Inyo County Health and Human Services
Behavioral Health

Cultural Competence Plan

Annual Update

FY 2018-2019

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2010 CULTURAL COMPETENCE PLAN REQUIREMENTS CRIERIA

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☒ **CRITERION 1: COMMITMENT TO CULTURAL COMPETENCE**

☒ **CRITERION 2: UPDATED ASSESSMENT OF SERVICE NEEDS**

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

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

☒ **CRITERION 5: CULTURALLY COMPETENT TRAINING ACTIVITIES**

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

☒ **CRITERION 7: LANGUAGE CAPACITY**

☒ **CRITERION 8: ADAPTATION OF SERVICES**

The mission of the Inyo County Health and Human Services - Behavioral Health Plan (ICHHS-BH) is to provide each eligible beneficiary with access to a high quality, effective, cost-efficient system of mental health care which is community based, culturally competent, and consumer guided

OVERVIEW

Inyo County is a frontier county with 18,144 citizens. It is located in the southeastern part of the state, is very isolated, and has a limited array of services. Inyo County Health and Human Services- Behavioral Health (ICHHS-BH) strives to deliver culturally, ethnically, and linguistically appropriate services to mental health clients and their families. This vision is reflected in our mission statement, informing materials, and client care plans. Discussions regarding improving delivery of culturally-sensitive services are held during staff meetings, supervision of staff members, and activities to welcome individuals into the service delivery system.

Inyo County Health and Human Services Behavioral Health (ICHHS-BH) is committed to promoting each person's voice, creating a culture of balance and healing for all persons receiving services, integrating families and natural support systems into services, whenever possible. Services are individualized to meet each person's needs and reflect cultural sensitivity to promote outcomes and reduce stigma. We work with our American Indian communities and the Latino population through outreach and coordinating services with other community agencies.

ICHHS-BH will endeavor to practice the National Standards on Culturally and Linguistically Appropriate Services (CLAS) in an effort to provide culturally and linguistically competent services.

ICHHS-BH Values

ICHHS-BH holds respect for each beneficiary as its central value, including beneficiary choice, satisfaction, and confidentiality. ICHHS-BH is committed to developing and maintaining a system of care for children, adults and older adults which is culturally competent and consumer guided. The following principles are the basis for the process of improving cultural competency and age-appropriate services:

- Planning and design of services will be delivered with respect for the diversity of each beneficiary.
- ICHHS-BH recognizes that the family, as defined by each culture, is a primary system of support, and therefore, should be incorporated into the service planning whenever possible.
- ICHHS-BH will provide language accessibility and cultural competence within the service system to the extent possible within our resources.

- ICHHS-BH is committed to hiring staff that are proficient and skilled in serving multi-cultural populations.
- ICHHS-BH is committed to providing timely and appropriate access to care.
- ICHHS-BH values prevention and early intervention as strategies to promote wellness, avert crises, and maintain each beneficiary within his/her community to the extent possible.
- ICHHS-BH staff will recognize and work with each beneficiary’s own desired outcome(s) in the provision of care.
- Positive outcomes will be achieved in partnership with families and other caregivers, community-based programs, private organizations, public agencies, and advisory groups.
- ICHHS-BH Staff will recognize and work with each beneficiary's own desired outcome(s) in the provision of care. Positive outcomes will be achieved in partnership with families and other caregivers, community-based programs, private organizations, public agencies, and advisory groups.
- ICHHS-BH will strive through treatment and discharge planning to allow each beneficiary to maintain the least restrictive setting and most appropriate level of care, enhancing community linkages, whenever possible

COMMITMENT TO CULTURAL COMPETENCE (CRITERION 1)

Copies of the following documents ensure the commitment to cultural and linguistic competence services are reflected throughout the entire system:

1. Mission Statement
2. Statements of Philosophy
3. Strategic Plans including Inyo County’s MHSA Plans, Implementation Plan
4. Policy and Procedure Manuals
5. Other Key Documents (Counties may choose to include additional documents to show system-wide commitment to cultural and linguistic competence

The documents listed above are currently available the at ICHHS-BH clinic in Bishop. Copies of these documents will be available on site during the compliance review.

ICHHS-BH is committed to providing culturally competent services to our clients. Our plans and efforts to reach individuals of diverse cultures are shown in our Mental Health Services Act (MHSA) Plan. See the attached plan for reference. Our values to integrate cultural sensitivity is equally relevant to a wide range of cultures, including persons who are Lesbian, Gay, Bi-sexual, Transsexual, Questioning, and Two-Spirit (LGBTQ 2-S), older adults, and Transition Age Youth (TAY), which are included in our outreach to diverse cultures.

These goals and objectives are outlined below and provide the framework for developing this CCP.

1. Improving access to services for Latinos, American Indians, older adults, and TAY
2. Offering services in each person's primary language
3. Delivering culturally relevant services in the community in coordination with other community agencies
4. Conducting training to staff and community partners
5. Increasing enrollment in Medi-Cal

Services are offered in the community, in collaboration with other community programs to help reduce stigma and improve access to services. All planning activities include input from the community to ensure that services are meeting the needs of collaborative partners

DATA AND ANALYSIS (CRITERON 2)

Geography and Socio-Economic Status

Geographical Characteristics

Inyo County contains astounding natural diversity. It includes Owens Valley and parts of Death Valley, and is located between the Sierra Nevada Mountains and the White Mountains along the California/Nevada border. Inyo County offers scenic views and multiple opportunities for outdoor sports enthusiasts in diverse landscapes. Inyo County encompasses both the lowest point in the U.S., Death Valley, and the highest point in the lower 48 states, Mount Whitney. It is the second largest county by area in California with 10,140 square miles; and, with a population of 18,144, Inyo has one of the smallest population densities in the state with only 1.8 persons per square mile. This is a fact that needs to be taken into account where there is any discussion of time/distance requirements for services. It can be termed a "frontier" county reflecting the challenges of being very isolated.

Ninety-six percent (96%) of the county's territory is designated "public land," managed by the U. S. government's Department of Agriculture, Forest Service, and Bureau of Indian Affairs; The City of Los Angeles owns 3.9% of the land for the purpose of maintaining water rights. The State of California owns 2.4%, and private landowners own a mere 1.7% of the land in Inyo County. The configuration of land ownership and management along with other factors influences the economy and restricts the development of the region. The rural nature and location of Inyo County somewhat limits residents' access to urban centers and to services like healthcare, especially specialized healthcare. Most residents live in the northern area of Inyo County around

its main population center, Bishop, and the closest urban area to Bishop is roughly 200 miles away, a 4-hour drive. Other communities that are served by ICHHS-BH are Lone Pine, Independence, and Southern Inyo to include Olancha/Cartago, Death Valley, and Tecopa. Transportation is limited to motor vehicles and minimal air service.

Socio-economic Characteristics

Economic conditions in Inyo County may impose hardships on many families and individuals due to the combination of a high cost of living and limited work availability. Inyo County relies heavily on tourism and government services to support the economy. Many available jobs are in the service industry or are seasonal. It is difficult to find entry level jobs for persons with a disability. The median family income in Inyo County is slightly below the 60% marker of the median family income for California as a whole.

In Inyo County, the per capita income for all residents in 2016 was $28,678 (U.S. Census Bureau data). When comparing this data in to other similar-sized counties and statewide, Inyo had the second highest per capita income (e.g., Mono, $31, 059; Plumas, $26,849). The statewide per capita income was $ 31,587, about $3,000 per person higher than Inyo County. This data clearly reflects the economic condition of this small, remote county. This shows the low median family income for Inyo County in comparison counties. Inyo County's median family income is $47,278, which is over $16,000 per household lower than the statewide average of $63,783.

Demographics and Penetration Rates

Demographic Data

A majority of Inyo County's population identifies as Euro-American, with a significant minority identifying as American Indian. Based on the 2010 census, 66% identify as white alone; 19% identify with Hispanic or Latino origin. Given the Hispanic population, Spanish is a threshold language for service. 13% identify as Native American; 2% identify as Asian; and less than I% identify as African American. 4% of people identify with 2 or more races. The federally-recognized Native American nations in Inyo County are the Bishop Paiute Tribe, Big Pine Paiute Tribe of the Owens Valley, Fort Independence Reservation, Lone Pine Paiute Shoshone Reservation, and Timbisha Shoshone Tribe. The Timbisha Shoshone Tribe, located in Death Valley National Park, is the only tribe located inside a national park in the US. The ethnic composition of Inyo County testifies to the rich heritage of Native American tribes in California and the recent history of the colonization of the Western United States. To meet the needs of the Native American population, there is a Federally Qualified Heath Care facility, Toiyabe Indian Health Project, that includes mental health and addiction serves as part of their family service offerings to the American Indian population in Inyo.

Figure 1 shows the total Inyo County population (2016 Census Bureau estimated data). Of the 18,144 persons who live in Inyo County, 20.50% are 0-17 years of age; 56.50% are 18-64; and 23% are 65 years and older. The majority of persons in Inyo County are Caucasian (80.7%) and

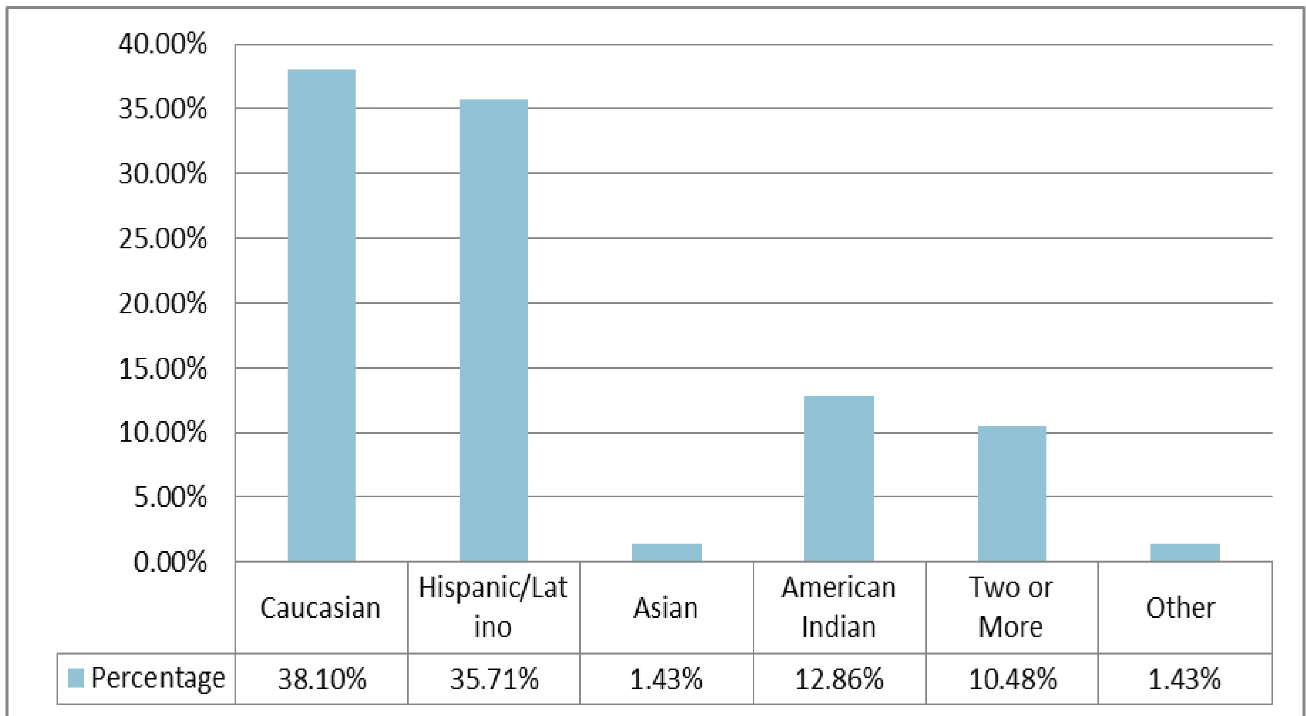
Latino/Hispanic (21.4%). 13.1% of the population is American Indian. There are a comparable number of males (50.3%) and females (49.7%) in the county.

Figure 1
Inyo County Residents
By Gender, Age, and Race/Ethnicity
(Population Source: U.S. Census Bureau)

	Inyo County Population 2010		Inyo County Population 2016*	
Age Distribution				
0-17	3,900	21.03%	3719.52	20.50%
18-64	11111	59.91%	10251.36	56.50%
65+	3,535	19.06%	4173.12	23.00%
Total	18546	100%	18144	100%
Race/Ethnicity Distribution				
Caucasian	13741	74.09%	14642.21	80.70%
African American	109	0.59%	181.44	1%
Alaskan Native/Native American	2121	11.44%	2376.864	13.10%
Asian/Pacific Islander	259	1.40%	308.448	1.70%
Two or More Races/other	640	3.45%	598.752	3.30%
Unknown	1676	9.04%	-	-
Non Hispanic or Latino	14949	80.60%	11758.16	63.40%
Hispanic or Latino	3597	19.40%	3133.433	21.40%
Gender Distribution				
Male	9354	50.44%	9126.432	50.30%
Female	9192	49.56%	9017.568	49.70%
Total	18546	100%	18144	100%
*estimated by US Census Bureau				

Figure 2 shows a high proportion of kindergarten children who are Latino in Inyo County. California Department of Education data (FY 2016/2017) shows that of the 210 children enrolled in kindergarten in Inyo County, 38.10% are Caucasian, 35.71% are Hispanic/Latino, and 12.4% are American Indian. This data clearly demonstrates the growing need for bilingual and bicultural services in our county.

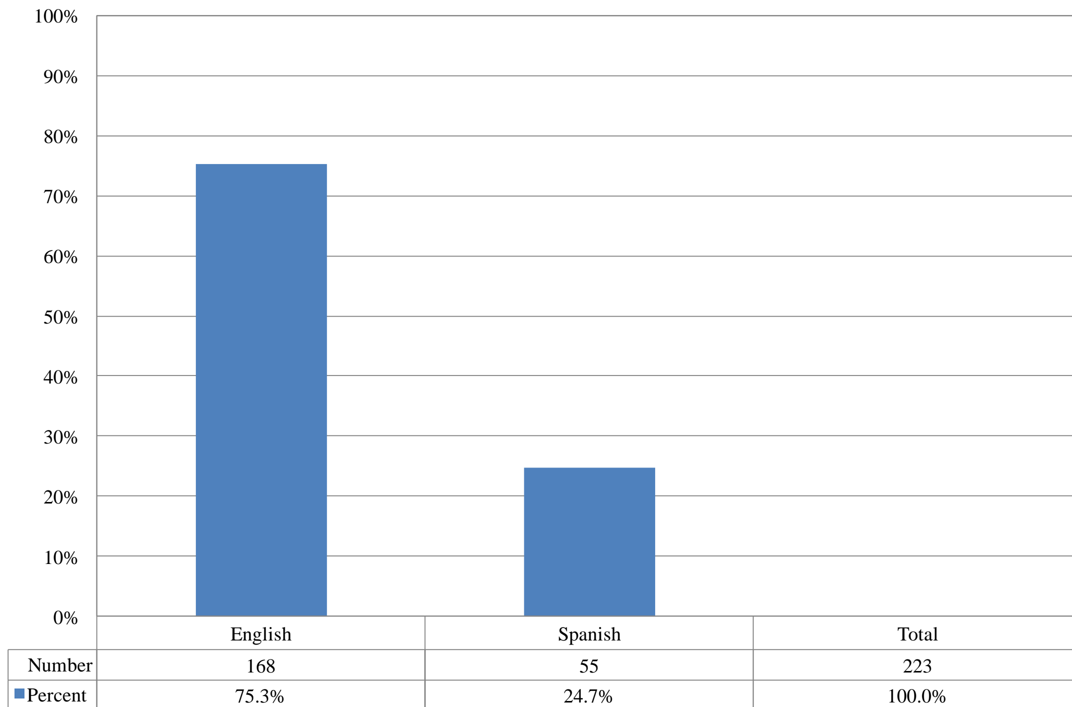
Figure 2
Inyo County Kindergarten Enrollment in FY 2016/2017
By Race/Ethnicity
(Source: California Department of Education)



	Caucasian	Hispanic/Latino	Asian	American Indian	Two or More	Other
Percentage	38.10%	35.71%	1.43%	12.86%	10.48%	1.43%

The Department of Education data (Figure 3) also shows that 24.7% of kindergarten children have a primary language of Spanish. As our mental health system plans for staff and service needs in our programs, this data clearly demonstrates the growing need for bilingual and bicultural services and staff for both mental health and other programs in our county.

Figure 3
Inyo County Kindergarten Enrollment in FY 2009/10
By Primary Language
(Source: California Department of Education)



	English	Spanish	Total
Number	168	55	223
Percent	75.3%	24.7%	100.0%

Mental Health Services Data

Figure 4 shows the number of persons in the county population (2016 U.S. Census Bureau data), the number of persons who have met Medi-Cal eligibility requirements (EQRO data), and the number of persons who received mental health services (FY 2016/2017). From this data, a penetration rate was calculated, showing the percent of persons in the population that received mental health services in FY 2016/2017. This data is shown by age, race/ethnicity, and gender. Primary Language was not available for the general population.

Figure 4
Inyo Penetration Rates 2016/2017
By Age, Race/Ethnicity, Gender, and Language
(Source: U.S. Census Data, CAEQRO Data)

	Inyo County Population 2010		Inyo County Population 2016*		Inyo County Medi-Cal Eligibles		Mental Health Clients FY 16/17		Inyo County Penetration Rate Population
Age Distribution									
0-17	3,900	21.03%	3719.52	20.50%	1743	32.25%	148	32.24%	3.98%
18-64	11111	59.91%	10251.36	56.50%	3094	57.24%	280	61.00%	2.73%
65+	3,535	19.06%	4173.12	23.00%	568	10.51%	31	6.75%	0.74%
Total	18546	100%	18144	100%	5405	100%	459	100.00%	2.53%
Race/Ethnicity Distribution									
Caucasian	13741	74.09%	14642.21	80.70%	2464	45.59%	282	61.44%	10.10%
African American	109	0.59%	181.44	1%	31	1%	3	0.65%	9.70%
Alaskan Native/Native American	2121	11.44%	2376.864	13.10%	1030	19.06%	54	11.76%	4.90%
Asian/Pacific Islander	259	1.40%	308.448	1.70%	47	0.87%	2	0.44%	4.30%
Two or More Races/other	640	3.45%	598.752	3.30%	27	0.50%	5	1.09%	18.50%
Unknown	1676	9.04%	-	-	233	4.31%	17	3.70%	5.60%
Non Hispanic or Latino	14949	80.60%	11758.16	63.40%	0				
Hispanic or Latino	3597	19.40%	3133.433	21.40%	1571	29.07%	96	20.92%	5.10%
Gender Distribution									
Male	9354	50.44%	9126.432	50.30%	2612	48.33%	224	48.91%	2.45%
Female	9192	49.56%	9017.568	49.70%	2793	51.67%	234	51.09%	2.59%
Total	18546	100%	18144	100%	5405	100%	458	100.00%	2.53%
Primary Language Distribution									
English	-	-	-	-	4483	82.94%	430	93.68%	8.40%
Spanish	-	-	-	-	869	16.08%	27	5.88%	2.60%
Unknown					53	0.98%	2	0.44%	2.00%
*estimated by US Census Bureau					5405	100.00%	459	100.00%	8.49%

The penetration rate data shows that 2.53% of the Inyo County population received mental health services. Of these individuals, Children ages 0-17 had a penetration rate of 3.98%; Adults ages 18-64 had a penetration rate of 2.73%; and Older Adults ages 65 and older had a penetration rate of .74%. This data clearly shows that older adults are underserved.

For race/ethnicity, persons who are White/Caucasian had a penetration rate of 10.0%; Latinos had a penetration rate of 1.1%; and American Indians had a penetration rate of 5.1%. The other race/ethnicity groups had small numbers of people in the county, so there is a large variability in the data. This data shows that persons who are Latino are underserved in the mental health system, especially compared to the non-Hispanic population.

Figure 5 shows the unduplicated eligibles data obtained from the Monthly Medi-Cal Eligibility File (MMEF). Each MMEF file contains 16 months of history and includes every client that had at least one month of Medi-Cal coverage where the county of responsibility Inyo County. To avoid duplication, eligibles are defined as: an eligible client is someone with Medi-CAL coverage with at least one aid code that covers Mental Health Service (MHS); for monthly counts, a client is only included when the county of responsibility matches the listed county; for

year-to-date (YTD) counts, a client is counted once if at least one month of eligibility for the listed county is identified.

Figure 5
Inyo County Monthly Medi-Cal Eligibles 2016/2017
By Age
(Source: CAEQRO Data)

Age Distribution for FY2016/2017

	07	08	09	10	11	12	01	02	03	04	05	06
00 - 05	639	638	634	635	649	642	654	662	672	676	671	655
06 - 11	644	647	642	617	611	614	603	607	599	587	568	562
12 - 17	486	489	483	477	477	475	479	485	489	488	482	491
18 - 20	212	207	208	206	216	220	238	245	240	234	225	220
21 - 24	262	271	273	269	267	265	260	256	258	252	255	248
25 - 34	775	782	778	784	788	782	786	780	796	798	770	747
35 - 44	642	640	642	625	632	629	622	628	631	620	622	610
45 - 54	587	589	582	579	569	576	584	591	593	585	579	580
55 - 64	609	623	622	622	616	613	617	626	620	629	608	605
65+	576	575	576	569	569	572	564	568	561	558	566	558
Total	**5,432**	**5,461**	**5,440**	**5,383**	**5,394**	**5,388**	**5,407**	**5,448**	**5,459**	**5,427**	**5,346**	**5,276**

	Avg	%
00 - 05	652	12.1%
06 - 11	608	11.2%
12 - 17	483	8.9%
18 - 20	223	4.1%
21 - 24	261	4.8%
25 - 34	780	14.4%
35 - 44	629	11.6%
45 - 54	583	10.8%
55 - 64	618	11.4%
65+	568	10.5%
	5,405	**100.0%**

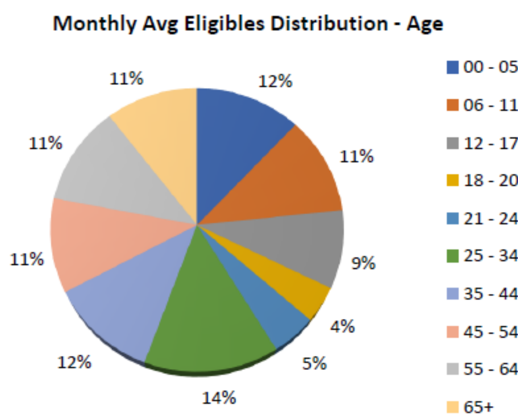


Figure 6 shows the unduplicated clients served by age. Services are limited to only those which were reported within the Client Served Index CSI reportable Unit/Subunit and for which a CSI record would have been submitted (based upon Mode/SFC). In addition, no shows/cancellations and services without durations have been excluded as these are for tracking purpose, but do not represent provided services. Clients served is therefore defined as follows: clients must have received a service having a non-zero duration (bed days are considered non-zero durations) ; clients must not have received a service flagged as a no show or cancellation ; clients must have received the service within a CSI reportable Unit/Subunit and the service must be CSI reportable;

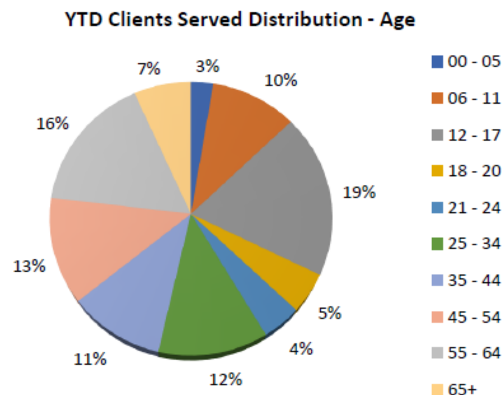
for monthly counts, a client is only included if the service was provided during that month; for year-to-date (YTD) counts, a client is counted once if at least one service was provided during the year.

Figure 6
Inyo County Monthly MH Clients Served 2016/2017
By Age
(Source: CAEQRO Data)

Age Distribution for FY2016/2017

	07	08	09	10	11	12	01	02	03	04	05	06
00 - 05	7	7	6	6	6	3	3	3	2	2	2	1
06 - 11	19	22	24	26	26	23	21	25	30	29	30	24
12 - 17	22	41	36	40	46	44	43	49	53	53	54	38
18 - 20	10	11	5	7	11	9	8	9	10	11	8	7
21 - 24	4	4	6	6	3	6	5	4	6	5	3	5
25 - 34	17	21	16	18	19	27	20	25	27	29	28	18
35 - 44	16	22	21	19	19	19	19	19	24	22	19	17
45 - 54	24	34	30	23	23	27	21	26	22	26	26	23
55 - 64	29	40	34	29	30	30	22	28	25	26	26	26
65+	16	22	19	19	19	21	21	17	22	18	18	18
Total	**164**	**224**	**197**	**193**	**202**	**209**	**183**	**205**	**221**	**221**	**214**	**177**

	YTD	%
00 - 05	12	2.6%
06 - 11	47	10.2%
12 - 17	89	19.4%
18 - 20	22	4.8%
21 - 24	20	4.4%
25 - 34	56	12.2%
35 - 44	49	10.7%
45 - 54	58	12.6%
55 - 64	75	16.3%
65+	31	6.8%
	459	**100.0%**



An analysis of the population assessment and utilization data; conclusions

Persons who are Latino and those who are American Indian are underserved. The penetration rate out of the total population shows that 5.1% of Latinos are served and 4.9% of American Indians are served. The penetration data for Medi-Cal clients compared to Medi-Cal eligibles shows that Caucasians have a rate of 11.4%, while Latinos and American Indians have a much lower penetration rate (6.1% and 4.9%, respectively).

As the data illustrates, persons who are Latino and persons who are American Indian are underserved. When data is available, persons with a primary language of Spanish are also underserved. Although possible mitigating issues are discussed above, we remain committed to

addressing these disparities and identifying ways to provide and track these services. We do this by continuing to recruit staff who are bi-lingual or who represent the under-represented cultures. We have also attempted to identify outreach and intervention strategies such as wraparound to engage these underserved populations within the community.

INCLUSION IN ICHHS-BH PLANNING PROCESS FOR CULTURALLY COMPETENT SERVICES AND STRENGTHENING OF COMMUNITY ORGANIZATIONS (CRITERON 3, 4, 8)

Community Services and Supports

It is the value and mission of ICHHS-BH to involve underserved communities in planning and management committees. Our threshold language is Spanish, with 21.4% of our population being Latino. 13.1% of the population is American Indian. We have small numbers of other racial groups in this small, rural community. We have diverse cultures represented on many of our committees. Our Mental Health Advisory Board is comprised of 70% Caucasian, 20% Latino, 50% consumers, and 20% family members. Our Cultural Competence Committee is comprised of 66% Caucasian, 22% Latino, 11% Native American, and includes 56% consumers. Our MHSA Steering Committee directs and implements our MHSA activities. This Committee is comprised of 70% Caucasian, 20% Latino, and 10% Native American, and includes 100% consumers.

These committees provide leadership and opportunities to give voice to consumers, persons of color, family members, youth, and other cultural groups. This leadership creates a forum for ensuring that we continually enhance our services to be culturally and linguistically relevant for our youth and adult clients and their families.

We also continue to offer Latino Outreach through both the wellness center sites and within the community. A contracted bilingual therapist, also employed by the schools, provides mental health services to Latino youth and their families. These youth and families may be hesitant to come into the traditional clinic especially if there are immigration issues. The therapist treats anxiety and depression related to trauma issue as well as provides family support. This year, there was an increased need expressed around youth impacted by DACA (or the Dream Act). The contracted therapist has worked to advocate for youth and to provide support services. Approximately 10 youth were served through this CSS strategy along with outreach to at least 50 additional persons. This year, we are proposing to use a new hired Spanish-speaking Licensed Clinical Social Worker to provide additional services to Spanish-speaking women to address issues of anxiety and trauma. This service will be provided at the wellness center or other community site.

Lessons and Identified Needs

Our biggest challenge is in hiring bilingual, bicultural staff to provide services to our Latino and American Indian communities. Through MHSA, we are very fortunate to have a staff member represent our underserved Native American community. We have continued to work closely with a bilingual contract clinician to provide outreach to the Latino population. It has been a very slow process to build trust within the local Latino community. Our staff members offer more informal services within the community, often without formal admission into services. We have been challenged, in the past, to track these services through our data management system but we have implemented a new process in Quarter 2 of FY 17/18 that will make tracking our outreach hours easier. Finally, in FY16/17 we hired a bilingual licensed therapist in our Adult Division that has been designated as our Cultural Competence Manager. She has worked with a bicultural bilingual Prevention Specialist to ensure community outreach. We have found that it is most advantageous to outreach to the Latino community in a variety of settings in order to make an impact. It seems most helpful to do this in informal settings within the community. For example, we have implemented a support group in Quarter 4 of FY 17/18 targeted at Spanish speaking women to address women's issues in our community.

As applied to the American Indian population, we are fortunate to have Toiyabe Family Services as a provider of Behavioral Health Services within our community. We seek to work collaboratively with this agency. Our staff continues to look for interventions that would be most beneficial to this population. We would be very open to technical assistance in this area.

We incorporate discussions of delivering culturally relevant services into our weekly staff meetings, as well as during clinical and staff supervision. Whenever possible, we take advantage of any regional and/or state training offered on promoting and delivering culturally-relevant services. However, it is difficult to send staff to most statewide trainings, because of the distance, cost, and small staff. If we send two staff to a three-day training, and it takes one day to travel to the training, and one day back, we have lost 40+ hours of direct service time for each staff person. This creates a burden on the small number of staff who remains at the clinic to deliver services. We have found online trainings helpful as well as implemented quarterly staff-led trainings to help fill the need for cultural competence training.

In delivering services, staff treats each client as an individual, with many different needs and cultures. In addition to delivering services in the person's preferred language and utilizing bicultural staff whenever possible, we also understand that age, health, gender, community, and lifestyle have an important role in meeting the individual needs of each client. It is also important to note that these needs may change over time, and staff must be sensitive to different needs as an individual may change, over time.

Efforts and Programs

An extensive planning process was followed to identify key populations with disparities. We held numerous stakeholder groups. In addition, we distributed surveys to ensure that we heard

the voice of persons who were not available to participate in the stakeholder groups. This planning process identified a number of different groups that are underserved, including persons who are Hispanic and Native American, persons who are LGBTQ 2-S, Transition Age Youth, adults, and older adults.

Workforce Education and Training Plan (WET) from MHSA Plan

Since the original WET Plan was approved, ICHHS as a whole developed several contracts and strategies with various learning providers to deliver a broad range of trainings to benefit the workforce. In a small rural isolated community, it has been an effective strategy to offer training that assists us to "grow our own" workforce from within our community from those dedicated to the community. We have offered training aimed at the development of consumers and family members. Behavioral Health staff members are trained separately and as part of the larger Health and Human Services staff that includes the Social Services and Aging Division and the Public Health and Prevention Division. Partner agencies such as Probation and Toiyabe Indian Health Plan are also trained. Training topics include a broad range of family engagement, child and family teaming, motivational interviewing, and delivering comprehensive services for promoting wellness and recovery. Team building and transformational change has also been a focus of our trainings.

The Inyo County MHSA Leadership Committee, comprised of consumers, family members, staff, and other stakeholders, reviewed and discussed the results of the survey and the Needs Assessment data. The group used these tools to determine the highest training needs, the most effective training methods, and possible recruitment strategies. Specific actions for each WET category were developed that will best fulfill our training and recruitment needs.

Input from these planning activities were compiled and developed into the core components of the WET Plan. An initial draft of the WET Plan was distributed to key stakeholders, including the Mental Health Board and MHSA Leadership Committee, for input and feedback. Their input was integrated into this proposed Workforce Education and Training Plan.

We have also increased our capacity to provide services to Spanish speaking persons through the addition of 2 bilingual contract providers (one providing outreach to youth and families, one providing services to older adults). Further, we are providing a training opportunity in Parent Child Interaction Therapy to an additional bilingual Latina therapist in the community. This has increased our capacity to provide services to Spanish-speaking persons as described in our WET plan.

Prevention and Early Intervention

Targeting one of our underserved communities the Elder Outreach Program has been helpful at identifying at-risk seniors who begin to exhibit signs of depression, prescription drug abuse, isolation, and other conditions related to the aging population. This Older Adult PEI Program has provided outreach and engagement, early mental health screening, and prevention services to

older adults who had been receiving services in the community and through county resources. This program also trains agency partners to recognize the signs and symptoms of mental illness in older adults. The Elder Outreach Program funds a mental health nurse to provide screening, referral and linkage, and support services to prevent the exacerbation of mental health conditions. The program, utilizing a Behavioral Health Nurse, offers comprehensive assessment services to those older adults at risk of developing mental health problems that may interfere with their ability to remain independent in the community. The Nurse then links these individuals to resources within the community, including County Behavioral Health services. This program offers service alternatives for older adults who have been unserved and underserved in this community. Services are voluntary and client-directed, strength-based, employ wellness and recovery principles, address both immediate and long-term needs of program members, and are delivered in a timely manner that is sensitive to the cultural needs of the population served.

The role of the Behavioral Health Nurse is first to provide the initial assessment to potential candidates for prevention services such as the Friendly Visitor Program or Healthy Ideas. A member of the Adult Services team will further involve the Behavioral Health Nurse when intervention may be warranted, especially if any suicidal ideation is noted. The Behavioral Health Nurse collaborates closely with other agencies that provide services to this population, including In-Home Supportive Services, Adult Protective Services, Eastern Sierra Area Agency on Aging, local physicians, Public Health, nursing homes, home health agencies, and the home delivery meals program. All agencies receive training to help them recognize signs and symptoms of mental illness in older adults. The Behavioral Health Nurse also provides services to older adults in community settings that are the natural gathering places for older adults, such as our Senior Center sites in the community sites of Bishop, Big Pine, Independence, Lone Pine, and Tecopa.

Older adults who need additional services are referred to a Friendly Visitor (see below) or to Behavioral Health for ongoing treatment, as appropriate. In the past year (16/17), outreach visits were made to 48 older adults. This results in a cost of $567.63 per individual. This strategy again targets the more isolated parts of the county. One Native American and one Hispanic older adult have been served with the remainder being Caucasian.

The FV program has been implemented to provide prevention services to isolated seniors who have evidenced symptoms of depression and are living alone in the community. We have funded two part-time Program Services Assistants, one in the northern part of the county and one in the southern part of the county. The meal delivery staff identifies seniors who evidence symptoms of depression and/or anxiety and who might benefit from a visitor. The visitor, who may also be a senior, develops a plan with the senior to address the depression and prevent further exacerbation of symptoms.

The program has provided services to 17 seniors at a cost of approximately $360.18. The average initial score on the PHQ9 was 11 with a range of 4 (very mild) to 23 (very severe) with four persons falling in this category. Five participants reported daily thoughts of "being better off dead". A majority of the participants (>75%) reported moderate to severe pain symptoms. The categories where persons reported the most daily difficulty were in "feeling tired" and "trouble with sleep". While there continue to be difficulty in obtaining "post" PHQ9s, participants' surveyed report a high degree of satisfaction with the FV and a decrease in feelings of depression.

Monitoring/Strategies for Reducing Disparities

We have a long history of using data to measure and monitor access and quality of services. Data is produced monthly for our Quality Improvement Committee (QIC) and other management meetings. Data is produced to show the number of persons served, the average hours of services, and types of services received. We closely monitor the quality of services by examining the number of individuals who are hospitalized, placed in higher levels of care (e.g., IMD), and length of stays. This data is analyzed by age and race/ethnicity. As the data is reviewed, managers and supervisors are able to discuss disparities and develop strategies for improving access and quality of services.

As different strategies are implemented, this monthly data provides immediate feedback for managers and staff to modify strategies and strength policies for improving services and reducing disparities.

MEETING CULTURAL AND LINGUISTIC REQUIREMENTS

ICHHS-BH has designated Carla Orieta as the county's Cultural Competence/Ethnic Services Manager. This individual is responsible for promoting mental health services that meet the needs of our diverse population, promotes the delivery of culturally sensitive services, and provides leadership and mentoring to other staff. She helps meet the needs of our threshold population since she is a Spanish speaking psychotherapist that specializes in our adult communities as well as Spanish outreach. The Cultural Competence manager will report to, and/ have direct access to, the Deputy Director of Behavioral Health regarding issues impacting mental health issues related to the racial, ethnic, cultural, and linguistic populations within the county.

We are also looking to find relevant, comprehensive training in delivering culturally and linguistically relevant services to our client community. Our Cultural Competence manager has recently implemented a support group for Latina women to address issues in our community. Any technical assistance in identifying and delivering training in this region would be very helpful.

Client driven/operated recovery and wellness programs that accommodate racially, ethnically, culturally, and linguistically specific diverse differences

All of our Wellness Center offerings are selected and facilitated by consumers or family members. A consumer/family member volunteer at the Wellness Center holds a weekly stakeholder meeting with the persons who attend the Center. All consumers are welcome to attend these stakeholder meetings. The stakeholders review issues of operation, create rules and hear all input regarding the Wellness Center. Stakeholders also suggest activities and group offerings and suggest consumers/family members interested in facilitating the group offerings. The current offerings include:

- Writing group
- Recovery group for co-occurring addiction issues: twice per week
- Gardening group
- Women's support
- Transition Age Youth: living skills
- Art Expression Group
- Handling Money
- Developing WRAPs
- Cooking group
- Walking/exercise group
- Community activities

In addition, consumers and staff together take local trips to events and cultural sites around the county. Past trips have included:

- Visiting Eastern California Museum (Native American)
- Attended Native American film series
- Visiting Manzanar Museum; increase cultural sensitivity regarding internment of Japanese
- Attending a Playhouse 395 performance
- Participated in St. Patrick's Irish feast and Irish entertainment

- Attended a Cesar Chavez Day event
- Outing to Cinco De Mayo celebration
- Outing to Vietnam War Memorial

Mechanisms for informing clients of culturally-competent services and providers, including culturally-specific services and language services; identify issues and methods of mitigation (CRITERON 7)

ICHHS-BH utilizes a 24/7 Access Line for Crisis and informational purposes. Those who staff this line are trained in cultural competence and are able to provide the link to language assistance and interpreter services as necessary. The ICHHS-BH *Guide to Behavioral Health Services* (in English and Spanish) highlights available services, including culturally-specific services. In addition, the guide informs clients of their right to FREE language assistance, including the availability of interpreters. This brochure is provided to clients at intake, and is also available at our Bishop clinic. A *Provider List* is available to clients which lists provider names, population specialty (children, adult, veterans, LGBTQ, etc.), services provided, language capability, and whether or not the provider is accepting new clients. This list is provided to clients upon intake and is available at our clinics and the wellness center. The Provider List is updated as changes occur.

Outline the process for capturing language needs and the methods for meeting those needs; identify issues and methods of mitigation

Our 24/7 Access Log includes a field to record a client's need for interpreters. This form is forwarded to clinical staff for the intake assessment. This information is also utilized during case assignments and clinical team meetings, to help determine the appropriate staff to provide ongoing services in the individual's primary language, whenever possible. This is reviewed for compliance by Inyo County HHS Evaluations & Outcomes team quarterly.

The Quality Improvement Committee (QIC) reviews complaints and grievances. The grievance log records if there are any issues related to cultural competency. The QIC reviews all issues and determines if the resolution was culturally appropriate. This committee meets quarterly and therefore has the ability to identify additional issues and objectives to help improve services during the coming year.

In addition, ICHHS-BH has a policy and form to allow beneficiaries to file a problem with MHSA programs and have a resolution process in place to address these identified issues. ICHHS-BH has a policy in place that outlines the requirements and processes for meeting a client's request for language assistance and an interpreter, including the documentation of providing that service.

Describe the process for reviewing grievances and appeals related to cultural competency; identify issues and methods of mitigation

Grievances and appeals that are submitted to Inyo County Behavioral Health are reviewed in accordance with the Client Problem Resolution Process policy and procedure. The issues are reviewed to determine if race/ethnicity and/or cultural competency is relevant to the grievance or appeal.

Cultural Competence Committee

ICHHS-BH QIC Committee is combined with our Cultural Competence Committee (CCC) and has approximately 18 members. Participants include consumers and staff members; our bilingual clinician is a Committee member. CCC members include persons who are Caucasian, Hispanic, and Native American. We work closely together to review data, organize cultural activities, and promote culture and healing to help balance the lives of the persons who we serve. The committee integrates with the county mental health system by participating in and reviewing MHSA planning process. The Cultural Competence Committee members have been involved in participating and providing leadership to the MHSA planning process from the initial funding and stakeholder meetings. In this small county, staff serve multiple roles. As a result, the promotion of culturally relevant services is an ongoing continuous improvement project. We are involved in developing strategies for improving access and quality of services for individuals who are underserved, including TAY; persons who are Hispanic; persons who are Native American; the LGBTQ community; and the consumer culture.

Cultural discussions are an integrated part of our children and adult service delivery system. We discuss how culture influences outcomes, and the importance of understanding an individual's culture so that we can combine and understand traditional health methods and balance it with traditional treatment strategies. Planning activities for MHSA promote culturally-sensitive services. MHSA planning discussions have outlined the importance of integrating a person's culture and the broader community, including involving families and support systems in treatment, whenever possible.

Resources Targeted for Culturally Competent Activities

Budget

As a small county, we do not have a specific budget allocated for these culturally sensitive services. ICHHS-BH integrates cultural activities and vision into all services; however, these services are not budgeted or tracked separately. All mental health services described in this plan are allocated to mental health realignment or Mental Health Services Act (MHSA) funding. ICHHS-BH also has a contract with Language Line in an amount not to exceed $8,000 from March 15, 2018 through June 30, 2019 to ensure linguistic competence.

STAFF TRAINING AND RECRUITMENT (CRITERON 5)

ICHHS-BH staff is encouraged to avail themselves to trainings which enhance cultural and linguistic sensitivity. All trainings are documented in the Training Log. Periodic reviews of the Training Log in the Cultural Competence Task Force help to assess staff training needs.

The ICHHS-BH is an equal opportunity employer and encourages bilingual and bicultural persons to apply for available positions. Exceptional efforts are made to recruit bilingual and bicultural staff. The ICHHS-BH will provide bilingual pay for those demonstrating proficiency in a threshold language, other than English, utilized by the ICHHS-BH to assist limited and non-English speaking clients on a regular basis.

During the interview process of bilingual and bicultural applicants, Spanish-speaking interviewers may sit on the interview panel so that they can assess the applicant's ability to communicate ideas, concerns, and rationales. Additional interview questions may be asked to determine the applicant's knowledge of the mental health field*.

Bilingual applicants may be required undergo a written test on behavioral health topics to assure the applicant's ability to communicate ideas, concerns, and rationales, as well as translation of the words used, and to certify their bilingual status so they can receive bilingual pay if hired*.

**ICHHS-BH will continue to work with County Administration to establish this proficiency.*

Culturally Competent Training Activities

Staff education and training are crucial to ensuring culturally and linguistically appropriate services. All staff will interact with clients representing different countries or origins, acculturation levels, and social and economic standing. Staff refers not only to personnel employed by the organization but also its subcontracted and affiliated personnel.

It is our system view that all staff will participate in a number of different learning experiences to help promote person-centered care and develop culturally sensitive services to all individuals in the mental health system. Staff will participate in a number of different learning opportunities that include face-to-face meetings and trainings, individual learning sessions on Essential Learning, and ongoing discussions during staff meetings and during supervision. Across a three-year period, all staff will participate in the required cultural competence training as outlined in our three-year training plan.

Cultural Competence will be imbedded into all training. Culture, and the way in which it is integrated into all trainings, is an essential component in promoting healthy outcomes. Staff learn from each other, and the input from each person, including those individuals from diverse cultures is integral. "Culture" may include various groups that include ages, race/ethnicity, gender, sexual orientation, veterans, and consumers of services. As we identify different training opportunities for staff and/or clients, we embed a discussion of culture into the educational materials. For example, when we train staff on writing Client Care Plans, we discuss that goals

need to reflect the values of the client: a goal of an older adult may be very different from that of a transition age youth. Similarly, a Client Care Plan for a Hispanic family with an SED child may include more family members as support persons than a Client Care Plan might have for a Caucasian child.

In the next three years we will strive to provide training to persons who serve as interpreters, as well as to staff who utilize interpreters. Interpreters will be trained to sit in the most effective location in the room, how to translate the client's words to their fullest, and how to avoid adding personal opinions or additional information to the translation. Persons who utilize interpreters will be trained to speak directly to the client, to speak in short, easily translatable paragraphs, and to learn a few words in the client's language to help build a relationship with the client and his/her family.

All staff are trained to effectively use the Universal Language Line, as well as the California Relay Service and TDD. The following chart outlines the Cultural Competence Trainings for FY 17/18:

Training Event	Date of Training	Description of Training	Frequency and Duration	Attendance by Function	No. of Attendees Total	Presenter
New Employee Orientation	Last Friday of every month	Tribal Nations Information	Monthly	All HHS Staff	+/- 7	Topah Spoonhunter ICHHS
QII	8/7/17	Cultural Sensitivity/Diverse Groups	Quarterly 30 min	Direct Service: 18	18	Carla Orieta ICHHS-BH
Aging and Mental Health	10/16/18	Cultural Diversity	Yearly 6 hrs	Direct Service: 3	3	UC Davis
QII	10/30/17	Cultural Competency	Quarterly 30 min	Direct Service: 10	10	Carla Orieta ICHHS-BH
Self-Neglect	2/18/18	Limits and Responsibility	Yearly 6 hrs	Direct Service: 2	2	UC Davis

Training Event	**Date of Training**	**Description of Training**	**Frequency and Duration**	**Attendance by Function**	**No. of Attendees Total**	**Presenter**
Staff Training	3/12/17	24/7Access Line	Annually	ICHHS-BH Staff	5	ICHHS Staff
Cenpatico Cultural Competency	3/26/18	CLAS Standards	Quarterly	Direct Service: 14	14	Michael Wright PhD, LAPSW
QII	6/4/18	Cultural Sensitivity/Diverse Groups	2 hours	Direct Service: 18	18	Relias online training system
QII	9/10/18	Native Americans: Historical Trauma Cultural Diversity	Quarterly 60 min (direct service) 75 min (online)	**Direct Service:** 19 Supervisors- 3 Administration- 1 Staff- 15 **Online:** 7 Supervisors- 1 Administration- 3 Staff- 3	26	Arlene Brown- Cultural & Family Coordinator TIHP Relias Online training
QII	11/5/18	Historical trauma and delivery of BH services to Native American Communities Advocacy and	Quarterly 90 min (direct service) 90 min	**Direct Service:** 16 Supervisors- 2 Administration- 1 Staff- 13 **Online:** 8	24	Arlene Brown- Cultural & Family Coordinator and Paul Chavez, LCSW TIHP Relias

Training Event	Date of Training	Description of Training	Frequency and Duration	Attendance by Function	No. of Attendees Total	Presenter
		Multicultural Care	(online)	Supervisors- 1 Administration- 3 Staff- 4		Online training

In addition to training on client culture, the ICHHS-BHP has a goal to provide training to mixed groups of consumers and other staff members together. The goal is to provide at least 25% of training opportunities to consumers as well as other staff members. In this way, training participants can represent the client cultural as well as other cultural perspectives in many different arenas. We have found this especially helpful in our efforts to address stigma and discrimination. Annual training will also be held to provide staff an understanding of persons with lived experience. Use of language, how to welcome individuals, and promoting opportunities to learn from individuals with lived experience will be developed. We will obtain training from U.C. Davis, Cinpatico, or other organizations, to promote staff's understanding of client culture. This will include training on children, TAY, families, family focused treatment, and navigating multiple agency services.

Training Plan

We have integrated cultural competence training and discussions in our weekly staff meetings and committee meetings. ICHHS-BH staff has expanded their knowledge of different cultures and infused this knowledge throughout rendered services. We have created a safe, learning environment where the staff members feel safe to ask questions about culture. Equally important, staff also feel comfortable in providing feedback to others regarding specific behaviors which may not have been as culturally sensitive. By creating a safe environment to ask and receive feedback, each person has the opportunity to learn and expand their services to better meet the needs of the community.

The to-be-written training plan will have a broad range of topics including Multicultural Knowledge, Cultural Sensitivity, Cultural awareness, Diverse Groups, and Mental Health Interpreter Training. Training to learn how to navigate the person's culture and broader community and support system will be discussed. In addition, training will focus on strength-based services, a person's cultural perspective, and an understanding of how treatment can incorporate an individual's traditional practices. We are committed to providing trainings to our Behavioral Health staff as well as our stakeholders and consumers. The following trainings have been scheduled:

Training Event	Date of Training	Description of Training	Frequency and Duration	Attendance by Function	No. of Attendees Total	Presenter
New Employee Orientation	Last Friday of every month	Tribal Nations Information	Monthly	All HHS Staff	+/- 7	Topah Spoonhunter ICHHS
QII	6/4/18	Cultural Diversity	75 min	Direct Service: 18	18	Relias online training system
QII	9/10/18 FY 18-19	Native Americans: Historical Trauma Cultural Diversity	Quarterly 60 min (direct service) 75 min (online)	**Direct Service:** 19 Supervisors- 3 Administration- 1 Staff- 15 **Online:** 7 Supervisors- 1 Administration- 3 Staff- 3	26	Arlene Brown- Cultural & Family Coordinator TIHP Relias Online training
QII	11/5/18 FY 18-19	Historical trauma and delivery of BH services to Native American Communities Advocacy and Multicultural	Quarterly 90 min (direct service) 90 min (online)	**Direct Service:** 16 Supervisors- 2 Administration- 1 Staff- 13 **Online:** 8 Supervisors- 1	24	Arlene Brown- Cultural & Family Coordinator and Paul Chavez, LCSW TIHP Relias Online

Training Event	Date of Training	Description of Training	Frequency and Duration	Attendance by Function	No. of Attendees Total	Presenter
		Care		Administration- 3 Staff- 4		training
HHS Staff Training	01/03/2019 & 04/29/2019	Unconscious Bias and Diversity	4 hours (direct service)	All HHS Staff		Tiffany Bizzack, UC Davis
Supervisors training	TBD FY 18-19	Increase understanding of cultural competency practices to reduce and eliminate racial and ethnic health disparities for individuals and health care organizations	TBD	TBD		HHS- Carla and Stephanie
QII	2/11/19 FY 18-18	Best Practices for Working with LGBTQ Children and Youth	75 min	TBD		Relias Online training
QII	5/13/19 FY 18-19	Groundwork for Multicultural Care	75 min	TBD		Relias Online training
QII	TBD- 1st quarter FY 19-20	A Culture-Centered Approach to Recovery	60 min	TBD		Relias Online training

Training Event	Date of Training	Description of Training	Frequency and Duration	Attendance by Function	No. of Attendees Total	Presenter
QII	TBD- 2nd quarter FY 19-20	Working with the Homeless: An Overview	75 min	TBD		Relias Online training
QII	TBD-3rd quarter FY 19-20	Military Cultural Competence	75 min	TBD		Relias Online training
QII	TBD-4th quarter FY 19-20	Respecting Cultural Diversity in Persons with IDD	60 min	TBD		Relias Online training

COMMITMENT TO GROWING A MULTI-CULTURAL WORKFORCE (CRITERON 6 & 7)

We are fortunate to have American Indian and Latino staff, and have experienced an improved ability to provide outreach and engagement to these communities. Given our population figures, we could use an additional staff presence in both the American Indian and Latino areas. For both these communities, it has been important to reach out to the community with culturally competent staff. The difficulties of identifying and hiring American Indian and Latino staff is even greater given our difficulty hiring qualified licensed staff with the expertise to work in remote geographic areas and the willingness to work in our remote area. It is our goal to hire clinical staff with the expertise to serve ethnic communities; however, in the past, such staff has been extremely difficult to attract and retain.

Staff and Service Assessment

Ethnicity by Function

Addictions Counselor III	2 Caucasian
Addictions Program Supervisor	Vacant
Administrative Secretary II	Caucasian
APAR - HHS Specialist I - TEMP	Caucasian
Beh Health Serv Director	Caucasian
Behavioral Health RN I	2 Caucasian
Program Services Assistant Friendly Visito	3 Caucasian
HHS Specialist IV	1 Native American, 1 Caucasian
HHS Specialist IV MHSA	1 Native American, 1 Hispanic, 2 Caucasian
Human Services Supervisor/MHSA	1 Caucasian
Office Clerk III	4 Caucasian
Office Tech III	1 Caucasian
Program Chief	Caucasian
Progress House Manager/Trainee	Caucasian
Psychiatrist - "at will"	Hispanic
Psychotherapist	1 Hispanic , 1 Caucasian
Registered Nurse (Corrections)	Caucasian
Residential Caregiver	6 Caucasian, 1 Tagalog
Supervising Nurse	Caucasian
SW IV/CMSP/GA/CalWORKS	1 Caucasian
SW IV/Psychotherapist	3 Caucasian

Staff Proficiency in Reading and/or Writing in a Language Other Than English by Function and Language:

We have one Native American MHSA HHS Specialist IV that speaks and writes limited Paiute. We have one Psychotherapists and one LMFT that are fluent in Spanish and can read and write in the Spanish language. We have one Residential Caregiver that is fluent in Tagalog and can read and write in Tagalog as well.