention, which was established in the HCA's Mental Health and Recovery Services area upon the direction of the Orange County Board of Supervisors in 2021.

Active listening, a person-centered motivational interviewing skill, is effective in establishing rapport and demonstrating empathy, and can be especially useful with callers in the pre-contemplative or contemplative stages of change. The WarmLine also uses Positive Psychology, a resilience-based model that focuses on positive emotions, traits, and institutions. This model trains mentors to focus on the positive influences in callers' lives such as character, optimism, emotions, relationships, and resources in order to reduce risk factors and enhance protective ones.

- The **Multi-Service Center for Homeless Mentally Ill Adults** (MSC) program in Santa Ana is to offer a safe facility for adults 18 years of age and older with serious mental illness who may have a co-occurring substance use disorder and are experiencing homelessness. The program provides an array of services to meet the most basic and immediate needs of adults including, but not limited to access to showers and laundry facilities, the provision of a mailing address, clothing assistance and access to phones and internet to contact family or conduct a job search and nutritious snacks and beverages. Clients also receive appropriate screening, assessment and linkage to behavioral health treatment and emergency housing, assistance with access to medical services, benefits acquisition, and additional food resources. Permanent housing placement assistance and access to pre-vocational services and employment opportunities are available. The program operates Monday through Friday, with the ability to serve 80 clients per day.

- **Recovery Open Access** serves individuals ages 18 and older living with serious and persistent mental illness and a possible co-occurring disorder who are in need of accessing urgent outpatient behavioral health services. The target population includes adults who are being discharged from psychiatric hospitals, released from jail or are currently enrolled in outpatient BHS services and have an urgent medication need that cannot wait until their next scheduled appointment. These individuals are at risk of further hospitalization or incarceration if not linked to behavioral health services quickly.

- The **Peer Mentor and Parent Partner Support** program serves individuals who are living with a serious emotional disturbance (SED) or serious mental illness (SMI), may also have a co-occurring substance use disorder, and would benefit from the supportive services of a Peer Specialist. Peer Specialists may include

peer or youth mentors and/or parent partners who work with participant's family members who would benefit from the supportive services of a parent mentor. Individuals referred to this program can receive support with linkage to services and/or with achieving one or more recovery goals. Program specializations include foster youth, parents, criminal-justice involved, ethnic communities, LGBTQ+, and Veterans/Military-Connected. Farsi, Mandarin, Spanish, and Vietnamese languages are available.

- Orange County funds three **Wellness Center** locations that serve adults 18 and older who are living with a serious mental illness and may have a co-occurring disorder. Members are relatively stable in, and actively working on their recovery, which allows them to maximize the benefits of participating in Wellness Center groups, classes and activities. The Centers serve a diverse member base and Wellness Center West, in particular, has a unique dual track program that provides groups, classes and activities in English and monolingual threshold languages that meet the cultural and language needs of the population located in the city of Garden Grove. The predominant threshold language in the monolingual track is Vietnamese.

- The **Adult Supported Employment** (ASE) program serves seriously and persistently mentally ill adults eighteen (18) years and older who are legally residing in Orange County and who require job assistance to obtain competitive or volunteer employment. Direct referrals shall be made to the Supported Employment Program from County and contracted Outpatient and Recovery programs, Full-Service Partnerships, select Prevention and Intervention and Innovations programs and the Wellness Centers. Clients referred to and enrolled in the Supported Employment program must be engaged in mental health services during their entire enrollment in the program and must have an assigned Plan Coordinator or Personal Services Coordinator who will collaborate with the Supported Employment staff to assist with mental or treatment issues that may arise with their clients. Typical population served are homeless/at risk of homelessness, recovery from SUD, LGBTIQ+, trauma-exposed, and veterans/military connected.

- The **Children and Youth Clinic Services** program serves youth under age 21 who meet the following eligibility criteria and their families/caregivers: Living with serious emotional disturbance (SED) or serious mental illness (SMI) and a)

qualifies for Early and Periodic Screening, Diagnosis, and Treatment as part of having full-scope Medi-Cal; b) has a condition placing the child/youth at high risk for a mental health disorder due to the experience of trauma evidenced by scoring in the high-risk range under a trauma screening tool, child welfare or juvenile justice system involvement, or experiencing homelessness; c) requires medically necessary treatment services to address the child's mental health condition. Youth can be referred by community agencies, other mental health providers, pediatricians, SSA, school personnel, general community, families, etc.

The OC Health Care Agency offers the overwhelming majority of its outpatient clinic services through non-Mental Health Services Act County-operated and County-contracted facilities located across Orange County. Because demand for services exceeds the clinics' capacity, the outpatient clinic programs have been able to increase services through the MHSA to address gaps in care. These expansion programs tailor their services to the unique needs and level of acuity of the target population being served.

- Starting in FY 2017-18, **Services for the Short-Term Residential Therapeutic Program** (S-STRTP; previously a track in the former Youth Core Services program called STRTP) was established to serve Wards and Dependents of the Court ages six to 17 and Non-Minor Dependents (NMD) ages 18 up to 21 who need the highest level of mental health care in a trauma-informed residential setting. Residential costs are paid through the foster care system, and the HCA contracts with the S-STRTP facilities to provide Medi-Cal Specialty Mental Health Services (SMHS) to eligible youth and NMDs placed under the Assembly Bill 403 mandate. All referrals to the program are made by Child Welfare or Probation with approval from the Interagency Placement Committee (IPC), which includes staff from Child Welfare, Probation and the HCA. The HCA is contracted for 126 beds with seven STRTP providers who have 18 facilities across the county.

- The **Outpatient Recovery** program is designed for adults ages 18 and older who are living with a serious mental illness and possible co-occurring substance use disorder. The program is operated at multiple locations throughout the county, with County-contracted locations referred to as Recovery Centers and County-operated locations referred to as Recovery Clinics. Individuals are referred to

the program by Plan Coordinators in the Adult and Older Adult Behavioral Health (AOABH) Outpatient Clinics after all emergent mental health issues have resolved. This typically occurs within the first 3 to 6 months of being opened in an AOABH clinic. Individuals are referred to the contracted Recovery Centers after they have been in the AOABH outpatient system of care for one year and have remained out of the hospital or jail, are stable on their medication regimen and have consistently attended their appointments. The language capacities of the direct service providers include Arabic, Farsi, Korean, Mandarin, Spanish, and Vietnamese. The program specializes in serving ethnic communities, especially those recovering from SUD and trauma-exposed individuals.

Challenges: After reviewing program data, the HCA modified how it calculated the rate of discharge to a lower level of care by removing from the calculation participants who dropped out of treatment for unidentified reasons (i.e., n=55 at Recovery Centers and 15 at Recovery Clinics in FY 2018- 19). Because these participants have left unexpectedly, a level of care determination cannot be made. In FY 2019-20, the HCA began tracking the progress a participant was making towards their goals (i.e., satisfactory, unsatisfactory), and goal progress at the time a participant leaves treatment for unknown reasons will be reported in future Plan Updates. Nevertheless, the program recognizes that individuals can struggle with staying engaged in services when they experience changes in their treatment team or uncertainty over graduating from the program. Therefore, the program has taken steps to minimize premature discontinuation of services, such as providing peer support, planning social activities to help create a home-away-from-home environment for participants, offering to attend the first appointment with the new provider prior to discharge, and linking participants to community-based programs for continued social support prior to graduation. Programs have also identified graduates who are willing to return to speak with participants at the graduation ceremonies. This helps to encourage participants and allay concerns associated with obtaining treatment in the community and leaving the program where they have become comfortable. Due to challenges with receiving appropriate referrals, the HCA has diligently worked on collaborating with referral sources and providing them with education on when, in the individual's recovery journey, it is most appropriate to refer clients to the program. In addition, the HCA has increased peer support provided in this program and hired 17 peers whose main focus is to assist individuals with transitions to different levels of care.

- **Older Adult Services** (OAS) serves individuals ages 60 years and older who are living with serious and persistent mental illness (SPMI), experience multiple functional impairments and may also have a co-occurring substance use disorder. Many of the older adults served in this program are homebound due to physical, mental, financial, or other impairments. Clients served in these programs are diverse and come from Black/African American, Latino, Vietnamese, Korean and Iranian communities. OAS accepts referrals from all sources.

- The **Children's Full-Service Partnership/Wraparound** programs provide intensive, community-based services to promote wellness and resilience in children living with serious emotional disturbance and their families. Services include case management; crisis intervention; education support; transportation; housing; and socialization and recreational activities. FSPs employ a "whatever it takes" team approach, are available 24/7, and provide flex funding. There are currently seven distinct programs within the Children's Full-Service Partnership (FSP)/ Wraparound category, and each program focuses on a specific target population as described below.

    - Project **Reaching Everyone Needing Effective Wrap (RENEW) FSP** provides services to children from birth to age 18 who are living with Serious Emotional Disturbance (SED). The program accepts referrals from the Outreach and Engagement teams, Crisis Assessment Team, general public, and County and contract clinics. Prominent among these referrals are children and youth who are homeless or at risk of homelessness. In addition to the treatment services provided to the children and youth, the parents frequently receive job assistance, especially when the needs of their child or youth with SED impact their ability to maintain employment.
    - Project **For Our Children's Ultimate Success (FOCUS) FSP** specializes in serving culturally- and/or linguistically isolated Asian-Pacific Islander youth living with SED or Serious Mental Illness (SMI), with a particular focus on the Korean and Vietnamese communities in the County. The program serves children and youth ages 0-25 and their families.
    - **Youthful Offender Wraparound** (YOW) FSP serves children and youth through age 25 who are experiencing SED/SMI and involved with the juvenile justice system. The program focuses on maintaining the gains

the youth made while receiving services in custody and reintegrating the youth into the community. Learning how to obtain and maintain employment despite significant mental health issues is a particular focus of this FSP.

- **Collaborative Courts (Girls and Boys Courts) FSP** program primarily works with the Juvenile Court to support youth through age 25 with SED/SMI who are in the foster care system and have experienced multiple placement failures. These youth face a considerable number of problems and stressors and may require services well into early adulthood.
- **Collaborative Courts** (Juvenile Recovery [formerly Drug] and PROGRAM SUMMARY Program Serves 0-15 Symptom Severity Severe Location of Services Community Based Field Based Typical Population Characteristic Students/Schools Parents Families Medical Co-Morbidities Criminal Justice Involved Ethnic Communities Homeless/At Risk-of Recovery from SUD Trauma Exposed Mental Health Services Act Annual Plan FY 2023-2024 through 2025-2026 | COMMUNITY SERVICES AND SUPPORTS (CSS) 194 Truancy Courts) FSP works with Juvenile Recovery Court youth with SED/SMI both while within the Court's prevue and after graduation when they are no longer on Probation. The goal of the program is to assist the youth develop alternative coping skills, educational opportunities and job training. This FSP also supports the Juvenile Court's Truancy Response Program, providing services to youth with SED/SMI. Many of these youth face multiple problems and stressors. This is often the first time they have come to the attention of the "helping system." Both parts of this FSP program serve children and youth up through age 25.
- The Children and Youth Behavioral Health **Program of Assertive Community Treatment** (CYBH PACT) is an individualized treatment approach that offers intensive services in the community. The children and transitional age youth served in this program struggle with the onset of acute and chronic symptoms of mental illness and often present with co-occurring diagnoses and multiple functional impairments. This diverse population needs frequent and consistent contact to engage and remain in treatment, and typically requires intensive family involvement. The target population is children and youth ages 14-21 with Serious Emotional Disturbance (SED) or Serious Mental Illness (SMI) who have

had a previous hospitalization or incarceration or are in need of more intensive mental health services than those provided in a traditional outpatient program.

- **OC Children with Co-Occurring Mental Health and Physical Health FSP** serves children and youth with physical illness complicated by their mental health issues. These children's and youths' physical recovery is complicated by their mental health issues, and their reactions to physical health issues may exacerbate their mental health issues. Also included in this group are children and youth with severe eating disorders. The target population for this program is youth through age 18 who are being seen primarily by Oncology, Endocrinology and Neurology services at a local hospital. Parents and siblings are an integral part of the treatment process, given the disruption to the family structure when the survival of one family member becomes the family's main focus. Many of these children and youth are Medi-Cal beneficiaries and MHSA funds serve as a match to the drawdown of federal funds.

- The **Transitional Aged Youth (TAY) Full-Service Partnership (FSP)** serves youth aged 16-25 through an array of who are homeless or at risk of homelessness, who are culturally or linguistically isolated, and/or who are at risk of incarceration or psychiatric hospitalization due to Serious Emotional Disturbance (SED) or Serious Mental Illness (SMI), frequently complicated by substance use. There are currently five programs within the Transitional Age Youth FSP category, which serve target populations. Younger TAY may also be served in the children's RENEW FSP and older TAY may also be served in the Adult FSP programs depending on their age and needs.

    - **Support Transitional Age Youth (STAY) Process FSP serves TAY** who are living with SED or Serious Mental Illness (SMI) that is frequently complicated by substance use, almost all of whom are at some risk of homelessness. TAY are provided support and guidance to help them increase their abilities and skills essential to being self-sufficient adults.
    - **Project For Our Children's Ultimate Success (FOCUS) FSP** specializes in serving culturally and/or linguistically isolated Asian-Pacific Islander youth living with SED or SMI), with a particular focus on the Korean and Vietnamese communities in the County. The program serves youth through age 25 and their families.

- **Youthful Offender Wraparound (YOW) FSP** serves youth through age 25 who are experiencing SED/SMI and involved with the juvenile justice system. The program focuses on maintaining the gains the youth made while receiving services in custody and reintegrating the youth into the community. Learning how to obtain and maintain employment despite significant mental health issues is a particular focus of this FSP.
- **Collaborative Courts** (Girls and Boys Courts) FSP program primarily works with the Juvenile Court to support youth through age 25 with SED/SMI who are or were in the foster care system and have experienced multiple placement failures. These youth face a considerable number of problems and stressors and may require services well into early adulthood.
- **Collaborative Courts** (Juvenile Recovery [formerly Drug] and Truancy) FSP works with Juvenile Recovery Court youth with SED/ SMI both while within the Court's prevue and after graduation when they are no longer on Probation. The goal of the program is to assist with alternative coping skills, educational opportunities and job training. This FSP also supports the Juvenile Court's Truancy Response Program, providing services to youth with SED/SMI. Many of these youth face multiple problems and stressors. This is often the first time they have come to the attention of the "helping system." Both parts of this FSP program serve children and youth up through age 25.
- The **Program of Assertive Community Treatment (PACT)** is the County-operated version of a Full-Service Partnership program. PACT utilizes the evidence-based Assertive Community Treatment model to provide comprehensive, "whatever it takes," field-based outpatient services to persons ages 16-25 who are living with serious emotional disturbance (SED) or serious mental illness (SMI). Individuals enrolled in the PACT may also have a co-occurring substance use disorder, experience social, cultural and/or linguistic isolation, and have had difficulty engaging with more traditional outpatient mental health services.

- The **Adult Full-Service Partnership (FSP)** programs provide intensive, community-based outpatient services which include peer support, supportive education/employment services, transportation services, housing, benefits acquisition, counseling and therapy, integration and linkage with primary care, intensive case management, 24/7 on-call response, crisis intervention and co-

occurring disorder treatment. These programs strive to reduce barriers to accessing treatment by bringing treatment into the community. Adult FSP programs provide services in a linguistically and culturally competent manner to diverse, underserved populations in Orange County, which includes individuals who may have co-occurring substance use disorders. The target population for the Full-Service Partnership (FSP) programs includes adults who have a mental illness and are unserved or underserved and who may be homeless or at risk of homelessness, involved in the criminal justice system, or are frequent users of inpatient psychiatric treatment. The adult FSP programs operating in Orange County each target unique populations:

- **Criminal Justice FSP** program serves adults who have current legal issues or experience recidivism with the criminal justice system.
- **General Population FSP** serves adults who live with a serious mental illness and who are homeless or at risk of homelessness. These individuals typically have not been able to access or benefit from traditional models of treatment.
- **Enhanced Recovery FSP** is a program that targets adults who are on LPS conservatorship and returning to the community from long-term care placements such as Institutions for Mental Disease (IMDs), and adults who have offenses and are referred by the Public Defender's Office to the Mental Health Court (Assisted Intervention Court).
- **Collaborative Court FSP** is a voluntary program for non-violent offenders who are referred through the Collaborative Court. The program works in collaboration with probation, the court team and judge, District Attorney's Office and the Public Defender's Office to provide treatment that re-integrates members into the community and reduces recidivism.
- **Assisted Outpatient Treatment FSP** serves adults who have been court-ordered to participate in assisted outpatient treatment and individuals who have voluntarily agreed to participate in treatment and are referred by the county Assisted Outpatient Treatment Assessment and Linkage Team.
- **Housing FSP** serves individuals who are living in permanent housing but struggling to maintain their housing and are at risk of becoming homeless.
- **FSP for Special Populations (new program)** is proposed as an expansion of the adult FSP program. The intention is to provide culturally

congruent wraparound services for underserved populations, including but not limited to Veterans, Vietnamese, and Spanish speaking populations.

- The **Program of Assertive Community Treatment** (PACT) is the County-operated version of a Full-Service Partnership program. PACT utilizes the evidence-based Assertive Community Treatment model to provide comprehensive, "whatever it takes," field-based outpatient services to persons ages 18-59 who are living with serious emotional disturbance (SED) or serious mental illness (SMI). Individuals enrolled in the PACT may also have a co-occurring substance use disorder, experience social, cultural and/or linguistic isolation, and have had difficulty engaging with more traditional outpatient mental health services.

- The **Older Adult Full-Service Partnership (FSP)** includes both County operated Program of Assertive Community Treatment (PACT) and contracted Older Adult FSP program services. The FSP program provides intensive, community-based outpatient mental health services. The program strives to reduce barriers to access by bringing treatment out into the community. The team provides many services in the field, seeing the individuals at home, in hospitals, or in jail to reduce barriers to access treatment. Services are provided in a linguistically and culturally congruent manner to the diverse, underserved older adult population in Orange County. FSP programs utilize multidisciplinary teams which include mental health specialists, clinical social workers, marriage family therapists, life coaches and psychiatrists.

  The target population for the Older Adult FSP program is unserved adults ages 60 and older living with a mental illness and who may be homeless or at risk of homelessness, involved in the criminal justice system, frequent users of inpatient psychiatric treatment or emergency rooms, and/or experiencing a reduction in personal and/or community functioning. In addition, those who have repeated emergency room visits or excessive 911 calls due to behavioral health issues are also appropriate for PACT.

- **Year-Round Emergency Shelter** (formerly called Short-Term Housing) serves adults with serious mental illness who may have a co-occurring substance use disorder, are experiencing homelessness and in need of immediate shelter. Individuals referred to the program are actively participating in services at

Mental Health and Recovery Services Adult and Older Adult County clinics including PACT or County-contracted outpatient clinic.

- Homeless **Bridge Housing** offers interim housing for adults who have been matched to a permanent housing opportunity. The program also serves adults experiencing homelessness who are in the beginning stages of obtaining permanent housing. Adults (including women with children) are eligible if they are homeless, are living with a serious mental illness, and may have a co-occurring substance use disorder. Referrals for the Homeless Bridge Housing Services are accepted on an ongoing basis by Mental Health and Recovery Services Adult and Older Adult Services Housing and Supportive Services. Participants can only be referred to the Homeless Bridge Housing Services if they are actively participating in treatment at an BHS outpatient clinic or a County contracted Full-Service Partnership (FSP). The Bridge Re-Entry program serves individuals exiting jail that are in need of shelter and permanent housing.

- In contrast to the programs described that provide time-limited shelter in combination with behavioral health services and supports, the **MHSA/CSS Housing Program** facilitates the creation of long-term, independent supportive housing for transitional aged youth, adults and older adults with serious mental illness who may have a co-occurring substance use disorder and are experiencing homelessness or risk of homelessness. Additional eligibility requirements can vary at each location due to requirements of other funding partners. The program funds development costs and Capitalized Operating Subsidy Reserves (COSR). Development costs are used for the acquisition, construction and/or rehabilitation of permanent supportive housing. COSR primarily helps cover the difference between what a resident is able to pay and the cost of operating the unit during the time the resident is working on obtaining entitlement and/or employment income. Behavioral health and other supportive services are located on- and off-site to ensure access to a continuum of services that help residents adjust to and maintain their independent housing.

WET Plan:

California's public behavioral health system has experienced a shortage of behavioral health workers, changes in mental health occupational classifications, and underrepresentation of diversity of professionals with consumer and family

member experience. To address challenges faced by the public behavioral health workforce, the MHSA included a component for Mental Health Workforce Education and Training (WET) programs. WET is a program that provides training opportunities to the BHS' staff and contract agency staff, promotes the recruitment and hiring of a culturally diverse workforce, offers financial incentives, facilitates clinical intern programs, supports the inclusion and incorporation of consumers and their family members into the behavioral health workforce, and is committed to addressing the workforce shortage within Orange County through utilization of various strategies to recruit and retain qualified behavioral health employees. WET carries forth the vision of the MHSA to create a transformed, culturally competent system that promotes wellness, recovery, and resilience across the lifespan of all age groups and all cultural backgrounds.

- The **Workforce Staffing Support** (WSS) program performs three functions: (1) Workforce Education and Training Coordination; (2) Consumer Employment Specialist Trainings and One-on-One Consultations; and (3) the Liaison to the Regional Workforce Education and Training Partnership. WSS services are provided for the OC behavioral health workforce, consumers, family members and the wider OC community. During FY 2021-22, WSS provided 150 trainings to County staff, County-contracted staff, and general community members. The Consumer Employment Support Specialist (CES) offers trainings and consultations to assist consumers of behavioral health receive valuable information on their benefits and returning to employment.

- The **Multicultural Development Program** (MDP) consists of staff with language proficiency and culturally responsive skills who support the workforce by providing trainings on various multicultural issues. The MDP also coordinates requests and provides translation/interpretation services through in-house staff and a contracted provider.

- Program staff translated, reviewed, and field-tested a total of 337 documents into the threshold languages of Spanish, Vietnamese, Farsi, Korean, Arabic, and Mandarin Chinese in FY 2022-23. In addition, a Licensed Marriage Family Therapist serves in the MDP as a Deaf and Hard-of-Hearing Coordinator to ensure that American Sign Language interpretation support is provided at trainings and community meetings. In FY 2022-23, the Ethnic Services Manager facilitated the Behavioral Health Equity Committee (BHEC) meetings, which consists of multi-ethnic partners and multi-cultural experts in OC who meet to

provide input on how to incorporate cultural sensitivity and awareness into the Behavioral Health Services (BHS) system of care and how to provide linguistically and culturally appropriate behavioral health information, resources, and trainings to underserved consumers and family members.

- The **Training and Technical Assistance** (TTA) program offers trainings on evidence-based practices, consumer and family member perspective, multicultural competency for mental health providers, and mental health training for law enforcement. The number of trainings offered in this area fluctuates from year to year depending on the number of professional development requests from HCA staff and community members. Additionally, the TTA program not only hosts several behavioral health trainings each year, but also provides Continuing Education (CE) or Continuing Medical Education (CME) credits to other departments in the HCA requesting trainings for their clinical or medical staff. Training topics included a Law and Ethics series that covered Legal and Ethical Considerations when Working with Multi-Client and Subpoenas, When Therapists and Client Values Conflict, and Legal and Ethical Issues in Times of COVID. Additional training topics included Cultivating Competency-Based Clinical Supervision, Making Recovery Practice Training Series; Meeting of the Minds Conference; Understanding and Responding to Childhood Trauma and ACEs; and Veterans Conference.

- **Mental Health Career Pathways** seeks to engage individuals in the community to enter the behavioral health field through a variety of pathways. One of the primary strategies has been to assist consumers and family members of consumers with higher education to seek gainful employment in the behavioral health field (or public mental health system). Recovery Education Institute (REI) offers courses that prepares individuals living with behavioral health conditions and their family members to pursue a career in behavioral health. REI provides training on basic life skills, career management and academic preparedness, and offers certified programs to solidify the personal and academic skills necessary to work in behavioral health. Most REI staff have personal lived experience.

- The **Residencies and Internships** program trains and supports individuals who aspire to work in the public mental health system. In collaboration with the Psychiatry Department at the University of California-Irvine (UCI) School of Medicine, supervised trainings were provided in the program to teach the

recovery philosophy; enhance cultural humility and understanding from the consumer and family perspectives; and recruit talented psychiatry residents and fellows into the public mental health system.

- The **Financial Incentives Program** (FIP) is designed to assist with retention of existing BHS staff. The original FIP was a program to expand a diverse bilingual and bicultural workforce by providing tuition coverage through a scholarship to existing BHS County employees seeking bachelor's (BA/BS) and master's (MA/MS) degrees, and to address the community psychiatrist shortage by offering loan repayment for psychiatrists working in the OC public mental health system. Recently, this program has expanded to include the Southern Counties Regional Partnership (SCRP) funded Loan Repayment program for existing BHS and contract provider staff. This program is a loan forgiveness program to those that qualify and commit to serving the public mental health system (BHS) for one year.

PEI Plan:

Prevention and Early Intervention (PEI) program services are envisioned to develop and implement strategies that stop mental illness from becoming severe and disabling, giving emphasis to improvement in timely access to services for underserved populations. Strategies and activities are applied early on to avert the onset of mental health conditions or relapse among individuals. PEI programs serve all age ranges, however, 51% of services must target individuals aged 25 and under and their families. The component also seeks to change community conditions known to contribute to behavioral health concerns. PEI programs incorporate the values of cultural competence, consumer and community empowerment, collaboration, and inclusion in providing services that emphasize recovery, wellness, and resilience. PEI programs continue to strive to meet the needs identified by the California Mental Health Services Oversight and Accountability Committee (MHSOAC) and local diverse community stakeholders, meet the key community and priority population needs outlined in the Mental Health Services Act and transform the public mental health system.

PEI also provides the following programs to reduce disparities:

- The **Mental Health Community Education Events for Reducing Stigma and Discrimination** program hosts mental health-related educational and artistic events that aim to reduce stigma and discrimination related to mental health.

Collectively, the events are open to individuals of all ages living in Orange County, with specific events intended to reach identified unserved and underserved communities. A time-limited Request for Application (RFA) is periodically released inviting individuals and organizations to submit proposals for events. Examples of events that have received funding include art workshops and exhibits, plays, conferences, multi-cultural musical and dance performances, and other related activities. Events cater to various ethnic communities, including those who speak Arabic, Farsi, Khmer, Korean, Spanish, Vietnamese, and Mandarin. Additionally, programs cater to LGBTQ+, as well as Older Adults.

- The **Outreach for Increasing Recognition of Mental Illness** program This project collaborates with a network of community partners to provide trainings related to increasing awareness of signs and symptoms of mental health and/or substance use issues. To meet the needs of community, the program offers educational sessions and resources in both virtual and in-person, community-based settings.

- **Mental Health and Well Being Promotion for Diverse Communities** program is a new program that utilizes a peer supported approach to promote mental health and wellness, reduce stigma, raise awareness regarding preventing behavioral health conditions (recognizing signs and symptoms), increase resilience and recovery by building on protective factors, address the risk factors and providing peer support. This is accomplished through outreach, information dissemination, community education and events, skill building, socialization group activities, and one-to-one interactions and relationships with families and individuals representing diverse populations. Appropriate referrals and linkages to community resources and support are also provided, as needed.

- **Service for Transitional Age Youth (TAY) and Young Adults** program services are designed to support, engage, and empower TAY and young adults between the ages 16-24 years who may be at risk of developing behavioral health conditions or experiencing an increase in severity of an existing condition. The services are provided through community building and networking activities, outreach, and raising knowledge and awareness on mental health education and available resources.

  These services include three components:
  1) TAY Mental Health Community Networking Services,

2) TAY Mental Health Outreach Services, and
3) TAY Mental Health Education Activities.

- Early Childhood Mental Health Provider Training is a prevention based early childhood mental health consultation and training service with a goal to support the effective management of challenging behaviors in children up to 8 years of age and promote healthy social emotional development of young developing children in Early Childhood and Education (ECE) settings. This is accomplished by supporting and building the capacity of ECE providers, including site directors, owners and/or administrators and teachers, and the families they serve throughout Orange County through mental health consultation, education, coaching, and support services utilizing evidence-based practices (EBP).

- Mental Wellness Campaign program was started as an extension of the PEI Statewide Projects Initiative. Orange County was able to leverage statewide efforts to maximize the local impact by implementing a targeted local campaign to start this program. This program covers large-scale, local mental health awareness campaigns and community educational activities. These efforts partner with and leverage the community reach and existing efforts of local professional sports teams (i.e., Angels Baseball, Anaheim Ducks hockey), County Agency partners, etc.

- Mental Health Community Education Events for Reducing Stigma and Discrimination program hosts mental health-related educational and artistic events that aim to reduce stigma and discrimination related to mental health. Collectively, the events are open to individuals of all ages living in Orange County, with specific events intended to reach identified unserved and underserved communities. Examples of events that have received funding include art workshops and exhibits, plays, conferences, multi-cultural musical and dance performances, and other related activities.

- Prevention Services and Support for Youth program is the result of a consolidation of two previously approved Prevention Category programs: School-Based Behavioral Health Intervention and Support Services and School-Based Gang Prevention Services. These two prevention programs have been combined to streamline programming and service delivery. The Early Intervention portion of the School-Based Behavioral Health Intervention and Support program will continue to be reported under the Early Intervention Program Category.

The primary goal of these new services is to strengthen the coping skills, prosocial behaviors, personal empowerment, and resilience of youth to prevent and address distress and high-risk behaviors. This shall include specialized group education services to address a spectrum of risk factors that may impact youth, including stress, trauma, exposure to violence/bullying, and substance use and education and supports for strengthening family relationships, involving the youth, their caregivers, and siblings of the youth as appropriate.

- **Prevention Services and Support for Families** is a comprehensive new programmatic approach that provides a milieu of prevention services designed to be delivered in a culturally and linguistically congruent manner to diverse county residents. This program includes the consolidation of three existing/approved programs from the previous plan, along with an expansion of services for identified additional priority populations. The three previous programs that were combined into one program include the School Readiness program, Parent Education Services, and Family Support Services.

- **Suicide Prevention Services** program services are available to individuals of all ages who 1) are experiencing a behavioral health crisis and/or suicidal thoughts, 2) have attempted suicide and may be living with depression, 3) are concerned about a loved one possibly attempting suicide, and/or 4) are coping with the loss of a loved one who died by suicide. The program serves a broad range of people of all ages, and individuals can be self-referred or referred by family members, providers, or other partner agencies. This program is now supported by a new Office of Suicide Prevention, which was established in the HCA's Mental Health and Recovery Services area upon the direction of the Orange County Board of Supervisors in 2021.

- **OC LINKS** is the Mental Health & Recovery Services (BHS) line that provides information and linkage to any of the OC Health Care Agency's BHS, including crisis services, via telephone and online chat. Because the navigators who staff the line are clinicians and mental health professionals, they can work with callers and chatters experiencing any level of behavioral health issue, ranging from prevention through crisis identification and response.

- **Outreach and Engagement for Homeless** provides field-based access and linkage to treatment and/or support services for those who are homeless and who have had difficulty engaging in mental health, housing, and other

supportive services on their own. O&E staff identifies participants through street outreach and referrals from community members and/or providers.

- **Integrated Justice Involved Services** is a collaboration between Mental Health Recovery Services (BHS) and Correctional Health Services (CHS) that serve adults ages 18 and older who are living with mental illness and detained in Orange County Jails. This program is a combination of two programs which include the Jail to Community Re- Entry Program (JCRP) and a new program, the Re-Entry Adult Success Center. The Community Support and Recovery Center (CSRC) program, which was previously funded under Proposition 47 grant, transitioned to the Re-Entry Adult Success Center (RSC).

- **School Aged Mental Health Services** program provides early intervention services to Middle School students with mild to moderate symptoms of depression or anxiety due to a recent trauma. Students are referred by school staff and screened by a PEI mental health specialist to determine early onset of a mental health condition and program eligibility.

- **OC Center for Resiliency, education, and Wellness (OC CREW)** serves youth ages 12 through 25 who are experiencing a first episode of psychotic illness with symptom onset within the past 24 months. The program also serves the families of eligible youth. To be eligible for services, the youths' symptoms cannot be caused by the effects of substance use, a known medical condition, depression, bipolar disorder, or trauma. The program receives self-referrals and referrals from County-operated and County-contracted specialty mental health clinics and community providers.

- **OC PARENT Wellness** offers a full spectrum of mental health services to at-risk and stressed families with children under 18 to provide specialized approaches for families with young children (aged 0-8) exhibiting concerning behaviors, families at risk of child welfare involvement, and pregnant women and their partners affected by the pregnancy or birth of a child within the past 12 months. The program meets with families to assess needs to create individualized care plan intended to strengthen the familial unit.

- **Community Counseling and Supportive Service**s serves residents of all ages who have, or are at risk of developing, a mild to moderate behavioral health condition and have limited or no access to behavioral health services with face-to-face individual and collateral counseling, groups (i.e., psycho-educational,

skill-building, insight oriented, etc.), clinical case management, and referral and linkage to community services.

- **OC4Vets** are veteran-focused early intervention programs that support targeted subpopulations within the Orange County veteran community: adult veterans and military connected individuals, veterans engaged with County Courts, veteran college students, and military connected families with children under the age of 18 (the latter of which used to be the standalone Innovation project, Behavioral Health Services for Military Families). The OC4Vets, County- and contract-operated programs serve Orange County veterans and families who currently or previously served in the United States Armed Forces, regardless of the branch, component, era, location(s) or characterization of discharge from their service.

3-IV: Additional Strategies/Objectives/Actions/Timelines and Lessons Learned.

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

Several Innovation projects address the current disparities across Orange County:

The following is a description of a newly proposed Innovation project concepts planned to be introduced and implemented during this reporting period. Upon local approval in this Plan, the draft Innovation Component Projects will be further developed for state approval and presented to the Mental Health Services Oversight and accountability Commission (MHSOAC).

PROGRESSIVE IMPROVEMENTS OF VALUED OUTPATIENT TREATMENT - New Project Concept

The current multitude of state initiatives will have unknown impacts across the public Behavioral Health system. The current system of care is not currently designed to easily integrate these changes. There- fore, the need to modify how OC BHS conducts business and delivers services must be updated.

The multiple initiatives make is clear that the state is envisioning an updated paradigm for public behavioral health services, especially those services provided through the specialty mental health plan (MHP). County specialty mental health plans need to respond and reimagine their systems of care in order to meet the requirements. The “re-imagining” of the overall system, along with the testing of

new processes is proposed under the Progressive Improvements for Valued Outpatient Treatment (PIVOT) project.

The overall Innovation, the Progressive Improvements for Valued Outpatient Treatment (PIVOT) project, proposes to redesign the OCBHS system and create and test service models where the delivery, care coordination, and payment for care is aligned to make a seamless and integrated experience for behavioral health clients that result in improved client outcomes. The project also intends to test innovative approaches to workforce recruitment and retention that have worked in other systems to strengthen the pathways to becoming a clinical service provider and provide incentives for retention of highly qualified staff.

This multi-component project will result in an overall system redesign while simultaneously addressing key areas in the current BH system of care and allows pilot projects intended to identify and develop successful behavioral health approaches that can be integrated across the system of care. The pilots, or components, include:

- Innovative approaches to Delivery of Care
- Full Service Partnership Re-Boot: Testing a Social Finance Approach to Improve Client Outcomes
- Integrated Complex Care Management: Testing Whole Person Approaches for Care in the Older Adult Population
- Developing Capacity for the Delivery of Specialty Mental Health Plan Services in Diverse Communities
- Innovative, Countywide Workforce Initiative

<u>Innovative Approaches to Delivery of Care</u>

In the current system, Primary Care (physical health), substance use disorder, and mental health systems operate according to each systems charting, billing, and regulatory requirements. Despite state movement toward a more integrated model, the simultaneous changes and initiatives have not allowed time for County systems to respond and think through the ways the systems need to be redesigned. The current structure limits access to holistic, integrated services forcing clients to navigate bifurcated systems to meet their healthcare needs. Even clinical space is often set up according to the system that primarily funds the clinic limiting access to person centered approaches to care.

To be responsive to the changes envisioned by the state, Orange County (OC) Behavioral Health Services is proposing a comprehensive project to redesign clinical care with an opportunity to focus on multiple pilot projects within the redesign. Each component focuses on areas of the system that have been identified as benefiting from focused attention to resolve ongoing challenges. The learning from each pilot will be evaluated and integrated into a new overall system of care and OC BHS will update policies and processes to support and integrate system updates.

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

CSS: What is working well, and lessons learned include:

The Mental Health Services Act (MHSA) currently requires a majority of the Community Services and Supports (CSS) funding be directed toward Full Service Partnership Programs. Full Service Partnership (FSP) programs provide intensive outpatient services and case management for individuals living with serious behavioral health conditions. The full-service partnership framework is based on a "no fail" philosophy and does "whatever it takes" to meet the needs of clients, and when appropriate their families, including providing supportive services. This framework builds strong connections to community resources, and provides 24 hours per day, 7 days per week (24/7) field-based treatment and recovery services. The primary goal of FSP programs is to improve quality of life by implementing prac- tices which consistently promote good outcomes for the client. These outcomes include reducing the subjective suffering associated with behavioral health conditions, increasing safe and permanent housing, reducing out of home placement for children and youth, avoiding criminal or juvenile justice involvement, and reducing high frequency use of psychiatric hospitalizations or emergency and crisis services.

FSP programs strive to provide stabilizing services for the client at the lowest level of care allowing for maximum flexibility to support wellness, resilience, and recovery.

Proposition 1, voted for and passed by California voters on March 5, 2024, requires 35% of the total MHSA budget be directed toward

FSP programs. Orange County currently funds FSP programs that are implemented through a combination of contracted provider agencies and County clinics. While the FSP framework is similar across all programs, there are differences in the details of contracts and variation in the cost per service recipient. In addition, there are differences in the way FSPs are managed and in the service capacity/capability of both contracted providers and County-staffed teams. Even with those differences, FSPs across the County have very similar objectives and, overall, make up a homogeneous service. The FSP workforce delivers care to people with very complex histories and ongoing needs daily and provide client-directed services. While this "whatever it takes" approach is successful, it also conflicts with the state expectation that as much Medi-Cal as possible should be billed to draw down revenue for delivery of these services. While "whatever it takes" drives the model, "whatever can be billed" is becomes incentivized. This places counties in a quandary as the sustainability of the services relies on generating revenue.

The FSP Reboot may become a statewide Innovation project that provides the ability to explore alternative ways for performance and payment through testing a social finance approach for client care. At this time, OC is conceptualizing the project solely for implementation in this County.

The FSP Re-Boot concept will focus primarily on Program Performance and Performance Management that is implemented through real-time technical assistance with County staff and contracted providers. The enhanced service will test various approaches to performance-based contracts and improved performance management. As a place holder, the three possible approaches to piloting performance-based contracts include:

- A new, purpose-led outcomes contract running alongside FSPs;
- An amendment to FSP contracts to create a Follow-On program;
- A new, place-based outcomes contracts (jail and/or encampment community).

<u>PEI: What is working well, and lessons learned include</u>:

In 2023 the Orange County Older Adult Behavioral Health Advisory Board (BHAB) Committee identified the need to improve care for older adults living with co-morbid neurocognitive and behavioral health conditions. The group identified that older adults are the fastest growing population in OC. Long-term stable housing, treatment and services are often inaccessible, inadequate, or unavailable to older

adults who are homeless or at risk of homelessness and living with dual mental health conditions and dementia. Additionally, care for this population is split between the managed care system and specialty mental health plan, with each system responsible for specific portions of care. Each system utilizes different screening

and assessment tools and views the treatment of the co-morbid condition through the lens of their system. The purpose of this pilot is proposed to begin to develop and plan a system of care for older adults living with both health and physical/neurocognitive conditions which may include individuals who are homeless or at risk of home- lessness. Objectively, a multi-disciplinary team that includes managed care providers, social services, neurocognitive health care providers, housing experts, Older Adult BHAB committee members, research analysts, and representatives from the Public Guardian will be identified to provide the focused foundation, scope, and direction of the project. This advisory group will facilitate ongoing collaborative meetings to inform the development of promising practices for integrated complex care management for this population.

The projects grounded in three objectives:

1. **Outreach and Engagement:** To create a process for identifying older adults considering the challenges and barriers reaching and engaging this unserved/underserved population.
    - Utilize existing data and sources to gather information.
    - Create an assessment tool and personnel training plan to identify this target population.
    - Develop strategies to engage this population including hard to reach isolated and monolingual older adults.
2. **Assessment:** Engage experts in the field to create a different model for assessment that is recognized across the various systems.
    - Review existing assessment tools.
    - Determine the methods for how to best identify this population.
    - Create, identify, or modify a screening tool to help identify the target population.
    - Develop a multidisciplinary assessment model.

3. **Complex Care Management/Navigation Plan:** The multi-disciplinary team will collaborate on funding structures and care strategies to meet the comprehensive needs of older adults.

    - Discuss funding mechanism/sources for individuals that meet the criteria.
    - Develop recommended strategies for care for the target population,
    - Develop a customized, comprehensive physical, mental, emotional, and social health care plan template that is recognized across multiple service systems.

When discussing this population traditional treatment from one system has not proven to be successful. Since this disorder is both a physical and a mental illness, the medical treatment and psychological intervention must be integrated to provide the best results. That is why a multidisciplinary team approach is essential for successful

treatment. No one professional has the expertise to fill all the patient's medical and psychiatric needs. While multidisciplinary teams are a standard approach for treatment, most are working without an established continuum of care, by which, an individual in treatment may receive more and less intensive services in a coordinated fashion. Additionally, these teams have very little input in the determinations on how the system of care should been organized.

To address this, the multi-disciplinary team will be established to improve treatment and care coordination for diverse older adults with co-morbid conditions seeking treatment with BHS. Ongoing educational concerns were identified at multiple points during planning meetings. This group noted the need for a coordinated educational effort to improve understanding of co-morbid conditions to increase the probability of earlier detection, as well as educate those providing treatment to the resources available and barriers experienced within the existing system of care. Specifically, there is a lack of data-driven education informed by the best practices and experiences from the treatment team. While having a multi-disciplinary team approach to the treatment of complex disorders is a standard practice, incorporating this team in the development and delivery of training is not.

The group indicated that any training on treatment modalities is appreciated, training influenced by the treatment team's real-world experience would have benefits for the larger system of care. Previous attempts at constructing this type

of training infrastructure were limited based on the time available to the treatment team.

Currently BHS and local managed care providers meet to find solutions to complex cases for older adults living with co-morbid neuro- cognitive and behavioral health conditions. Staff come together to determine the best course of treatment for individual cases because a system to effectively manage these cases does not currently exist. A system to manage complex care management does not exist for many reasons, including frequent changes in staff, lack of resources, no clear funding stream for clients, and fragmented communication between clients and family members. Outcomes to these cases tend

to be highly individualized because of an inconsistent approach to cases, predicated by no clear funding stream or reporting structure, forcing providers to piece meal individualized treatment plans. A lack of consistent training also adds an extra layer to the inconsistency.

Individual doctors, therapists, alcohol and drug counselors, and case managers may develop different treatment plans, even when working for the same organization, based on their level of comfort, training, knowledge of community resources, and personal understanding

of the available funding sources. Because a formal structure for analyzing and reporting outcomes does not exist, the current meeting method does not produce system-wide best practices that could be shared or further developed to improve efficiency. Individuals are left to overcome system challenges and institutional barriers outside of any documented process improvement effort. Additionally, ongoing discussions in this group noted the treatment barriers that were preventing better outcomes on cases had similarities between income level and health insurance coverage.

3-V: Planning and Monitoring of Identified Strategies/Objectives/Actions/Timelines to Reduce Mental Health Disparities

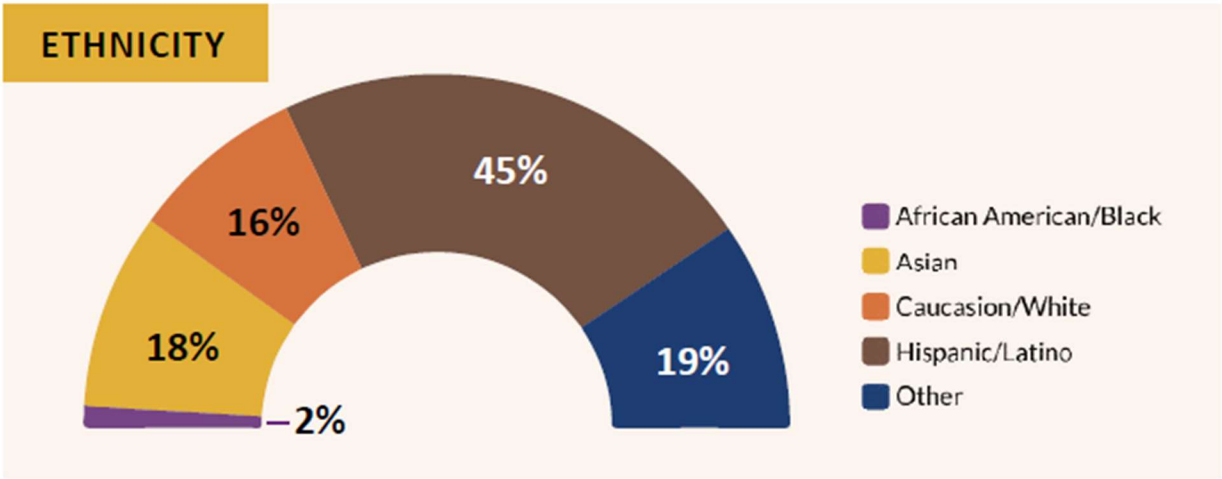
(Criterion 3, Section I through IV requires counties to identify strategies, objectives, actions, and timelines to reduce disparities. This section asks counties to report processes, or plan to put in place, for monitoring progress.)

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

Orange County (OC) is home to about 3.2 million people making it the third most populous County in California and the second most densely populated County in the state, behind San Francisco, and is home to diverse populations. BHS operates as both the OC Specialty Mental Health Plan (MHP) and as a provider of specialty mental health services, coordinating and providing specialized behavioral health services for Medi-Cal recipients and uninsured individuals who meet the criteria for medically necessary care under the MHP.

Many CSS programs leverage Medi-Cal in the delivery of MHSA services. A review of Medi-Cal beneficiary demographics provides additional context for the target populations served through the MHP and assists in potentially identifying underserved, unserved, or inappropriately served populations. The number of Medi-Cal eligible beneficiaries is calculated each month by California Health and Human Services (CalHHS) and published online. The information below represents the Calendar Year 2021 average of Medi-Cal eligible beneficiaries. For CY 2021, an average of 954,394 Orange County residents were identified as Medi-Cal Eligible.

The information provides a snapshot of the demographics for Orange County Medi-Cal eligible beneficiaries during that time. Medi-Cal eligible beneficiaries by Ethnicity and Ancestry was as follows: 2% were African American, 18% were Asian/Pacific Islander, 16% were Caucasian, 45% were Latino, .1% were Native American (illustrated as 0% in the graph), and 19% identified as not reported/other. N=954,394.



Disparities can be identified by comparing the Medi-Cal eligible beneficiaries group to the Mental Health Medi-Cal consumers served in Calendar Year 2021. A recent review conducted by the CalEQRO for Calendar Year (CY) 2021 reviewed OC BHS Medi-Cal claims as a method to analyze utilization and other variables. For

CSS programs, Medi-Cal is frequently leveraged to expand services. One of the variables CalEQRO analyzes is penetration rate. The penetration rate is a measure of total beneficiaries served based upon the total Medi-Cal eligible.

This measure can partially assist in identifying disparities. It is important to note that Medi-Cal utilization only represents a portion of MHSA services. Individuals served through non-billable MHSA services are not included in this analysis. The table below shows beneficiaries served by ethnicity in CY 2021.

The review of the CY 2021 claims indicated that the Asian Pacific Islander group had the lowest penetration rate of any group, whereas African-Americans had the highest penetration rates in comparison to County Medi-Cal beneficiary rates, while still being underserved in comparison to state rates. White beneficiaries were the most disproportionately overrepresented racial/ethnic group served. Asian/Pacific Islander (API) beneficiaries were the most disproportionately underrepresented.

OC penetration rates were lower than those seen statewide across all racial/ethnic groups and all age groups. The lowest penetration rates were among adults over the age of 65 (0.46 percent), children from birth to five (0.64 percent), and API (1.07 percent). On average, 19.3% of Asian or Pacific Islander residents were eligible for Medi-Cal services, yet only 8.0% received an approved service. Residents over 60 years of age comprised 16.4% of the Medi-Cal eligible population, yet only 6.1% had an approved service. There was also a noticeable difference for those who speak a language other than English at home. Spanish speakers comprised almost one-third of the Medi-Cal population (30.8%), but only 16.1% had an approved service. Similarly, those who spoke an Asian or Pacific Islander language made up 11.9% of the Medi-Cal population and only 3.0% had an approved service.

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

The new law passed to modernize MHSA to BHSA will significantly change the way data and outcomes are measured and reported in Orange County and at the State level.

The proposal replaces the existing MHSA funding-specific plan with a new County Integrated Plan for Behavioral Health Services and Outcomes, which includes all local behavioral health funding and services, including Medi-Cal.

• Requires counties to demonstrate coordinated behavioral health planning using all services and sources of behavioral health funding (e.g., BHSA, opioid settlement funds, realignment funding, federal financial participation), to provide increased transparency, stakeholder engagement, and outcomes for all local services.

• Requires stratified local data analysis to identify behavioral health disparities in geography and demography, including age, gender, ethnicity, and race, and include approaches to eliminate those disparities.

• Requires the Department of Health Care Services (DHCS) to work with counties and stakeholders to establish outcome metrics for state and county behavioral health services and programs.

3-V-C: Identify County technical assistance needs.

No technical assistance required at this time.

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

CLAS Standard: 13

4-I: The County has a Cultural Competence Committee, or other Group that Addresses Cultural Issues and has Participation from Cultural Groups, that is reflective of the Community.

4-1-A: Brief description of the Cultural Competence Committee or other similar group (organizational structure, frequency of meetings, functions, and role).

The Cultural Competence Committee (formed in 2016) consists of members from the community and the Health Care Agency who also represent or serve persons from the diverse racial, ethnic, and cultural groups in Orange County. The overarching goal was "to increase cultural awareness, sensitivity, and responsiveness to the needs of diverse cultural populations in order to foster hope, wellness, resilience and recovery in our communities."

In 2020, following the devastating inequities highlighted by the Coronavirus pandemic, as well as the murder of George Floyd, a Community Relations and

Education (CoRE) sub-committee was formed to develop a governing structure for the CCC that puts equity at the forefront. The result was a change in the name from CCC to Behavioral Health Equity Committee (BHEC), and the Governing Structure document was finalized in December 2020.

BHEC's vision as defined by the Governing Structure states that: "*Our efforts are focused on the promotion of behavioral health equity for unserved and underserved racial and ethnic communities, as well as lesbian, gay, bisexual, transgender, questioning/queer and intersex (LGBTQI), Veterans, Deaf and Hard of Hearing and other cultural groups.*" In accordance with the Governing Structure, a Steering Committee and several Work Groups were formed in the first quarter of 2021. At that time, the Director of Behavioral Health Services appointed Bijan Amirshahi, the ESM at the time, as the Co-Chair on its behalf and the community members of the Steering Committee elected Iliana Soto Welty as the community Co-Chair. In September 2021, Bijan Amirshahi stepped down from his position as Co-Chair (while still serving as the ESM), and Deana Helmy was appointed as his replacement.

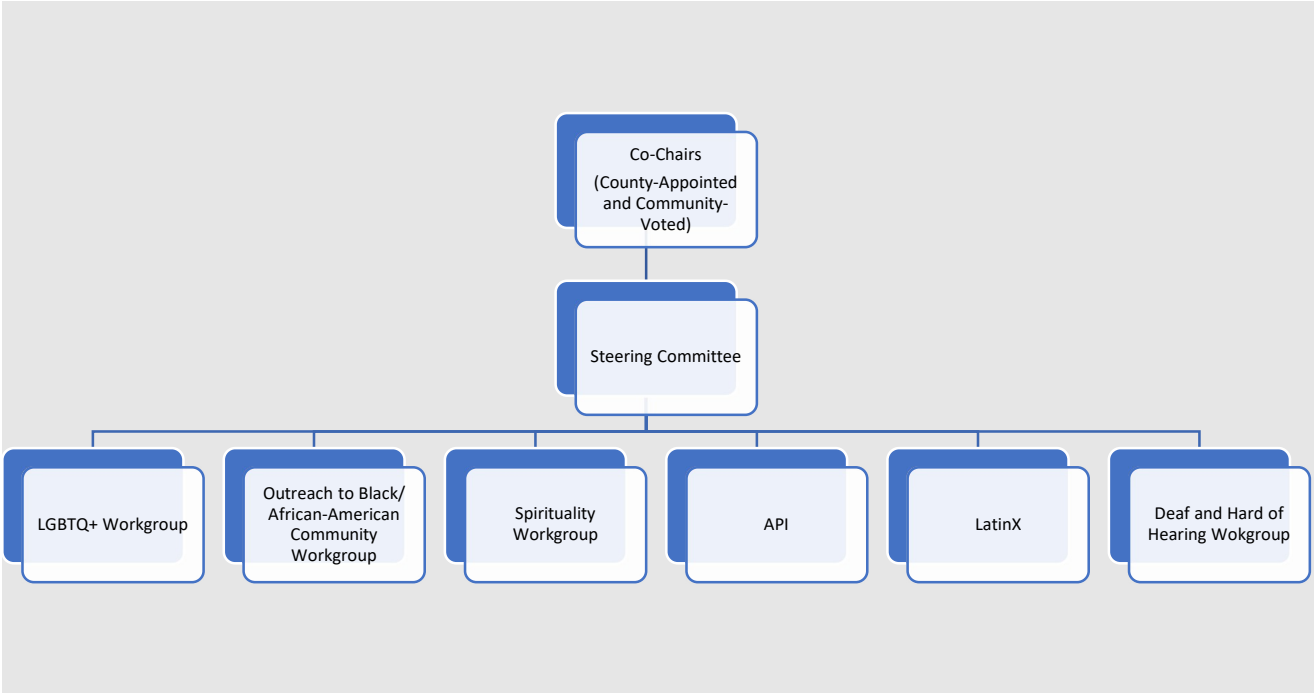
A copy of the Governing Structure as approved by BHS is included in Appendix II.

4-1-B: The County shall include the following in the CCPR: Policies, procedures, and practices that assure members of the Cultural Competence Committee will be reflective of the community, including county management level and line staff, clients and family members from ethnic, racial, and cultural groups, providers, community partners, contractors, and other members as necessary.

The BHEC has a governing structure and by-laws that address the values, objectives, structure, scope, and purpose of the committee.

4-I-C: Organizational Chart

Current Organizational Chart of the Behavioral Health Equity Committee:



4-I-D: Committee membership roster listing member affiliation, if any.

Behavioral Health Equity Committee Participants

First Name	Last Name	Organization/Affiliation
Debbie	Acosta	Peer
Alan	Albright	OC Behavioral Health Advisory Board
Mae	Alfaddaghi	MECCA
Michael	Arnot	CCOC
Virginia	Arvizu-Sanchez	Sacred Path Indigenous Wellness Center (Native American population)
Mary	Barranco	CalOptima Health
Nancy	Beltran	Goodwill of Orange County-Employment Works
Lei Portugal	Calloway	Telecare AOT/Care Court
Helen	Cameron	MHSA stakeholder
Alejandra	Capitran	Nami OC
Yennga Cecilia	Chau	Asian

First Name	Last Name	Organization/Affiliation
Deb	Diaz de Leon	NAMI
Rhiannon	Doscher	MECCA
Cheryl	Downes	Seneca/homeless outreach
Sohail	Eftekharzadeh	CCS/Pathways- Wellness Center Central
Luisa	Estanga	Abrazar Inc.
Tanji	Ewing	OCHCA
Michael	Fotion	Friendship Shelter
Daniel	Gibbs	OCHCA MHSA
Luis	Gonzalez	Office of Population Health and Equity and
Claudia	Gonzalez de Griese	OCHCA
Michelle	Harris	HCA/ CAT
Deana	Helmy	OCHCA/Spirituality
Maryam	Jibaly	ICNA Relief
Connie J	Jones	NAN OC
Marian	Kettler	OCHCA
Heidi	Kim	AASCSC
Luna	Lu	AASCSC
Pennie	Mack	Break Every Chain Foundation Incorporated
Belinda	McCleese	Deaf & Hard of Hearing Community
Annie	Medina	Pacific Clinics Recovery Education Institute
Michael	Mullard	HCA - Spirituality Workgroup
Carolina	Nevarez	Mental Health Association of Orange County / Wellness Center West
Lisa	Nguyen	Abrazar Inc.
Thuy	Nguyen	OCHCA
Dalia	Oregel	Deaf
Mario	Ortega	Abrazar Inc.
Princess	Osita-Oleribe	HEAAL
Andrew	Parker	Work for County of Orange in HCA QMS
Luyen	Pham	OCHCA
Scott	Pham	Goodwill OC Mission Services
Tania	Quevedo	ASL Interpreter
Teresa	Renteria	OCHCA/ Spirituality

First Name	Last Name	Organization/Affiliation
Karina	Rodriguez	Abrazar Inc
Arlene	Rosa	OCHCA
Deepa	Shanadi	OCHCA
Linda	Smith	Community advocate
Michelle	Smith	OCHCA-BHS
April	Thornton	OCHCA
Duan	Tran	Cal State Fullerton/ BHAB
Katie	Tran	Advance OC
Jeffrey	Vu	OCHCA
Sarah	Wareh	ICNA Relief
Iliana	Welty	Mind OC
Brittany	Whetsell	OCHCA
Erika	Williams	Older adults- OCHCA
Fred	Williams	BHAB
Johnice	Williams	Outreach and Engagement for Blacks/African Americans
Raquel	Williams	Thrive Together OC
Ryan	Yowell	OCHCA

4-II: The Cultural Competence Committee, or Other Group with Responsibility for Cultural Competence, is Integrated within the County Mental Health System.

4-II-A: Evidence of policies, procedures, and practices that demonstrate the Cultural Competence Committee's activities including the following:

The BHEC bylaws and governing structure, attached, highlight the role of BHEC as it pertains to the MHSA planning and stakeholder process, CCPR development, and communicating to the Chief of Mental Health and Recovery Services. Currently, the Office of Equity is being formed and will continue to collaborate and integrate with the MHSA community planning process, as well as working closely with the client developed programs (wellness, recovery, and peer support programs).

4-II-B: Provide evidence that the Cultural Competence Committee participates in the above review process

The MHSA Coordinator and the BHEC Chair work together to ensure that the BHEC is involved in the community planning process, provides feedback to the MHSA Coordinator, and reviews the MHSA Plan. Moving forward, the MHSA Coordinator and the BHEC Chair will ensure community involvement

and participation in the development of client-centered programs. Additionally, the CCPR incorporates feedback provided from the BHEC steering committee and workgroup members.

4-II-C: Annual Report of the Cultural Competence Committee's Activities including:

- **Detailed discussion of the goals and objectives of the committee;**
  - Were the goals and objectives met?
  - If yes, explain why the county considers them successful.
  - If no, what are the next steps?
- **Reviews and recommendations to county programs and services;**
  The BHEC and subcommittees review and make recommendations to departments' programs and services annually through the MHSA annual update (at various community planning process meetings) and as requested by BHS and its partners.
- **Goals of cultural competence plans;**
  The required goals of the CCP are:
  - Commitment to Cultural Competence
  - Updated assessment of service needs
  - Strategies and efforts for reducing racial, ethnic, cultural and linguistic mental health disparities
  - Client/Family/Family member/Community Committee: Integration of the Committee within the county mental health system
  - Culturally competent training activities
  - County's commitment to growing a multicultural workforce: Hiring and retaining culturally and linguistically competent staff
  - Language Capacity
  - Adaptation of Services

  No updates or changes to the cultural competency plan goals have been made.

- **Human resources report;**
  Not applicable – there was no report requested by BHEC Committee
- **County organizational assessment;**
  In FY 2022/2023, the BHEC did not conduct a formal county organizational assessment. However, ongoing feedback from BHEC participants is used to inform the direction of BHEC.

- **Training plans**
  Training plans were developed in collaboration with the department's Workforce Education and Training (WET) program, also referred to as Behavioral Health Training Services (BHTS).

CRITERION 5: CULTURALLY COMPETENT TRAINING ACTIVITIES

CLAS Standard: 4

5-I: The County System shall require all Staff and Stakeholders to receive Annual Cultural Competence Training.

5-I-A: The County shall develop a three-year training plan for required cultural competence training that includes the following:

• The projected number of staff who needs the required cultural competence training. This number should be unduplicated;
• Steps the county will take to provide required cultural competence training to 100% of their staff over a three-year period 3.
• How cultural competence has been embedded into all trainings

In 2022/2023, 1,970 staff and contracted providers completed the annual cultural competence training.

BHS (Policy 2.01.01 requires all BHS County and County Contracted staff to complete an annual cultural competency training. Per the policy:

- The Behavioral Health Training Services (BHTS) unit shall indicate on all training announcements and certificates if the particular training qualifies to meet the requirement for cultural competence training.
- The Service Chief/Supervisor of each BHS staff person shall be responsible to ensure that the mandatory annual cultural competence training occurs and shall keep evidence of the training for each staff person.
- Contract organizations are expected to ensure that all staff have, at a minimum, one hour of training in and related to cultural competence annually. Contract organizations shall keep documentation of this training and report completion of such training by all direct service providers, administration, and support staff to the Contract Monitor/Consultant.

BHS county and contracted staff are expected to take Cultural Competence trainings. It is the goal of the ESM, with the support of the Chief of BHS, to develop new material specifically related to cultural competency and how staff incorporate culturally and linguistically appropriate services into their work with clients, consumers, co-workers, and the public alike. All staff are required to complete at least one hour of cultural competency training

annually. Contracted providers are required to take this training as well and is highlighted as a requirement in all contracts.

Additionally, it is required that cultural considerations are embedded into all trainings providing Continuing Education (CE/CME) units, as described in the training description, objectives, listed references, and training contents. Trainers are expected to incorporate cultural references in all training topics, bulletin notices and learning objectives relative to the topic. Trainings focused on skill building and education are conducted to address cultural sensitivity and humility, as well as reduce stigma and discrimination within the behavioral health system. This is done to prepare, develop, and maintain a culturally responsive, bicultural/bilingual workforce that also includes consumers and family members with valuable, lived experience.

5-II: Annual Cultural Competence Trainings

5-II-A: Please report on the cultural competence trainings for staff. Please list training, staff, and stakeholder attendance by function:

Cultural competence trainings are comprised of several categories: those related to behavioral health best practices; those requiring on-going recertification; clinical skills development related to common evidence-based practices; and trauma-informed care. These trainings were developed for clinicians, service providers and community members. Trainings were also provided to medical community members, such as doctors and registered nurses, in order to improve their daily practices. Additional trainings were targeted toward support for staff who translate materials into the threshold languages so that monolingual consumers/family members or community members can participate in services. This training effort also includes learning opportunities as well as training materials for persons who are Deaf and Hard of Hearing and have limited English or other written language reading skills.

Cultural competence trainings were provided for staff, stakeholders, and community members on a variety of topics. Table 5.1 below is a chart that provides information on the cultural development trainings provided during FY 2022-23 (See Appendix IV for training descriptions and details). These topics helped to address the unique strengths and needs of clients from the diverse ethnic and cultural communities in Orange County.

Table 5.1 Name of Cultural Development Trainings, FY 2022-23[1]

	Total Trainings	*Number of Attendees*	*Combined Hours*	*Combined CEs Given*
2022 Conference: Orange County Substance Abuse Prevention Network	1	3551	4.0	4
2023 Emergency Medical Services Administrators Association of California (EMSAAC) Annual Conference	1	18	10.0	10.5
2023 Meeting of the Minds Mental Health Conference "Wellness for All: Equity in Mental Health Care"	1	129	5.0	5
Addressing Substance Abuse and Trauma: With A Youth Focus	1	39	3.0	3
Clinical High-Risk and First Episode Psychosis	1	26	1.0	1
Cognitive Behavioral Therapy for Psychosis	1	78	3.0	3
Coping with the Journey of Grief and Mourning	1	81	6.0	6
Cultivating Competency-Based Clinical Supervision	1	45	6.0	6
Cultivating Competency-Based Clinical Supervision for NEW Supervisors	1	37	9.0	9
Cultural and Contextual Consideration in the Early Identification of Risk for Psychosis	1	38	1.0	1
Cultural Competency 3.0 Training	1	1533	1.0	0
Dialectical Behavior Therapy for Psychosis	1	122	3.0	3
Dialectical Behavior Therapy Training	1	141	3.0	3
EMDR Boot Camp: A Basic Training Refresher and Fidelity to Model Course	1	46	6.0	6
Exploring the Depths of Clinical Supervision	1	37	6.0	6
Implementing Strategies for Eating Disorder Management and Treatment	1	104	6.0	6
Intersection Between Autism and Clinical High Risk for Psychosis	1	69	1.0	1
Mental Health and Recovery Services MD/NP Series	3	87	6.0	6
Recent Traumatic Events Protocol (R-TEP) and Group Traumatic Events Protocol - An Advanced EMDR Training	1	17	12.0	12
Self Care and the Professional: Creating a Culture of Self Care Part I and II	1	43	3.0	0

Table 5.1 (Continued) Name of Cultural Development Trainings, FY 2022-23[1]

	Total Trainings	*Number of Attendees*	*Combined Hours*	*Combined CEs Given*
Solution Focused Brief Therapy for School Based Mental Health Professionals	1	109	11.0	11
Structured Interview for Psychosis Risk Syndromes ("SIPS")	1	8	5.0	6
Structured Interview for Psychosis Risk Syndromes: "SIPS" Training - Day 1	1	16	12.0	12
Suicide Assessment and Intervention	1	114	6.0	6
Suicide Prevention Center Clinical Presentation	2	17	6.0	6
The Mental and Emotional Health Complete Series	2	15	12.0	12
The New Faces of Anxiety in Light of the Pandemic	1	60	6.0	6
Trauma and Parenting: Creating a Safe Home Base	1	44	3.0	3
Trauma Informed Foundations	1	39	3.0	3
Trauma-Informed Approaches to Addressing Suicide and Self Harm	1	84	3.0	3
Understanding Non-Suicidal Self-Injury	1	49	2.0	2
Youth Mental Health First Aid	1	12	8.0	0
Total	*36*	*3399*	*172.0*	*157*

Note: No CEUs were given for CIT or MHFA

[1]Source: Behavioral Health Training Services, Internal Data Tracking System (FY 22-23)

Tables 5.2 and 5.3 below describe staff and stakeholders professional and personal role identification. In some cases, one person may identify as multiple roles. Most participants identified as County Direct Service Providers, followed by County Administrator/Manager. Personally speaking, the majority of participants identified as Community Members and Family Members.

Table 5.2 Cultural Development Training Attendance by Participants' Professional Role, FY 2022-23

*Attendance by function**	*Total Number*
County Administrator/Manager	192
County Direct Service Provider	482
County Support Staff	17
Community-Based Administrator/Manager	139
Community-Based Direct Service Provider	187
Community-Based Support Staff	14
Total	*1,031*

**Some attendees reported multiple professional roles*

Source: Behavioral Health Training Services, Evaluation Form Data (FY 22-23)

Table 5.3 Cultural Development Training Attendance by Participants' Personal Role, FY 2022-23

*Attendance by function**	*Total Number*
Consumers	249
Parents	122
Family Members	215
Community Member	611
Caregiver	127
Total	*1,324*

**Some attendees reported multiple personal roles*
Source: Behavioral Health Training Services, Evaluation Form Data (FY 22-23)

5-II-B: The County shall include the following in the CCPR: Annual cultural competence trainings topics shall include, but not be limited to the following:

- Cultural Formulation
- Multicultural Knowledge
- Cultural Sensitivity
- Cultural Awareness
- Social/Cultural Diversity (Diverse groups, LGBTQ, SES Elderly, Disabilities, etc.)
- Mental Health Interpreter Training
- Training staff in the use of mental health interpreters
- Training in the use of Interpreters in the mental health setting

The annual cultural competence training is provided to both County- and Contract-operated staff. In September 2020, a revised Cultural Competence training was launched and focused on unconscious bias and how it may affect one's behavior in the workplace. The training includes research findings, illustrated different aspects of unconscious bias at the workplace and provided an opportunity to test one's knowledge. The training also provided an opportunity to take an Implicit bias Assessment Test (IAT).

The new cultural competence training that will launch in FY23/24 covered n Introduction to Culturally and Linguistic Competency, which will explore the following topics:

- Culture, cultural Identity, and intersectionality
- Cultural competency and humility in behavioral health care

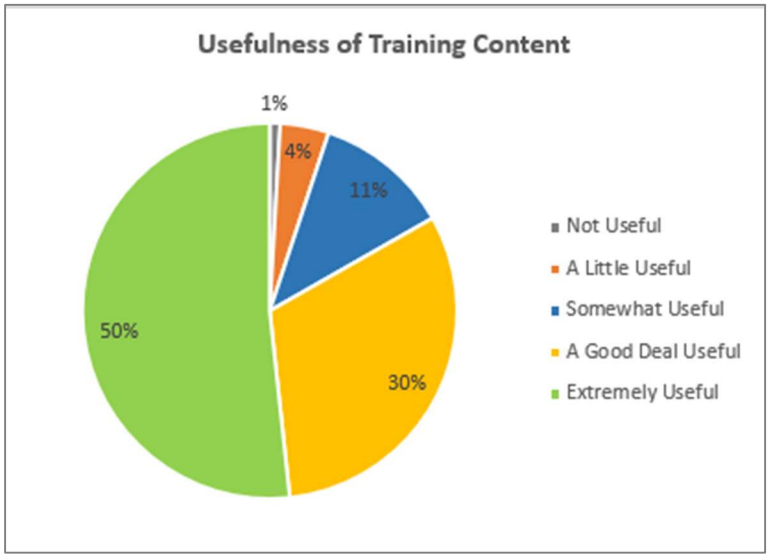
- Cultural competency and the behavioral health workforce
- Cultural and linguistic competency and quality of care

5-III: Relevance and Effectiveness of all Cultural Competence Trainings.

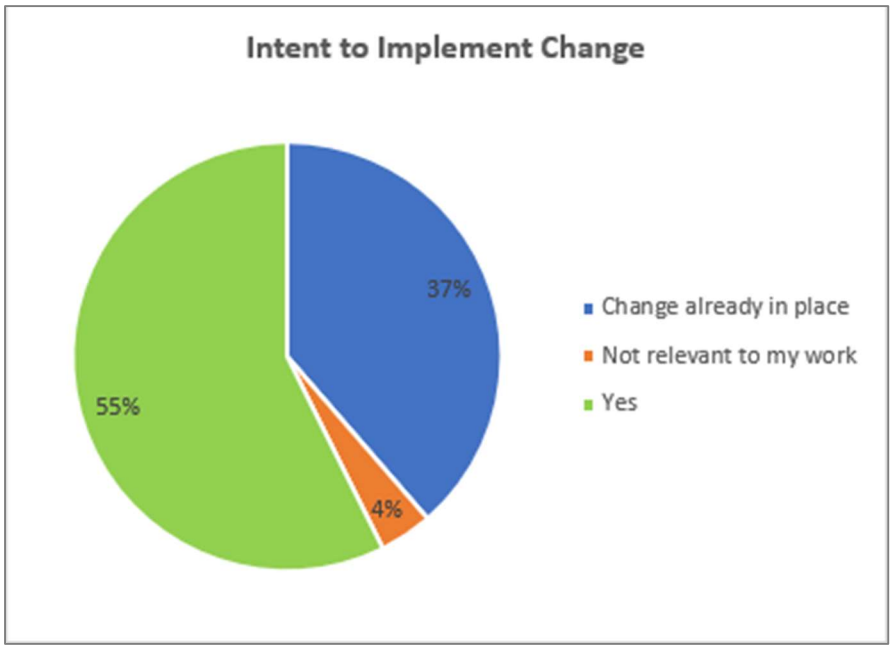
5-III-A: Training Report on the relevance and effectiveness of all cultural competence trainings, including the following:

- Rationale and need for the trainings: Describe how the training is relevant in addressing identified disparities;
- Results of pre/post-tests (Counties are encouraged to have a pre/post-test for all trainings);
- Summary report of evaluations; and
- Provide a narrative of current efforts that the county is taking to monitor advancing staff skills/post skills learned in trainings.
- County methodology/protocol for following up and ensuring staff, over time and well after they complete the training, are utilizing the skills learned.

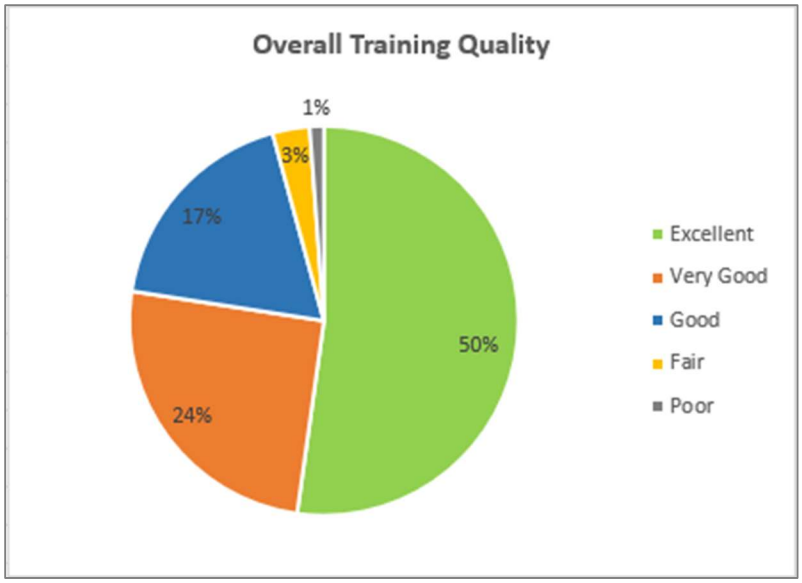
The annual cultural competence training is provided to both County- and Contract-operated staff. In 2023, a revised Cultural Competence training was launched and focused on culture identity, intersectionality, competency, humility, and linguistic competency. At the end of the training, participants were encouraged to take an online evaluation regarding their experiences. Overall, participants felt the educational objectives discussed during the training were useful. As a result of the training, the majority of participants who engaged in the FY 2022-23 training felt the content was extremely useful, with 30% stating it was a good deal useful and 11% stating it was a somewhat useful.



In examining staffs' intent to implement changes as a result of the training, 90% indicated they either had an intent to implement change (55%) or were already implementing changes (37%). This illustrates that the training provided additional insight into unconscious bias in the workplace.



While no Continuing Education (CE) units were provided, this training focused on understanding and identifying unconscious/implicit bias in the workplace. Of those who provided feedback for this training, 50% rated the overall quality of the training as excellent, 24% rated it as very good, 17% rated it as good, and 3% rated the training as fair.



The cultural competence and cultural development trainings focus on skills and knowledge that value diversity, help staff understand and respond to cultural differences, and increase awareness of providers' and care organizations' cultural norms. Trainings can provide facts about patient cultures or include more complex interventions such as intercultural communication skills training, exploration of potential barriers to care, and institution of policies that are sensitive to the needs of patients from culturally and linguistically diverse (CALD) backgrounds.

A key component of the cultural development/competence trainings are to increase attendees' cultural understanding and skills related to increased client satisfaction and improved behavioral health outcomes. These concepts also reduce disparities among underserved or underrepresented groups.

5-IV: Counties must have Process for Incorporation of Client Culture Training throughout the Mental Health System.

5-IV-A: Evidence of an annual training on Client Culture that includes a client's personal experience inclusive of racial, ethnic, cultural, and linguistic communities.

- Multiple workshops at Meeting of the Minds
- Cultural and Contextual Considerations in the Early Identification of Risk for Psychosis
- Cultural Competency 3.0 Training (implicit bias)
- Think Cultural Health (intersectionality)
- The Mental and Emotional Health Complete Series

- The New Faces of Anxiety in Light of the Pandemic

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

- Family focused treatment;
- Navigating multiple agency services; and
- Resiliency.

Family Focused Treatment:

- Multiple workshops at Meeting of the Minds Conference
- Addressing Substance Abuse and Trauma – Youth Focus
- Clinical High-Risk and First Episode Psychosis
- Implementing Strategies for Eating Disorder Management and Treatment
- Intersection Between Autism and Clinical High Risk for Psychosis
- Trauma and Parenting: Creating a Safe Home Base

Navigating Multiple Agency Services

- Mental Health and Recovery Services MD/NP Series

Resiliency:

- Coping with the Journey of Grief and Mourning
- Dialectical Behavior Therapy for Psychosis
- Cognitive Behavioral Therapy for Psychosis
- EMDR Boot Camp: A Basic Training Refresher and Fidelity to Model Course
- Recent Traumatic Events Protocol (R-TEP) and Group Traumatic Events Protocol (G-TEP) – An Advanced EMDR Training
- Solution Focused Brief Therapy for School Based Mental Health Professionals
- Trauma Informed Foundations
- Trauma-Informed Approaches to Addressing Suicide and Self-Harm
- Understanding Non-Suicidal Self-Injury
- Mental Health First Aid
- Youth Mental Health First Aid

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

CLAS Standard: 3 & 7

6-I: Recruitment, Hiring, and Retention of a Multicultural Workforce from, or Experienced with, the Identified Unserved and Underserved Populations.

BHS remains strongly committed to recruiting, retaining, and promoting a multi-cultural, highly skilled workforce. The following section provides information about recruitment and retention efforts of our behavioral health professionals that are in line with the Recovery-focused philosophy. At present, BHS is coping with a vacancy rate of approximately 27%. This means that approximately one third of our positions are waiting to be filled or are recently vacated. There are many reasons contributing to this vacancy rate such as the impact of COVID on staff resilience, current hiring and retention practices, and competitive pay.

One of the main agency goals for this year's Cultural Competence Plan Update is the hiring and retention of a bi-lingual and bi-cultural workforce. This has become a priority for management to increase penetration rates and further create linkages to the community to increase trust and build confidence in our services.

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

Workforce Education and Training (WET) Component from the Mental Health Services Act Three Year Integrated Plan for Fiscal Years 2020/2023.

The passage of the Mental Health Services Act (MHSA) in November 2004, provided a unique opportunity to increase staffing and other resources to support public behavioral health programs.

MHSA funds increased access to much needed services, and progress toward statewide goals for serving children, Transitional Age Youth (TAY), adults, older adults, and their families.

California's public behavioral health system has suffered from a shortage of behavioral health workers, changes in mental health occupational classifications,

and underrepresentation of diversity of professionals with consumer and family member experience. To address challenges faced by the public behavioral health workforce, the MHSA included a component for Mental Health Workforce Education and Training (WET) programs.

WET is a program that provides various training opportunities to BHS staff and contract agency staff, promotes the hiring of a culturally diverse workforce, offers financial incentives to recruit and retain staff, recruits volunteers for the department, facilitates clinical intern programs, supports the inclusion and incorporation of consumers and their family members into the behavioral health workforce, and is committed to addressing workforce shortage within Orange County through utilization of various strategies to recruit and retain qualified behavioral health employees.

WET carries forth the vision of the MHSA to create a transformed, culturally competent system that promotes wellness, recovery, and resilience across the lifespan of all age groups and all cultural backgrounds.

WET MHSA Legislative Goals

Address workforce shortages and deficits identified in the workforce needs assessment:

- Increase in the number of employees hired in identified needs assessment areas.
- Increase in pre-licensed to licensed baseline statistics.
- Increase in the number of qualified applications received for clinical positions.
- Increase in BHS pre-licensed clinicians hired (interns vs. non-interns)

Designate a WET Coordinator:

- WET Coordinator designated.

Educate the workforce on incorporating the general standards:

- Training documented addressing these standards.
- Training evaluations.

Increase the number of clients and family members of clients employed in the public mental health system:

- Increased number of peer support specialists and parent/youth partners hired.

Conduct focused outreach and recruitment to provide equal employment opportunities in the public mental health system for individuals who share the racial/ethnic, cultural, and/or linguistic characteristics of clients, family members of clients, and others in the community who have serious mental illness and/or serious emotional disturbance:

- Documented efforts that target the identified population
- Documented career fairs including locations.

Recruit, employ, and support the employment of individuals in the public mental health system who are culturally and linguistically competent, or at a minimum, are educated and trained in cultural competence:

- Documented efforts that target the identified populations.
- Adherence to cultural competency training requirement.
- Increase in hiring of culturally competent staff.
- Increase in the number of bilingual staff, bilingual applicants, and bilingual interns.

Provide financial incentives to recruit or retain employees within the public mental health system:

- Financial incentives implemented.
- Tracking for employee scholarship applicants.

Incorporate the input of clients and family members of clients, and when possible, utilize them as trainers and consultants in public mental health WET programs and/or activities:

- Documented meetings with clients and family members.
- Documented trainings facilitated by clients and family members.

Incorporate the input of diverse racial/ethnic populations that reflect California's general population into WET programs and/or activities:

- Documented meetings with diverse racial/ethnic populations

Establish regional partnerships:

- Participate in meetings.

In FY 2021/2022, BHS conducted a workforce analysis and needs assessment in conjunction with our Southern California Regional Partnership (SCRP) partners. The needs assessment determines workforce patterns and trends to assist in informing

the development on a new five-year plan, which can be used to increase recruitment and retention strategies, ensure the hiring of a culturally responsive workforce, and build interest in the public mental health field. The new WET five-year plan is programmed to be completed in 2025 and will include data on the utilization rates of the five new WET focus areas. The five new focus areas include recruitment and retention, pipeline development, scholarships, stipends, and loan assumption programs. These five new focus areas were determined as a result of our Southern California Regional Partnerships (SCRP).

6-I-B: Compare the Workforce Needs Assessment data for the WET component of the Plan with the general population, Medi-Cal population, and 200% of poverty data. Rationale: Will give ability to improve penetration rates and eliminate disparities.

BHS is working on collecting information on the ethnic make-up of its workforce. The information provided in Table 6.1 below lists the clinicians in our workforce (County clinicians and combined County and Contracted Clinicians) – while these numbers are from FY21/22, they have not significantly changed in FY22/23. The greatest disparity indicates the female workforce at 72.6% (County clinicians) and 75.8% (combined County and contracted clinicians). This is an overrepresentation of the 50.5% in the general population, and 51.8% of beneficiaries who received an approved service under the Mental Health Plan and 34.2% under the DMC-ODS. Male clinicians represent 27.4% of County clinicians and 24.1% (combined county and contracted clinicians), which is an underrepresentation of the 49.5% of males in the general Orange County population and the 47.8% of Medi-Cal beneficiaries who received an approved service under the Mental Health Plan and 65.5% under the DMC-ODS.

Table 6.1 Current Workforce by Gender Fiscal Year 2021/2022

	Total Population[1]		*County Wide Estimated Population Living at or Below 200% FPL (Medi-Cal Clients)*[2]		*Average Number of Medi-Cal Eligibles per Month*[3] *(Mental Health Plan)*		*Medi-Cal Beneficiaries who Received an Approved Service per Year*[4] *(Mental Health Plan)*		*Average Number of Medi-Cal (Mental Health Plan) Eligibles per Month*[3] *(DMC-ODS)*	*Medi-Cal Beneficiaries who Received and Approved Service per Year*[4] *(DMC-ODS)*		*BHS Workforce** (County Clinicians)	*BHS Workforce (County & Contracted Clinicians)*	
Total	3,135,755		510,000		1,019,974		24,827		635,670	5,976		759	1056	
Female	1,583,727		309,000		549,219		12,865		355,868	2,046		551	798	
Percentage of Female	50.5%		60.6%		53.8%		51.8%		55.8%	34.2%		72.6%		
Male	1,552,028		201.000		470,756		11,859		281,757	3,917		208	254	
Percentage of Male	49.5%		39.4%		46.2%		47.8%		44.2%	65.5%		27.4%	%	
Transgender Male to Female	-		-		-		-		-	-		1	1	
Percentage Transgender Male to Female	-		-		-		-		-	-				
Undisclosed Count	-	-	-	-	-	-	103	0.4%		13	0.2%	3	0%	0%

[1]*American Community Survey (ACS) 2023, US Census*

[2]*California Health Interview Survey (2023). Counts are estimates.*

[3]*Eligibles for Mental Health Plan and DMC-ODS*

[4]*Approved Services for Mental Health Plan and DMC-ODS*

6-I-C: If applicable, the county shall report in the CCPR, the specific actions taken in response to the cultural consultant technical assistance recommendations as reported to the county during the Department's review of the WET component of its plan.

Not applicable

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

<u>Recruitment</u>

The purpose of the booklet is to introduce high school students, college students, and those interested in pursuing all the exciting career opportunities that exist in the mental health and substance use field in the counties of California's public service departments.

Additionally, through the Southern Counties Regional Partnership (SCRP) efforts to develop workforce pipelines and reach students in high schools and local colleges, career development handouts and brochures have been developed in partnership with Health Workforce Initiative (HWI) and will be distributed to all of the SCRP 10 Counties, including Orange County.

In an effort to attract candidates to Orange County Mental Health and Recovery Services positions, the Workforce and Education Training (WET) office developed a pamphlet called Workforce Education and Reimbursement Programs. This pamphlet has been distributed at hiring fairs and is available on our website as well as on the Human Resources recruiting website. This tool has also assisted current staff in locating scholarships and loan repayment programs which has become a retention tool as well.

Needs by Occupational Category

Across County-operated BHS programs, there is a need to fill vacant positions among Public Mental Health Services (PMHS) employees who provide direct and non-direct services in order to meet the needs of the current clientele (Table 6.3). Based on the most recent needs assessment, roughly 73% of the needed positions are currently filled. Comparing the number of filled to vacant positions, the greatest need were both Behavioral Health Clinicians and Psychiatrists. BHS plans to add Alcohol and Other Drug (AOD) certified counselors to the list of staff positions along with the creation of a Peer Support Specialist classification.

Table 6.2 Number of PMHS Employees and Vacancies, November 2023[1]

	Total Number
Total Number of Current PMHS Employees	1,317
Total Number of PMHS Vacancies	313
Total Number of Current PMHS Direct Service Filled Positions	655
Total Number of Current PMHS Direct Service Vacancies	213

[1] *The total number of current PMHS direct service filled positions does not include Executive and Management staff (see Table 6.2). The numbers presented in this table are reflective of only staff who provide direct services to the community.*

Table 6.3 Currently Filled and Vacant BHS Clinical Positions, November 2023[1]

	Number of Positions Filled	*Number of Vacancies*	*Total Number of Positions*
Behavioral Health Clinician	379	113	492
Mental Health Specialist	111	45	156
Licensed Clinical Psychologist	48	10	58
Mental Health Worker	33	21	54
Executive and Management Staff	48	10	58
Psychiatric Mental Health Nurse Practitioner	1	1	2
Behavioral Health Nurse	11	5	16
Psychiatrist - Child and Adolescent	11	6	17
Psychiatrist - General	24	7	31
Total	*666*	*218*	*884*

[1] *Position classifications not currently used in Orange County include Case Manager, Licensed Marriage and Family Therapist, Licensed Professional Clinical Counselor, Licensed Psychiatric Technician, Occupational Therapist, Physician Assistant, Psychiatric Mental Health Clinical Nurse Specialist, Psychiatrist – Geriatric, Substance Abuse/AOD/SUD Counselor.*

BHS has a Peer Workforce Development Initiative (PWDI) that consults with the Director's Office to support and promote peer positions throughout BHS. Currently, there are 34 employed peer specialists (which include Mental Health Worker I and II, along with Community health Assistants), and the PWDI is exploring ways to recruit and retain qualified peer workers.

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

The WET program experienced the following challenges for FY2022/2023:

- Competitive salary.
- Lengthy process from application to on-boarding.
- Lack of availability of flexible schedules (including telecommuting).
- Burnout.
- Competition for qualified staff with other systems.
- Breakdown in behavioral health pipeline and career pathways.
- Shortages in specific classifications (licensed therapists, psychiatrists, mental health specialists, and an absence of Certified Alcohol and Drug Counselor as a classification).
- Decentralized BHS internship program.

The WET program has taken the following actions to address the challenges:

- Developing behavior health expertise in primary care by using paraprofessional staff to develop the capacity of the system (including behavior health coaching).
- Develop core competencies and training plans (based on staff roles and responsibilities).
- Establish a behavior health career pipeline in collaboration with the K-12 system.
- Partner with local higher education institutes to provide education that will enable workers to advance professionally.
- Initiate development of a leadership development program for staff working in BHS.
- Continue to provide relevant trainings offering free continuing education units (CE's).
- Centralize the coordination of supervision and internships.

6-I-F: Identify County technical assistance needs.

There are no identified technical assistance needs at this time.

CRITERION 7: LANGUAGE CAPACITY

CLAS Standard: 5, 6 & 8

7-I: Increase Bilingual Workforce Capacity

7-1-A: Evidence of dedicated resources and strategies counties are undertaking to grow bilingual staff capacity, including the following:

7-1-A-1: Evidence in the Workforce Education and Training (WET) Plan on building bilingual staff capacity to address language needs:

BHS is committed to providing culturally and linguistically appropriate services to our clients, and as such, aims to recruit bilingual and bicultural applicants, and retain bilingual and bicultural staff. The language skills needed are listed on job announcements in an effort to appeal to candidates with various backgrounds and language capacities.

In FY 2022/2023, BHS employed 478 bilingual employees, accounting for 48% of the workforce.

The majority of bilingual staff speak Spanish (76.8%), but other languages spoken by staff include:

- Vietnamese
- Korean
- Farsi
- Arabic
- Cantonese
- Mandarin
- Tagalog
- Japanese
- ASL

7-I-A-2: Updates from the CSS or WET component of the county's Plan on bilingual staff members who speak the languages of the target populations.

Table: BHS Bilingual Staff by Language and Skill Level for FY 2022/2023 (*Updated November 2023)*

Title Description	ARABIC	CANTONESE	FARSI	JAPANESE	KOREAN	MANDARIN	OTHER LANGUAGE	SPANISH	TAGALOG	VIETNAMESE	TOTAL
BEHAVIORAL HEALTH CLINICIAN I	3	1	1	1	1	0	1	68	0	13	89
BEHAVIORAL HEALTH CLINICIAN II	2	0	4	0	9	0	1	71	0	13	100
BEHAVIORAL HEALTH NURSE	0	0	0	0	0	0	0	3	0	0	3
CLINICAL PSYCHOLOGIST I	1	0	1	0	0	0	0	4	0	0	6
CLINICAL PSYCHOLOGIST II	0	0	1	0	2	0	0	8	0	2	13
COMMUNITY HEALTH ASSISTANT II	0	0	0	0	0	0	0	2	0	0	2
COMMUNITY WORKER II	0	0	0	0	1	0	0	3	0	0	4
COMPREHENSIVE CARE NURSE II	0	0	0	0	1	1	0	3	0	0	5
CONTRACT EMPLOYEE	0	0	0	0	0	0	0	1	0	2	3
DATA ENTRY TECHNICIAN	0	0	0	0	0	0	0	0	0	1	1
HCA PROGRAM SUPERVISOR I	0	0	1	0	0	0	0	2	0	0	3
HCA SERVICE CHIEF I	1	0	1	0	0	0	0	9	0	2	13
HCA SERVICE CHIEF II	0	0	0	0	0	1	0	13	0	2	16

Title Description	ARABIC	CANTONESE	FARSI	JAPANESE	KOREAN	MANDARIN	OTHER LANGUAGE	SPANISH	TAGALOG	VIETNAMESE	TOTAL
HEALTH PROGRAM SPECIALIST	0	0	0	0	2	0	0	3	1	0	6
INFORMATION PROCESSING SPECIALIST	0	0	0	0	0	0	0	1	0	0	1
INFORMATION PROCESSING TECHNICIAN	0	0	0	0	0	0	0	9	0	0	9
MENTAL HEALTH SPECIALIST	0	0	0	0	0	0	2	48	0	11	61
MENTAL HEALTH WORKER II	0	0	0	0	0	0	0	19	0	1	20
MENTAL HEALTH WORKER III	0	0	0	0	0	0	0	2	0	0	2
NURSING ASSISTANT	0	0	0	0	0	1	0	0	0	0	1
OFFICE ASSISTANT	0	0	0	0	0	0	0	5	0	1	6
OFFICE SPECIALIST	0	0	1	0	1	0	0	58	0	4	64
OFFICE SUPERVISOR C	0	0	0	0	0	0	0	2	0	0	2
OFFICE SUPERVISOR D	0	0	0	0	0	0	0	3	0	0	3
OFFICE TECHNICIAN	0	0	0	0	0	0	0	15	0	2	17
PSYCHIATRIST	0	0	1	0	1	0	0	2	0	3	7
RESEARCH ANALYST III	0	0	0	0	0	0	0	1	0	0	1
RESEARCH ANALYST IV	0	0	0	0	1	0	0	1	0	0	2
SECRETARY III	0	0	0	0	0	0	0	1	0	0	1
SR. COMPREHENSIVE CARE NURSE	0	0	0	0	0	0	0	0	0	1	1

Title Description	ARABIC	CANTONESE	FARSI	JAPANESE	KOREAN	MANDARIN	OTHER LANGUAGE	SPANISH	TAGALOG	VIETNAMESE	TOTAL
SR. OFFICE SUPERVISOR (C/D)	0	0	0	0	0	0	0	1	0	0	1
STAFF ASSISTANT	0	0	0	0	0	0	0	4	0	2	6
STAFF SPECIALIST	0	0	0	0	1	0	0	5	0	2	8
SUPVG COMPREHENSIVE CARE NURSE	0	0	0	0	0	0	0	0	0	1	1
Total	**7**	**1**	**11**	**1**	**20**	**3**	**4**	**367**	**1**	**63**	**478**

7-I-A-3: Total annual dedicated resources for interpreter services in addition to bilingual staff.

As mentioned in Criterion 1, BHS utilizes Language Line for interpretation (telephonic and onsite) and translation services, and Accurate Communications for American Sign Language (ASL) services. These services are budgeted based on utilization rates and estimates for each year. A contract for the agency-wide vendor, Language Line, is budgeted for up to $200,000 annually. For American Sign Language services, the budget is up to $200,000 agency-wide.

Language assistance is offered to Orange County beneficiaries of Health Care Agency Services using a myriad of resources, both County- and Contract-operated. The Tables 7.1 through 7.6 examine the interpretation and translation services utilized during FY 2022-23. During this fiscal year, the Multi-Cultural Development Program provided interpretation and translation services in-house. Language Line, the contracted vendor, also provided document translation and interpretation services. Additionally, American Sign Language (ASL) services were contracted through a vendor called Accurate Communications, Inc.

Starting in November of 2017, Language Line began providing telephonic interpretation services to several behavioral health programs across Orange County. In FY 2022-23, this program facilitated 4,785 calls, which accumulated to roughly 1,525.5 hours of telephonic interpretations (see Table 7.1). Additionally, most telephonic interpretation services provided during FY 2022-23 were in Spanish, followed by Vietnamese, Korean, Mandarin Chinese, and Arabic (see Table 7.2). In FY 2022-23, out of the 4,603 total calls, roughly 96% were made in one of those languages.

Table 7.1 Total Number of Telephonic Interpretation Services Provided by Month, FY 2022-23

Month	Number of Calls	Minutes on Call	Facilitated Hours
July-22	352	5,828	97.1
August-22	366	5,403	90.0
September-22	414	7,576	126.3
October-22	435	7,839	130.6
November-22	323	6,695	111.6
December-21	371	6,935	115.6
January-23	395	8,319	138.6
February-23	436	8,243	137.4
March-23	488	9,636	160.6
April-23	409	9,026	150.4
May-23	494	9,881	164.7
June-23	302	6,156	102.6
Total	*4,785*	*91,537*	*1,525.5*

Source: Language Line Telephone Interpretation Report, FY 2022-23

Table 7.2 Top Five Telephonic Interpretation Requests, FY 2022-23

	Number of Calls	Minutes on Call	Facilitated Hours
Spanish	3,502	63,341	1,055.7
Vietnamese	627	12,320	205.3
Mandarin	204	5,966	99.4
Korean	198	4,125	68.7
Farsi	72	1,888	31.5
Total	*4,603*	*87,640*	*1,460.6*

Source: Language Line Telephone Interpretation Report, FY 2022-23

The HCA departments that most often requested telephonic interpretation services included, MHSA Community Supportive Services (Children and Adults), Children and Youth Services, Prevention and Early Intervention, and Adult Mental Health Services (Outpatient/Crisis), (see Table 7.3).

Table 7.3 Health Care Agency Programs to Request Telephonic Interpretation Services, FY 2022-23

	Number of Calls	Minutes on Call	Facilitated Hours
Children and Youth Services	1,533	29,796	496.6
MHSA - Community Supportive Services - Children	1,465	31,216	520.3
MHSA - Prevention and Early Intervention	764	10,583	176.4
MHSA – Community Supportive Services - Adults	582	9,637	160.6
Adult Mental Health Services - Outpatient/Crisis	279	6,694	111.6
Alcohol and Drug Use Services	114	2,633	43.9
Public Guardian	40	779	12.9
Adult Mental Health Services – Inpatient/Housing	3	104	1.7
Mental Health & Recovery Services - Admin.	3	87	1.4
Total	*4,783*	*91,529*	*1,525.4*

Source: Language Line Telephone Interpretation Report, FY 22-23

Staff from the Multi-Cultural Development Program also helped to coordinate across HCA, as well as provided in-person interpretation services (see Table 7.4). In-person interpretation services were provided primarily in American Sign Language.

Table 7.4 Hours for In-Person Interpretation Services, FY 22-23

	Number of Interpretations	Facilitated Minutes	Facilitated Hours
Requested by the Multi-Cultural Development Program			
American Sign Language	84	10015	166.92
Requested by Health Care Agency Program(s)			
Vietnamese	41	5,010	83.5
Spanish	81	13,635	227.25
American Sign Language	315	39,500	658.3
Korean	28	5,550	92.5
Arabic	11	1,320	22
Mandarin	8	2,775	46.25
Farsi	5	660	11
Total			

Data was pulled from the two sources in the WET Interpretation Log and Accurate Communications Inc.

Source: WET Interpretations Database, FY 22-23 and Accurate Communications Inc. Invoices FY 22-23

**Source: MDP Log – FY 22-23*

In FY2022-23, the Multi-cultural Development Program utilized Accurate Communications Inc. for 84 ASL interpretation services which totaled 166.92 hours of service (see Table 7.5). Additionally, 308 ASL interpretation services were provided by Accurate Communications, Inc. for various program needs of the Health Care Agency totaling 650.5 hours of service (see Table 7.5).

Table 7.5 Contracted American Sign Language Services Total Number of Hours by Type of Event, FY 2022-23

	Total Number of Services	Facilitated Minutes	Facilitated Hours
Services Facilitated for the Multi-Cultural Development Program			
Meeting	50	4,600	76.67
Training	29	5,205	86.75
Other	5	210	3.5
Total	***84***	***10,015***	***166.92***
Services Facilitated for Health Care Agency Program(s)			
Behavioral Health Services	258	31,740	529
Other Services	50	7,290	121.5
Total	***308***	***39,030***	***650.5***

Source: WET Interpretations Database, FY 22-23 and Accurate Communications Inc. Invoices FY 22-23

The Multi-Cultural Development Program also helped with the creation and review of document translations (see Table 7.6). This included PowerPoint presentations, brochures, and surveys that were used across BHS. During FY 2022-23, 391 document translation requests were primarily made for Vietnamese, Arabic, Korean, Farsi, and Chinese.

Table 7.6 Document Translation Request by Threshold Language (Language Line), FY 2022-23[1]

	Total Number	Percent
Vietnamese	73	19%
Arabic	46	12%
Farsi	41	10%
Spanish	116	30%
Korean	48	12%
Other[3]	15	4%
Chinese[2]	52	13%
Total	***391***	100%

[1] All Canceled or No Reply Requests were removed from this analysis
[2] Includes Simplified Chinese/Mandarin or Traditional Chinese
[3] Other includes Khmer, Japanese and Tagalog
Source: WET Interpretations Log Database, FY 22-23

7-II: Provide Services to Persons who have Limited English Proficiency (LEP) by using Interpreter Services.

7-II-A: Evidence of policies, procedures, and practices in place for meeting clients' language needs, including the following:

- **A 24-hour phone line with statewide toll-free access that has linguistic capability, including TDD or California Relay Service, shall be available for all individuals.**

  BHS provides and maintains 24-hour Access & Referral Lines for all clients. The line links callers to behavioral health services, responds to urgent conditions, and provides beneficiary problem resolution through grievances and appeals.

  - Medi-Cal clients seeking specialty mental health (SMH) services are directed to call the 24/7 Access Line at (800) 723-8641. Clients who speak a language other than English can call (866) 308-3074; TTY services are available at 866-308-3073.

- Drug Medi-Cal clients seeking Substance Use Disorder (SUD) services are directed to call the SUD Beneficiary Access Line at (800) 723-8641. Clients who speak a language other than English can call (855) 625-4657; TTY services are available at 714-834-2332.

Access & Referral Lines are equipped, and required to, provide language services and interpretation for all individuals through bilingual staff or through one of the six (6) contracted language services providers. It is the department's policy to ensure beneficiaries have access to appropriate linguistic services and ensure beneficiaries are made aware of these services offered for both mental health and substance use disorder services. This information is located in the Beneficiary Handbooks all members receive, and information is posted at all department locations. The Mental Health Plan Beneficiary Handbook and the Drug Medi-Cal Organized Delivery System Member Handbooks are posted on the BHS Website https://www.ochealthinfo.com/providers-partners/county-partnerships/medical/mental-health-plan-and-provider-information in English, Spanish, Arabic, Farsi, Korean, Vietnamese, and large print. Additionally, these handbooks are available in an audio format as listening files in the aforementioned languages. Hard printed copies are available at all department locations. Below is a data sample of the MHP and SUD Utilization for the 24/7 Access Line from September through November 2021.

- **Consider use of new technologies such as video language conferencing. Use new technology capacity.**

The Multicultural Development Program, in conjunction with Behavioral Health Training Services, have utilized video interpretation for ASL interpreters. Additionally, interpretation rooms area available via Zoom during virtual meetings and trainings.

- **Description of protocol used for implementing language access through the county's 24-hour phone line with statewide toll-free access.**

BHS has a phone line that individuals may call to access support and services. **OC LINKS Information and Referral Hotline** (1-855-OC-LINKS/625-4657) is a 24-hour hotline for individuals to call or chat online with a clinical navigator at www.ochealthinfo.com/oclinks. This is the behavioral health line for information, referral, crisis, and assessment. OC Links navigators serve at the Crisis Assessment Team dispatch as well.

The protocol used for implementing language access through the County's 24-hour phone line with state-wide access is provided below:

- For **telephonic interpretation services** the service requester can call 1 (844) 898-7557. During this call, they should indicate the language services needed in, input a 4-digit unit number, and provide the caller's name and telephone number.
- For **on-site (in-person) interpretation services**, the service requester completes the *Onsite Interpreter Request Form* and emails it to: onsiterequests@fluentLS.com.
- For **documents translation services**, an email request can be sent to Language Line services at translation@languageline.com. A request can also be submitted through the website at: https://www.languageline.com/translation-localization-request.

- **Training for staff that may need to access the 24-hour phone line with statewide tollfree access so as to meet the client's linguistic capability.**

All BHS staff receive training on how to access the 24-hour language phone line in order to meet the client's linguistic capability and are required to learn how to use this language line provided by the County's contracted provider. All instructions and service request forms are available on HCA's intranet page.

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

Language posters are in each of the BHS clinic waiting rooms to assist consumers and family members in asking for an interpreter in their preferred language. Clients are informed in writing, in their primary language, of their rights to language at no cost.

Outlined in written materials provided to each client, it states that Orange County "is responsible to provide the people it serves with culturally and linguistically appropriate specialty mental health services." This means that all non-English or limited English-speaking persons have the right to receive services in their preferred language and can request an interpreter. If an interpreter is requested, one must be provided at no cost and people seeking services do not have to bring their own interpreters. Verbal interpretation of a client's rights, benefits, and treatments is also available in one's preferred language. Information is provided in alternative formats if someone cannot read or has "visual challenges." The written

materials are available in Orange County's six threshold languages including Spanish, Vietnamese, Farsi, Korean, Arabic and Simplified Chinese as well as English.

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

Evidence that the County accommodates individuals with LEP by providing bilingual staff or interpreter services may be found in the County's contract for interpreter services.
Also, each client receives a client handbook which outlines the rights of clients to be provided an accommodation, such as an interpreter. BHS has developed policies requiring that such assistance be provided. (Meeting Beneficiary/Client Language needs Policy 02.01.02).

7-II-C-1: Share lessons learned around providing accommodation to persons who have LEP and have needed interpreter services or who use bilingual staff.

Currently, there is no infrastructure in place for providing standardized feedback to the contract vendor. This is something we hope to look forward to exploring in order to improve services.

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

The need to have multi-lingual and multi-cultural staff available at each of the clinic sites, along with proper training for each staff member on the availability of language services and how to utilize these services.

7-II-E: Identify County technical assistance needs.

- Guidance on written/printed materials
- Shortage of in-person ASL interpreters
- Guidance on alternative formats for written information for individuals who are visually impaired

7-III: Provide Bilingual Staff and/or Interpreters for the Threshold Languages at all Points of Contact.

Note: The use of language line is viewed as acceptable provision of services only when other options are unavailable.

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

Bilingual staff and interpreter vendors are available in languages spoken by the community. Front office staff greet the client and if they notice the client does not speak English, they point to the language poster that is available and visible to the client to identify the language needed. If there is a bilingual staff who speaks the client's language, they are called upon to provide interpretation. If not, staff use the Language Line for interpretation, and this is documented in the client's file.

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

Language posters are available and posted in a visible manner for clients to reference. Staff are trained to assist clients who speak a language.

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

BHS bilingual and contracted language services vendors are available during business hours in the county's threshold languages. BHS bilingual staff proficiency is tested by the county Human Resources Department. Contract language vendors provide evidence of their staff's proficiency in threshold languages in their proposals to provide services and as requested by the county.

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

To ensure BHS bilingual staff are linguistically proficient, they must pass a verbal and written exam. This is done through the Human Resources Department. The testing

7-IV: Provide Services to all LEP Clients not Meeting the Threshold Language Criteria who Encounter the Mental Health System at all Points of Contact.

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

The following is provided as part of Policy 02.01.02: Meeting Beneficiary/Client Language Needs:

When beneficiary/client's language needs fall outside the identified threshold languages, the following steps shall be taken to link the beneficiary/client to appropriate services:

A. Staff shall refer to the BHS Staff Bilingual Directory of linguistically proficient staff interpreters to attempt to link the consumer with services in their primary language.
B. When a staff interpreter is identified, the immediate supervisor shall make every attempt to ensure staff availability to provide the requested interpreting service.
C. If there is no staff person available to act as an interpreter, staff may access a language line to determine what services the consumer needs and/or to provide services using the language line until other appropriate interpretive services are located.
D. Staff shall attempt to locate and link consumers with services that are linguistically and culturally appropriate. Linkage may be made with a community service organization providing interpretive services.
E. Staff shall not expect that family members will provide interpreter services.

    1. A beneficiary/client may choose to use a family member or friend as an interpreter after being informed of the availability of free interpreter services.

    2. Minor children should not be used as an interpreter.

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

Clients who do not met the threshold language criteria are appropriately linked to bilingual certified staff. If there is no staff available, BHS staff will utilize the

Language Line to provide appropriate language services. Table 7.1 above shows evidence of telephonic interpretation services.

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

The aforementioned criteria are addressed in multiple BHS Policies, including, but not limited to: Policy 02.01.02: Meeting Beneficiary/Client Language Needs and Policy 02.01.07: Meeting Deaf and Hard of Hearing Language Needs at Key Points of Contact.

CRITERION 8: ADAPTATION OF SERVICES

CLAS Standard: 12

8-I: Client-Driven/Operated Recovery and Wellness Programs.

8-I-A: List client-driven/operated recovery and wellness programs.

BHS has three client driven/operated recovery and wellness centers:

1. Wellness Center South – located in Lake Forest
2. Wellness Center Central – located in Orange
3. Wellness Center West – located in Garden Grove

8-I-A-1: Evidence the county has alternatives and options available within the above programs that accommodate individual preference and racially, ethnically, culturally, and linguistically diverse differences.

All of the Wellness Centers listed above accommodate for various ethnic and linguistic differences. Wellness Center West has a Vietnamese track that offers groups for that specific population. Additionally, bilingual staff offer Spanish groups as well. Wellness Center Central offers programming in Spanish, Vietnamese, Korean, Japanese and Farsi, while Wellness Center South offers programming in both Farsi and Spanish.

In addition to language, each of the Wellness Centers listed above also has programming catered to various cultural groups that include Older Adults, TAY population, various spiritual groups, and LGBTQ+ community.

8-I-A-2: Briefly describe, from the list in 'A' above, those client-driven/operated programs that are racially, ethnically, culturally, and linguistically specific.

Each of the Wellness Centers provides a wide range of groups and classes, several of which are racially, ethnically, culturally, and linguistically specific. Some examples of these groups are:

- LGBTQ+ Share & Care Support Group – provides an open-minded, helpful, safe, and kind environment and atmosphere for LGBTQ+ community to discuss their successes and concerns exclusive of outside influence.
- Tai Chi Group – provides space to learn and practice of this Eastern exercise, using breath and slow movement to build energy to bring about a state of mental calm and clarity.

- Group de Apoyo Support Group – for Spanish speaking members and young adults aged 18-26 to discuss hope and plan for the future.
- Vietnamese Depression Bipolar Support Alliance (DBSA) Support Group – for Vietnamese members with mood disorders to obtain helpful, positive feedback from the group within the context of Vietnamese culture.
- West African Drumming Group – teaches the history of drums from West African regions while practicing rhythms that have specific meanings; drums are authentic, imported from West African countries.

8-II: Responsiveness of Mental Health Services

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

The BHS website includes a link to the Online Provider Directory for both MHP and DMC-ODS. The Medi-Cal Provider Directory is listed on the website and is available electronically as well as in hard copy to beneficiaries. This is available in all threshold languages, in both regular and large print.

Beneficiary Informing Materials

English

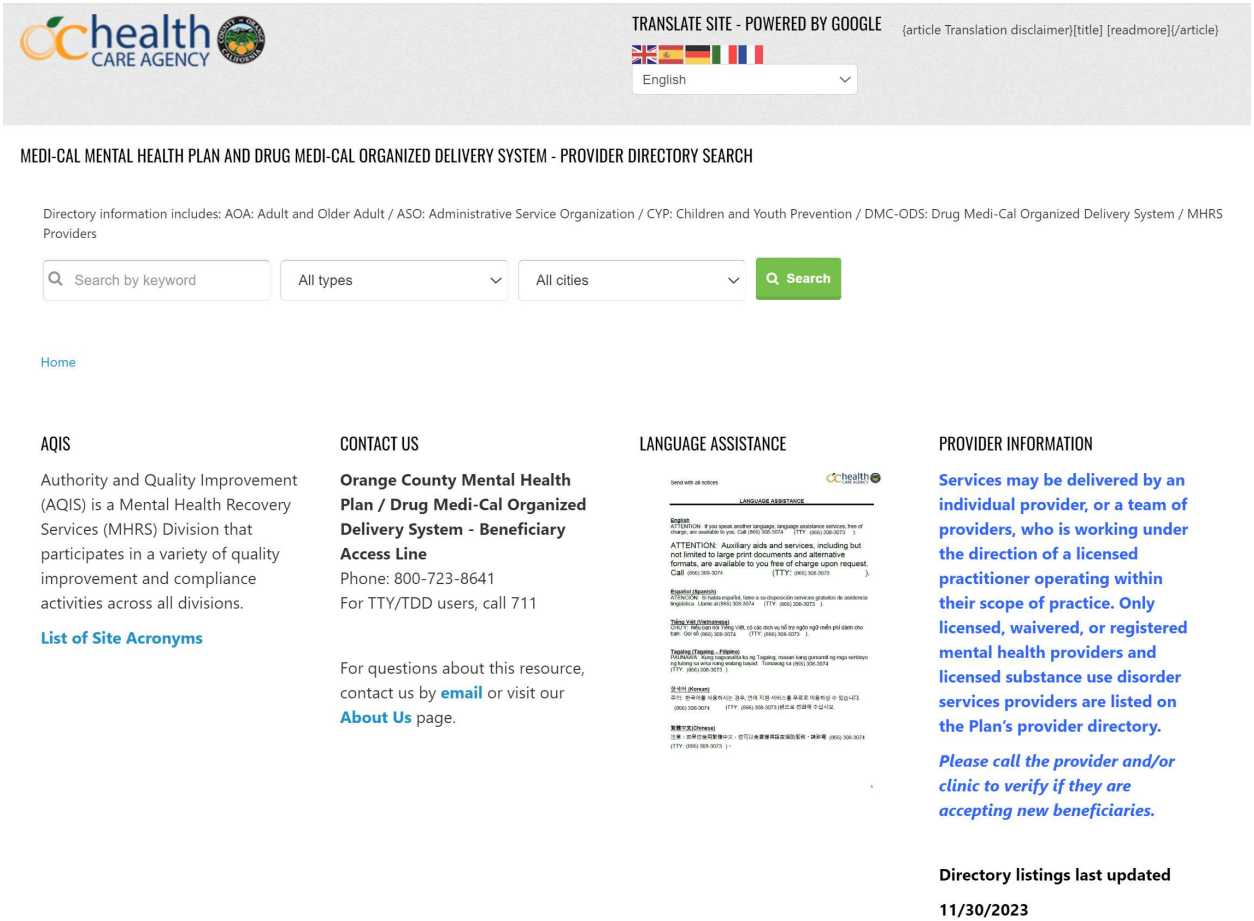
DMC-ODS Beneficiary Handbook

- **Arabic** - **Regular Print** / **Large Print** *NEW 2024 edition*
- **English** - **Regular Print** / **Large Print** *NEW 2024 edition*
- **Español - Manual del Derechohabiente de DMC-ODS** - **Regular Print** / **Large Print** *NEW 2024 edition*
- **Farsi** - **Regular Print** / **Large Print** *NEW 2024 edition*
- **Korean** - **Regular Print** / **Large Print** *NEW 2024 edition*
- **Chinese (Simplified)** - **Regular Print** / **Large Print** *NEW 2024 edition*
- **Vietnamese** - **Regular Print** / **Large Print** *NEW 2024 edition*

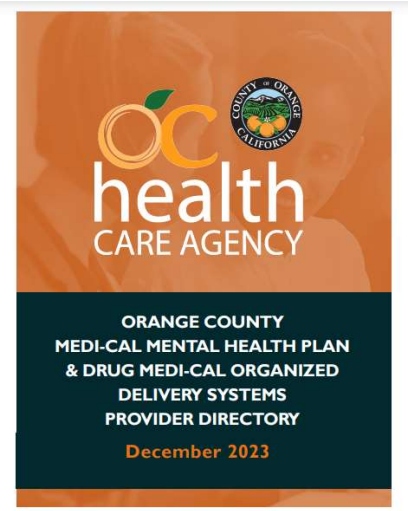
Audio Format (use Windows Media Player)

- **Arabic** *NEW 2024 edition*
- **Chinese** *NEW 2024 edition*
- **English** *NEW 2024 edition*
- **Farsi** *NEW 2024 edition*
- **Korean** *NEW 2024 edition*
- **Spanish** *NEW 2024 edition*
- **Vietnamese** *NEW 2024 edition*

Hyperlink to the Online Provider Directory: www.ochealthcareagency.com/mhp-dmcods



Provider Directory:



MHP: https://www.ochealthcareagency.com/mhp/

DMC-ODS: https://www.ochealthinfo.com/providers-partners/authority-quality-improvement-services-division-aqis/quality-assurance-18

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

The Member Services Brochure and Provider Directories contain information on the availability and location of all providers. A link to these materials is available on the website, which is posted in each of the lobbies in all threshold languages.

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

BHS publishes and maintains the Medi-Cal Beneficiary Handbook for both specialty mental health services as well as services under the Drug Medi-Cal Organized Delivery System (DMC-ODS). These handbooks include information on the scope and nature of services provided, as well as information on how to access these services.

- Policy 01.03.06 (Access Criteria for Specialty Mental Health Services)
- Policy 01.03.07 (Access Criteria for Drug-Medi-Cal Organized Delivery System)

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

- Location, transportation, hours of operation, or other relevant areas; Cultural Competency Plan Update Fiscal Year 2022-2023.

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

- Locating facilities in settings that are non-threatening and reduce stigma, including co-location of services and /or partnerships, such as primary care and in community settings. (The county may include evidence of a study or analysis of the above factors, or evidence that the county program is adjusted based upon the findings of their study or analysis.)

Transportation:

- The Transportation program serves adults ages 18 and older, who have a serious mental illness or substance use disorder, and who need transportation assistance to and from necessary County behavioral health or primary care appointments or select supportive services (particularly housing-related). Individuals are referred by their BHS treatment provider, following an assessment of their transportation needs and history of scheduled appointments missed due to transportation issues.

- Transportation services are offered Monday through Friday for most behavioral health programs, and seven days per week for the County's CSU's and Royale Therapeutic Residential Center. Individuals are provided curb-to-curb service or door-to-door service if they are living with physical disabilities that may require additional assistance entering or exiting the vehicles. All that is required for the person to do is schedule the appointment in advance and a driver will pick them up at their specified location, take them to their appointment, pick them up after the appointment and take them back to their destination of origin. Individuals can also stop and get their prescriptions filled as necessary. Transportation services have also been authorized for use by both CSS and PEI field outreach teams for a one-time use to link participants served in the field to their initial behavioral health appointments. In addition, Transportation services are also used to link participants being discharged from the County and County-contracted Crisis Stabilization Units or Royale Therapeutic Residential Center to their follow-up appointments at either of the County's Open Access clinics. CSU's and RTRC, staff make the transportation arrangements on behalf of clients, and those clients will be assessed at their permanent clinical homes for future authorization for the use of Transportation Services and the ability to make their own arrangements.

Test Calls:

- Policy 06.02.01 (Test Call Procedure for Monitoring Administrative Service Organization (ASO) Access Quality and Compliance. BHS monitors the Beneficiary Access Line (BAL) and their compliance with their regulations and quality of the services they provide. Test calls are conducted quarterly and assess the following areas:

  - Responsiveness of the Access Line 24-hours a day, seven days a week;
  - Access to afterhours care;
  - Knowledge and helpfulness of the access line staff; and
  - Recording of the call on the Telephone Access Log. Calls made in threshold languages are to test response capability to non-English languages.

Family Resource Centers

Orange County has 16 Family Resource Centers (FRCs) located throughout the county. These FRC's are an example of non-threatening settings that reduce stigma and offer a variety of prevention and early intervention services supporting the health and wellness of individuals and families. FRC locations within local communities allows services to be tailored to the specific needs and cultural requirements of individualized communities. Every FRC provides six core services: (1) parenting classes, (2) counseling, (3) information and referral, (4) family support services, (5) case management, and (6) domestic violence personal empowerment program.

8-III: Quality of Care: Contract Providers

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

Orange County's commitment to ensure that services are culturally competent is also documented in provisions that have been incorporated into BHS provider contracts. Below is standard language in all BHS contracts under Compliance Sections:

CONTRACTOR shall comply with the provisions of the ADMINISTRATOR's Cultural Competency Plan submitted and approved by the state. ADMINISTRATOR shall

update the Cultural Competency Plan and submit the updates to the State for review and approve annually. (CCR, Title 9, §1810.410.subds. (c)-(d)).

Failure to comply with the obligations stated in this Compliance Paragraph shall constitute a breach of the Agreement on the part of CONTRACTOR and grounds for COUNTY to terminate the Agreement. Unless the circumstances require a sooner period of cure, CONTRACTOR shall have thirty (30) calendar days from the date of the written notice of default to cure any defaults grounded on this Compliance Paragraph prior to ADMINISTRATOR's right to terminate this Agreement on the basis of such default.

In addition, "CONTRACTOR shall provide services pursuant to this Agreement in a manner that is culturally and linguistically appropriate for the population(s) served. CONTRACTOR shall maintain documentation of such efforts which may include, but not be limited to, records of participation in COUNTY-sponsored or other applicable training; recruitment and hiring policies and procedures; copies of literature in multiple languages and formats, as appropriate; and descriptions of measures taken to enhance accessibility for, and sensitivity to, persons who are physically challenged."

Below are some samples of contracts from BHS service areas:

- The contract for Mental Health Services Act (MHSA) Community Services and Supports (CSS) -funded Wellness Center provides that the contractor shall provide a program that is "culturally and linguistically appropriate." The contract also states that, "The philosophy of the Wellness Center shall draw upon cultural strengths and utilize service delivery and assistance in a manner that is trusted by, and familiar to, many of Orange County's ethnically and culturally diverse populations. Cultural competence shall be a continuous focus in the develop0/28ment of the programming, recruitment, and hiring of staff that speak the same language and have the same cultural background of the members that are to be served. This inclusion of Orange County's multiple cultures is assisting in maximizing access to services offered at the Wellness Center. The Orange County Health Care Agency (HCA) has provided training for all staff on cultural and linguistic issues."
- The contract for Transitional Age Youth (TAY) Crisis Residential Services includes the requirement that, "CONTRACTOR shall include bilingual/bicultural services to meet the needs of persons speaking in threshold

languages as determined by COUNTY. Whenever possible, bilingual/bicultural therapists should be retained. Any clinical vacancies occurring at a time when bilingual and bicultural composition of the clinical staffing does not meet the above requirement must be filled with bilingual and bicultural staff unless ADMINISTRATOR consents, in writing, to the filling of those positions with non-bilingual staff."

- For the Prevention and Early Intervention (P&I) contracts, language capability is a condition of employment and a specific program need to meet program goals. Specific contract language is used such as, "Contractor shall make every reasonable effort to accommodate participants' developmental, cultural and linguistic needs," which is needed to effectively serve the target populations, i.e., the unserved and underserved. In the staffing section of P&I contracts, additional language is used, such as, "Contractor shall make its best effort to include bilingual/bicultural services to meet the diverse needs of the community threshold languages as determined by County. Whenever possible, bilingual/bicultural staff should be retained. Any staffing vacancies occurring at a time when bilingual and bicultural composition of the staffing does not meet the above requirement must be filled with bilingual and bicultural staff unless Administrator consents."

8-IV: Quality Assurance Requirement

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

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

Quality Management Services (QMS) is a BHS function area that supports programming in the other two BHS function areas: Adult and Older Adult Behavioral Health (AOABH) and Children, Youth and Prevention Behavioral Health (CYPBH) Services. It supports BHS' two managed care programs, the Mental Health Plan (MHP) and the Drug Medi-Cal Organized Delivery System (DMC-ODS) as well as their other mental health and Substance Use Disorder (SUD) programming.

Outcome measures vary by the type of program and their specific goals. Clients are assessed on a variety of domains (e.g., recovery, social support, life functioning) depending on the type of services received. When selecting outcome measures, we aim for measures that are psychometrically sound and validated with diverse populations. Outcome measures are translated in all threshold languages and information on race/ethnicity, age, gender, language spoken, and other detailed demographics are collected. This allows for outcome measures to be broken out for diverse groups, when needed to assess for differences.

The Consumer Perception Surveys are offered to all mental health plan clients who obtain services during one-week periods in November and in May. Clients in Adult Services receive the Mental Health Statistics Improvement Program (MHSIP). Clients in Children and Youth Services who are age 12 or older receive the Youth Services Survey (YSS). Parents and guardians of clients in Children and Youth Services receive the Youth Services Survey for Families (YSS-F). These instruments include validated scales that measure the following:

1. Service Satisfaction
2. Accessibility of services
3. Service quality/cultural appropriateness
4. Participation in treatment planning
5. General satisfaction
6. Service Outcomes
7. Perception of outcomes
8. Functioning
9. Social connectedness

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

While the Workplace Wellness Advocacy Program sends out a survey measuring recovery orientation in various worksites – this survey is completed by the identified Workplace Wellness Advocate(s) after speaking to staff and supervisors/managers. In the upcoming year, the Office of Equity will collaborate with WWA to include cultural diversity in its workforce and measure the perception of staff towards culturally and linguistically competent services at their specified sites.

Additionally, monthly townhall meetings are held with the Chief of BHS and serves as an opportunity to provide feedback to leadership.

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

The beneficiary problem resolution process for grievance and complaint/issues are as follows: In this section we describe our beneficiary problem resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve Grievance and Appeals.

The beneficiary has several ways to file a grievance:

- Use a Grievance/Appeal Form and self-addressed envelope available to the beneficiary at the various County and County-Contracted outpatient behavioral health programs.
- Call (866) 308-3074 or TDD (866) 308-3073 and speak with a person who will accept and submit your grievance.
- Tell the treatment provider (either the staff or the facility's representative) that you would like to submit a grievance on your behalf, and they will complete a Grievance/Appeal form with the beneficiary and submitted for them.

An appeal is available only to a Medi-Cal beneficiary, some services need to be pre-authorized by the health plan before the beneficiary can receive them. When the behavioral health provider thinks the beneficiary will need ongoing services, but the health plan denies, reduces, delays or terminates any of your pre-authorized services, the beneficiary may request a review of this action. This process is called an appeal. If the beneficiary is denied services because the health plan determines the services are not medically necessary, the beneficiary may request a review of this action. This process is also called an appeal. There are three ways to file an appeal, as mentioned above. The beneficiary may request an expedited appeal, which must be decided within 72 hours, if the beneficiary believe that a delay would cause serious problems with their behavioral health including problems with the ability to gain, maintain or regain important life functions.

The grievance/appeal forms are in the County's threshold languages - Chinese, Korean, Vietnamese, English, Spanish, Farsi, Arabic and can be readily accessible at the county/county-contracted outpatient behavioral health program lobby and via County website - BHS Medi-Cal Provider Information | Orange County, California - Health Care Agency (ochealthinfo.com)

Quality Management Services (QMS) has a team of competent clinical staff under the Managed Care Support Team (MCST) who have the cultural and linguistic capability of investigating grievance via English and Spanish. Within QMS, MCST can utilize staff to provide translation and interpreter services in Chinese, Korean, Vietnamese and Farsi. Arabic, American Sign Language and other language services are available, and assistance can be found using the County Employee Directory to locate an available interpreter and/or translations services. The County also has the Language-Access Phone Line for interpreter services that is available at any time. In addition, the County also utilizes contracted entities to provide translation services for the publication of materials (i.e., brochures, posters, etc.) when in-house resources are not readily available as well.

The County recently contracted services to Mental Health Systems, TURN Behavioral Health Services to provide Patients' Rights Advocacy Services (PRAS) as of July 2020. The MCST has oversight of the advocates who conduct investigations for grievances/appeals using the County grievance/appeal forms. This program has patients' rights postings, grievance/appeals form and other materials in the threshold languages and are made available to the beneficiaries at the various locations listed below:

- County and County-Contracted Outpatient Behavioral Health Clinics
- County and County-Contracted Behavioral Health Residential Facilities
- County Correctional Behavioral Health Services
- Inpatient Behavioral Health Facilities

Their materials are also online and available at Orange County Patients' Rights Advocacy Services - MHS/TURN (turnbhs.org).

Once the investigator/advocate is assigned to the grievance/appeal, they have 90 days to investigate and come up with a resolution letter. The investigation entails:

- Interviewing the beneficiary to collect information about their dissatisfaction
- Reviewing the beneficiary chart records
- Interviewing the providers (i.e., clinician, Service Chief, Program Director) for detailed information related to the beneficiary's dissatisfaction
- An objective analysis to mediate and determine a resolution

Any grievance/appeal received in a written language (other than English) will be translated into the language that the beneficiary wrote in.

Grievance Process and CLAS

The QMS investigators is made up of culturally diverse and qualified clinicians and counselors that are educated and trained in cultural competency via their graduate education and requirements from their board-certified organization (i.e., Board of Behavioral Sciences). The County requires all employees to complete an annual Cultural Competency training offered by the BHTS. In addition, the BHTS offers a wide variety of optional cultural competency trainings throughout the year that are specific to racial, ethnic and cultural backgrounds. Including trainings on how to work with an interpreter and conflict resolution. The staff may also seek these types of trainings outside of BHTS for enrichment and continued education.

The PRAS advocates attend an annual statewide patients' rights 3-day conference hosted by the California Office of Patients' Rights. The conference entails a wide variety of workshops that train advocates on the distinct components of patients' rights, conflict resolution and how to conduct proper and detailed investigations including the various types of patients' rights trainings that can be offered to providers and patients. As part of their County-contractual requirement, PRAS is required to provide annual trainings to all providers and patients at the various programs/facilities that serve the behavioral health population about their rights. BHTS also offers cultural competency trainings and interpreter trainings that are made available to the advocates as well.

The PRAS provides notice in signage, translated materials, and other media about their mental health rights, including the right to file a complaint or grievance.

QMS and PRAS have ensured that all notice in signage, contact numbers, translated materials and other media mediums are available for individuals to provide feedback about the rights and the right to file a grievance/appeal is made available county-wide. The materials are accessible via the County and PRAS website. Paper grievance/appeal forms, brochures and posters are accessible and available at the County and County-Contracted Outpatient Behavioral Health clinics, inpatient, correctional and residential behavioral health facilities.

The MCST and PRAS are in frequent contact with the beneficiaries throughout the investigation process and provides new updates to the beneficiary during the grievance/appeals process. Also, a final resolution letter is given to the beneficiaries generally describing the steps taken to finalize the conclusion of the grievance/appeal. If conflict arises when attempting to resolve a grievance/appeal at the lowest level, then it can be escalated to the County program managers for

further assistance to ensure the grievance/appeal is resolved to the beneficiary's satisfaction. The cultural and linguistic appropriateness is maintained throughout the grievance/appeal process.

The MCST program provides consultation and education to the programs daily and trains on a regular basis about the grievance requirement and process. The MCST also educates the individual beneficiaries who filed a grievance/appeal about their rights and the grievance requirements and process. MCST also obtains feedback, suggestions and comments from California Department of Health Care Services (CDHCS) and other auditing entities. MCST is also receptive with obtaining feedback, suggestions and comments from behavioral health programs/facilities and beneficiaries to help improve the grievance/appeal system.

The PRAS also provides education, consultation, trainings, system advocacy and community outreach that includes obtaining feedback, suggestions and comments. Their services entails:

- **Provide Trainings:** Patients' Rights Advocates provide trainings and in-services on patient/resident rights to patients in inpatient psychiatric units; outpatient mental health services, residents in Board and Care facilities, correctional facilities and the mental health community. Advocates are also certified to provide CEUs for mental health professionals and Board and Care Administrators.
- **System Advocacy:** Patients' Rights Advocates monitor mental health facilities for compliance with patients' rights laws. The advocates review and comment on policies and practices that impact recipients of mental health services. They coordinate with other advocates for system reform and analyze state and federal legislation, along with regulatory developments.
- **Community Outreach:** Patients' Rights Advocates provide education and reach out to mental health patients to improve their ability to advocate for themselves and represent patients' interest in public forums (e.g., town-hall meetings, Mental Health Board, Residential Community Meetings, etc.).
- Hire patient advocates or ombudspersons (QSource, 2005).

The County contracted services with Mental Health Systems TURN Behavioral Health Services to provide Patients' Rights Advocacy Services as of July 2020. It was created in response to California legislation requiring each county mental health director to appoint patient rights advocates to protect and further the Constitutional and statutory rights of people receiving mental health services. The

MCST has oversight of the advocates who conduct investigations on grievances/appeals specific to the inpatient behavioral health setting. PRAS has a contractual agreement to educate, train, investigate and advocate for patients in the locations listed above. The materials they provide are readily available in the various setting mentioned above and are available online at Orange County Patients' Rights Advocacy Services - MHS/TURN (turnbhs.org).

QMS has a team of competent clinical staff under the Managed Care Support Team (MCST) who have the cultural and linguistic capability of investigating grievance via English and Spanish. Within QMS, MCST can utilize staff to provide translation and interpreter services in Chinese, Korean, Vietnamese and Farsi. Arabic, American Sign Language and other language services are available, and assistance can be found using the County Employee Directory to locate an available interpreter and/or translations services. The County also has the Language-Access Phone Line for interpreter services that is available at any time. In addition, the County also utilizes contracted entities to provide translation services for the publication of materials (i.e., brochures, posters, etc.) when in-house resources are not readily available as well.

If conflict arises when attempting to resolve a grievance/appeal at the lowest level, then it can be escalated to the County program managers for further assistance to ensure the grievance/appeal is resolved to the beneficiary's satisfaction. The cultural and linguistic appropriateness is maintained throughout the grievance/appeal process.

The MCST also conducts a quarterly review to identify specific and multiple complaints about a provider to initiate a Corrective Action Plan (CAP). The purpose of the CAP is to address the specific and multiple concerns brought up by the beneficiaries during this process, including ensuring improvement in the ability to provide quality of care and services. In the event a particular provider continues to receive grievances related to the services and interactions with the beneficiaries, a formal corrective action is implemented to escalate the concerns. This has resulted in some providers being terminated or reported to Human Resources for further disciplinary actions. This process helps maintain the overall quality assurance for the programs that the County oversees.

APPENDIX I: POLICIES AND PROCEDURES GOVERNING CULTURAL COMPETENCE

Policy 02.01.01 - Cultural Competency

Health Care Agency **Mental Health and** **Recovery Services** **Policies and Procedures**	Section Name: Sub Section: Section Number: Policy Status:	Client's Rights Cultural Competency 02.01.01 ☐New ☒Revised

	SIGNATURE	DATE APPROVED
Director of Operations Mental Health and Recovery Services	Signature on File	2/14/2023

SUBJECT: Cultural Competency

PURPOSE:

The purpose of this policy is to set standards and expectations for the provision of culturally competent service delivery.

POLICY:

All of Mental Health and Recovery Services (MHRS) County and County Contracted providers shall be culturally competent.

SCOPE:

This policy applies to all functions of MHRS providing Mental Health Services and/or Substance Use Services.

REFERENCES:

Department of Mental Health Information Notice 02-03: Addendum for Implementation Plan for Phase II Consolidation of Medi-Cal Specialty Mental Health Services - Cultural Competence Plan Requirements

County of Orange Health Care Agency, Mental Health and Recovery Services, Cultural Competency Plan Updated, 2022

California Code of Regulations, Title IX, Chapter 11

Code of Federal Regulations (CFR), Title 42, Section 438.206 (c) 2

National Culturally and Linguistically Appropriate Services (CLAS) Standards (2013)

Page 1 of 2

PROCEDURES:

I. Each program will follow the guidelines for cultural competency as agreed in the State's approved Cultural Competency Plan.

II. Consultation regarding said guidelines shall be obtained as needed from the Multicultural Development Program.

III. All MHRS County and County Contracted staff shall complete an annual cultural competence training. This training will include gender identity as a component of culturally appropriate care.

IV. The Behavioral Health Training Services (BHTS) unit shall indicate on all training announcements and certificates if the particular training qualifies to meet the requirement for cultural competence training.

V. The Service Chief/Supervisor of each MHRS staff person shall be responsible to ensure that the mandatory annual cultural competence training occurs and shall keep evidence of the training for each staff person.

VI. Contract organizations are expected to ensure that all staff have, at a minimum, one hour of training in and related to cultural competence annually. Contract organizations shall keep documentation of this training and report completion of such training by all direct service providers, administration, and support staff to the Contract Monitor/Consultant.

VII. The BHTS unit shall report annually to the Community Quality Improvement Committee on the attendance at cultural competence trainings. The reporting shall include the reporting requirements of DHCS Information Notice 10-17, or any subsequent DHCS requirements that may supersede Information Notice 10-17.

Policy 02.01.02 - Meeting Beneficiary/Client Language Needs

Health Care Agency	Section Name:	Client's Rights	
Mental Health and	Sub Section:	Cultural Competency	
Recovery Services	Section Number:	02.01.02	
Policies and Procedures	Policy Status:	☐New ☒Revised	

	SIGNATURE	DATE APPROVED
Director of Operations Mental Health and Recovery Services	_Signature on File_	___2/14/2023___

SUBJECT: Meeting Beneficiary/Client Language Needs

PURPOSE:

To ensure that beneficiaries/clients have access to linguistically appropriate services through staff or interpreters proficient in the beneficiary/client's primary language.

POLICY:

All Mental Health and Recovery Services (MHRS) beneficiary/clients shall have access to linguistically appropriate services.

SCOPE:

These procedures apply to all MHRS County and County contracted programs involved in the linkage and treatment of consumers receiving services.

REFERENCES:

California Code of Regulations (CCR), Title 9, Chapter 11, Section 1810.410

Department of Mental Health Information Notice No. 02-03

County of Orange, Health Care Agency, BHS, Cultural Competency Plan, Criterion 7 - Language Capacity (Update 12/30/10)

Dymally-Alatorre Bilingual Services Act 1973

PROCEDURE:

I. Signage shall be posted at each MHRS County and County Contracted clinic notifying Limited English Proficient (LEP) consumers that they have the right to receive free language assistance services.

II. Each MHRS clinic will have available a MHRS Staff Bilingual Directory of Linguistically proficient staff/interpreters throughout MHRS. This MHRS Staff Bilingual

Directory shall be updated at least every two years. The Multicultural Development Program may be contacted for the updated MHRS Staff Bilingual Directory.

III. Each MHRS County and County Contracted clinic shall have access to a Language Line or other identified interpretative service.

IV. Access logs shall indicate whether an interpreter was needed and the response by the consumer to offers of interpretive services.

V. When beneficiary/client's language needs fall outside the identified threshold languages, the following steps shall be taken to link the beneficiary/client to appropriate services:

A. Staff shall refer to the MHRS Staff Bilingual Directory of linguistically proficient staff interpreters to attempt to link the consumer with services in their primary language

B. When a staff interpreter is identified, the immediate supervisor shall make every attempt to ensure staff availability to provide the requested interpreting service.

C. If there is no staff person available to act as an interpreter, staff may access a language line to determine what services the consumer needs and/or to provide services using the language line until other appropriate interpretive services are located.

D. Staff shall attempt to locate and link consumers with services that are linguistically and culturally appropriate. Linkage may be made with a community service organization providing interpretive services.

E. Staff shall not expect that family members will provide interpreter services.

1. A beneficiary/client may choose to use a family member or friend as an interpreter after being informed of the availability of free interpreter services.

2. Minor children should not be used as an interpreter.

VI. In order to facilitate Cultural/Linguistic Proficiency and access, MHRS will:

A. At least every other year, all MHRS County and County Contracted clinicians, student interns, and volunteers shall be surveyed to determine proficiency in a variety of cultural/linguistic skills that they are able to make available at each clinic. Cultural proficiencies will be self-declared.

B. Program Managers shall be informed in advance of the survey distribution. The Service Chiefs/Program Directors for each clinic site shall be responsible for ensuring the survey of all clinicians under their supervision.

C. The Service Chiefs/Program Directors shall ensure all completed surveys are forwarded to the Multicultural Development Program within the established timeframe.

D. The Multicultural Development Program shall approve the MHRS Staff Bilingual Directory using only those staff with cultural/linguistic proficiencies that are supported by current survey documentation.

Policy 02.01.03 - Distribution of Translated Materials

Health Care Agency	Section Name:	Client's Rights
Mental Health and	Sub Section:	Cultural Competency
Recovery Services	Section Number:	02.01.03
Policies and Procedures	Policy Status:	☐New ☒Revised

	SIGNATURE	DATE APPROVED
Director of Operations Mental Health and Recovery Services	Signature on File	2/14/2023

SUBJECT: Distribution of Translated Materials

PURPOSE:

To ensure availability of culturally and linguistically appropriate written information in the identified threshold languages to assist consumers in accessing Specialty Mental Health Services (SMHS) in the Mental Health Plan (MHP).

POLICY:

Mental Health and Recovery Services (MHRS) is committed to providing beneficiaries/clients with culturally/linguistically appropriate written materials in all threshold languages or in alternate formats.

SCOPE:

These procedures apply to all MHRS County operated and County Contracted programs within the Mental Health Plan (MHP) involved in the linkage and direct provision of SMHS to beneficiaries/clients.

REFERENCES:

California Code of Regulations, Title IX, Chapter 11, Section 1810.410 (a)

Department of Mental Health Information Notice No. 97-14, Page 14

County of Orange, Health Care Agency, BHS, Cultural Competency Plan, Update, 2022.

FORMS:

Mental Health Plan Consumer Handbooks

Grievance and Appeal Process Pamphlets, F346-656 (06/16) DTP58

Grievance and Appeal Process Posters, F346-675 (06/16) DTP64

Mental Health Plan Provider List

PROCEDURES:

I. The Service Chief/Program Director of each County operated or County Contracted program providing SMHS for the MHP is responsible for maintaining adequate numbers of these materials at their programs and for ensuring that the materials are posted and made readily available to beneficiaries/clients.

II. Grievance and Appeal posters in each threshold language shall be prominently displayed in an area accessible to all consumers at each location.

III. Mental Health Plan Consumer Handbooks in the appropriate threshold languages shall be offered to consumers during the initial intake to each clinic, or upon request. These Consumer Handbooks shall be available in an area accessible to all beneficiaries/clients at each location.

IV. Mental Health Plan Provider Directory in the appropriate threshold language shall be offered to beneficiaries/clients during the initial intake to each clinic or upon request.

Policy 02.01.04 - MHP and DMC-ODS Provider Directory

Health Care Agency **Mental Health and** **Recovery Services** **Policies and Procedures**	Section Name: Sub Section: Section Number: Policy Status:	Client's Rights Cultural Competency 02.01.04 ☐New ☒Revised

	SIGNATURE	DATE APPROVED
Director of Operations Mental Health and Recovery Services	_Signature on File__	_2/14/2023___

SUBJECT: MHP and DMC-ODS Provider Directory

PURPOSE:

To ensure that Medi-Cal Mental Health Plan (hereby referred to as Orange MHP) and Drug Medi-Cal Organized Delivery System (DMC-ODS) beneficiaries receive and or have access to a Provider Directory that includes alternatives and options for cultural / linguistic services.

POLICY:

All beneficiaries receiving behavioral health services from the County of Orange Health Care Agency (HCA) Mental Health and Recovery Services (MHRS) will receive and/or have access to a copy of the appropriate Provider Directory.

SCOPE:

This policy pertains to all MHRS Orange MHP and DMC-ODS County and County contracted clinicians, Plan Coordinators, student interns and volunteers providing services within the Orange MHP and DMC-ODS programs.

REFERENCES:

MHSUDS Information Notice: 18-020 Federal Provider Directory Requirements for Mental Health Plans (MHPs) and Drug Medi-Cal Organized Delivery System (DMC-ODS) Pilot Counties

Department of Mental Health Information Notice No: 02-03 - Addendum for Implementation Plan for Phase II Consolidation of Medi-Cal Specialty Mental Health Services Cultural Competency Plan Requirements

County of Orange Health Care Agency, Behavioral Health Services, Cultural Competency Plan Update 2022

Mental Health Plan Intake/Advisement Checklist (F346-753)

Drug Medi-Cal Organized Delivery System (DMC-ODS) Intake/Advisement Checklist (F346-791)

PROCEDURES:

I. Provider Directory Requirements

A. The Orange MHP and DMC-ODS Provider Directory shall be made available in electronic form and paper form upon request.

B. Both the Orange MHP and DMC-ODS Provider Directories are available in the threshold languages and comply with the language and format requirements outlined in 42 CFR §438.10(d).

1. Information is presented in a manner and format that is easily understood and readily accessible;

2. Include taglines in the prevalent non-English languages in the State explaining the availability of free written translation or oral interpretation services to understand the information provided;

3. Use 12 point or larger font size for all text;

4. Include a large print tagline (18 point font or larger) and information on how to request auxiliary aids and services, including the provision of materials in alternative formats, at no cost to the beneficiary; and,

5. Include the toll-free and TTY / TDY or California Relay Service telephone number for the Orange MHP and DMC-ODS customer service unit (i.e., 24 hours, 7 days per week toll-free telephone number).

C. The Orange MHP and DMC-ODS Provider Directory is monitored monthly for accuracy and includes the following information for licensed, waivered, or registered mental health providers and licensed substance use disorder services providers employed by the Orange MHP and DMC-ODS or County Contracted providers who provide Medi-Cal services.

D. Orange MHP and DMC-ODS Provider Directories includes:

1. The provider's name and group affiliation, if any;

2. Provider's business address (e.g., physical location of the clinic or office);

3. Telephone number(s);

4. Email address, as appropriate;

5. Website URL, as appropriate;

6. Specialty, in terms of training, experience and specialization, including board certification (if any);

7. Services / modalities provided, including information about populations served (i.e., perinatal, children/youth, adults);

8. Tagline statement regarding needing to contact the provider to verify if they are accepting new beneficiaries.

9. The provider's cultural capabilities (e.g., veterans, older adults, Transition Age Youth, Lesbian, Gay, Bisexual, Transgender);

10. The provider's linguistic capabilities including languages offered (e.g., Spanish, Tagalog, American Sign Language) by the provider or a skilled medical interpreter at the provider's office; and,

11. Whether the provider's office / facility is Americans with Disabilities Act (ADA) compliant.

E. In addition to the information listed above, the Provider Directory also includes the following information for each rendering provider:

1. Type of practitioner, as appropriate;

2. National Provider Identifier number;

3. California license number and type of license; and,

4. An indication of whether the provider has completed cultural competence training.

F. The following notation is included in both the Orange MHP and DMC-ODS Provider Directory:

> "Services may be delivered by an individual provider, or a team of providers, who is working under the direction of a licensed practitioner operating within their scope of practice. Only licensed, waivered, or registered mental health providers and licensed substance use disorder services providers are listed on the Plan's provider directory."

II. The staff shall give the appropriate version of the Provider Directory to all beneficiaries at the time of admission and shall be made available upon request to any beneficiary or their active representative. The Provider Directory shall be available in all threshold languages as well as in paper form and electronically via the Orange County internet webpage.

III. The person to whom the request for a Provider Directory is made shall be responsible to ensure the beneficiary, family member or significant others receives the appropriate Provider Directory.

IV. For every newly admitted beneficiary, the admitting staff shall document the provision or offer of the appropriate Provider Directory on the appropriate Intake/Advisement Checklist.

Policy 02.01.05 - Field Testing of Written Materials

Health Care Agency **Behavioral Health Services** **Policies and Procedures**	Section Name: Sub Section: Section Number: Policy Status:	Client's Rights Cultural Competency 02.01.05 ☐New ☒Revised

	SIGNATURE	DATE APPROVED
Director of Operations Behavioral Health Services	Signature on File	9/21/16

SUBJECT: Field Testing of Written Materials

PURPOSE:

To ensure written materials for Behavioral Health Services (BHS) Mental Health Plan (MHP) have been field tested by consumers, family members or significant others to ensure comprehension.

POLICY:

Written materials provided to consumers, family members or significant others of the BHS MHP shall be field tested in the threshold languages to ensure comprehension.

Written materials include, but are not limited to:

- MHP Consumer Handbook
- MHP Provider List
- General Correspondence
- Beneficiary grievance and fair hearing materials
- Confidentiality and release of private health information
- MHP orientation materials
- SMHS education materials

SCOPE:

All County and County Contracted clinics providing Specialty Mental Health Services (SMHS) through BHS MHP.

REFERENCES:

State Department of Mental Health - Approved Cultural Competency Plan, 2010

SUBJECT: Field Testing of Written Materials

Department of Mental Health Information Notice No: 02-03 - Addendum for Implementation Plan for Phase II Consolidation of Medi-Cal Specialty Mental health Services- Cultural Competency Plan Requirements

County of Orange, health Care Agency, BHS Cultural Competency Plan, Update, 2010

California Welfare and Institutions Code, Division 9, Part 3, Chapter 8.8, Article 5, 14684

FORMS:

Publication Field Test Feedback Sheet

PROCEDURE:

I. Each BHS Program is responsible for notifying the Multicultural Development Program (MDP) when new or altered forms and/or documents need translation.

II. MDP translates the forms or send to a contractor for translation into threshold languages.

III. Upon translation of forms, the MDP will, when available, have the document reviewed for accuracy of translation.

IV. Upon completion of translation, the MDP shall field test the document.

V. MDP staff shall coordinate obtaining assistance from consumers, family members, or significant others. Each shall participate in field testing the written material and compete a brief questionnaire documenting their ability to understand the written material.

VI. After feedback has been received, the MDP and Authority and Quality Improvement Services (AQIS) shall analyze the results of the submitted questionnaires and make appropriate changes if needed.

VII. Feedback regarding any recommended changes shall be given to the respective programs. Once changes have been implemented, the document shall be stamped "Field Tested and Approved by the Multicultural Development Program."

Policy 02.01.06 - Cultural Competence Committee

Health Care Agency **Behavioral Health Services** **Policies and Procedures**	Section Name: Sub Section: Section Number: Policy Status:	Client's Rights Cultural Competency 02.01.06 ☒New ☐Revised	

	SIGNATURE	DATE APPROVED
Director of Operations Behavioral Health Services	Signature on File	10/12/16

SUBJECT: Cultural Competence Committee

PURPOSE:

To provide policy direction and procedural guidelines for the Cultural Competence Committee (CCC) of the Orange County Health Care Agency (HCA) Behavioral Health Services (BHS).

POLICY:

It is the policy of BHS to seek and incorporate input from the service providers and community representatives, consumers and families representing the diverse ethnic and cultural groups of Orange County into service design and implementation.

SCOPE:

The CCC will be reflective of the community, including county management level and line staff, consumers and family members from ethnic, racial, and cultural groups, providers, community partners, contractors, and other members as necessary.

The BHS CCC will function as a local forum for service providers and community representatives, consumers and families representing the diverse ethnic and cultural groups of Orange County.

The CCC will provide BHS with cultural competence related information, community feedback and recommendations regarding:

1. The functioning of local behavioral health service systems.
2. The mental health service needs of ethnic and cultural groups.
3. The provision by BHS of a collaborative process that is informed and influenced by community interests, expertise, resources and needs.
4. The establishment and maintenance of a meaningful dialogue with HCA BHS that addresses cultural and linguistic issues referenced from the active participation of cultural groups that are reflective of the community.

The CCC will be integrated within the Behavioral Health system, and:

1. Address cultural and linguistic competence; review the cultural competence plans of all BHS services and programs; and address the cultural competence issues at the county.

2. Provide reports to the BHS Quality Assurance/Quality Improvement Program, and an annual Report of CCC activities.

3. Provide input into the planning and implementation of services at the county.

4. Directly transmit recommendations to HCA executive level, and transmit concerns to the Behavioral Health Director.

5. Participate in and review county Mental Health Services Act (MHSA) planning and stakeholder process, and review county MHSA plans for all MHSA components.

6. Participate in and review client developed programs (wellness, recovery, and peer support programs).

7. Participate in revised Cultural Competence Plan Requirements (CCPR) (2014) development.

REFERENCES:

CCPR: http://www.dhcs.ca.gov/services/MH/Documents/CCPR10-02Enclosure1.pdf

National CLAS Standards: http://minorityhealth.hhs.gov/omh/browse.aspx?lvl=2&lvlid=53

County of Orange Health Care Agency, Behavioral Health Services, Cultural Competence Plan, 2010.

County of Orange Health Care Agency, Behavioral Health Services, Cultural Competence Plan, Updated 2015.

Cross, T.L., Bazron, B.J., Dennis, K.W. & Isaacs, M.R. (1989), Towards *a* culturally competent system of care. Washington, DC: Georgetown University Child Development Center, CASSP Technical Assistance Center.

National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care: A Blueprint for Advancing and Sustaining CLAS Policy and Practice. (April, 2013).

DEFINITIONS:

Definitions of terms which operationalize the aim and scope of the BHS Cultural Competence Committee:

Culture - The integrated pattern of human behavior that includes thought, communication, actions, customs, beliefs, values and institutions of a racial, ethnic, religious or social group.

Culture defines the preferred ways for meeting needs. Culture may include parameters such as age, county of origin, degree of acculturation, generation, educational level, family and household composition, gender identity and sexual orientation, health practices including the use of traditional healer techniques, linguistic characteristics—including language(s) spoken, written, or signed, perceptions of health and well-being and related practices, physical ability or limitations and cognitive ability or limitations, political beliefs, racial and ethnic groups, religious and spiritual characteristics, socioeconomic status, etc. (CLAS Standards, April 2013).

Cultural Competence - Cultural competence refers to the ability of organizations and individuals to work effectively in cross-cultural or multicultural situations. The emphasis is on the interaction/communication with diverse communities and among ethnic groups to assess their needs and effectively engage with them. Cultural competence is an evolving process, which at its core is "quality of care".

Organizational Cultural Competence - The existence of policies, procedures, practices, and organizational infrastructure to support the delivery of culturally and linguistically sensitive and appropriate health care services where "culture" is broadly defined.

Individual Cultural Competence - Set of congruent attitudes, knowledge, and skills that enable the person or individual to interact effectively in cross-sectional situations.

PROCEDURES:

I. The CCC will be represented by five categories of members to ensure that the various ethnic and cultural groups, and persons and providers with knowledge and experience can articulate their perspectives and concerns:

   A. Consumers;

   B. Family members;

   C. Community service providers;

   D. Local management staff of HCA BHS; and

   E. Community representatives.

II. The CCC will have a minimum of two members from each category that reflects the county's demographics of ethnic and cultural diversity.

III. The CCC and the Ethnic Services Manager (ESM) will assess CCC membership annually to ensure that all five categories are represented, and will actively work to suggest persons who can be of benefit to the ethnic and cultural community, and consumers of HCA BHS programs and services.

IV. The CCC members should live and/or work in the Orange County area.

V. The ESM will submit an annual report to the HCA BHS Director, indicating pertinent population trends and developments that should be represented in the CCC membership.

VI. At least annually, the Multicultural Development Program should offer new CCC members appropriate orientation and training regarding the objectives, policies and programs of HCA BHS.

VII. CCC membership will be inclusive to community members interested in participating. CCC members who have not attended for several meetings will be asked if they wish to continue their CCC membership.

VIII. The CCC Co-Chairs (ESM and appointed Co-Chair) report to the HCA BHS Director.

IX. CCC Goals:

A. To provide BHS with community perspectives in culturally competent program functioning and new and/or changed programs needed for county residents to assure optimal performance outcomes.

B. To review the cultural competence effectiveness of new BHS programs and services and proposed changes that impact the access to services for both county operated and county contracted programs.

X. Principles of CCC Formation and Cooperation:

A. The CCC shall consist of not less than 10 members, with at least two members representing each of the five categories of membership. New members should be recruited to ensure that each category is fully represented. While there is no fixed size limit on the number of members for the CCC, the CCC Co-Chairs can set limits for the size of each group to assure that each can function at optimal levels.

B. The CCC annual report to the BHS Director should include particular attention to the Committee's activities, projects, and accomplishments. In addition, problems, obstacles, needs, new issues, and changing priorities should be addressed that pertain to Cultural Competence.

C. The CCC is Co-Chaired by the ESM and a member of the committee. The Co-Chair will be nominated by the CCC and appointed by the ESM.

D. The ESM and CCC Co-Chair will function as a team, dividing responsibilities and activities in a complementary manner in order to promote full and complete discussion and deliberation by members and to increase CCC productivity and effectiveness.

E. The CCC will form sub-committees and task forces as appropriate and necessary each year for conducting cultural competency requirements and activities.

F. The CCC may adopt its own bylaws and procedures to facilitate its work, as long as there is no conflict with Departmental policy, County/State statutes, regulations and policies.

G. The CCC should participate in the Countywide MHSA Planning Committee to foster consensus on the planning strategies and directions to be taken by HCA BHS.

XI. CCC Meetings:

A. Meetings may occur as needed during the year, at places and times to be determined by the CCC, based on objectives, issues to be addressed and tasks to be accomplished.

B. All of the CCC general meetings are to be open to the public.

C. Brief minutes (including records of attendance, proposals, recommendations, etc.) shall be taken at every general and special meeting of the CCC. Each matter reported should reflect the consensus of the Committee as well as alternative perspectives. Copies of the minutes should be forwarded to the BHS Director and other BHS management staff, Co-Chairpersons of the CCC, the Mental Health Board, the Alcohol Drug Advisory Board and other staff as appropriate.

D. The ESM will encourage full and appropriate participation and involvement of all CCC members. Clerical support and services shall be made available as appropriate and needed to further the work of the CCC and its sub-committees.

E. The ESM, will take responsibility for providing the CCC with a range of appropriate, informational materials concerning HCA BHS, County and State guidelines, policies, procedures, evaluations and programs. The ESM will endeavor to assure that these and other materials are received by CCC's and distributed to members in a timely manner.

Policy 02.01.07 - Meeting Deaf and Hard of Hearing Language Needs at Key Points of Contact

Health Care Agency **Mental Health and** **Recovery Services** **Policies and Procedures**	Section Name: Sub Section: Section Number: Policy Status:	Client's Rights Cultural Competency 02.01.07 ☐New ☒Revised	

	SIGNATURE	DATE APPROVED
Director of Operations Mental Health and Recovery Services	Signature on File	2/14/2023

SUBJECT: Meeting Deaf and Hard of Hearing Language Needs at Key Points of Contact

PURPOSE:

To ensure that all Deaf and Hard of Hearing Medi-Cal beneficiaries receiving services in Orange County Mental Health and Recovery Services (MHRS) within the Mental Health Plan (hereby referred to as Orange MHP) and Drug Medi-Cal Organized Delivery System (DMC-ODS) have access to linguistically appropriate services through staff or interpreters proficient in beneficiary's primary language, e.g., American Sign Language (ASL). This policy also applies to non-Medi-Cal clients receiving services within MHRS.

POLICY:

All MHRS beneficiaries/clients shall have access to linguistically appropriate services.

SCOPE:

This policy apply to all functions of MHRS County and County contracted programs involved in the linkage and treatment of beneficiaries/clients receiving services.

REFERENCES:

Code of Federal Regulations (CFR), Title 28, Part 35, ADA of 1990

California Code of Regulations (CCR), Title 9, Chapter 11, Section 1810.410 (a) (2) (b) (e) (3)

DMH Information Notice No. 02-03 Addendum for Implementation Plan for Phase II Consolidation of Medi-Cal Specialty Mental Health Services-Cultural Competence Plan Requirements

Dymally-Alatorre Bilingual Services Act 1973

PROCEDURE:

I. As defined in the Orange MHP and in the DMC-ODS, each service site is considered a key point of contact for Orange County.

II. Auxiliary aides must be made available to Deaf and Hard of Hearing beneficiaries/clients. Aides to be used will be determined in consultation with the beneficiary/client to determine what aide(s) is (are) the best fit. These aides may include but are not limited to the following:

A. Qualified sign language interpreter

B. Note takers

C. Screen readers

D. Written materials

E. Telephone handset amplifiers

F. Assistive listening systems or devices

G. Hearing aid-compatible telephones

H. Communication boards

I. Open or closed captioning, including real-time captioning

J. Video remote interpreting services (VRI)

K. voice, text and video-based telecommunication products and systems

L. Videotext displays

M. Description of visually presented materials

N. Exchange of written notes

O. Video relay services

P. Other effective methods of making orally delivered materials available to the Deaf and people who are hard of hearing.

III. For Non-Emergency Sign Language Interpreting Service, the MHRS County staff shall contact the MHRS contracted interpreting agency (current agency information available at HCA Forms under MHRS Forms-Language Service ASL Interpretation - Instructions) with requests for ASL interpreters during routine clinic hours. The Deaf Services Coordinator may be contacted for assistance with the request procedure if needed. A short notice fee will be applied by the contracting agency, if a request is made in less than 72 hours for non-emergency counseling services. County Contracted providers will need to contract with an interpreting agency to arrange for Non-Emergency Sign Language Interpreting Services.

IV. For Emergency Sign Language Interpreting Service when the primary MHRS contracted agency is unable to provide services or is unavailable, if the immediate need arises during the day, on a weekend, or after hours, the staff shall contact a secondary interpreting agency. (Secondary interpreting agency information available at HCA Forms under MHRS Forms-Language Service ASL Interpretation-Instructions). The Deaf Services Coordinator may be contacted for assistance with the request procedure during business hours, if needed. The higher fees are applied to all emergency cases. County Contracted providers will need to contract with an interpreting agency to arrange for Emergency Sign Language Interpreting Services.

V. Each key point of contact in MHRS shall be provided with a roster of linguistically proficient staff/interpreters throughout the Health Care Agency (HCA). This language roster shall be updated annually.

VI. Clinics with deaf or hard of hearing staff are familiar with and able to utilize Video Relay Services (VRS) in order to take calls or make calls to deaf or hard of hearing beneficiaries/clients in Orange County. Any caller using the deaf or hard of hearing's videophone numbers will be automatically connected to VRS.

VII. Initial access logs maintained at the service sites shall indicate whether an interpreter was needed and the response to offers of interpreting services.

VIII. Signage shall be posted at each MHRS County and County Contracted clinic indicating interpreting Services for the Deaf and Hard of Hearing are available free of charge to each beneficiary.

IX. Staff shall not expect that family members will provide interpreter services.

A. A beneficiary may choose to use a family member or friend as an interpreter after being informed of the availability of free interpreter services.

B. Minor children should not be used as an interpreter.

Policy 02.06.02 - Informing Materials for Mental Health Plan Beneficiaries/Clients and Intake/Advisement Checklist

Health Care Agency **Mental Health and** **Recovery Services** **Policies and Procedures**	Section Name: Sub Section: Section Number: Policy Status:	Client's Rights Informing Materials 02.06.02 ☐New ☒Revised

	SIGNATURE	DATE APPROVED
Director of Operations Mental Health and Recovery Services	Signature on File	2/22/2023

SUBJECT:	Informing Materials for Mental Health Plan Beneficiaries/Clients and Intake/Advisement Checklist

PURPOSE:

To provide County of Orange Mental Health and Recovery Services (MHRS) beneficiaries/clients with appropriate informing materials and accurately document the provision of these materials as well as Advance Directives.

POLICY:

Required distribution of informing materials shall be documented so as to be easily audited. The Advance Directives shall be documented as required in CFR 42, Chapter 4.

SCOPE:

This policy applies to all beneficiaries/clients of the Orange County Mental Health Plan (MHP) and will be followed by all Mental Health and Recovery Services (MHRS) County and County Contracted staff providing Specialty Mental Health Services (SMHS).

REFERENCES:

MHRS P&P 02.06.01 Advance Directives

MHRS P&P 02.05.01 Notice of Privacy Practices

Title 42, Code of Federal Regulations (CFR),§422.128

FORM:

Health Care Agency Mental Health Plan (MHP) Intake/Advisement Checklist, F346-753

PROCEDURE:

I. All newly admitted beneficiaries/clients in the Mental Health Plan shall be given, at a minimum, the following materials:

A. Notice of Privacy Practices (NPP)

B. The Advance Directives Information Sheet (For adults only)

C. The MHP Beneficiary Handbook

D. MHP Provider Directory

II. If, at the time of admission, the beneficiary/client is unable to accept and utilize these materials due to the beneficiary/client's emotional condition, then the information shall be given as soon as the beneficiary/client is able to accept and utilize it.

III. These materials shall be available in the threshold languages in hard copy and in audio version.

IV. MHRS Staff shall provide the materials in the appropriate language and/or format to meet the beneficiary/client's needs.

V. MHRS Staff shall actively inquire of each newly admitted consumer whether the beneficiary wishes to have the informing materials in audio version. The response shall be documented on the MHP Intake/Advisement Checklist.

VI. Completion of the Mental Health Plan (MHP) Intake/Advisement Checklist:

A. The provision of the above materials shall be documented using the Mental Health Plan Intake/Advisement Checklist (Advisement Checklist).

B. The Intake/Advisement Checklist shall be completed each time a beneficiary is admitted for mental health services. MHRS Staff shall:

1. Inquire and document the language in which the beneficiary/client would like to receive the informing materials.

2. Offer or ask if the beneficiary/client would like to receive the informing materials in audio version and in their preferred language.

a) Have the beneficiary/client document by checking "yes" or "no" to this question.

3. For all MHP beneficiaries/clients, have the beneficiary/client/legal guardian check "yes" or "no" to the question to document receipt of each of the following informing materials:

a) The MHP Beneficiary Handbook

b) MHP Provider Directory

c) Notice of Privacy Practices (NPP)

d) Completed Receipt of the Notice of Privacy Practices

e) Car Seat Regulation

f) Offered Voter Registration (over 18 consumers or guardian)

VII. Advance Directives

A. All beneficiaries 18 years and older shall be provided with, and note the receipt of, the Advance Health Care Directives Information Sheet on the Intake/Advisement Checklist.

B. All beneficiaries/clients shall be informed that at any time they develop an Advance Directive or want to update the one on file, they can provide the revision and the MHRS staff shall place the update in the beneficiary's record (reference MHRS P&P 02.06.01 Advance Directives).

VIII. Signatures

A. Once the Intake/Advisement Checklist has been completed both the beneficiary/legal guardian and MHRS staff are to sign and date the Intake/Advisement Checklist and file in the beneficiary/client record.

Policy 03.01.03 - Trainings Specifically Pertaining to Cultural Competency

Health Care Agency	Section Name:	Human Resources
Behavioral Health Services	Sub Section:	Staff Development
Policies and Procedures	Section Number:	03.01.03
	Policy Status:	☐New ☒Revised

	SIGNATURE	DATE APPROVED
Director of Operations Behavioral Health Services	Signature on File	9/21/16

SUBJECT: Trainings Specifically Pertaining to Cultural Competency

PURPOSE:

The purpose of this policy is to establish a uniform method of reviewing the nature and adequacy of Behavioral Health Services (BHS) trainings that address cultural issues and to define class attendance requirements for all County and County Contracted BHS staff providing clinical care.

POLICY:

BHS trainings that address cultural issues shall be of the highest possible quality. Toward this end, the Multicultural Development Program shall provide review, feedback and consultation on all trainings that address cultural issues prior to the training date.

SCOPE:

This applies to all BHS County and County Contracted programs.

REFERENCES:

County of Orange Health Care Agency, Behavioral Health Services, Cultural Competency Plan Updated, 2010

Department of Mental Health: DMH Information Notice 02-03 Addendum for Implementation Plan for Phase II Consolidation of Medi-Cal Specialty Mental Health Services- Cultural Competency Plan Requirements

California Welfare & Institutions Code Section 5600.2 (g)

California Welfare & Institutions Code Section 5600.9 (a)

National CLAS Standards, 2013

PROCEDURES:

I. Proposed trainings that meet the criteria of addressing cultural issues shall be forwarded to the Multicultural Development Program for review and comment at least two months prior to the training event.

II. An outline and instructor vitae for the proposed course shall be submitted to the Multicultural Development Program for review.

III. The Multicultural Development Program shall review the materials and provide feedback to the training coordinator within three working days.

   A. Feedback shall include at a minimum suggestions, if any, regarding cultural content.

IV. The Multicultural Development Program shall provide consultation as needed to improve the quality of trainings that address cultural issues.

V. It is required that all BHS County and County Contracted staff will complete a mandatory annual cultural competence training.

APPENDIX II: BEHAVIORAL HEALTH EQUITY COMMITTEE (BHEC)

GOVERNING STRUCTURE

BEHAVIORAL HEALTH SERVICES

Behavioral Health Equity Committee (BHEC)

GOVERNING STRUCTURE

I. Vision

Our efforts are focused on the promotion of behavioral health equity for unserved and underserved racial and ethnic communities, as well as lesbian, gay, bisexual, transgender, questioning/queer and intersex (LGBTQI), Veterans, deaf and hard of hearing and other cultural groups. Based on SAMHSA's Behavioral Health Equity[1] tips, key strategies will be focused on data, policy, quality, and communication:

a) **The *data strategy* utilizes available federal, state, county and community data to identify, monitor, and respond to behavioral health disparities.**

b) **The *policy strategy* promotes policy initiatives that strengthen the impact of BHS programs in advancing behavioral health equity.**

c) **The *quality practice and workforce development strategy* helps BHS to expand the behavioral health workforce capacity to improve outreach, engagement, and quality of care for unserved and underserved populations.**

d) **The *communication strategy* increases awareness and access to information about behavioral health disparities and strategies to promote behavioral health equity.**

The BHEC will further develop and make recommendations around these key strategies to be included in the Cultural Competency Plan annual update.

II. Role and Purpose

The BHEC seeks to impact and advise BHS policies and initiatives by:

a) **Strategically focusing on racial, ethnic, LGBTQI and other cultural groups in BHS programs**

b) **Using a data-informed quality improvement approach to address racial and ethnic disparities in BHS programs**

c) **Recommending that BHS policies, initiatives, and collaborations include emphasis on decreasing disparities**

d) **Proposing innovative, cost-effective training strategies to a diverse workforce**

The BHEC will satisfy the above role by conducting the following activities to promote increased cultural awareness, sensitivity and responsiveness in OC's behavioral health services:

a) **Culturally and linguistically appropriate services: The BHEC will advise Orange County Behavioral Health Services on ways to improve access and engagement with individuals who have Limited English Proficiency (LEP) and/or other communication needs.**

[1] https://www.samhsa.gov/behavioral-health-equity

b) **Trainings: The BHEC, through the Multicultural Development Program (MDP), works with Behavioral Health Training Services to create and coordinate trainings focused on cultural sensitivity, awareness and humility; and to ensure that other trainings include cultural considerations related to the subject of the training and that such considerations are included as one of the training objectives.**

c) **Leadership: The BHEC will work closely with the BHS leadership in promoting elimination of community health disparities and inequity in Behavioral Health Services.**

III. Operationalized Values

The BHEC will strive to work in a manner that is consistent with its values:

a. **Equity** – ***Attaining the highest level of behavioral health for all by addressing root causes of inequities.*** **The BHEC's membership, activities, and planning processes will be inclusive of the diverse communities in Orange County, especially those where data indicate to have disparities in health.**

b. **Inclusive** – ***Health includes physical, mental, spiritual, economic, environmental, and educational factors that contribute to it.*** **The BHEC's membership and planning processes will be inclusive of a broad range of perspectives representing the various factors that contribute to health.**

c. **Collaborative** –***requires a partnership between many entities including residents, health care providers, community-based organizations, faith-based organizations, schools, businesses, and government.*** **The BHEC will conduct its activities in a collaborative manner and actively engage community partners in working towards its shared vision and goals.**

d. **Multi-dimensional** – ***Culture must be understood at the individual, family, and system levels.*** **The BHEC will ensure that planning processes consider the various dimensions of culture.**

IV. Membership

a. **Representation: The BHEC is composed of individuals who are dedicated to cultural diversity and equity and come from a variety of backgrounds. The BHEC shall be a body representing a broad cross-section of interests and experiences. The BHEC does not limit membership from for-profit entities. Joining the BHEC as a means for solicitation or using meetings as a forum for solicitation is prohibited and may be cause for removal. The BHEC shall strive to include at minimum:**

i. **Representation from the following suggested organizations:**
   - **Orange County Health Care Agency, Public Health Services**
   - **Orange County Health Care Agency, Behavioral Health Services**
   - **Orange County Social Services Agency**
   - **Orange County Department of Education**
   - **Cal Optima**
   - **Children and Families Commission of Orange County**
   - **Orange County 211**

ii. **Representatives with the following expertise or perspectives:**
   - **Community based organizations**
   - **Outreach and engagement programs**
   - **Bilingual/bi-cultural**
   - **Black/African Americans**
   - **LGBTQI**

Veterans
Faith-based organizations
Community health center
Healthcare provider or other affiliation
Local government
Public safety
Transportation
Universities, colleges, and other research institutions
Advocacy organizations

iii. Individuals, including community members, who can represent perspectives of populations identified as having lived experience with the Behavioral Health system. Examples include, but are not limited to, persons with behavioral health conditions or family members of a person with a behavioral health condition.

iv. Other at-large members involved in assessing and/or promoting cultural diversity and equity

b. **Term:** There is no limit to the number of years a member may serve. Membership will be renewed based on members' interest and ability to serve every two years.

c. **Selection:** Individuals or representatives of organizations wishing to participate on the BHEC may request to join the BHEC as a voting member by submitting a written application. The application will be reviewed and voted upon by the BHEC Steering Committee. Applications approved by the BHEC Steering Committee will be forwarded via email to BHEC members for review prior to the next BHEC meeting. The BHEC will strive to come to consensus about approval of applications. When consensus cannot be reasonably reached, a vote of BHEC members will be conducted via email. Approved applicants will join the BHEC as a voting member at the first BHEC meeting after their application is approved.

d. **Member Responsibilities:** In order to complete these tasks, BHEC members have the following responsibilities:
   i. Participate in scheduled meetings. Meetings will occur at least three times a year. Attendance to meetings will be monitored. The BHEC Steering Committee may contact members with excessive absences to discuss their interest and ability to serve on the BHEC.
   ii. Commit to serving on at least one BHEC work group.
   iii. Communicate information about the activities of the BHEC to the community and partners.
   iv. Assist the BHEC in identifying resources to support the work of the BHEC.
   v. Support BHEC activities, such as data collection, town halls, etc.

V. **Officers**

a. **Co-Chairs:** There shall be two Co-Chair positions. These shall be one **Behavioral Health Services Co-Chair** position filled by Ethnic Services Manager or a designated representative from Orange County Health Care Agency, Behavioral Health Services and one **Community Co-Chair**, selected by the BHEC from among the members unaffiliated with the County of Orange and its agencies.

b. **Community Co-Chair Term:** The term for the Community Co-Chairs shall run for two years from January to December.

c. **Community Co-Chair Selection:** The Community Co-Chair shall be selected by the BHEC by majority vote at the last scheduled BHEC meeting before the start of a new term, usually in December.

d. Officer Responsibilities:

i. **Behavioral Health Services Co-Chair:** The Ethnic Services manager or a representative of Orange County Health Care Agency, Behavioral Health Services shall serve as a permanent Co-Chair of the BHEC. In collaboration with the Community Co- Chair, the BHS Co-Chair will set meeting agenda; facilitate BHEC meetings; establish committees and ad-hoc work groups as needed. The BHS Co-Chair shall rotate the responsibilities of chairing individual meetings with the other BHEC Co-Chair.

ii. **Community Co-Chair:** The BHEC shall select a Co-Chair from members unaffiliated with the County of Orange agencies participating on the BHEC. The Community Co-Chair, in collaboration with the Behavioral Health Services Co-Chair, will set the meeting agenda; facilitate BHEC meetings; establish committees and ad-hoc work groups as needed. Each Community Co-Chair shall rotate the responsibilities of chairing individual meetings with the BHS Co-Chair.

VI. Voting

The BHEC will strive to govern by consensus. When consensus cannot be reasonably reached, official actions taken by the BHEC shall be adopted by a majority vote. Each individual member present, not by proxy, will have one vote.

VII. Meetings

The BHEC shall schedule meetings at least three times per year at the discretion of the BHEC Steering Committee. Meetings will be open to the public, but only members may vote.

VIII. Committees and Work Groups

a) **Steering Committee:** The BHEC Steering Committee will be charged with the general oversight of affairs of the BHEC including review and setting of the BHEC agenda and review and recommendation of BHEC member applications. Seats on the BHEC Steering Committee will be determined by the BHEC and may include Co-Chairs, representatives from each committee, and other individuals such as representation from the school districts, hospital, city government, and academic institutions and representation of specific populations.

b) **Work Groups:** The BHEC shall establish or identify work groups, or task forces as it deems necessary to accomplish its purpose and role. This may include establishing or designating work groups to implement strategies related to priorities identified in the Cultural Competence Plan.

c) **Suggested work groups:** Community Relations and Education; Spirituality; Outreach and Engagement to Black/African Americans, populations who speak in one of the threshold languages or have Limited English Proficiency (LEP) and or other communication needs; Veterans and Military; LGBTIQ

IX. Additional rules and procedures

The BHEC may establish any rules or procedures it so deems appropriate by consensus or majority action of the BHEC.

BY LAWS

Orange County Behavioral Health Equity Committee
BYLAWS

Adopted July 2021

ARTICLE I

Name

The name of this board shall be THE ORANGE COUNTY BEHAVIORAL HEALTH EQUITY COMMITTEE, hereinafter referred to as the "BHEC"

ARTICLE II

Section 1:

Authority and Purpose

The BHEC is authorized by the State of California through […] supporting Criterion #4 of the Cultural Competence Plan—

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).

Section 2:

In accordance with applicable federal and state statutory and regulatory requirements, the BHEC shall:

a. Act in an advisory capacity to the Director of Behavioral Health Services, hereinafter referred to as "Behavioral Health Services."
b. Review, evaluate and make recommendations regarding the community's mental health needs, services, facilities, and special problems, keeping the goals of the BHEC as priority.

c. Review and approve the procedures used to ensure diverse stakeholder involvement in all stages of the County's mental health planning process.
d. Provide an annual report to the Director of Behavioral Health Services
e. Develop the Cultural Competence Plan update and oversee its implementation by BHS

Section 3:

The BHEC seeks to impact and advise BHS policies and initiatives by:

a) Strategically addressing equity among racial, ethnic, LGBTQI and other cultural groups in BHS programs
b) Using a data-informed quality improvement approach to address racial and ethnic disparities in BHS programs
c) Recommending that BHS policies, initiatives, and collaborations include emphasis on decreasing disparities
d) Proposing innovative, cost-effective training strategies to a diverse workforce

The BHEC will satisfy the above role by conducting the following activities to promote increased cultural awareness, sensitivity, and responsiveness in OC's behavioral health services:

a) Culturally and linguistically appropriate services: The BHEC will advise Orange County Behavioral Health Services on ways to improve access and engagement with individuals who have Limited English Proficiency (LEP) and/or other communication needs.
b) Trainings: The BHEC, through the Multicultural Development Program (MDP), works with Behavioral Health Training Services to create and coordinate trainings focused on cultural sensitivity, awareness and humility; and to ensure that other trainings include cultural considerations related to the subject of the training and that such considerations are included as one of the training objectives.
c) Leadership: The BHEC will work closely with the BHS leadership in promoting elimination of community health disparities and inequity in

Behavioral Health Services – both county and contracted programs.

Section 4:

The BHEC will strive to work in a manner that is consistent with the following values:

a. **Equity** – *Attaining the highest level of behavioral health for all by addressing root causes of inequities.* The BHEC's membership, activities, and planning processes will be inclusive of the diverse communities in Orange County, especially those where data indicate to have disparities in health.
b. **Inclusive** – *Health includes physical, mental, spiritual, economic, environmental, and educational factors that contribute to it.* The BHEC's membership and planning processes will be inclusive of a broad range of perspectives representing the various factors that contribute to health.
c. **Collaborative** –*requires a partnership between many entities including residents, health care providers, community-based organizations, faith-based organizations, schools, businesses, and government.* The BHEC will conduct its activities in a collaborative manner and actively engage community partners in working towards its shared vision and goals.
d. **Multi-dimensional** – *Culture must be understood at the individual, family, and system levels.* The BHEC will ensure that planning processes consider the various dimensions of culture.

ARTICLE III

Membership

Section 1:

Representation: The BHEC is composed of individuals who are dedicated to cultural diversity and equity and come from a variety of backgrounds. The BHEC shall be a body representing a broad cross-section of interests and experiences. The BHEC does not limit membership from for-profit entities. Joining the BHEC as a means for solicitation or using meetings as a forum for solicitation is prohibited

and may be cause for removal. The BHEC shall strive to include at minimum:

i. Representation from the following suggested organizations:
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   - Orange County Health Care Agency, Behavioral Health Services
   - Orange County Social Services Agency
   - Orange County Department of Education
   - Cal Optima
   - Children and Families Commission of Orange County
   - Orange County 211

ii. Representatives with the following expertise or perspectives:
   - Community based organizations
   - Outreach and engagement programs
   - Bilingual/bi-cultural
   - Black/African Americans
   - LGBTQI
   - Veterans
   - Faith-based organizations
   - Community health center
   - Healthcare provider or other affiliation
   - Local government
   - Public safety
   - Transportation
   - Universities, colleges, and other research institutions
   - Advocacy organizations

iii. Individuals, including community members, who can represent perspectives of populations identified as having lived experience with the Behavioral Health system. Examples include, but are not limited to, persons with behavioral health conditions or family members of a person with a behavioral health condition.

iv. Other at-large members involved in assessing and/or promoting cultural diversity and equity

Section 2:

Term: There is no limit to the number of years a member may serve. Membership will be renewed based on members' interest and ability to serve every two years.

Section 3:

Selection: Individuals or representatives of organizations wishing to participate on the BHEC may request to join the BHEC as a voting member by submitting a written application. The application will be reviewed and voted upon by the BHEC Steering Committee. Applications approved by the BHEC Steering Committee will be forwarded via email to BHEC members for review prior to the next BHEC meeting. The BHEC will strive to come to consensus about approval of applications. When consensus cannot be reasonably reached, a vote of BHEC members will be conducted via email. Approved applicants will join the BHEC as a voting member at the first BHEC meeting after their application is approved.

Section 4:

Member Responsibilities: In order to complete these tasks, BHEC members have the following responsibilities:

i. Participate in scheduled meetings. Meetings will occur at least three times a year. Attendance to meetings will be monitored. The BHEC Steering Committee may contact members with excessive absences to discuss their interest and ability to serve on the BHEC.
ii. Commit to serving on at least one BHEC work group.
iii. Communicate information about the activities of the BHEC to the community and partners.
iv. Assist the BHEC in identifying resources to support the work of the BHEC.
v. Support BHEC activities, such as data collection, town halls, etc.

ARTICLE IV

Officers

Section 1:

a. **Co-Chairs:** There shall be two Co-Chair positions. These shall be one **Behavioral Health Services Co-Chair** position filled by the Behavioral Health Services Director or a designated representative from Orange County Health Care Agency, Behavioral Health Services and one **Community Co-Chair**, selected by the BHEC community members from among the members unaffiliated with the County of Orange and its agencies.

b. **Community Co-Chair Term:** The term for the Community Co-Chairs shall run for two years from January to December.

c. **Community Co-Chair Selection:** The Community Co-Chair shall be selected by the BHEC by majority vote of BHEC community steering committee members at the last scheduled BHEC meeting before the start of a new term, usually in December.

d. **Officer Responsibilities:**

   i. **Behavioral Health Services Co-Chair:** The Ethnic Services manager or a representative of Orange County Health Care Agency, Behavioral Health Services shall serve as a permanent Co-Chair of the BHEC. In collaboration with the Community Co- Chair, the BHS Co-Chair will set meeting agenda; facilitate BHEC meetings; establish committees and ad-hoc work groups as needed. The BHS Co-Chair shall rotate the responsibilities of chairing individual meetings with the other BHEC Co-Chair.

   ii. **Community Co-Chair:** The BHEC shall select a Co-Chair from members unaffiliated with the County of Orange agencies participating on the BHEC. The Community Co-Chair, in collaboration with the Behavioral Health Services Co-Chair, will set the meeting agenda; facilitate BHEC meetings; establish committees and ad-hoc work groups as needed. Each Community Co-Chair shall rotate the responsibilities of chairing individual meetings with the BHS Co-Chair.

Section 2:

Meetings: Meetings will be co-led by the Co-Chairs with Co-Chairs alternating in facilitating agenda items and jointly developing the agenda prior to the meeting. A consensus process will be used for making decisions as illustrated in Exhibit A. In the event a decision cannot be reached through this process, then a deliberative discussion will be conducted using Rosenberg's Rules of Order as published by the California League of Cities.

Community members will have opportunities to attend quarterly steering committee meetings and participate through polls/chat, and provide public comments as directed by Co-Chairs.

ARTICLE V

Committees

The Co-Chairs shall appoint members of standing committees, such as ad hoc,task force, work group, or other entities as necessary to carry out the responsibilities of the BHEC.

Section 2:

There shall be a Steering Committee comprised of the Co-Chairs, Committee Chairpersons, and others as appointed by the Co-Chairs. The Steering Committee shall carry out any responsibilities delegated to it by the BHEC and act in emergencies in any way it deems necessary when there is not time for the entire BHEC to act.

Section 3:

Committee chairs or their delegates shall report to the BHEC at least once a month.

ARTICLE VI

Meetings

Section 1:

General meetings shall be held each month, the time and place to be announced prior to adjournment of the preceding meeting.

Section 2:

Special meetings may be held by giving 48-hour notice to all members at the call of the Co-Chairs or of a majority of the BHEC.

Section 3:

All meetings will be open to the public as much as possible.

Section 4:

A simple majority of the BHEC shall constitute a quorum and a vote of a simple majority of that quorum shall constitute a vote of the BHEC when a decision cannot be reached by consensus through the process outlined in Exhibit A.

Section 5:

All general meeting Agenda items which require a vote of the BHEC must be submitted to the Chairperson one (1) week in advance of the meeting.

ARTICLE VII

Adoption and Amendment

Section 1:

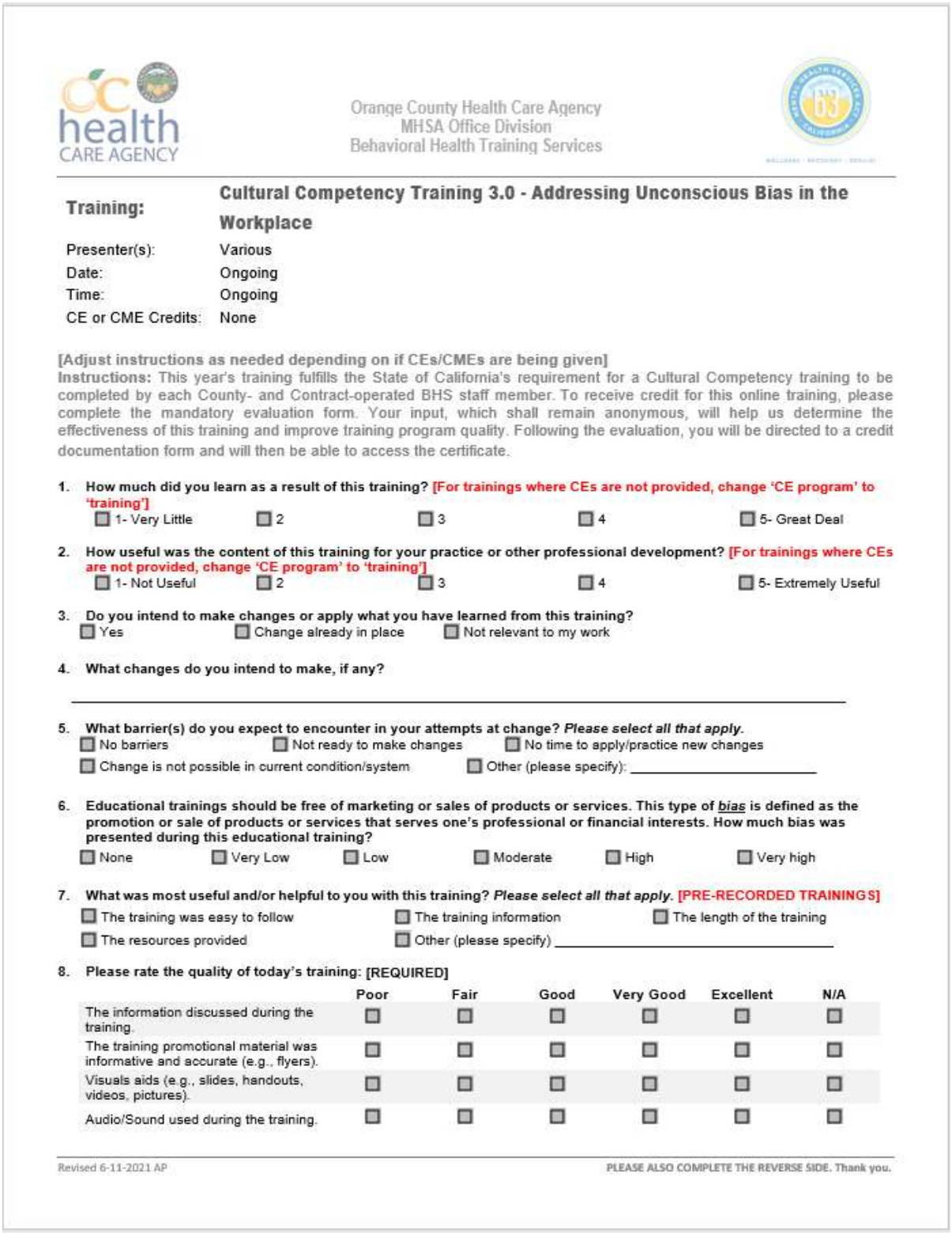
These Bylaws and amendments thereto shall be recommended to the BHEC by the Steering Committee.

Section 2:

Amendments to the bylaws may be introduced and voted upon by the BHEC at a regular meeting so long as such amendments are e-mailed to all members at least one (1) week in advance of the meeting.

APPENDIX III: SAMPLES OF TRAINING EVALUATION FORMS

Cultural Competence 3.0 Online Training Survey



Orange County Health Care Agency
MHSA Office Division
Behavioral Health Training Services

Training:	**Cultural Competency Training 3.0 - Addressing Unconscious Bias in the Workplace**
Presenter(s):	Various
Date:	Ongoing
Time:	Ongoing
CE or CME Credits:	None

[Adjust instructions as needed depending on if CEs/CMEs are being given]
Instructions: This year's training fulfills the State of California's requirement for a Cultural Competency training to be completed by each County- and Contract-operated BHS staff member. To receive credit for this online training, please complete the mandatory evaluation form. Your input, which shall remain anonymous, will help us determine the effectiveness of this training and improve training program quality. Following the evaluation, you will be directed to a credit documentation form and will then be able to access the certificate.

1. **How much did you learn as a result of this training? [For trainings where CEs are not provided, change 'CE program' to 'training']**
   ☐ 1- Very Little ☐ 2 ☐ 3 ☐ 4 ☐ 5- Great Deal

2. **How useful was the content of this training for your practice or other professional development? [For trainings where CEs are not provided, change 'CE program' to 'training']**
   ☐ 1- Not Useful ☐ 2 ☐ 3 ☐ 4 ☐ 5- Extremely Useful

3. **Do you intend to make changes or apply what you have learned from this training?**
   ☐ Yes ☐ Change already in place ☐ Not relevant to my work

4. **What changes do you intend to make, if any?**
   _____

5. **What barrier(s) do you expect to encounter in your attempts at change? *Please select all that apply.***
   ☐ No barriers ☐ Not ready to make changes ☐ No time to apply/practice new changes
   ☐ Change is not possible in current condition/system ☐ Other (please specify): _____

6. **Educational trainings should be free of marketing or sales of products or services. This type of *bias* is defined as the promotion or sale of products or services that serves one's professional or financial interests. How much bias was presented during this educational training?**
   ☐ None ☐ Very Low ☐ Low ☐ Moderate ☐ High ☐ Very high

7. **What was most useful and/or helpful to you with this training? *Please select all that apply.* [PRE-RECORDED TRAININGS]**
   ☐ The training was easy to follow ☐ The training information ☐ The length of the training
   ☐ The resources provided ☐ Other (please specify) _____

8. **Please rate the quality of today's training: [REQUIRED]**

	Poor	Fair	Good	Very Good	Excellent	N/A
The information discussed during the training.	☐	☐	☐	☐	☐	☐
The training promotional material was informative and accurate (e.g., flyers).	☐	☐	☐	☐	☐	☐
Visuals aids (e.g., slides, handouts, videos, pictures).	☐	☐	☐	☐	☐	☐
Audio/Sound used during the training.	☐	☐	☐	☐	☐	☐

Revised 6-11-2021 AP

PLEASE ALSO COMPLETE THE REVERSE SIDE. Thank you.

The location of the training met my needs.	☐	☐	☐	☐	☐	☐
The location where I took the training was comfortable and accessible.	☐	☐	☐	☐	☐	☐
The overall quality of this training.	☐	☐	☐	☐	☐	☐

9. **Based on your experience(s) today, please select how much you agree or disagree with the following statements regarding the quality of the training: [PRE-RECORDED TRAININGS]**

	Strongly Disagree	Disagree	Agree	Strongly Agree	N/A
Delivery of information was clear.	☐	☐	☐	☐	☐
The training was engaging/kept my interest.	☐	☐	☐	☐	☐
The online training clearly outlined presenter/staff contact information in case there were follow-up questions.	☐	☐	☐	☐	☐
Information was presented in a fair and balanced manner.	☐	☐	☐	☐	☐
Information presented was current.	☐	☐	☐	☐	☐
Information presented was accurate.	☐	☐	☐	☐	☐
The training was easy to navigate (going from one section of the training to another, being able to go back, if needed).	☐	☐	☐	☐	☐
Enough time was provided to reflect on the topics that were presented.	☐	☐	☐	☐	☐
The presenter(s) communicated knowledge of the subject.	☐	☐	☐	☐	☐

10. **Based on my experience(s) with this training: [REQUIRED]**

	Strongly Disagree	Disagree	Agree	Strongly Agree	N/A
I would recommend this training to someone I know.	☐	☐	☐	☐	☐
The staff treated me with courtesy and respect during this training.	☐	☐	☐	☐	☐
Overall, I am satisfied with this training.	☐	☐	☐	☐	☐

11. **Please provide any comment(s) about your experience and/or suggestions for this training.**

_____

PARTICIPANT INFORMATION

1. **Of the Behavioral Health (BH) personal or community roles listed below, which ones do you best identify with? *Please select all that apply.***

- ☐ Advocate for BH clients/services
- ☐ Consumer of BH services
- ☐ Community Member / General Public
- ☐ Caregiver of someone with a BH condition
- ☐ Parent of someone with a BH condition
- ☐ Other Family Member of someone with a BH condition
- ☐ I do not identify with any of these roles

2. **BHTS would like to know why you are attending today's training. Of the licensed or unlicensed occupations listed below, which ones were you seeking professional development for? *Please select all that apply.***

☐ Physician (MD)	☐ LMFT	☐ Intern	☐ Teacher
☐ Registered Nurse (RN)	☐ LPCC	☐ Peer Support Worker	☐ Unlicensed Staff (e.g., Associates)
☐ Psychologist	☐ Case Manager	☐ Faith-based Partner	☐ Other Licensed Staff
☐ LCSW	☐ CADC/CATC/RAS	☐ School Counselor	☐ Not a Service Provider

AGE

3. **What is your age?**
☐ 18-25 years ☐ 26-59 years ☐ 60+ years ☐ Decline to State

RACE / ETHNICITY *(Please select ALL of the race and ethnicity categories you identify with.)*

4. **What is your race/ethnicity?**

☐ American Indian / Alaska Native	☐ Latino / Hispanic
☐ African / African American / Black	☐ White / Caucasian
☐ Asian	☐ Decline to State
☐ Pacific Islander	☐ Other (please specify):_____

LANGUAGE – PRIMARY / PREFERRED

5. **What is your primary language?**

☐ Arabic	☐ Armenian	☐ ASL	☐ Cambodian
☐ Cantonese	☐ English	☐ Farsi	☐ Khmer
☐ Korean	☐ Mandarin	☐ Russian	☐ Spanish
☐ Tagalog	☐ Vietnamese	☐ Other _____	☐ Decline to State

GENDER INFORMATION *(Please select ONE that best describes you.)*

6. **What is your current gender identity?**
☐ Male ☐ Female ☐ Transgender ☐ Genderqueer / Non-Binary ☐ Decline to State
☐ Questioning or unsure of gender identity ☐ Another gender identity _____

Community & Agency Staff Training (WET) Evaluation Form

Training: Cultural Competency Training 3.0 – Follow Up Form

1. **Please enter your name (precisely with Last, First) as it will appear on the Certificate of Completion (example: Luna, Bella) [REQUIRED]**

2. **What is your supervisor's name (Last, First)? [REQUIRED]**

3. **What is your supervisor's email address? [REQUIRED]**

4. **Are you currently employed by a County Agency or a Community-Based Organization/Contractor (Please select ONE)? [REQUIRED]**
   - ☐ County Agency **[Complete Question 2-5 as applicable, then Skip to Question 8]**
   - ☐ Community-Based Organization/Contractor **[Skips to Question 6]**
   - ☐ I do not work for a County Agency or a Community-Based Organization/Contractor **[Skips to Question 8]**

5. **[IF *COUNTY* IS SELECTED]: At which County Agency do you currently work? [REQUIRED]**
   - ☐ Orange County CEO
   - ☐ District Attorney
   - ☐ Sheriff-Coroner
   - ☐ Office of Independent Review
   - ☐ Probation
   - ☐ Interim Public Defender
   - ☐ Child Support Services
   - ☐ Health Care Agency
   - ☐ OC Community Resources
   - ☐ Social Services Agency
   - ☐ John Wayne Airport
   - ☐ OC Public Works
   - ☐ OC Waste & Recycling
   - ☐ Assessor
   - ☐ Auditor-Controller
   - ☐ Clerk-Recorder
   - ☐ Treasurer-Tax Collector
   - ☐ Clerk of the Board
   - ☐ County Counsel
   - ☐ Internal Audit
   - ☐ OC Ethics Commission
   - ☐ Registrar of Voters
   - ☐ Other

6. **[IF *HEALTH CARE AGENCY* IS SELECTED]: In which HCA Department do you currently work? [REQUIRED]**
   - ☐ Executive Office
   - ☐ Administrative Services
   - ☐ Mental Health & Recovery Services
   - ☐ Public Health Services
   - ☐ Regulatory / Medical Health Services
   - ☐ Correctional Health Services

7. **[IF *BEHAVIORAL HEALTH SERVICES* IS SELECTED]: What is the name of your division and program? [REQUIRED]**

Name of your Division (e.g., CYBH, P&I)	Open-ended response
Name of your Program (e.g., CAT, CCSS)	Open-ended response

8. **[IF *COUNTY* IS SELECTED]: What is your role within your program? [REQUIRED]**
   - ☐ Manager/Supervisor
   - ☐ Administrative Staff
   - ☐ Direct Service Provider
   - ☐ Office/Support Staff

9. **[IF *COMMUNITY-BASED ORGANIZATION/CONTRACTOR* IS SELECTED]: What is the name of the Agency/Program you work for? [REQUIRED]**

   Open-ended response

10. **[IF *COMMUNITY-BASED ORGANIZATION/CONTRACTOR* IS SELECTED]: What is your role within your Agency/Program? [REQUIRED]**
    - ☐ Manager/Supervisor
    - ☐ Administrative Staff
    - ☐ Direct Service Provider
    - ☐ Office/Support Staff

By clicking the statement below, I attest to having viewed/completed: **[REQUIRED]**

- All 14 micro-learnings through Cornerstone Cares
- TED Talk by Verna Myers
- Implicit Association Test
- Article Titled "How to Identify and Mitigate Unconscious Bias in the Workplace"

☐ I understand and agree to the statements above.

APPENDIX IV:

List of Culturally Competent Trainings

Training Title	Date(s)	Training Description
2022 Conference: Orange County Substance Abuse Prevention Network by Multiple Presenters	13-Oct-22	Promotion and enhancement of the quality, quantity, coordination, and cooperation of substance abuse prevention services in Orange County.
2023 Emergency Medical Services Administrators Association of California (EMSAAC) Annual Conference by Multiple Presenters	31-May-23 & 1-Jun-23	The EMS Administrators' Association of California (EMSAAC) cordially invites California's EMS leaders and professionals to join us for a virtual EMSAAC Annual Conference 2023. EMSAAC continues to lead the way in creating conferences that are meaningful and exciting to attend. This year's theme," Engineering Excellence" provides a broad variety of subject matter to interest all levels of prehospital care personnel and managers including ambulance providers, fire department personnel, military and law enforcement partners, EMS agency personnel, ED nurses, physicians and emergency preparedness coordinators, and all of you who provide life-saving EMS services to your communities. The conference includes lectures, panel discussions and opportunities to network with current leaders and innovators in EMS as well as preview new and upcoming equipment, products and services
2023 Meeting of the Minds Mental Health Conference "Wellness for All: Equity in Mental Health Care" by Multiple Presenters	5-May-23	The Meeting of the Minds conference brings together the full spectrum of the behavioral health of Orange County to raise awareness, enhance skills, increase cultural diversity and reduce stigma. The conference also provides opportunities for participants to network, develop new alliances, and help improve care for persons impacted by mental illness.
Addressing Substance Abuse and Trauma: With A Youth Focus by Gabriella Grant, M.A.	17-May-23 & 24-May-23	This training focuses on concepts to improve the co-occurring treatment of trauma and substance use disorders, as well as the integration of both issues when only one condition is under treatment. Using the standards from SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed

		Approach and TIP 57, attendees will develop a strong set of skills to treat clients who struggle with historically challenging yet far too common conditions. Evidence-based practices will be identified, and foundational skills will be practiced during the training.
Clinical High-Risk and First Episode Psychosis by Jason Schiffman, Ph.D.	22-Feb-23	This training provides an introduction to Clinical High-Risk (CHR) and first episode (EP) psychosis. We will begin with an in-depth overview of psychosis and psychosis-risk syndromes, followed by a discussion of issues regarding assessment and intervention. We will also provide a primer on the use of the SIPS and the PRIME Screen and touch on assessment best practices, existing screening instruments, misconceptions and stigma, psychosocial interventions and modular approaches to treatment, and other practical clinical considerations. Interactive exercises using example clients and vignettes will also be incorporated throughout the presentation. In addition, you will learn about resources such as OC CREW to support youth and young adults ages 12-25 experiencing first-episode psychosis and how to refer clients to OC CREW.
Cognitive Behavioral Therapy for Psychosis by Maggie Mullen, LCSW, DBT-LBC	29-Mar-23	This presentation will provide an overview of the psychosis risk syndrome and how racial and ethnic factors have influenced diagnosis, treatment, and outcomes—both historically and in the current time. The presentation will also touch on the current state of psychosis risk screening, including the strengths and weaknesses of currently available risk screening tools, and what needs to be done to develop more culturally and contextually sensitive instruments to prevent over- and misdiagnosis of psychosis-risk.
Coping with the Journey of Grief and Mourning by Deborah Silveria, Ph.D.	9-Mar-23	In this workshop, participants will learn about the different types of grief and mourning and an overview of four major theories of how people grieve: Kubler Ross, Worden, Rando and Berger. Cultural and social identity considerations that impact grieving will also be reviewed. Participants will be able to identify the psychological and psychophysiological factors contributing to grief

		and mourning. Using ICD-11 and DSM-5 criteria, participants will be able to differentiate between normal grief and mourning and complicated bereavement and depression. The current and projected impact of COVID-19 on mental health, taking into consideration culture and premorbid conditions, will be presented. Participants will learn practical tools for assisting consumers in their grief process through cultural awareness, humility and sensitivity, (using the ASK model) in building resilience during periods of mourning. Participants will learn self-care strategies for clinicians to protect them from burnout and build vicarious resilience
Cultivating Competency-Based Clinical Supervision by Multiple Presenters	8-Nov-22	This 6-hour clinical supervision training is intended for current clinical supervisors who seek to improve their clinical supervision skills and develop knowledge of competency-based supervision. Specific time will be allotted to discuss the need to move toward a competency-based approach to supervision. Through this training, clinicians will learn the 12 core competencies of the Southern Counties Regional Partnership (SCRP), several models of clinical supervision, and methods to implement them in individual and group supervision. Additionally, supervisors will be updated on the legal and ethical changes from the various licensing boards. The training is also intended to focus on best practices of clinical supervision including healthy supervisory alliances. Specific attention will be paid to cultural competency in supervision.
Cultivating Competency-Based Clinical Supervision for NEW Supervisors by Multiple Presenters	27-Jul-22 28-Jul-22	On January 1, 2022, the California State Board of Behavioral Sciences (BBS) mandated that new clinical supervisors (except licensed psychologists and physicians) are now required to receive a total of 15 hours of training in clinical supervision. This 9-hour training, in addition to the standard 6-hour training, will meet the requirements of the BBS for new supervisors. In this presentation, new supervisors will learn the following: Supervisory Excellence model; the use of the SCRP Core Competencies in evaluation of supervisees; ways to structure a clinical supervision session; elements of

		Trauma-Informed Clinical Supervision; ways of managing the supervisor/supervisee relationship including the repair of ruptures; a case conceptualization model; LGBTIQ+ affirmative practices; and the use of transference and countertransference in clinical supervision. Time will be provided for vignettes, role plays, videos and other types of learning experiences.
Cultural and Contextual Consideration in the Early Identification of Risk for Psychosis by Jason Schiffman, Ph.D.	12-Jan-23	This presentation will provide an overview of the psychosis risk syndrome and how racial and ethnic factors have influenced diagnosis, treatment, and outcomes—both historically and in the current time. The presentation will also touch on the current state of psychosis risk screening, including the strengths and weaknesses of currently available risk screening tools, and what needs to be done to develop more culturally and contextually sensitive instruments to prevent over- and misdiagnosis of psychosis-risk. Finally, recommendations for clinicians to begin developing culturally sensitive practices in clinical assessment and intervention will be offered. The training will be presented by Jason Schiffman, PhD. Dr. Schiffman has over 25 years of research and service experience and expertise on Clinical High Risk (CHR) syndromes of psychosis.
Cultural Competency 3.0 Training by Multiple Presenters, and **Think Cultural Health**	Ongoing	This training provides an overview of a culturally responsive approach to incorporate into service attitudes and interactions with clients. The concepts of culture, race, ethnicity, and diversity, as well as stigma and self-stigma, are discussed. The training also demonstrates the influence of unconscious thought on our judgment as it relates to stereotyping and racism. Strategies are also provided to recognize diversity and embrace the uniqueness of other cultures beyond the mainstream American culture.
Dialectical Behavior Therapy for Psychosis by Maggie Mullen, LCSW, DBT-LBC	18-Apr-23	Dialectical Behavioral Therapy (DBT) has often been utilized to help those that struggle with intense experiences of emotion dysregulation. Yet, when one thinks of psychosis, an experience that can greatly disrupt one's ability to engage in emotional regulation, DBT is not commonly thought of as a therapeutic intervention. By examining the four

		modules of DBT (distress tolerance, emotional regulation, mindfulness, and interpersonal effectiveness), we will learn how to apply DBT-informed concepts and principles to benefit clients with Psychotic Spectrum Disorders. There will be an emphasis on skill building interventions derived from DBT, rather than a strict adherence to DBT treatment protocol that is customary for DBT programs. This interactive two-part presentation will introduce you to DBT skills adapted for psychotic experiences through discussion, case examples, and practical tools.
Dialectical Behavior Therapy Training by Maggie Mullen, LCSW, DBT-LBC	3-May-23 10-May-23	This training will outline the basics of Dialectical Behavior Therapy (DBT), an evidence-based psychotherapy for emotion dysregulation that helps people become more mindful as they simultaneously work on improving interpersonal relationships, tolerating distress, and regulating intense emotions. This presentation will introduce practical applications of DBT through discussion, vignettes, video clips, and opportunities to practice. By examining the four modules of DBT (distress tolerance, emotional regulation, mindfulness, and interpersonal effectiveness), learn how to apply DBT concepts and principles to benefit clients. There will be an emphasis on practical skill building interventions derived from DBT, rather than on building a full DBT program. The intended audience is any clinician with interest in DBT
EMDR Boot Camp: A Basic Training Refresher and Fidelity to Model Course by Deborah Silveria, Ph.D.	2-Mar-23	This 6-hour course reviews the basic concepts of EMDR Therapy including: Adaptive Information Processing (AIP) model, the 8 phases and 3-Pronged Approach. Common errors in all 8 phases due to therapist drift will be covered. Attention to dissociative processes will be emphasized. Ethical issues in EMDR treatment will be reviewed for in person and the virtual environment. Strategies to remove blocked processing, including cognitive interweaves, will be reviewed. EMDR therapy is ideal for working with clients from different cultures and backgrounds. Core components of EMDR therapy that have contributed to its cultural transferability and suggestions for obtaining

		cultural competence in your practice will be presented. Socially based negative beliefs within the domain of connection and belonging will be presented, and ways clinicians can improve their cultural competence will be reviewed. Possible targets involving discrimination and intergenerational trauma will be discussed. Vignettes and role plays will be incorporated with didactic instruction and videos to potentiate adult learning. This training is appropriate for all those who have completed the two weekend EMDR training and subsequent 10 hours individual or group consultation.
Exploring the Depths of Clinical Supervision by Multiple Presenters	22-Jun-23 5-Oct-23	This 6-hour clinical supervision training is intended for current clinical supervisors who seek to improve their clinical supervision skills and knowledge of competency-based clinical supervision. Time will be allotted to focus specifically on best practices regarding clinical assessment and intervention skills within the context of clinical supervision. Through this training, clinicians will review and update knowledge of the supervisory alliance, multi-cultural supervision, and legal and ethical issues. Chalkboard Case Conceptualization will be presented as a useful model of clinical supervision that can assist supervisees in developing cognitive complexity and ability to think at a more relativistic level about their clients. Finally, updates from the Board of Psychology and Board of Behavioral Sciences will be reviewed and discussed.
Implementing Strategies for Eating Disorder Management and Treatment by Terra Towne, Ph.D.	30-Mar-23	This training is a continuation of the introductory eating disorders training presented to Mental Health and Recovery Services in October of 2021. It is designed to help mental health professionals better understand and identify eating disorders, assess for eating disorder symptoms, implement transdiagnostic eating disorder treatment strategies, and manage comorbid conditions. Cultural considerations in the assessment, diagnosis, and treatment of eating disorders will be discussed. The training will also provide information on the eating disorder treatment landscape, helping providers make appropriate

		treatment referrals and involve family members/supports in treatment when indicated.
Intersection Between Autism and Clinical High Risk for Psychosis by Jason Schiffman, Ph.D.	9-Feb-23	Schizophrenia and autism spectrum disorders have been historically linked, and even today are found to have substantial overlap in symptomatology. This presents challenges for clinical diagnosis and intervention, and points to a need for further research as a foundation that will enable clinicians to reliably delineate the common and distinct features of both disorders. This presentation will cover an overview of the current state of research in the field, including its historical context, the prevalence of this comorbidity, working theories of the association, the overlap in diagnostic criteria, challenges in assessment, implications of comorbidity, tips for clinical assessment and treatment, and a discussion of case-studies. The presentation will be given by Jason Schiffman, PhD, the Director of Clinical Training at the University of California, Irvine. Dr. Schiffman has over 25 years of research and service experience and expertise on Clinical High Risk (CHR) syndromes of psychosis.
Mental Health and Recovery Services MD/NP Series by Multiple Presenters	11-Jan-23 through 08-Nov-23	MHRS Regularly Schedules Series: Updates and Training for MDs and NPs. This is a regularly scheduled series (RSS) designed to provide crucial program updates to Mental Health & Recovery Services (MHRS) to MD and NP staff. This time will also be used to provide other practice oriented trainings on subjects to be determined later—including such topics as implicit bias, cultural conciderations, and specific populations.
Recent Traumatic Events Protocol (R-TEP) and Group Traumatic Events Protocol - An Advanced EMDR Training by Deborah Silveria, Ph.D.	30-Mar-23 31-Mar-23	The Recent Traumatic Episode Protocol (R-TEP) and Group Traumatic Episode Protocol (G-TEP) are part of a comprehensive approach to Early EMDR Intervention (EEI). These approaches can also be used successfully by EMDR practitioners for clients who are not ready to receive the full 8- Phase Protocol due to high levels of emotional distress. Workshop participants will learn how to apply R-TEP and G-TEP principles for early intervention in emergent trauma situations, and with clients experiencing high levels of emotional distress including those with complex trauma and dissociation. Participants will identify and apply key features, procedures, and concepts of both R-TEP

		and G-TEP as well as demonstrate their use through active participation within the workshop practicum setting. Participants will learn how to adapt both protocols for online tele-health formats.
Self Care and the Professional: Creating a Culture of Self Care Part I and II by Gabriella Grant, M.A.	01-Feb-23 07-Feb-23	This training is designed to promote standards of self-care within trauma-informed organizations and systems. Using the Harris and Fallot "impact of trauma work" model, this training looks at the impact of primary trauma on the workforce and its role in the development of work-related trauma symptoms. Attendees will be able to assess themselves, create a self-care plan and experience an active demonstration of self-care during the training.
Solution Focused Brief Therapy for School Based Mental Health Professionals by Johnny S. Kim, Ph.D., LCSW	6-Dec-22 7-Dec-22	This training introduces attendees to Solution Focused Brief Therapy (SFBT) as an evidence-based brief model that was developed to provide a strengths based alternative to traditional problem-focused services. Solution Focused Brief Therapy strategies can be used to address a number of concerns, including behavioral and emotional issues, academic problems, social skills, and dropout prevention.
Structured Interview for Psychosis Risk Syndromes ("SIPS") by Jason Schiffman, Ph.D.	16-May-23 18-May-23	This workshop provides training in the use of the Structured Interview for Psychosis Risk Syndromes (SIPS), the nation's gold standard tool for diagnosing people at risk for psychosis. Participants will become familiar with the general signs and symptoms of individuals at risk for psychosis, review the SIPS diagnostic and symptom severity measures, and will be able to reliably rate a SIPS interview. This workshop will be led by Jason Schiffman, Ph.D., who has over 25 years of research and service experience and is one of only 3 certified SIPS trainers.
Suicide Assessment and Intervention by Deborah Silveria, Ph.D.	14-Feb-22	In this workshop, participants will learn techniques and tools for assessing suicidal risk among consumers with cultural awareness, humility, and sensitivity. They will learn crisis intervention techniques that allow them to practice to the standard of care. Evidence-based therapies for working with suicidal clients will be highlighted; and self-care for clinicians, including coping

		strategies, to protect them from burnout and vicarious trauma with this population, will also be discussed. Participants will be able to identify the warning signs of suicide, apply evidence-based suicide objective assessment, safety planning tools, and evidence-based suicide-specific treatment plans to improve their clinical skills to better identify and treat suicidal individuals in their practice.
Suicide Prevention Center Clinical Presentation by Lauren Delfin, M.A., PPSC	20-Jul-22 25-Aug-22	This presentation will provide an overview of suicide prevention. Our presenters will discuss the nature of suicide, suicide related statistics, risk factors, and invitations, formally viewed as warning signs. They will discuss how to assess for lethality, how to manage a client/patient who is suicidal and will provide information on resource referrals. Participants will gain an understanding of warning signs and risk factors for suicide and learn how to perform a suicide risk assessment and build a safety plan with a suicidal client.
The Mental and Emotional Health Complete Series by Jayna Bonfini	7-Feb-23 14-Jun-23	The Mental and Emotional Health Series is a flexible curriculum for working with clients experiencing mild to moderate mental and emotional health challenges. The number of Americans experiencing these challenges and seeking mental health services grows every year and is on an expedited rise due to recent world events. Using evidence-based approaches including acceptance and commitment therapy, cognitivebehavioral therapy, and dialectical behavior therapy, learners will gain tools and skills through the curriculum's targeted exercises to help clients experiencing mental health concerns build new skills and move towards wellness. At the end of this training learners will have a facilitator guide, workbook and corresponding videos that addresses 6 mental and emotional health concerns.
The New Faces of Anxiety in Light of the Pandemic by Marwa Azab, Ph.D.	12-Jan-23	Anxiety disorders have always been prevalent in the clinic. However, recent chronic threats have mutated some anxiety symptoms in ways that have challenged diagnosis and treatment. Be at the forefront of successfully treating anxiety in this new era. The seminar will update clinicians'

		understanding of traditional anxiety diagnoses such as generalized anxiety, social anxiety, and panic disorders. The bidirectional relationship between long COVID symptoms and these diagnoses will be discussed. In addition, the seminar will elucidate the clinical significance of the rise of pathological health anxiety and existential anxiety. Tools and strategies based on the most recent neuroscientific findings will be demonstrated.
Trauma and Parenting: Creating a Safe Home Base by Gabriella Grant, M.A.	4-Apr-23 5-Apr-23	This training provides a framework to enhance parenting safety. A research-based overview, it focuses on safety, child abuse law, casework practice and the interaction between parenting and the impact of trauma and disaster on both the child and parent. It considers emerging research into the intergenerational transmission of trauma as well as practice approaches to help parents increase both physical and emotional safety with their interactions with their children.
Trauma Informed Foundations by Gabriella Grant, M.A.	14-Jul-22	This training provides line staff, managers and administrators with six key elements of a trauma-informed program. Based on the core values of SAMHSA's TIP 57, it incorporates the 2001 "Using Trauma Theory to Design Service Systems" framework. A written statement of commitment is developed to be applied on the agency-level. Additional resources are provided to assess and transform agencies to become more trauma-informed. Appropriate for all levels of staff.
Trauma-Informed Approaches to Addressing Suicide and Self Harm by Gabriella Grant, M.A.	6-Jun-23 13-Jun-23	This training provides approaches for understanding trauma, PTSD and complex PTSD as keys to working with individuals at risk for suicide or self-harm. It considers how a trauma informed framework helps services prevent suicide and self-harm in trauma-exposed populations and how to develop a relapse prevention intervention that addresses suicide. Special attention will be given to the multicultural aspects of suicide and self-harm.
Understanding Non-Suicidal Self-Injury by Janis Whitlock, Ph.D.	7-Sep-22	Self-injury is intentionally hurting the body (e.g. cutting, burning, etc.) but without suicidal intent. Because it often looks like a suicidal gesture it tends to evoke fear and confusion. Why would someone choose to cut or otherwise hurt their body in a way

		that looks like a suicide attempt, but then insist that it actually has nothing to do with suicide at all? In addition to covering self-injury basics, this workshop will address effective detection and intervention approaches in school settings and best practices for early intervention and prevention.
Youth Mental Health First Aid by Certified Mental Health First Aid Trainers	Multiple Dates	Youth Mental Health First Aid teaches you how to identify, understand and respond to signs of mental illness and substance use disorders in youth. This 6-hour training gives adults who work with youth the skills they need to reach out and provide initial support to children and adolescents (ages 6-18) who may be developing a mental health or substance use problem and help connect them to the appropriate care. The training covers common signs and symptoms of mental illness and substance use, as well as how to interact with a child or adolescent in crisis and connect them with help.

APPENDIX V:

NOTICE OF DISCRIMINATION

NOTICE OF NONDISCRIMINATION

AFFORDABLE CARE ACT (ACA) 45 CFR 92 SECTION 1557

The Orange County Health Care Agency complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Orange County Health Care Agency does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Orange County Health Care Agency:

- Provides free aids and services to people with disabilities to communicate effectively with us such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English such as:
  - Qualified interpreters
  - Information written in other languages

Let our staff know if you need these services.

If you have any difficulty obtaining these services, believe you have been discriminated against, or wish to file a grievance related to any of these services or policies, you can file a grievance in person or by mail, fax or email at the contact information listed directly below. Kelly K. Sabet, Civil Rights Coordinator at Orange County Health Care Agency, is available to help you as needed.

Orange County Health Care Agency
Attn: Kelly K. Sabet, Civil Rights Coordinator, Office of Compliance
405 W. 5th Street, Santa Ana, CA 92701
714-568-5787, 711 (TTD), 714-834-6595 (Fax)
officeofcompliance@ochca.com

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf , or by mail or phone at:
U.S. Department of Health and Human Services
200 Independence Avenue, SW Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at www.hhs.gov/ocr/office/file/index.html.

APPENDIX VI:

INTERPRETATION SERVICES AVAILABLE

INTERPRETATION SERVICES AVAILABLE

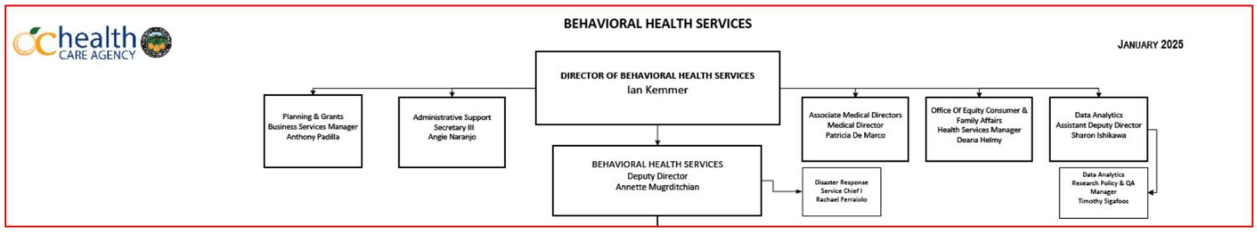
You have the right to an interpreter at no cost to you. Ask at the front desk.

Arabic	لك الحق في الحصول على مترجم فوري بدون تحمل اي رسوم من تجاهك. اسأل في مكتب الاستقبال.
Armenian	Դուք իրավունք ունեք անվճար թարգմանչի ծառայություն ստանալ: Հարցրեք գրանցման սեղանի մոտ:
Cambodian	លោកអ្នកមានសិទ្ធិទទួលបានអ្នកបកប្រែផ្ទាល់មាត់ម្នាក់ដោយឥតគិតថ្លៃ។ សូមសាកសួរនៅតុទទួលភ្ញៀវ។
Cantonese	您有權免費獲得一位口譯人員。請在前臺諮詢。
Farsi	شما این حق را دارید که بطور رایگان از خدمات یک مترجم استفاده کنید. در مورد این خدمات از کارکنان جلوی دفتر یا پشت پیشخوان جویا شوید.
Hindi	आपको निःशुल्क दुभाषिया प्राप्त करने का अधिकार है। फ्रंट डेस्क पर पूछताछ करें।
Hmong	Koj muaj cai tau txais ib tug kws txhais lus pub dawb. Nug ntawm lub rooj ua haujlwm nyob sab ntawm xub thawj.
Japanese	あなたには無料で通訳者のサービスを受ける権利があります。フロントデスクにお尋ねください。
Korean	당신은 통역사를 무상으로 이용할 권리가 있습니다. 프론트 데스크에 문의하세요.
Lao	ທ່ານມີສິດມີວ່າມ.ຕປພາສາໂດຍບໍ່ເສຍຄ່າ. ຖາມຢູ່ໂຕະຕ້ອນຮັບ.
Mandarin	你有权利免费获得翻译服务。请问前台。
Punjabi	ਤੁਹਾਡੇ ਕੋਲ ਬਿਨਾਂ ਕਿਸੇ ਖ਼ਰਚ ਦੁਭਾਸ਼ੀਏ ਦੀ ਮਦਦ ਲੈਣ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਇਸ ਬਾਰੇ ਫਰੰਟ ਡੈਸਕ ਤੋਂ ਪੁੱਛੋ।
Russian	Вы имеете право на получение бесплатных услуг переводчика. Спросите на стойке регистрации.
Samoan	E iai lau aiia tatau mo se fa'amatalaupu e leai se totogi. Fesisli i le tagata oi le laulau i luma.
Spanish	Usted tiene el derecho a un intérprete sin costo alguno para usted. Pregunte en la recepción.
Tagalog	Mayroon kang karapatan sa isang tagapagsalin nang walang bayad. Magtanong sa front desk.
Thai	คุณมีสิทธิเป็นล่ามได้โดยที่คุณไม่ต้องมีค่าใช้จ่าย สอบถามได้ที่แผนกต้อนรับ
Vietnamese	Quý vị có quyền yêu cầu một thông dịch viên miễn phí. Xin hỏi ban tiếp tân.

**Translation services are also available in other languages, free of charge.
If another language is needed, please inquire at the front desk.

APPENDIX VII:

BEHAVIORAL HEALTH SERVICES RE-ORGANIZATION CHART



APPENDIX VIII: ACCESS CRITERIA FOR SPECIALTY MENTAL HEALTH SERVICES

Policy 01.03.06

Health Care Agency **Mental Health and** **Recovery Services** **Policies and Procedures**	Section Name: Sub Section: Section Number: Policy Status:	Care and Treatment Access 01.03.06 ☒New ☐Revised

	SIGNATURE	DATE APPROVED
Director of Operations Mental Health and Recovery Services	Signature on File	9/14/2022

SUBJECT: Access Criteria for Specialty Mental Health Services

PURPOSE:

To describe the County of Orange Mental Health Plan (hereby referred to as Orange MHP) access criteria for Medi-Cal beneficiaries residing in Orange County to comply with the California Advancing and Innovating Medi-Cal (CalAIM) initiative to address beneficiaries' needs across the continuum of care, ensure that all Medi-Cal beneficiaries receive coordinated services, and improve health outcomes.

POLICY:

Orange County Health Care Agency (OCHCA) adheres to California state regulations and guidelines for providing access to Specialty Mental Health Services (SMHS) in accordance with California Advancing and Innovating Medi-Cal (CalAIM) initiative.

SCOPE:

The provisions of this policy are applicable to all County and County contracted staff providing SMHS throughout the Orange MHP.

REFERENCES:

Behavioral Health Information Notice (BHIN) 21-073 Criteria for beneficiary access to Specialty Mental Health Services (SMHS), medical necessity and other coverage requirements

Early and Periodic Screening, Diagnostic, and Treatment | Medicaid

The ICD 10-CM Updates and Information

Welfare and Institutions Code (WIC) §14184.402

DEFINITIONS:

Specialty Mental Health Services (SMHS) - Medi-Cal mental health services available to children, youth, and adults. SMHS include medically necessary services to correct or ameliorate impairments and mental illnesses or conditions available through the Medi-Cal Early and

Periodic Screening, Diagnostic and Treatment (EPSDT) benefit. This benefit is available to beneficiaries under the age of 21 who are eligible for full scope Medi-Cal. These services may include crisis counseling, individual/group/family therapy, medication management, targeted case management, psychological testing, psychiatric inpatient hospitalization, and recovery services.

Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT) - The federally mandated Medi-Cal benefit that entitles full-scope Medi-Cal-covered beneficiaries less than 21 years of age to receive any Medi-Cal service necessary to correct or ameliorate a defect, mental illness, or other condition, such as a substance-related disorder, that is discovered during a health screening.

Involvement in Child Welfare System - The beneficiary has an open child welfare service case, or the beneficiary is determined by a child welfare service agency to be at imminent risk of entering foster care but able to safely remain in their home or kinship placement with the provision of services under a prevention plan, or the beneficiary is a child whose adoption or guardianship occurred through the child welfare system. A child has an open child welfare services case if: a) the child is in foster care or in out of home care, including both court-ordered and by voluntary agreement; or b) the child has a family maintenance case (pre-placement or post-reunification), including both court-ordered and by voluntary agreement. A child can have involvement in child welfare whether the child remains in the home or is placed out of the home.

Juvenile Justice Involvement - The beneficiary (1) has ever been detained or committed to a juvenile justice facility, or (2) is currently under supervision by the juvenile delinquency court and/or a juvenile probation agency. Beneficiaries who have ever been in custody and held involuntarily through operation of law enforcement authorities in a juvenile justice facility, including youth correctional institutions, juvenile detention facilities, juvenile justice centers, and other settings such as boot camps, ranches, and forestry/conservation camps, are included in the "juvenile justice involvement" definition. Beneficiaries on probation, who have been released home or detained/placed in foster care pending or post-adjudication, under probation or court supervision, participating in juvenile drug court or other diversion programs, and who are otherwise under supervision by the juvenile delinquency court and/or a juvenile probation agency also meet the "juvenile justice involvement" criteria.

Homelessness - The beneficiary meets the definition established in section 11434a of the federal McKinney-Vento Homeless Assistance Act.15 Specifically, this includes (A) individuals who lack a fixed, regular, and adequate nighttime residence (within the meaning of section 103(a)(1) of the Act); and (B) includes (i) children and youths who are sharing the housing of other persons due to loss of housing, economic hardship, or a similar reason; are living in motels, hotels, trailer parks, or camping grounds due to the lack of alternative adequate accommodations; are living in emergency or transitional shelters; or are abandoned in hospitals; (ii) children and youths who have a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings (within the meaning of section 103(a)(2)(C)); (iii) children and youths who are living in cars, parks, public spaces, abandoned buildings, substandard housing, bus or train stations, or similar settings; and (iv) migratory children (as such term is defined in section 1309 of the Elementary and Secondary Education Act of 1965) who qualify as homeless for the purposes of this subtitle because the children are living in circumstances described in clauses (i) through (iii).

Trauma Screening Tools - The trauma screening tools referenced are screening measures that have been approved by DHCS to aid in determining whether a beneficiary has met the access criteria. MHPs are not required to implement screening tool(s) until DHCS issues additional guidance regarding approved trauma screening tool(s) for the purposes of SMHS access criteria.

Medical Necessity or Medically Necessary –

- Pursuant to Welfare and Institutions Code section 14184.402(a), for individuals 21 years of age or older, a service is "medically necessary" or a "medical necessity" when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain as set forth in Welfare and Institutions Code section 14059.5.

- For individuals under 21 years of age, a service is "medically necessary" or a "medical necessity" if the service meets the standards set forth in Section 1396d(r)(5) of Title 42 of the United States Code. This section requires provision of all Medi-Cal coverable services necessary to correct or ameliorate a mental illness or condition discovered by a screening service, regardless of whether such services are covered under the State Plan. Services that sustain, support, improve, or make more tolerable a mental health condition are considered to ameliorate the mental health condition are thus medically necessary and covered as Early Periodic Screening, Diagnostic, and Treatment (EPSDT) services.

- Services provided to a beneficiary must be medically necessary and clinically appropriate to address the beneficiary's presenting condition.

PROCEDURE:

I. Criteria for Adult Beneficiaries to Access the SMHS Delivery System

A. For beneficiaries 21 years of age or older, SMHS shall be provided for beneficiaries who meet both of the following criteria in 1 and 2 below:

1. The beneficiary has one or both of the following:

a) Significant impairment, where impairment is defined as distress, disability, or dysfunction in social, occupational, or other important activities.

b) A reasonable probability of significant deterioration in an important area of life functioning. AND

2. The beneficiary's condition as described above in 1 is due to either of the following:

a) A diagnosed mental health disorder, according to the criteria of the current editions of the Diagnostic and Statistical Manual of Mental Disorders (DSM) and the International Statistical Classification of Diseases and Related Health Problems (ICD).

b) A suspected mental disorder that has not yet been diagnosed.

II. Criteria for Beneficiaries under Age 21 to Access the SMHS Delivery System

A. Beneficiaries under 21 years of age shall be provided all medically necessary SMHS required pursuant to Title 42 U.S.C.§1396d(r). Covered specialty mental health services shall be provided to enrolled beneficiaries who meet either of the following criteria in 1 or 2 below.

1. The beneficiary has a condition placing them at high risk for a mental health disorder due to experience of trauma evidenced by any of the following: scoring in the high-risk range under a trauma screening tool approved by the department, involvement in the child welfare system, juvenile justice involvement, or experiencing homelessness. OR

2. The beneficiary meets both of the following requirements in a) and b) below:

a) The beneficiary has at least one of the following:

i) A significant impairment

ii) A reasonable probability of significant deterioration in an important area of life functioning

iii) A reasonable probability of not progressing developmentally as appropriate.

iv) A need for SMHS, regardless of presence of impairment, that are not included within the mental health benefits that a Medi-Cal managed care plan is required to provide. AND

b) The beneficiary's condition as described in 2 above is due to one of the following:

i) A diagnosed mental health disorder, according to the criteria of the current editions of the Diagnostic and Statistical Manual of Mental Disorders (DSM) and the International Statistical Classification of Diseases and Related Health Problems (ICD).

ii) A suspected mental health disorder that has not yet been diagnosed.

iii) Significant trauma placing the beneficiary at risk of a future mental health condition, based on the assessment of a licensed mental health professional.

3. If a beneficiary under age 21 meets the criteria as described in 1 above, the beneficiary meets criteria to access SMHS. It is not necessary to establish that the beneficiary also meets the criteria in 2 above.

III. Additional Coverage Requirements

A. Criteria for a beneficiary to access the SMHS delivery system (except for psychiatric inpatient hospital and psychiatric health facility services) set forth above shall not be construed to exclude coverage for, or reimbursement of, a clinically appropriate and covered mental health prevention, screening, assessment, treatment, or recovery service under any of the following circumstances:

1. Services were provided prior to determining a diagnosis, including clinically appropriate and covered services provided during the assessment process.

2. The prevention, screening, assessment, treatment, or recovery service was not included in an individual treatment plan.

3. The beneficiary has a co-occurring substance use disorder.

B. All Medi-Cal claims, including SMHS claims, are required to include a CMS approved ICD-10 diagnosis code.

APPENDIX IX: ACCESS CRITERIA FOR DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM

Policy 01.03.07

Health Care Agency **Mental Health and** **Recovery Services** **Policies and Procedures**	Section Name: Sub Section: Section Number: Policy Status:	Care and Treatment Access 01.03.07 ☐New ☒Revised

	SIGNATURE	DATE APPROVED
Director of Operations Mental Health and Recovery Services	Signature on File	1/30/2023

SUBJECT: Access Criteria for Drug Medi-Cal Organized Delivery System

PURPOSE:

To describe the County of Orange Drug Medi-Cal Organized Delivery System (DMC-ODS) access criteria for Medi-Cal beneficiaries residing in Orange County to comply with the California Advancing and Innovating Medi-Cal (CalAIM) initiative to address beneficiaries' needs across the continuum of care, ensure that all Medi-Cal beneficiaries receive coordinated services, and improve health outcomes.

POLICY:

Orange County Health Care Agency (OCHCA) adheres to California state regulations and guidelines for providing access to DMC-ODS in accordance with California Advancing and Innovating Medi-Cal (CalAIM) initiative.

SCOPE:

The provisions of this policy are applicable to all County and County contracted staff providing DMC-ODS and Substance Use Disorder (SUD) services throughout Orange County.

REFERENCES:

Behavioral Health Information Notice (BHIN) 23-001 Drug Medi-Cal Organized Delivery System (DMC-ODS) Requirements for the Period of 2022 – 2026

Behavioral Health Information Notice (BHIN) 21-071 Medical Necessity Determination and Level of Care Determination Requirements for Drug Medi-Cal (DMC) Treatment Program Services

The ICD 10-CM Updates and Information

Welfare and Institutions Code (WIC) §14184.402

Welfare and Institutions Code § 14059.5

Title 42 of the United States Code § 1396d(r)(5)

Page 1 of 4

DEFINITIONS:

Medical Necessity or Medically Necessary –

- Pursuant to Welfare and Institutions Code section 14184.402(a), for individuals 21 years of age or older, a service is "medically necessary" or a "medical necessity" when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain as set forth in Welfare and Institutions Code section 14059.5.

- For individuals under 21 years of age, a service is "medically necessary" or a "medical necessity" if the service meets the standards covered under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) mandate.

PROCEDURE:

I. Criteria for Adult Beneficiaries to Access the DMC-ODS

A. For beneficiaries 21 years of age or older, DMC-ODS services shall be provided for beneficiaries who meet one of the following criteria in 1 and 2 below:

1. Have at least one diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM) for Substance-Related and Addictive Disorders, with the exception of Tobacco-Related Disorders and Non-Substance Related Disorders, OR

2. Have had at least one diagnosis from the DSM for Substance- Related and Addictive Disorders, with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders, prior to being incarcerated or during incarceration, determined by substance use history.

B. Narcotic Treatment Programs (NTPs) conduct a history and physical exam by an LPHA pursuant to state and federal regulations. This history and physical exam done at admission to a NTP qualifies for the purpose of determining medical necessity under the DMC-ODS.

II. Criteria for Beneficiaries under Age 21 to Access the DMC-ODS

A. Beneficiaries under 21 years of age shall be provided all medically necessary DMC-ODS services required pursuant to Title 42 U.S.C.§1396d(r).

B. Federal EPSDT statutes and regulations require States to furnish all Medicaid-coverable, appropriate, and medically necessary services needed to correct and ameliorate health conditions, regardless of whether those services are covered in the state's Medicaid State Plan.

C. Consistent with federal guidance, services need not be curative or completely restorative to ameliorate a mental health condition, including substance misuse and SUDs.

D. Services that sustain, support, improve, or make more tolerable substance misuse or an SUD are considered to ameliorate the condition and are thus covered as EPSDT services.

III. Level of Care Determination

A. In addition to being medically necessary, all SUD treatment services provided to a DMC-ODS beneficiary must be clinically appropriate to address that beneficiary's presenting condition.

B. In accordance with Welfare and Institutions Code (WIC) §14184.402(e), providers must use the criteria adopted by the American Society of Addiction Medicine (ASAM) to determine the appropriate level of SUD treatment service for DMC-ODS beneficiaries.

1. However, a full assessment utilizing the ASAM criteria is not required for a DMC-ODS beneficiary to begin receiving covered and reimbursable SUD treatment services; an abbreviated ASAM screening tool may be used for initial screening, referral, and access to clinically appropriate services.

2. These requirements for ASAM Level of Care assessments apply to NTP clients and settings.

C. For DMC-ODS beneficiaries 21 and over, a full assessment using the ASAM Criteria shall be completed within 30 days of the beneficiary's first visit with a licensed professional of the healing arts (LPHA) or registered/certified counselor.

D. For DMC-ODS beneficiaries under 21, or for adults experiencing homelessness, a full assessment using the ASAM criteria shall be completed within 60 days of the DMC-ODS beneficiary's first visit with an LPHA or registered/certified counselor.

E. If a DMC-ODS beneficiary withdraws from treatment prior to completing the ASAM assessment and later returns, the time period starts over.

1. The assessment time period re-sets in cases where the Episode of Care (EOC) has been closed, as open EOC must follow established timelines.

IV. Additional Coverage Requirements

A. Consistent with WIC §14184.402(f), clinically appropriate and covered SUD prevention, screening, assessment, treatment, and recovery services are covered and reimbursable Medi-Cal services even when:

1. Services are provided prior to determination of a diagnosis or prior to determination of whether DMC-ODS criteria are met, as described above.

2. Services are provided during the assessment process and if is later determines through the assessment that the beneficiary does not meet criteria for DMC-ODS services.

3. The prevention, screening, assessment, treatment, or recovery services were not included in an individual treatment plan; or

4. The beneficiary has a co-occurring mental health condition.

    a) Reimbursement for covered DMC-ODS services provided to a beneficiary who meets DMC-ODS criteria and has a co-occurring mental health condition shall not be denied as long as DMC-ODS criteria and requirements are met.

B. All Medi-Cal claims, including DMC-ODS claims, are required to include a CMS approved International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM), or current version, diagnosis code.

APPENDIX X: TEST CALL PROCEDURE FOR MONITORING ADMINISTRATIVE SERVICE ORGANIZATION (ASO) ACCESS QUALITY AND COMPLIANCE

Policy 06.02.01

Health Care Agency	Section Name:	Quality Improvement
Mental Health and	Sub-section Name:	Access
Recovery Services	Section Number:	06.02.01
Policies and Procedures	Policy Status:	☐New ☒Revised

	SIGNATURE	DATE APPROVED
Director of Operations Mental Health and Recovery Services	Signature on File	2/14/2023

SUBJECT: Test Call Procedure for Monitoring Administrative Service Organization (ASO) Access Quality and Compliance

PURPOSE:

To establish a Policy and Procedure for monitoring the Administrative Service Organization (ASO)'s compliance to County of Orange Mental Health Plan (MHP) (hereby referred to as Orange MHP) Access Line requirements.

POLICY:

The Orange MHP will monitor the ASO in order to assure that the ASO is complying with the MHP's Access Line regulations.

SCOPE:

The procedure is applicable to the ASO.

REFERENCES:

California Code of Regulations, Title 9, Chapter 11, Section 1810.405(d)

California Code of Regulations, Title 9, Chapter 11, Section 1810.405(f)

DEFINITIONS:

Test calls to the MHP's ASO are made in order to test the Orange MHP's Access Line in the following areas:

- Responsiveness of the Access Line 24-hours a day, seven days a week;
- Access to afterhours care;
- Knowledge and helpfulness of the access line staff; and

Page 1 of 2

- Recording of the call on the Telephone Access Log. Calls made in threshold languages are to test response capability to non-English languages.

PROCEDURE:

I. Once per quarter the Adult and Older Adult (AOA) ASO contract monitor will arrange, with the assistance of Authority and Quality Improvement Services (AQIS), to make a minimum of four test calls.

II. AOA will maintain a desk procedure for test calls to the ASO and provide a worksheet and call scenarios for test callers to utilize in order to monitor the ASO's Access Line for access, quality, and compliance. AQIS will collaborate with AOA to modify procedures per State requirements and as needed.

III. Worksheets will be compiled and the results in the form of a Test Call Summary will be shared at the Quality Improvement ASO quarterly management meetings with a request for ASO follow-up and correction.