KINGS COUNTY
BEHAVIORAL HEALTH

CULTURAL COMPETENCE PLAN

ANNUAL UPDATE

FY 2019/2020

KINGS COUNTY
behavioral health
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Kings County Behavioral Health Cultural Competency Plan
2019 UPDATE

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The Fiscal Year 2019/2020 Cultural Competency Plan Update was recommended for approval by the Cultural Humility Task Force on January 9, 2020 and approved by the Kings County Behavioral Health Advisory Board on January 27, 2020.

CRITERION 1

Commitment to Cultural Competence

I. County Mental Health System commitment to cultural competence

The County of Kings, its Behavioral Health Department and its community based providers seek to continuously improve the delivery of a broad range of behavioral health services, including mental health, prevention and early intervention, and substance use disorders which are based in cultural humility, are culturally responsive and appropriate for the communities that make up Kings County.

A. The County shall have the following documents to ensure the commitment of to cultural and linguistic competence services are reflected throughout the entire system:

1. *Mission Statement*;

   To promote, support, and invest in the wellness and recovery of individuals living in the communities of Kings County by creating opportunities to contribute, learn, work and find hope in each day.

2. *Statements of Philosophy*;

   Vision**:** Kings County Behavioral Health (KCBH) and its partners build programs that empower individuals and their families to achieve sustained well-being from mental illness and addiction.

   Guiding Values:

   - Meet each individual where they are-focusing on the person, not an illness
   - Seek to understand and embrace diversity
   - Demonstrate ethics, integrity and commitment in all that we do
   - Share knowledge and information, which fosters authority and empowerment in everyone.
   - Create partnerships that are preventative, creative, and positive to our mission.

3. *Strategic Plans*

   KCBH continues to strive to meet beneficiaries were they are and provide appropriate services to their community. In order to address the needs of the rural areas, as evidenced in the 2017-2020 Kings County Mental Health Services Act (MHSA) Plan, KCBH is increasing the availability of drop-in clinics in three locations in the County. KCBH has begun the MOST Telepsychiatry project, guided by the County's MHSA Innovation Plan, which will further the reach of services that all community members can access. KCBH continues to work with minority populations to understand and address their specific needs, including hiring bilingual staff and providers.

KCBH's current focus is supporting the Full Service Partnership (FSP) programs for youth and adults available in Hanford, Avenal, and Corcoran. KCBH understands the importance of building the success of these programs for rural communities. They will also work with partner organizations to increase awareness of programs available in rural and minority populations (e.g., free transportation to mental health wellness appointments in Hanford from BlueCross and CalViva). [KCBH: MHSA Annual Update FY 19-20, 24]

4. *Policy and Procedure Manuals;*

   Policies and procedures include the following they are available upon request:

   a. MPP A-015: Cultural Competency Policy
   b. MPP A-016: Cultural Competence Taskforce
   c. MPP A-029: Interpreter Policy
   d. MPP A-30: Language Services Requirement Policy
   e. MPP A-042: Requirement of Culturally and Linguistically Appropriate Services (CLAS) Standards for all Direct Service Providers
   f. MPP A-052: Language and Interpreter Services
   g. Kings County Employee Handbook: Bilingual Pay

5. *Other Key Documents*;

   a. Contractor Requirements contained in the KCBH agreement boilerplate, item 26, Culturally and Linguistically Appropriate Services Standards.

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

KCBH expects that all contracted network providers are accountable for providing culturally and linguistically competent specialty mental health and substance use disorder treatment services. Contractor agreements include a provision that states, "To ensure equal access to quality care by diverse populations, Contractor shall adopt and implement the federal Office of Minority Health (OMH) national Culturally and Linguistically Appropriate Standards (CLAS), and will be demonstrated through policies, training and cultural competency plans its efforts address the CLAS requirements" (KCBH agreement boilerplate, item 26) Contractors are also required to participate on the Cultural Humility Task Force, report any necessary data for the Cultural Humility Plan, and provide their staff a minimum of four (4) hours of cultural competency training annually.

A. Given the geographic and demographic profile of Kings County, the needs assessment found that KCBH should continue to strive to meet people "where they are" - in terms of their location, culture, and mental health needs. Transportation and language were cited as barriers to access by many participants and are likely to continue to be ongoing challenges. Participants suggested alternative means such as using an app or online program to stay connected to consumers who are unable to travel to Hanford regularly. These connections to consumers would also provide a pathway for KCBH to outreach in rural areas—another identified need—by increasing familiarity with their services among rural community members. [KCBH: MHSA Annual Update FY 19-20, 24]

B. During the 2017-18 Fiscal Year, the Behavioral Health Department underwent a major restructuring and due to this departmental reorganization, the Cultural Ambassador Program was not initiated at this time. KCBH did convene the Kings County Cultural Competency Task Force monthly, which worked to develop the 2018-2019 Cultural Competency Plan. KCBH's outreach and marketing reached thousands of residents through billboards, radio ads, and their website. [KCBH: MHSA Annual Update FY 19-20, 57]

C. Program challenges include having limited time and resources dedicated to outreach efforts for specific target populations. A bilingual Community Outreach Specialist was hired by KCBH to mitigate these challenges and focus on reducing stigma and discrimination with target populations. [KCBH: MHSA Annual Update FY 19-20, 57]

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

Current CC/ESM reports directly to the Clinical Services Deputy Director, who in turn has access direct access to the Mental Health Director. This team prioritizes issues affecting mental health of the diverse racial, ethnic, cultural, and linguistic populations of Kings County.

A. Designated CC/ESM responsible for cultural competence

Currently the designated CC/ESM is under the Adult System of Care Division as Recovery Support Coordinator III. The CC/ESM works in collaboration with Quality Assurance Manager and with Executive Leadership to develop services that meet individuals of diverse cultural, ethnic, and linguistic needs in this county.

IV. Identify budget resources targeted for culturally competent activities

A. Evidence of a budget dedicated to cultural competence activities which may include:

1. Funds applicable to cultural humility efforts and the work of the Cultural Humility Task Force can be found within the Mental Health Services Act, Prevention and Early Intervention, Stigma and Discrimination Reduction service category. Given the nature of this program and the widely distributed outreach efforts, KCBH was unable to track the exact number of individuals impacted by this program. It is estimated that over 100,000 are reached through radio commercials and that KCBH had over 35,000 unique website views per month. Additional funds for cultural humility activities and the Cultural Humility Task Force are a part of the Department's overall training costs, which are not specifically broken out into categorical areas.

- **Number of individuals to be served in FY 2019-2020: 30,000**
- **Cost per person to be served in FY 2019-2020: $3**
- **Proposed FY 2019-20 Budget: $90,000**

CRITERION 2

Updated Assessment of Service Needs

I. General Population

Kings County is geographically dispersed, taking 40 minutes to drive from Avenal to Hanford and 27 minutes from Hanford to Corcoran. The ethnic makeup of Kings County is predominantly White and Latino, with 55 percent of residents identifying as Latino and 32 percent identifying as White in 2018. Kings County has one of the highest proportions of Latino residents in California. The Tribal/Native American presence is significant and comprises 3.2 percent of the population. The Santa Rosa Rancheria is located 4.5 miles outside of Lemoore and belongs to the federally recognized Tachi Yokut tribe. [KCBH: MHSA Annual Update FY 19-20, 7]

Kings County is composed of a population of 150,029 in 2019, according to http://www.kpfp.org/demographicdata. The race, ethnicity, age and sex breakdowns are as follows.

	County: Kings		State: California	
Population by Race	***Persons***	***% of Population***	***Persons***	***% of Population***
White	77,916	51.93%	21,884,750	54.76%
Black/African American	9,282	6.19%	2,353,434	5.89%
American Indian/Alaskan Native	2,654	1.77%	388,756	0.97%
Asian	6,169	4.11%	5,915,491	14.80%
Native Hawaiian/Pacific Islander	325	0.22%	160,940	0.40%
Some Other Race	45,850	30.56%	7,112,692	17.80%
2+ Races	7,833	5.22%	2,148,785	5.38%

	County: Kings		State: California	
Population by Ethnicity	***Persons***	***% of Population***	***Persons***	***% of Population***
Hispanic/Latino	83,298	55.52%	15,802,941	39.54%
Non-Hispanic/Latino	66,731	44.48%	24,161,907	60.46%

	County: Kings		State: California	
Population by Age	***Persons***	***% of Population***	***Persons***	***% of Population***
Under 18	41,783	27.85%	9,168,044	22.94%
18+	108,246	72.15%	30,796,804	77.06%
25+	91,818	61.20%	27,000,715	67.56%
65+	15,571	10.38%	5,791,217	14.49%
85+	1,740	1.16%	722,531	1.81%

	County: Kings		State: California	
Population by Sex	***Persons***	***% of Population***	***Persons***	***% of Population***
Male	80,360	53.56%	19,835,968	49.63%
Female	69,669	46.44%	20,128,880	50.37%

II. Medi-Cal population service needs

A. *Summarize Medi-Cal population and client utilization, utilizing EQRO data.*

The following table demonstrates the average number of Medi-Cal Beneficiaries in Kings County and served by the Mental Health Plan each month by Race/Ethnicity in Calendar Year 2017, provided by the External Quality Review Organization.

Kings MHP Medi-Cal Enrollees and Beneficiaries Served in CY 2017, by Race/Ethnicity				
Race/Ethnicity	***Average Monthly Unduplicated Medi-Cal Enrollees***	***% Enrollees***	***Unduplicated Annual County Beneficiaries Served***	***% Served***
African-American	2,739	4.70%	212	8.10%
Asian/Pacific Islander	1,245	2.10%	44	1.70%
Latino/Hispanic	38,624	66.40%	1,205	46.00%
Native American	215	0.40%	15	0.60%
White	9,754	16.80%	779	29.70%
Other	5,605	9.60%	366	14.00%
Total	58,182	100%	2,621	100%

The following table reflects Medi-Cal Approved Claims Data for Beneficiaries in Kings County during Calendar Year 2018, provided by the External Quality Review Organization.

	KINGS					SMALL		STATEWIDE	
	Average Number of Eligibles per Month (4)	Number of Beneficiaries Served per Year	Approved Claims	Penetration Rate	Approved Claims per Beneficiary Served per Year	Penetration Rate	Approved Claims per Beneficiary Served per Year	Penetration Rate	Approved Claims per Beneficiary Served per Year
TOTAL									
	58,892	2,824	$13,458,289	4.80%	$4,766	4.96%	$5,602	4.66%	$6,454
AGE GROUP									
0-5	8,399	189	$470,150	2.25%	$2,488	1.67%	$3,698	2.11%	$4,948
6-17	16,883	791	$3,198,599	4.69%	$4,044	6.88%	$6,227	6.57%	$7,366
18-59	28,017	1,662	$9,145,065	5.93%	$5,502	5.27%	$5,499	4.84%	$6,185
60 +	5,594	182	$644,475	3.25%	$3,541	3.18%	$4,623	2.83%	$5,371
GENDER									
Female	31,585	1,484	$7,238,042	4.70%	$4,877	4.73%	$5,370	4.28%	$5,999
Male	27,308	1,340	$6,220,247	4.91%	$4,642	5.21%	$5,838	5.10%	$6,897
RACE/ETHNICITY									
White	9,463	866	$3,974,377	9.15%	$4,589	5.71%	$5,631	6.50%	$6,093
Hispanic/ Latino	39,149	1,316	$5,183,463	3.36%	$3,939	4.23%	$4,788	3.78%	$5,904

	KINGS					SMALL		STATEWIDE	
	Average Number of Eligibles per Month (4)	Number of Beneficiaries Served per Year	Approved Claims	Penetration Rate	Approved Claims per Beneficiary Served per Year	Penetration Rate	Approved Claims per Beneficiary Served per Year	Penetration Rate	Approved Claims per Beneficiary Served per Year
African-American	2,721	262	$1,458,135	9.63%	$5,565	8.26%	$6,302	7.99%	$6,916
Asian/ Pacific Islander	1,231	50	$463,350	4.06%	$9,267	1.65%	$5,228	2.25%	$6,557
Native American	236	36	$81,364	15.25%	$2,260	4.94%	$7,537	6.88%	$7,149
Other	6,094	294	$2,297,600	4.82%	$7,815	5.74%	$7,603	5.25%	$8,175
ELIGIBILITY CATEGORIES									
Disabled	4,719	724	$4,028,771	15.34%	$5,565	12.80%	$6,826	15.23%	$7,274
Foster Care	536	265	$1,265,545	49.44%	$4,776	41.14%	$8,033	48.41%	$9,340
Other Child	17,975	602	$1,691,531	3.35%	$2,810	5.01%	$5,009	4.98%	$5,872
Family Adult	10,134	432	$1,874,110	4.26%	$4,338	3.76%	$3,212	3.11%	$3,975
Other Adult	4,999	44	$98,386	0.88%	$2,236	1.04%	$3,395	0.68%	$4,319
MCHIP	6,688	159	$469,544	2.38%	$2,953	3.98%	$4,617	4.07%	$5,345
ACA	14,474	774	$4,030,403	5.35%	$5,207	4.30%	$4,626	4.01%	$5,460

B. The primary disparity noted in the data from the tables above is the penetration rate for Hispanic/Latinos. Hispanic/Latinos make up 66.4% of the persons enrolled in Medi-Cal on a monthly basis in CY 2017, and the MHP penetration rate for Hispanic/Latinos in CY 2017 is 46.0%. Additionally, the Medi-Cal approved claims for beneficiaries penetration rate in CY 2018 is almost 1% less than other small Counties in California and less then the State average for Hispanic/Latinos. The MHP's penetration rates are below other small counties in the following areas: Youth Ages 6-17 (2.19% Lower), (Males (.3% Lower), Hispanic/Latinos (.87% Lower), Other Child (1.66% Lower), Other Adult (.16 % Lower), and MCHIP (1.6% Lower).

III. 200% of Poverty (minus Medi-Cal) population and services need.

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

200% of poverty data was extracted from the Department of Health Care Services at https://www.dhcs.ca.gov/provgovpart/Documents/CaliforniaPrevalenceEstimates.pdf.

Estimates of Need for Mental Health Services for SMI/SED in Kings County	Total Population	Households below 200% Poverty	Household below 200% SMI/SED Estimate	Household below 200% SMI/SED Estimate %
AGE				
Youth (0-17)	41,320	25,131	2,238	8.91 %
Adults (18+)	107,444	36,795	2,918	7.93 %
GENDER				
Female Youth (0-17)	19,975	12,169	1,083	8.90 %
Male Youth (0-17)	21,345	12,961	1,155	8.91 %
Female Adults (18+)	43,444	19,742	1,842	9.33 %
Male Adults (18+)	64,000	17,053	1,076	6.31 %
ETHNICITY				
White-NH Youth (0-17)	11,723	4,508	383	8.49 %
Afican Am-NH Youth (0-17)	1,785	1,202	105	8.76 %
Asian-NH Youth (0-17)	1,026	372	33	8.78 %
Pacific I-NH Youth (0-17)	72	32	3	9.67 %
Native-NH Youth (0-17)	408	269	24	9.06 %
Other-NH Youth (0-17)	-	-	-	-
Multi-NH Youth (0-17)	1,101	728	63	8.62 %
Hispanic Youth (0-17)	25,205	18,020	1,627	9.03 %
White-HN Adults (18+)	43,233	9,211	902	9.79 %
African Am-NH Adults (18+)	9,096	1,505	111	7.36 %
Asian-NH Adults (18+)	3,615	1,005	38	3.78 %
Pacific I-NH Adults (18+)	184	42	2	3.80 %
Native-NH Adults (18+)	1,106	422	653	12.53 %
Other-NH Adults (18+)	-	-	-	-
Multi-NH Adults (18+)	1,216	577	53	9.21 %
Hispanic Adults (18+)	49,020	24,032	1,760	7.32 %

Currently there is a lack of available information on the number and percentage of individuals in Kings County at 200% Poverty who are not Medi-Cal Beneficiaries, therefore we believe there isn't enough information to make any conclusions on this population's services needs.

IV. MHSA Community Services and Supports population assessment and services needs.

Per MHSA Kings County Annual update during FY 2017-2018 the following chart demonstrates the race and the total consumers that received services funded through MHSA.

Race/Ethnicity	*Persons*	*% of Persons Served*
Non-White - Other	1,265	41.64%
White	1,151	37.89%
Black/African American	328	10.80%
American Indian or Alaska Native	88	2.90%
Unknown/Not Reported	79	2.60%

Asian	69	2.27%
Prefer not to answer	46	1.51%
Native Hawaiian or Other Pacific Islander	12	0.39%

The disparities identified in this data set are that 4.11% of the County identifies as Asian (see data from Criterion 2, I. General Population) and only 2.27% of those served by MHSA funded programs identify as Asian. Additionally, 51.93% of the County (see data from Criterion 2, I. General Population) identified as White and only 37.89% of those served by MHSA funded programs identify as White. It is difficult to draw a conclusion based upon the White, Non-White – Other population, and Prefer not to Answer as the categories used in the Criterion 2, Section I do not sync precisely with the MHSA reporting data for Race/Ethnicity.

Criterion 3

County Mental Health System: Strategies and Efforts for Reducing Racial, Ethnic, Cultural, and Linguistic Mental Health Disparities

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

A. Medi-Cal – Identified from Medi-Cal Approved Claims Data for Calendar Year 2018 (Lower penetration rate than Small-Sized County Average). Reference Data in Criterion 2.

1. Youth Ages 6-17
2. Male
3. Hispanic/Latino
4. Other Child
5. Other Adult
6. MCHIP

B. Community Services and Supports (CSS) – Identified from the 2019/2020 MHSA Community Planning Process and in Criterion 2.

1. Asian
2. Children and Youth Ages 0-15 with serious emotional disturbance
3. Transition Aged Youth Ages 16-25 with serious emotional disturbance or serious mental illness
4. Adults Ages 26-59 with serious mental illness
5. Older Adults 60+ with serious mental illness
6. Availability of Crisis Beds
7. Information, outreach and engagement
8. Expanded services for youth and schools
9. Homelessness
10. Substance Abuse

C. Workforce Education and Training (WET) – Identified from the 2019/2020 MHSA Community Planning Process

1. Bilingual and Bicultural staff
2. Turnover of Bilingual staff

D. Prevention and Early Intervention (PEI) - Identified from the 2019/2020 MHSA Community Planning Process

1. Children and Youth Ages 0-15
2. Transition Aged Youth Ages 16-25
3. Adults Ages 26-59
4. Older Adults 60+

II. Identified disparities, strategies, objectives, actions and timelines(within target populations)

A. Medi-Cal

1. Summary: The greatest disparities exist within the penetration rates for the 6-17 age group, MCHIP, Other Child and Hispanic/Latino. The penetration rates are additionally lower than other small counties for Male, and Other Adult.

2. Strategies: Enhanced outreach and engagement strategies for identified populations include:
    i. Increase community based/school based mental health services for Children, Youth and Transition Aged Youth.
    ii. Increase cultural humility training trainings for all County staff and contracted provider staff by:
        a. Providing Health Equity Multi-Cultural Diversity Training on a routine basis and requiring all staff and contracted provider staff to attend.
        b. Providing access to culture specific trainings
    iii. Rebrand the MHP in a culturally responsive manner and target marketing to cultural communities.

B. CSS/PEI/WET

1. Summary: MHSA programs seek to address the identified disparities across age groups, racial and ethnic and linguistic disparities. The MHP's overall penetration is slightly lower than other small counties (.16% lower) and higher than the statewide average (.14% higher).

2. Strategies: The following strategies have been developed to reduce the disparities within identified unserved and underserved populations:

Children & Transition Aged Youth (TAY)

The MHP envisions a system that provides a full spectrum of services — from prevention and early intervention through clinical and crisis supports — and responds to the unique needs of children, youth, and their families by:

- Identifying and engaging children and youth with mental health challenges in appropriate and timely mental health services.
- Providing services that are available when and where children and youth already are, during hours when children and youth can attend.
- Providing adequate support to prevent children, youth, and their families from becoming involved in the juvenile justice and child welfare systems, making efforts to keep children and youth at home and avoiding unnecessary out of home placements.
- Providing crisis services when children, youth, and families need them, wherever they are, and connecting them to services that are likely to prevent future crises.

Strategies are evidenced through the following programs:

Full Service Partnership/Wraparound (CSS): Program goals include 1) Reduce out-of-home placements for FSP enrolled children/TAY, 2) Increase service connectedness for FSP enrolled children/TAY, and 3) Reduce involvement in child welfare and juvenile justice.

Parent Child Interactive Therapy (CSS): Goals include 1) Increase parenting skills, including positive discipline, 2) Reduce maladaptive behavior and increase pro-social behaviors, 3) Improve the parent-child relationship, and 4) Decrease frequency and severity of disruptive behaviors.

Intensive Case Management/Intensive Outpatient Program (CSS): Goals include 1) Improve functioning and quality of life for consumers who are eligible for specialty mental health services that are not in FSP, 2) Reduce symptoms and impacts of mental illness for consumers who qualify for specialty mental health services, and 3) Reduce the need for a higher level of care for consumers.

School Based Services (PEI): Goals include 1) Increase student connectedness and relationship building skills, 2) Increase student coping mechanisms skills, 3) Increase student capacity for seeking help, and 4) Decrease depression and anxiety among students.

Truancy Intervention Program (PEI): Goals include 1) Reduce youth and family involvement in the criminal justice system and prevent school failure, 2) Reduce truancy and chronic absenteeism among youth, and 3) Reduce the symptoms of the root causes that contribute to chronic absenteeism.

Adults & Older Adults

The MHP envisions a system that provides a warm and welcoming service delivery experience that promotes recovery and interrupts the cycle of incarceration, hospitalization, and homelessness for individuals with mental health challenges by:

- Providing targeted outreach to identify, engage, and connect people in need to mental health services.
- Considering all of a person's needs and strengths, from initial assessment throughout their treatment.
- Meeting adults "wherever they are at" in the community and in their recovery process.
- Providing recovery oriented mental health services, placing peer professionals throughout the entire system.
- Coordinating between service levels, providing appropriate and timely transitions between levels of care, and helping people navigate and stay engaged in the mental health system.

Strategies are evidenced through the following programs:

Full Service Partnership (CSS): Program goals include 1) Promote wellness, recovery, and independent living for consumers, 2) Reduce hospitalization, homelessness, and incarceration for adults with serious mental illness, and 3) Support the development of life skills and psychosocial outcomes for consumers including social, educational, and vocational rehabilitative outcomes.

Full Service Partnership Assertive Community Treatment (CSS): Program Goals include 1) Provide treatment and care that promotes wellness, recovery, and independent living, 2) Reduce hospitalization, homelessness, and incarceration for adults with serious mental illness, and 3) Support the recovery of individuals and the development of life skills and psychosocial outcomes, including social, educational, and vocational rehabilitative outcomes.

Intensive Case Management/Intensive Outpatient Program (CSS): Goals include 1) Improve functioning and quality of life for consumers who are eligible for specialty mental health services that are not in FSP, 2) Reduce symptoms and impacts of mental illness for consumers who qualify for specialty mental health services, and 3) Reduce the need for a higher level of care for consumers.

Collaborative Justice Treatment Court(CSS): Goals and strategies include 1) Reduce substance use and promote recovery among program clients, 2) Improve consumers' family functioning outcomes, 3) Reduce recidivism and other crimes related to substance use and mental health challenges, and 4) Enhance collaboration and systems integration across County agencies.

Mental Health Services for Domestic Violence Survivors (CSS): Strategies include 1) Identify and engage individuals and families in mental health services, 2) Connect victims of domestic violence to mental health services, and 3) Increase self-sufficiency among residents with the goal of moving individuals to permanent, independent housing.

KARELink/Kings Whole Person Care Pilot (CSS): 1) Reduce instances of incarceration, hospitalization, and homelessness, 2) Increase service connectedness across agencies and providers, and 3) Reduce need for higher level of care.

Senior Access for Engagement (PEI): Strategies include 1) Reduce out of home placements for seniors/older adults, 2) Increase service connectedness, 3) Increase socialization and reduce isolation among senior population, and 4) Reduce caregiver stress.

Additional programs that support the community and address disparities include:

Access and Linkage: Goals include 1) Increase the number of referrals to existing services, 2) Connect community members to various social services, and 3) Create support services to assist community members with various concerns.

Prevention and Wellness (PEI): Goals include 1) Increase service connectedness to outside agencies and 2) Increase linkages to mental health services for children, youth, adults, and older adults in Kings County.

Community Wide Outreach & Engagement (PEI): Goals include 1) Increase community member's knowledge and capacity to recognize and respond to various mental health needs, 2). Provide trainings that teach community members how to engage individuals who are experiencing suicide ideation, and 3) Develop workshops that provide strategies on how to better serve families and veterans.

Community Wide Stigma & Discrimination Reduction: Strategies include 1) Increase the prevalence of social media to share information and reduce stigma on mental health, 2) Increase knowledge and awareness of mental health and mental health services, 3) Reduce stigma regarding mental health, 4) Increase cultural competency, and 5) Increase access to mental health services for Latino community.

Suicide Prevention: Strategies include 1) Increase knowledge among high school students around mental health and suicide prevention, 2) Increase service linkages to mental health services for residents at risk of suicide, and 3) Connect friends and family member of suicide victims to resources and support services.

Criterion 4

Client/Family Member/Community Committee: Integration of the Committee within the County Mental Health System

I. **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 and integrates its responsibilities into the mental health system.**

A. The current ESM works directly with Deputy Director and collaborates with other members of KCBH as well as contracted providers to help develop Cultural Competency Planning. The Cultural Competence Taskforce is composed of representatives from the agency's contracted providers as well as other community representatives such as Veteran Services Office and Office of Education.

B. Meetings are scheduled on a monthly basis, and input from the group is taken into consideration for the development of the plan. The ESM has begun providing reports to the Quality Improvement Committee on the activities and updates that take place with the Cultural Humility Taskforce. In addition, a cultural humility survey was provided to all contracted providers and requested that their beneficiaries complete to help with determining cultural competency needs. The results with such survey were provided to the taskforce for their input and review.

Criterion 5

Culturally Competent Training Activities

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

The MHP takes steps to provide access to in person cultural competency training for it's staff, contracted provider staff and stakeholders on an annual basis and requires that all staff and contracted provider staff participate in a minimum of four (4) hours of cultural competency training annually. The Cultural Humility Task Force will be exploring additional online training opportunities during the coming calendar year. The following is a list of the most recent cultural competency trainings:

Training Event	Description of Training	How long and often	Attendance by Function	No. of Attendees & Total	Date of Training	Name of Presenter
Disability Culture Training	This presentation will also provide education on different types of disabilities, available resources, and best practice for working with those who have disabilities.	90 Minutes	*Direct Services (5) *Direct Services Contractors (17) *Administration (1) *Interpreters *Community Members (2)	25	8/1/2018	Resources for Independence Central Valley, Charity Tokash and Violeta Tapia
LGBTQ + Cultural Humility		120 Minutes	*Direct Services (3) *Direct Services Contractors (8) *Administration (7) *Interpreters *Community Members (6)	24	9/13/2018	The Source
Mental Health from the Pulpit	Panel presentation for faith leaders about mental health and substance use disorders	150 Minutes	*Direct Services (1) *Direct Services Contractors (4) *Administration (1) *Interpreters *Community Members (29)	35	9/14/2018	Tulare Kings Suicide Prevention Task Force
Trans 101 - Sex, Gender and Sexuality		120 Minutes	*Direct Services (8)*Direct Services Contractors (12) *Administration (7) *Interpreters *Community Members (3)	30	11/15/2018	The Source
HIV PEP & PREP		120 Minutes	*Direct Services (4) *Direct Services Contractors (5) *Administration (3) *Interpreters *Community Members (7)	19	12/13/2018	The Source
Implicit Bias/Black History Month		180 Minutes	*Direct Services (6)*Direct Services Contractors (6) *Administration (12) *Interpreters *Community Members (13)	37	2/8/2019	Tiffany White, EdD, Devondria Sanchez, LMFT

LGBT Youth-Homelessness and Foster Care		120 Minutes	*Direct Services (6) *Direct Services Contractors (3) *Administration (1) *Interpreters *Community Members (8)	19	2/14/2019	The Source
Behavioral Health Interpreter Training for Interpreters	This workshop is designed to immerse bilingual interpreters in the principles and practices of interpreter communication skills.	2 Days	*Direct Services (2) *Direct Services Contractors (8) *Administration *Interpreters *Community	10	2/19/2019-2/20/2019	Tulare County & the National Latino Behavioral Association
Behavioral Health Interpreter Training for Providers	This workshop is designed to provide instruction on the fundamental principles of using interpreters.	1 Day	*Direct Services *Direct Services Contractors (9) *Administration *Interpreters *Community Members	9	2/21/2019	Tulare County & the National Latino Behavioral Association
2019 African-American Mental Health Conference		1 Day	*Direct Services (2) *Direct Services Contractors *Administration *Interpreters *Community Members	2	2/28/2019	LA County, Various Speakers
Importance of SOGI Data		120 Minutes		* Missing Data	3/14/2019	The Source
Trevor Project & LGBTQ Youth Suicide Prevention		120 Minutes	*Direct Services (1) *Direct Services Contractors (5) *Administration (1) *Interpreters *Community Members 3)	10	4/11/2019	The Source
PFLAG - What is an Ally?		120 Minutes	*Direct Services (2) *Direct Services Contractors (1) *Administration (1) *Interpreters *Community Members (7)	11	6/13/2019	The Source
400 Years: Reflections on Lessons Learded & Imagining Our Futures - Black Women Wellness		1 Day	*Direct Services (1) *Direct Services Contractors *Administration *Interpreters *Community Members	1	8/26/2019	California Endowment

Central Valley Latino Conference		2 Days	*Direct Services (2) *Direct Services Contractors *Administration (3) *Interpreters *Community Members	5	9/19/2019-9/20/2019	The Latino Commission, Various Presenters
Health Equity & Multicultural Diversity Training		14 Hours	*Direct Services (1) *Direct Services Contractors *Administration (2) *Interpreters *Community Members	3	12/4/2019-12/5/2019	California Institute for Behavioral Health Solutions
Spiritual Care Summit	Learn about the importance of Spirituality in relation to mental health.	4 hours	*(1) Direct Services *Direct Services Contractors *Administration *Interpreters *Community Members	1	10/29/2019	Noah Whitaker, Norbie Lara, Chris Roup

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

The following is a list of the MHP's Client Culture Training.

Implicit Bias/Black History Month		180 Minutes	*Direct Services (6)*Direct Services Contractors (6) *Administration (12) *Interpreters *Community Members (13)	37	2/8/2019	Tiffany White, EdD, Devondria Sanchez, LMFT

Criterion 6

County's Commitment to Growing a Multicultural Workforce: Hiring and Retaining Culturally and Linguistically Competent Staff

I. **Workforce Needs Assessment**

a. Data Source – 2019 Cultural Humility Agency Staff Survey

	Agree	Disagree	Neutral	Unknown	Total
The agency I am employed with is committed to serving clients/families of diverse cultural backgrounds.	110	3	5	0	118
Percentage of Responders	93.22%	2.54%	4.24%	0.00%	100.00%
This agency's policies value staff diversity and encourage staff enhancement in cultural competency/humility	102	5	11	0	118
Percentage of Responders	86.44%	4.24%	9.32%	0.00%	100.00%
This agency's printed materials such as brochures, flyers, posters reflect various cultural backgrounds of people who are served.	75	12	23	8	118
Percentage of Responders	63.56%	10.17%	19.49%	6.78%	100.00%
My agency's leadership allow clients, staff, and volunteers in the organizational decision making.	74	20	14	10	118
Percentage of Responders	62.71%	16.95%	11.86%	8.47%	100.00%
My agency provides opportunities for advancement for all staff including those of diverse backgrounds.	83	12	17	6	118
Percentage of Responders	70.34%	10.17%	14.41%	5.08%	100.00%
My agency's hiring process is supportive of recruiting diverse personnel.	92	9	13	3	117
Percentage of Responders	78.63%	7.69%	11.11%	2.56%	100.00%
My agency values individuals of diverse cultural backgrounds.	98	9	9	2	118
Percentage of Responders	83.05%	7.63%	7.63%	1.69%	100.00%
My agency enforces policies that are against discrimination and harassment.	99	5	9	4	117
Percentage of Responders	84.62%	4.27%	7.69%	3.42%	100.00%
My agency supports staff to bring up issues that arise from cultural differences.	85	8	16	8	117
Percentage of Responders	72.65%	6.84%	13.68%	6.84%	100.00%
My agency is active and effective in outreach methods to consumers of diverse cultural backgrounds.	78	10	24	6	118
Percentage of Responders	66.10%	8.47%	20.34%	5.08%	100.00%
My agency consults community representatives of diverse backgrounds in the development of new programs and services directly affecting their communities.	61	7	27	22	117
Percentage of Responders	52.14%	5.98%	23.08%	18.80%	100.00%

	Aspiranet	Behavioral Health	Champions	Kings View	Mental Health Systems	Westcare	Total
What agency are you employed with?	10	21	21	49	6	10	117
Percentage of Responders	8.55%	17.95%	17.95%	41.88%	5.13%	8.55%	100.00%

	Yes	No	Total
Have you or a loved one ever participated in mental health or substance use services?	77	41	118
Percentage of Responders	65.25%	34.75%	100.00%

	0-15	16-25	26-59	60+	Prefer Not to Answer	Total
What age group do you best identify with?	0	2	53	2	2	59
Percentage of Responders	0.00%	3.39%	89.83%	3.39%	3.39%	100.00%

	Asian	Black or African American	White	More than One Race	Prefer Not to Answer	Total
What best defines your race?	2	3	27	5	16	53
Percentage of Responders	3.77%	5.66%	50.94%	9.43%	30.19%	100.00%

	African	Central American	Eastern European	European	Korean	Mexican/ Mexican-American/ Chicano	Other	Prefer Not to Answer	Total
What best defines your ethnicity: (Please mark all that apply)	3	1	2	9	1	21	11	8	56
Percentage of Responders	5.36%	1.79%	3.57%	16.07%	1.79%	37.50%	19.64%	14.29%	100.00%

	Yes	No	Total
Do you identify as Hispanic or Latino?	23	29	52
Percentage of Responders	44.23%	55.77%	100.00%

	English	Spanish	Other	Prefer Not to Answer	Total
Please mark preferred language:	58	0	0	1	59

	Foster Youth	LGBTQ	Veteran	No	Prefer Not to Answer	Total
Do you identify with any of the following demographic classifications? (Check all that apply)	2	0	1	49	3	55
Percentage of Responders	3.64%	0.00%	1.82%	89.09%	5.45%	100.00%

Criterion 7

Language Capacity

I. **Increase bilingual workforce capacity**

The threshold language is Spanish, with 40% of the community speaking a language other than English at home. The following chart is staff from KCBH as well as agency providers that are bilingual in English and Spanish per July 2019 NACT.

Total Bilingual Staff per July 2019 NACT

	# of Direct Providers	# Who Are Bilingual	% of Bilingual Staff
Kings View	63	20	31.75%
JDT	11	4	36.36%
KCBH	17	11	64.71%
MHS	10	3	30.00%
Aspiranet	11	2	18.18%
TOTAL	112	40	36.20%
TOTAL English/Spanish Bilingual	112	39	35.88%

In addition, there is a contract currently in place with Language Line Inc. for telephonic/video interpreter services. This is available to assist those who may need interpreter services for other languages outside of the threshold language Spanish.

II. **Provide services to persons who have Limited English Proficiency by using interpreter services.**

Per MPP A-030 Language Services Requirement Policy, KCBH has adopted a form "Notice of Language Services" is provided to the consumer. The form has information on 16 languages. This information is posted and has been placed in the reception area for individuals accessing services.

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

Per MPP A-30 If an individual is seeking services and they do not speak English or Spanish KCBH shall work to provide an interpret to the individual seeking the service at no cost to them. Language access shall also include populations who may be visually or hearing impaired.

Per MPP A-052 Language and Interpreter Services, consumers are to be provided services in their language at no cost to them. Availability of these services must be visible to them at service sites.

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

Per MPP A-052 policy if an on-site interpreter is not available, all staff must provide language and interpreter services through the language line provider as AT&T Language Line, Fox Interpreting for American Sign Language, TTY/TDY (Text Telephone/Telecommunication Device for the Deaf), California Relay Service (CRS), etc.

Criterion 8

Adaptation of Services

I. **Client driven/operated recovery and wellness programs.**

A. The MHP has an agreement with a Contracted Provider to operate the Oak Wellness Center. The Oak Wellness Center is open 7 days a week and is a beneficiary-driven wellness and recovery center in Hanford. The goal of the center is to help adults and older adults live independently in the community while promoting wellness and resiliency. The objectives to achieve the goal include: promote the development of independent living skills and provide meaningful daily activities; provide a safe, welcoming, and supportive environment for beneficiaries to engage in enrichment activities and support groups; increase the capacity of beneficiaries and peers for self-advocacy and mutual aid. Beneficiaries can access an array of beneficiary-driven services and social/recreational programming through ECHO and the Oak Wellness Center. Resources and services available include:

1. Peer-led discussion and support groups
2. Wellness and Recovery Action Plans (WRAP)
3. Transportation for field trips, conferences, and other enrichment activities
4. Games & Activities

II. **Responsiveness of mental health services.**

A. Kings County Behavioral Health (KCBH) and providers make available, alternatives and options that accommodate individual preference, or cultural and linguistic preferences. These include, but are not limited to:
   i. A Provider Directory made available online (http://www.kcbh.org/) and in each clinic with information regarding:
      1. Specialty populations served and specific services offered;
      2. The provider's cultural capabilities (e.g., veterans, older adults, Transition Age Youth, Lesbian, Gay, Bisexual, Transgender);
      3. 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,

4. Whether the provider's office/facility has accommodations for people with physical disabilities.

ii. Clinic lobbies have information and postings in the County's threshold languages of English and Spanish.

iii. Each client is provided with the ability to have a copy of the State template Beneficiary Handbook at the time of intake, per State requirement, in English and Spanish or in alternate format as needed such as through oral interpretation or large print. The handbook informs the client on how to obtain Medi-Cal specialty mental health services through their respective County of residence as well as explains their benefits and rights.

iv. All materials that are required to be distributed to consumers are translated into the County's threshold language which is Spanish, in addition to English. The ability to have materials translated appropriately is done by multiple methods:

1. Several required materials come as translated templates from State entities such as the Consumer Perception Survey, Beneficiary Handbook, and Notice of Adverse Beneficiary Determination are translated first by the California Institute for Behavioral Health Solutions (CIBHS) as contracted by the Department of Health Care Services, as such it is implied the State is releasing translated material with accurate translation and at an appropriate reading level.
2. Materials translated internally such as Grievance Acknowledgement and Resolution Forms are translated by Ixoye Translation Services.

v. Services are not only provided in the city which is the County Seat, Hanford, but also has offices in some of the more rural outlying communities such as in the communities of Avenal and Corcoran. Services are also provided in the field in addition to within the clinic, when and where appropriate.

III. Quality Assurance

A. Kings County Behavioral Health utilizes many measures and reports to assess the quality of care provided for all consumers through the Mental Health Plan, and strives to review these data sets not only for the system as a whole, but also by filters to include consumer demographic such as gender, age, language, and race/ethnicity to ensure there are no disparities in access, timeliness, quality, and outcomes for any given population. These measures and reports are consolidated into the KCBH Quality Assessment and Performance Improvement (QAPI) Work Plan which is a required work plan by the Department of Mental Health Services, and can be found on the County website at: http://www.kcbh.org/plans--documents.html. Some of the measures from within the Work Plan are highlighted below:

1. Consumer grievances and complaints – As part of the KCBH quality assessment and performance improvement process, the Quality Improvement Committee (QIC) conducts regular monitoring activities of the resolution of beneficiary grievances and appeals and submits an Annual Beneficiary Grievance and Appeal

Report to DHCS analyzing trends. When issues arise due to individual grievances and appeals, or if unexpected trends emerge based on numbers and percentages, the QIC looks for root causes and determines appropriate follow-up interventions to positively impact beneficiaries system-wide. The results of follow-up actions are evaluated at least annually. Additionally, KCBH also has a Mental Health Services Act (MHSA) Issue Resolution Process (IRP) to handle client disputes related to the provision of their mental health services funded through the MHSA. KCBH maintains a log to record issues submitted as part of the Issue Resolution Process. The log includes the date the issue was received; a brief synopsis of the issue; the final issue resolution outcome; and the date the final issue resolution was reached. Trend analysis is conducted by the QIC similar to the process described for Medi-Cal beneficiary grievances and appeals.

GRIEVANCES					
Category	**Process**		**Grievance Disposition**		
	Grievance	**Exempt Grievance**	**Grievances Pending, Unresolved as of Reporting June 30, 2019**	**Resolved**	**Referred**
ACCESS					
Services not available	0	0	0	0	0
Services not accessible	0	0	0	0	0
Timeliness of services	3	0	2	1	0
24/7 Toll-free access line	1	0	0	1	0
Linguistic services	3	0	2	1	0
Other access issues	0	0	0	0	0
TOTAL	**7**	**0**	**4**	**3**	**0**
QUALITY OF CARE					
Staff behavior concerns	16	4	6	6	0
Treatment issues or concerns	3	0	1	2	0
Medication concern	19	4	4	12	0
Cultural appropriateness	1	0	1	0	0
Other quality of care issues	32	2	13	16	0
TOTAL	**71**	**10**	**25**	**36**	**0**
CHANGE OF PROVIDER	**1**	**1**	**0**	**0**	**0**
CONFIDENTIALITY CONCERN	**1**	**0**	**0**	**1**	**0**
OTHER					
Financial	1	0	0	1	0
Lost property	0	0	0	0	0
Operational	10	0	4	4	2
Patients' rights	1	0	0	1	0
Peer behaviors	5	0	4	1	0
Physical environment	3	0	1	2	0
Other grievance not listed above	15	0	3	4	8
TOTAL	**35**	**0**	**12**	**13**	**10**
GRAND TOTAL	**115**	**11**	**41**	**53**	**10**
MHSA IRP	**0**	**0**	**0**	**0**	**0**

2. Consumer Perception Survey: – KCBH uses the Consumer Perception Survey (CPS) provided by the State Department of Health Care Services (DHCS) through its contractor California Institute for Behavioral Health Solutions (CIBHS), which is translated by CIBHS into Spanish and several other languages. The Consumer Perception Survey is a State survey given to consumers during a one-week period twice per year to include parent and caregivers of child consumers under 12 years of age regarding their perception of the services they've received and programs and providers who have provided said services. The results of the surveys are then reported at the Quality Improvement Committee to monitor results for potential disparities or trends that may need further investigation and response for process improvement. The surveys collect demographic information of the respondent, and as such, results can be filtered based on such demographics as gender, age, language, and race/ethnicity.

Date and Category	Sample Size	Overall Rating *1 least to 5 most satisfied*	Question Category			
			Satisfaction with Services	Access	Informed Consent/Participation	Effectiveness/ Well-Being
May 2018 Adult/Older Adult	140	4.22	4.45	4.22	4.29	3.94
May 2018 Child/Youth & Family	31	4.33	4.48	4.44	4.48	3.92