Inyo County Health and Human Services- Behavioral Health

Cultural Competence Plan

Annual Update

FY 2023-24

Table of Contents

2010 CULTURAL COMPETENCE PLAN REQUIREMENTS CRIERIA 4
OVERVIEW 5
ICHHS-BH Values 5
COMMITMENT TO CULTURAL COMPETENCE (CRITERION 1) 6
DATA AND ANALYSIS (CRITERON 2) 8
Geographic and Socio-Economic Status 8
Geographical Characteristics 8
Socio-economic Characteristics 9
Demographics and Penetration Rates 9
Demographic Data 9
Mental Health Services Data and Analysis 10
INCLUSION IN ICHHS-BH PLANNING PROCESS FOR CULTURALLY COMPETENT SERVICES AND STRENGTHENING OF COMMUNITY ORGANIZATIONS (CRITERON 3, 4, 8) 13
Community Services and Supports 13
Lessons and Identified Needs 14
Efforts and Programs 14
Prevention and Early Intervention 17
WET 18
Monitoring/Strategies for Reducing Disparities 19
MEETING CULTURAL AND LINGUISTIC REQUIREMENTS 20
Client driven/operated recovery and wellness programs that accommodate racially, ethnically, culturally, and linguistically specific diverse differences 20
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) 21
Outline the process for capturing language needs and the methods for meeting those needs; identify issues and methods of mitigation 22
Describe the process for reviewing grievances and appeals related to cultural competency; identify issues and methods of mitigation 23
Cultural Competence Committee 23
Resources Targeted for Culturally Competent Activities 24
Workgroups 24
Budget 24

STAFF TRAINING AND RECRUITMENT (CRITERON 5) 24
Culturally Competent Training Activities 25
Training Plan 26
COMMITMENT TO GROWING A MULTI-CULTURAL WORKFORCE (CRITERON 6 & 7) 28
Staff Proficiency in Reading and/or Writing in a Language Other Than English by Function and Language: 31

2010 CULTURAL COMPETENCE PLAN REQUIREMENTS CRITERIA

Name of County:	Inyo
Name of County Mental Health Director:	Kimball C. Pier
Name of Contact:	Lori Bengochia
Contact's Title:	ESM/Program Integrity and Quality Assurance Manager
Contact's Unit/Division:	Admin/Behavioral Health
Contact's Telephone:	(760) 872-3273
Contact's Email:	Lbengochia@inyocounty.us

☒ **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 honor each client's lived experience and to offer services that are client centered and culturally relevant.

Formatted: Heading 1, Centered

OVERVIEW

We are committed to providing each eligible beneficiary with access to a high quality, effective, cost-efficient system of care which is community based, culturally responsive, and consumer driven.

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, informational 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.

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

To accomplish the above objectives, ICHHS-BH will endeavor to practice the National Standards on Culturally and Linguistically Appropriate Services (CLAS).

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 culturally sensitive, client-centered a system of care for children, adults, and older. 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 each beneficiary's history and lived experience.

- ICHHS-BH recognizes that the family, as its members define it, is a primary system of support, and therefore, we invite participation by family members into the service plan whenever safe and appropriate.
- ICHHS-BH will provide language accessibility and will ensure cultural awareness and sensitivity within the service system.
- ICHHS-BH is committed to hiring staff who are proficient in and committed to serving our Spanish-speaking and indigenous community members.
- ICHHS-BH is committed to providing timely and appropriate access to care.
- ICHHS-BH values prevention and early intervention as strategies to promote wellness, educating beneficiaries in recognizing trauma and its effects, and maintaining each beneficiary within his/her community to the extent possible.
- ICHHS-BH Staff will recognize and work with each beneficiary's strengths and 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 throughout treatment and discharge planning to allow each beneficiary to maintain the least restrictive setting and most appropriate level of care, enhancing community linkages

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 and Implementation Plan
4. Policy and Procedure Manuals
5. Other Key Documents

The documents listed above are currently available at the 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. Our values to integrate cultural sensitivity is equally relevant to a wide range of cultures, including persons who are Lesbian, Gay, Bi-sexual, Transgender, Questioning, Intersex,

Asexual (LGBTQIA+), older adults, people with disabilities, veterans, 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.

Goal 1: Improving access to services for Latinx, Native American/American Indians, older adults, Veterans, TAY, and their families as measured by penetration rates and services rendered.

Objective A: Offering door-to-door services in each person's primary language. Provide bilingual staff training to include a basic training, proficiency test, and classification of staff by December 2021.

Objective B: Increase access by increasing documents and signage available in our threshold language from 75% to 100% in both clinics and on our website language by January 2022.

Objective C: Continue efforts to increase diversity, reflective of our community, in our workforce through the hiring process. Continuous with each recruitment.

Goal 2: To create, nurture, and sustain a culture of diversity, equity, and inclusion by fostering opportunities for hard conversations as well as personal and professional growth.

Objective D: Implement training for new hires at orientations that will provide the tools to recognize and respectfully honor the culture within our agency, community, and clients. These trainings will include topics surrounding local Tribal Nations presentations, Civil Rights Act, implicit bias, the aging population, the veteran population, social determinants of behavioral health, and recovery culture. Started in January 2021, add additional trainings through June 2022.

Objective E: Provide cultural and linguistic competency training for staff, leadership, and peers least once a year.

Goal 3: Continue outreach and engagement in coordination with other community agencies for our underserved populations

Objective F: Continue efforts of the HHS Equity Workgroup to engage in and develop partnerships with community organizations that represent our underserved populations. These include but are not limited to the five federally recognized tribal governments in Inyo County, Manzanar Historical Society, and the Fresno Mexican Consulate. Quarterly presentations.

Goal 4: To collect and maintain accurate demographic data to monitor and evaluate the impact of services on health equity and client outcomes. Data will be reviewed quarterly by the Quality Improvement Committee.

Objective H: Train front office staff, clinical staff, and subcontractors on data collection procedures to ensure consistent and accurate data is collected. By December 2021.

DATA AND ANALYSIS (CRITERION 2)

Geographic and Socio-Economic Status

Geographical Characteristics

At 2010 census, the population of Inyo County was 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 contains an abundance of natural diversity. It includes Owens Valley and 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 continental U.S., Death Valley, and the highest point in the, 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. Inyo County is a "frontier" county, defined as having a population density of fewer than six people per square mile, 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 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, Big Pine, Independence, and Southern Inyo to include Olancha/Cartago, Death Valley, Darwin, 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.

The following information was gathered using 2019 estimates from the U.S. Census Bureau (https://www.census.gov/quickfacts/fact/table/CA). The median family income in Inyo County is $57,316 compared to $75,235 in the state of California. The estimated per capita income for Inyo residents was $32,590. The statewide per capita income is $ 36,995, which is $4,365 per person higher than Inyo County. This data reflects the economic condition of this small, remote county.

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 Latinx 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 Indian 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 U.S. 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 an American Indian Health Facility (AIHF), Toiyabe Indian Health Project, which includes mental health and addiction services as part of their family service offerings to the American Indian population in Inyo.

Figure 1 shows the total Inyo County population (2019 Census Bureau estimated data). Of the 18,144 persons who live in Inyo County, 26.2% are 0-17 years of age; 50.4% are 18-64; and 23.4% are 65 years and older. The majority of persons in Inyo County are Caucasian (80.7%) and Latinx/Hispanic (23.4%). 13.5% 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		Population Estimates 2019
Age Distribution			
0-17	3,900	21.03%	26.2%
18-64	11,111	59.91%	50.4%
65+	3,535	19.06%	23.4%
Total	18546	100%	100%
Race/Ethnicity Distribution			
Caucasian	13741	74.09%	79.8%
African American	109	0.59%	1.2%
Alaskan Native/Native American	2121	11.44%	13.5%
Asian/Pacific Islander	259	1.40%	1.7%
Two or More Races/other	640	3.45%	3.6%
Unknown	1676	9.04%	*no data
Non-Hispanic or Latinx	14949	80.60%	60.8%
Hispanic or Latinx	3597	19.40%	23.4%
*estimated by U.S. Census Bureau			

Mental Health Services Data and Analysis

The information that appears on the following pages (Figures 2-4) reflect a comparison of four different population measurements: Medi-Cal eligibles (MMEF), Short Doyle/ Medi-Cal SD/MC clients (approved claims), clients served (CSI), and MH Prevalence estimates.

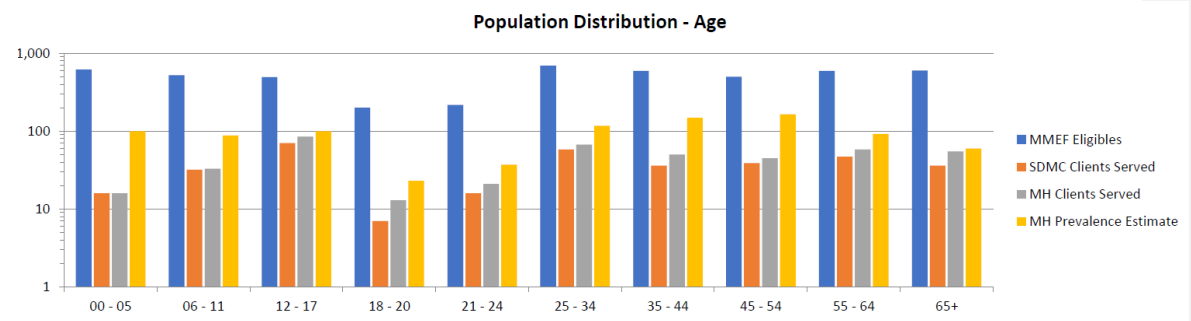
- Eligible counts are based upon the Monthly Medi-Cal Eligibility File (MMEF) and reflect the monthly average
- SD/MC counts are based upon approved claims
- Clients served are based upon a review of Cerner Community Behavioral Health (CBH) data for CSI reportable services
- MH Prevalence estimates reflect the work of Charles Holzer and group.

This information is from Kings View Information Technology and is given to Inyo County Quality Improvement Team and Leadership staff quarterly. From this data, a penetration rate was calculated, showing the percent of persons in the population that received mental health services in FY 2019/2020. We are using the Mental Health Clients Served compared to the Mental Health Prevalence Estimate. This data is shown by age, race/ethnicity, and gender.

Figure 3
Inyo Penetration Rates 2019/2020
By Age

Age Distribution for FY2019/2020

	MMEF Eligibles	SDMC Clients Served	MH Clients Served	MH Prevalence Estimate	SDMC Penetration Rate (%)	MH Penetration Rate (%)
00 - 05	616	16	16	100	2.6	16.0
06 - 11	521	32	33	88	6.1	37.5
12 - 17	496	70	85	100	14.1	85.0
18 - 20	200	7	13	23	3.5	56.5
21 - 24	217	16	21	37	7.4	56.8
25 - 34	692	58	67	117	8.4	57.3
35 - 44	595	36	50	148	6.1	33.8
45 - 54	500	39	45	165	7.8	27.3
55 - 64	593	47	58	92	7.9	63.0
65+	600	36	55	60	6.0	91.7
Total	**5,030**	**357**	**443**	**930**	**7.1**	**47.6**



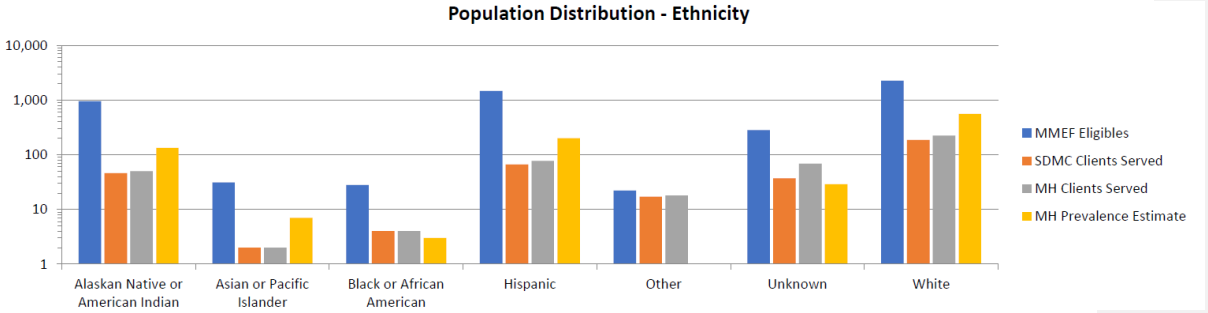
(Source: U.S. Census Data, CAEQRO Data)

The MH Prevalence estimate shows a penetration rate of 47.6% for youth. Which means, of the estimated mental health prevalence rate (930 people), we were able to provide services to 443. Of these individuals, Children ages 0-17 had an average penetration rate of 46.2%; Adults ages 18-64 had an average penetration rate of 49.11% and Older Adults aged 65 and older had an average penetration rate 91%.

Figure 4
Inyo Penetration Rates 2019/2020
By Ethnicity

Ethnicity Distribution for FY2019/2020

	MMEF Eligibles	SDMC Clients Served	MH Clients Served	MH Prevalence Estimate	SDMC Penetration Rate (%)	MH Penetration Rate (%)
Alaskan Native or American Indian	951	46	50	133	4.8	37.6
Asian or Pacific Islander	31	2	2	7	6.5	28.6
Black or African American	28	4	4	3	14.3	133.3
Hispanic	1,468	66	77	200	4.5	38.5
Other	22	17	18	0	77.3	0.0
Unknown	282	37	69	29	13.1	237.9
White	2,249	185	223	557	8.2	40.0
Total	**5,031**	**357**	**443**	**929**	**7.1**	**47.7**



For ethnicity, Alaskan Native or American Indians had a penetration rate of 28.6%, Asian or Pacific Islander 28.6%, Black or African American 133.3%, Hispanic 38.5%, and persons who are White had a penetration rate of 40%. It is important to note that in this category we have a substantial amount of clients identifying as “unknown”. One of our strategies is ensuring that we are getting accurate data in this area. Once we correct this data integrity issue, we feel that the race/ethnicity data will undergo significant changes. This data shows that persons, who are Alaskan Native/American Indian, as well as Latinx, are underserved in the mental health system, when compared to the White population.

When looking at SD/MC Penetration rates, which are based total Monthly Medi-Cal Eligibility File vs. approved Medi-Cal claims, the results are as follows: Alaskan or Native American 4.8%, Asian or Pacific Islander 6.5%, Black or African American 14.3%, Hispanic 4.5 %, White, 8.2%. The category “other” is at 0%, while “Unknown” is at 77.3%. This shows that the most approved Medi-Cal claims come from beneficiaries that have “unknown” selected for ethnicity and that Alaskan/Native American and Hispanic are underserved when compared to the White and Black or African American populations.

As the data illustrates, persons who are Latinx and persons who are Alaskan Native or American Indian are underserved and underrepresented in the data. 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 bilingual or who represent the underrepresented cultures. We have also attempted to identify outreach and intervention strategies such as using our Wellness Centers to engage these underserved populations within the community. Through MHSA we are able to focus on youth and elder outreach as a strategy in Prevention and Early Intervention.

In the past year, we looked at how data is collected regarding race and ethnicity. We have found that a lot of people would choose "other" instead of Caucasian if they were Hispanic because they do not identify as Caucasian. This may cause errors in our data and we are looking for a better way to capture this data accurately. There are also an alarming number of "unknown" selections. We feel that this could be a data collection and intake accuracy issue. We will address this as one of our Goals and Objectives in the upcoming year.

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

Community Services and Supports

It is the mission of ICHHS-BH to have diverse representation in planning and management committees. Our threshold language is Spanish, with 23.4% of our population being Latinx. 13.5% of the population is American Indian. We have small numbers of other racial groups in this small, rural community. Our Mental Health Advisory Board is focusing on recruitment of peers and underserved populations and families. We have struggled with maintaining a full Board that is representative of our community.

In the past, our Cultural Competence Committee was included in our Quality Improvement Meetings and last year we discussed separating the two in order to have more meaningful conversations and actions related to Cultural Competence. Because of this, Behavioral Health has supported the newly formed Equity Group in Health and Human Services which has the most diverse membership of all committees, and will serve as our Cultural Competence Committee. The Deputy Director of Behavioral Health facilitates the meetings and they are tasked with bringing recommendations on equity and inclusion to the HHS department as well as the County organization as a whole.

These committees provide leadership and opportunities to give voice to consumers, minorities, 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 Latinx Outreach through both the Wellness Center sites and within the community. A contracted bilingual therapist provides mental health services to Latinx 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. The contracted therapist has worked to advocate for youth and to provide support services. In 2020, we hired our Spanish-speaking volunteer intern as an Associate Marriage and Family Therapist (AMFT) to provide additional services to Spanish-speaking children and families. This service will be provided at the Bishop Clinic and in the field. This clinician has also started assisting with substance use disorder (SUD) classes and participates in our Equity Group.

Lessons and Identified Needs

Our biggest challenge is in hiring bilingual, bicultural staff to provide services to our Latinx 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 Latinx population. It has been a very slow process to build trust within the local Latinx 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 collect the data needed to show our outreach efforts. In FY 20-21 we worked closely with MHSA contractors and programs to square away data collection and outcomes information needed and results in FY 21-22.

We have a bicultural, bilingual Prevention Specialist who works on SUD Prevention and community outreach. We have found that it is most advantageous to outreach to the Latinx 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.

Efforts and Programs

In FY 20-21, with the formation of the Equity Group, we began reaching out to Latinx leaders in our community. These leaders will give presentations that provide insight into outreach and engagement in the Latinx community.

As applied to the Native American/American Indian population, we are fortunate to have Toiyabe Family Services as a provider of behavioral health services within our community. We are always seeking ways to collaborate with this agency. In FY 20-21 we have partnered with Owens Valley Career Development Center (OVCDC) which provides career development, early childhood education, and Temporary Assistance for Needy Families (TANF, which provides cash assistance and employment services to families that are unemployed or underemployed). OVCDC also provides Family Literacy and Indigenous Language services to American Indian/Alaska Native families and is a Trauma Informed Agency. OVCDC's Wellness

Navigator has provided a session on Adverse Childhood Experiences (ACES) to our Behavioral Health Team and provided data on our community's high ACE scores and historical trauma.

Our staff continues to look for interventions that would be most beneficial to this population. In FY 19-20 we developed a coordinated referral system, which includes our AIHF. In FY 20-21 we are fine-tuning the referral system and will start data analysis in May 2021. We are hopeful that this analysis will show us access and linkages throughout our community in order to strategically plan outreach activities. We would be very open to technical assistance in this area.

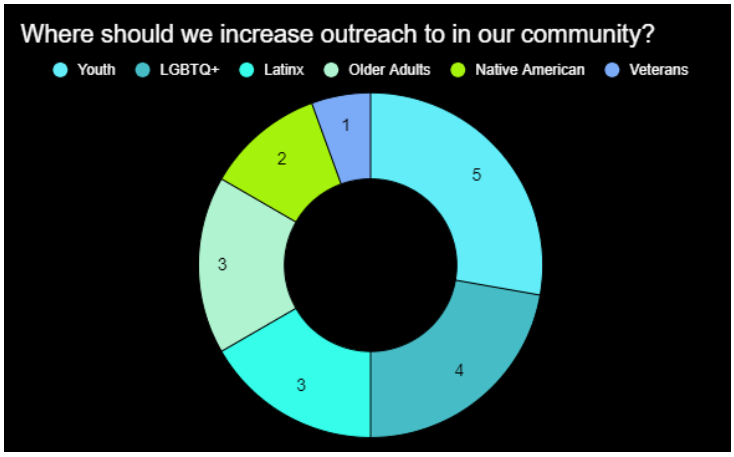
Another effort that we are making as an agency is partnering with other agencies in our community to bring a Trauma Informed Care (TIC) framework to Inyo County. Inyo County HHS (including Mental Health and SUD), OVCDC, Bishop Indian Head Start, and Inyo County Probation are collaborating to bring a Train the Trainer course called "Risking Connections" from the Klingberg Institute of Traumatic Stress.

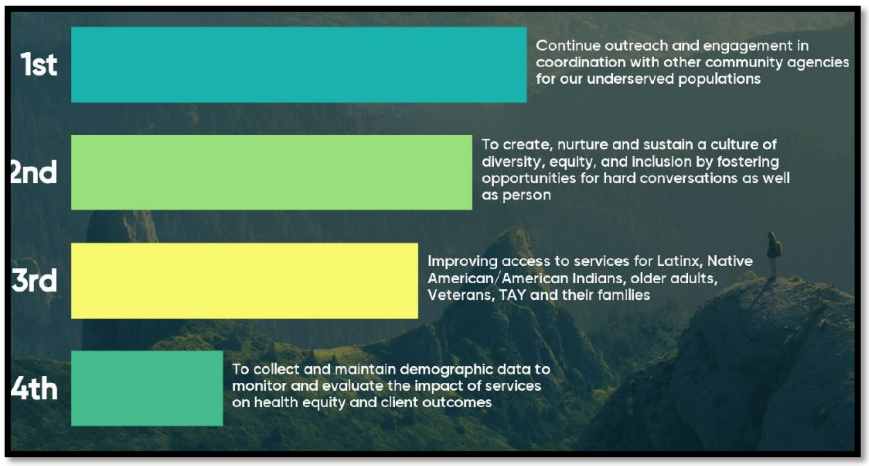
Whenever possible, we take advantage of any regional and/or state training offered on promoting and delivering culturally-relevant services. However, it is difficult to send staff to most statewide trainings because of the distance, cost, and small number of staff. If we send two staff to a three-day 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. The Covid-19 pandemic has been helpful in pushing organizations to offer their services online. Our staff was able to attend more training this year due to this improvement.

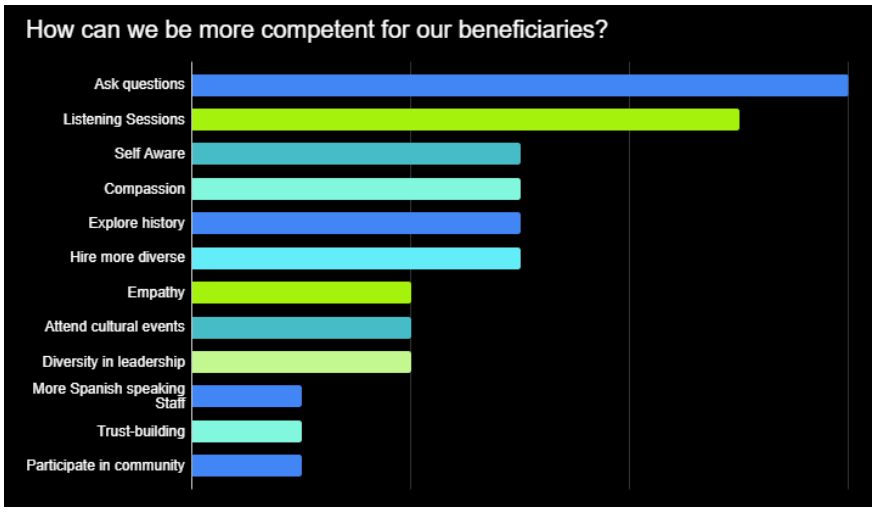
In delivering services, staff treats each client as an individual, with many different needs and cultures. In addition to delivering services in the person's preferred language and utilizing bicultural staff whenever possible, we also understand that age, health, gender, community, and lifestyle have 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.

An extensive planning process was followed to identify key populations with disparities. Covid-19 made it more difficult to host stakeholder groups but we were creative with online tools. The following images are from polls we conducted during our regularly scheduled staff meeting. We started incorporating discussions about delivering culturally relevant services during our weekly staff meetings, as well as during clinical supervision. The following images are from an online poll regarding planning for the CCP.


What does culture mean to you?
race
food
history
rituals
tribe
family
beliefs
morals
spirituality
language
traditions
differences
celebrations
tradition
values
gender
sexuality
lifestyle
color
expression
religion
community
heritage
interests


Where should we increase outreach to in our community?
Youth
LGBTQ+
Latinx
Older Adults
Native American
Veterans
1
2
5
3
3
4





Prevention and Early Intervention

In 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 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. This program provided 35.5 hours at-risk older adults in 19-20.

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 communities of Bishop, Big Pine, Independence, Lone Pine, and Tecopa.

Older adults who need additional services are referred to a Friendly Visitor (FV) or to Behavioral Health for ongoing treatment, as appropriate. In FY 19-20 outreach visits were made to almost 50 older adults. 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.

WET

Although we do not currently have plans to move MHSA funds into a local WET MHSA initiative, we have partnered with the central region to access regional funds available through the Office

of Statewide Health Planning and Development (OSHPD) to offer loan repayment opportunities to target unmet need for providers within our community.

Homeless Outreach and Engagement

ICHHS-BH has two Wellness Centers which provide outreach and support to our homeless population. We have Wellness Centers in both North and South County that are staffed with case managers to assist with the provision of hotel rooms, access to food, showers, medication assistance, phones, and other case management needs for our homeless population.

In January 2020 we collaborated across multiple agencies to perform the homeless count in Inyo County. This consisted of visiting known locations of our homeless population and collecting information using a cloud-based application on phones or tablets. We have also worked very closely with a local church and the non-profit Inyo Mono Advocates for Community Action to provide overnight Safe Parking. While we had temporary safe parking established in 2020, the County Board of Supervisors (BOS) voted against the land use agreement, which would allow the Safe Parking to be located in a church parking lot in Bishop. We are still committed to this effort to provide a safe location for our homeless population and look forward to finding a new location that will benefit this population.

The state-wide disparity between Covid-19 and homeless individuals propelled us to provide extra support for this population. Our case managers worked closely with County Public Health to establish a list of hotels that would provide respite or rooms for quarantined individuals. Our case managers are responsible for food delivery to the hotels and other quarantined individuals, and our Deputy Director of Behavioral Health has been a huge advocate for a specialty clinic that would provide access to single-dose vaccinations to our severely mentally ill (SMI) populations.

Monitoring/Strategies for Reducing Disparities

Data is produced quarterly 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 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 quarterly data provides immediate feedback for managers and staff to modify strategies and strengthen policies for improving services and reducing disparities.

QI staff sits on the Equity Group and will work on data collection strategies that are meaningful and can be used to improve access to services in Inyo County.

MEETING CULTURAL AND LINGUISTIC REQUIREMENTS

ICHHS-BH has designated the department's Civil Rights Coordinator as the Cultural Competence/Ethnic Services Manager (ESM). This individual is responsible for promoting mental health services that meet the needs of our diverse population, strategizing for the delivery of culturally sensitive services, and providing leadership and training to staff. The ESM will report 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. The ESM will also work receive updates and recommendations from the Equity Group.

We are always looking to find relevant, comprehensive training in delivering culturally and linguistically relevant services to our client community. FY 20-21 has been an innovative year on the training front with more partners offering virtual training which has increased access to quality training for our remote staff. Remote work and the pandemic aside, this has been has been an advantage for Inyo as a Frontier County. Going to in-person collaborative meetings has its benefit but it is difficult for us to schedule travel. Leaving Inyo County requires a day before and a day after to be blocked out for travel as we live 5-9 hours one-way to many training locations. Having virtual trainings have allowed us to increase attendance and spread the wealth of knowledge to our entire staff rather than a limited few.

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 recommend consumers/family members interested in facilitating the group offerings.

The Covid-19 pandemic initially reduced the amount of classes and groups we were able to accommodate but as the year went on, we were able to be creative and offer groups virtually, as well as some socially distanced groups at our Residential Care facility. The current offerings include:

- Recovery group for co-occurring addiction issues: twice per week

- Gardening group
- Music Therapy Group
- Women's Support
- Transition Age Youth: living skills
- Handling Money
- Developing WRAPs (Wellness and Recovery Action Plans)
- 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 Americans during World War II
- Attending a Playhouse 395 performance
- Attended a Cesar Chavez Day event
- Outing to Cinco De Mayo celebration
- Outing to Vietnam War Memorial
- Mental Health Awareness Day in the Park

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 access 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 and Lone Pine clinics. A *Provider List* is available to clients which lists provider names, population specialty (children, adult, veterans, IA+, 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 both clinics and Wellness Centers. The Provider List is updated monthly and as changes occur.

Goal 1B for this Plan is to increase access by going from 75% of documents and signage available in our threshold language to 100% of documents. This would apply to both clinics, Wellness Centers, and on our website by January 2022. In 2020 we hired a bilingual Office Manager for Behavioral Health. Having a Spanish-speaking person available to our clients has been instrumental in our ability to increase access to services in both Mental Health and SUD. Our Office Manager has dedicated time to identifying documents and signage that need to be translated, correcting signage, and translating documentation. She is also the lead interpreter and translator for Public Health during the Covid-19 pandemic and is working to help decrease disparity and increase outreach and education to the Latinx population.

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

The first sheet in our intake packet is the language services document, which identifies the preferred language of the client as well as the option for free interpreting services.

Our 24/7 Access Line Log includes a field to record a client's need for interpreters and preferred language. 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. During intake clients fill out a Language Needs Form which indicates their preferred language and if they need an interpreter. They are notified at this time that one will be provided free of charge. This is reviewed for compliance by Inyo County HHS Program Integrity and Quality Assurance (PIQA) Team quarterly.

Goal 4 in this plan is tied to identifying issues and mitigation in Criterion 7. The PIQA Team has noticed that we have a large number of "unknown" clients in the race/ethnicity section of our demographics form. We think this is a result of incomplete intake packets at intake, client knowledge of the selections, and possible stigma around selecting their race/ethnicity. The PIQA Team will be working on this in FY 21-22 as a QI Effort. The PIQA Team will concentrate on training and educating intake staff and consumers. Our goal is that the large percentage of others will filter in to their specific race/ethnicity category and we will have an accurate and realistic look at our access information to use in strategic planning.

In addition, ICHHS-BH has a policy and form to allow beneficiaries to file a complaint/ grievance with MHSA programs, as well as 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 QIC reviews complaints and grievances quarterly. 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.

Cultural Competence Committee

In the past ICHHS-BH QIC Committee was combined with our Cultural Competence Committee (CCC) and had approximately 18 members. Participants included consumers, community partners, and staff members. Most CCC members were persons who were Caucasian but we also had representation from Latinx and Native American staff.

This year has brought a renewed commitment to ensuring that the CCC is meaningful and is representative of Inyo County's population. Behavioral Health has supported the newly formed Equity Group in Health and Human Services which has the most diverse membership of all committees, and will serve as our Cultural Competence Steering Committee. The Deputy Director of Behavioral Health facilitates the meetings and the group is tasked with bringing recommendations on equity and inclusion to the HHS department as well as the County as a whole. The ESM will present data to this group quarterly and integrate recommendations within the CCP Planning Process, as well use recommendations to improve equity in the county mental health system.

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 and older adults; persons who are Latinx; persons who are Native American; the IA+ community; persons with disabilities; veterans; 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

Workgroups

The ESM has been involved in the Statewide Quarterly California Counties Ethnic Service Managers CCESM Collaborative as well as the Monthly Regional CCESM Virtual Check-ins. These groups, especially the Regional Collaborative, have been a wealth of information. The Central Region Counties are supportive and knowledgeable, and are open to sharing tools and best practices in implementing cultural humility and equity frameworks. This group has provided a safe and brave space that allows for open communication about the realities of implementing culturally competent activities in our own mental health systems.

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 MHSA funding. ICHHS-BH also has a contract with Language Line in an amount not to exceed $8,000, which is renewed each FY, to ensure linguistic competence and a contract for bilingual training not to exceed $15,000.

STAFF TRAINING AND RECRUITMENT (CRITERON 5)

ICHHS-BH staff is encouraged to avail themselves to trainings which enhance cultural and linguistic sensitivity. Training and credentialing have been set up in the County Learning Management System, Target Solutions. This platform is able to create training plans, and keep track of required paths for each job description. We are able to monitor trainings, track past due trainings, and assign trainings. The Training Plan will be brought to the Equity Group for feedback and input into future trainings. 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.

It is our hope in the upcoming years to establish a bilingual hiring process with County Administration. This would include updating the interview process to include Spanish-speaking panel members to assess the applicant's ability to communicate ideas, concerns, and

rationales; additional interview questions in Spanish to determine the applicant's knowledge of the mental health field; 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 testing to establish level of proficiency at time of hireIn FY 20-21 we entered into a contract for Bilingual Training and Proficiency Testing, which was a joint effort between our ESM and County Personnel. This project was a long time in the making and we are excited to have a mechanism to train Behavioral Health staff in the best practices regarding interpreting services. The initial training should be completed in FY 20-21, and in FY 21-22 we will identify staff proficient for specialty areas such as written translation and mental health interpreting.

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 behavioral health system. Staff will participate in a number of different learning opportunities that include face-to-face meetings and trainings, individual learning sessions on Relias Learning, and ongoing discussions during staff meetings and during supervision. Across a three-year period, all staff will participate in the required 4 hours of annual training as outlined in our training plan.

Although there will be specific required trainings to meet this requirement, 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 older adult and TAY, race/ethnicity, gender, sexual orientation, veterans, disabled persons, and consumers. 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 the need for goals to reflect the values of the client: a goal of an older adult may be very different from that of a TAY. Similarly, a Client Care Plan for a Latinx family with a Serious Emotional Disturbance SED child may include more family members as support persons than a Client Care Plan might have for a Caucasian child.

In addition to training on client culture, the ICHHS-BH 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 culture 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, Relias Learning, 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 focused on creating a safe learning environment where the staff members feel brave enough 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.

Our FY 20-22 training plan will have a broad range of topics including Cultural Sensitivity, Cultural Awareness, Working with Diverse Groups, and Interpreter Basic 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 table reflects our 19-22 Training Plan: =

Training Event	Date of Training	Description of Training	Frequency and Duration	Attendance by Function	Presenter
QII	9/4/2019	Cultural Diversity	75 min	Direct Service: 18	Relias online training system
QII	9/4/2019	Cultural Diversity	75 min	Direct Service: 18	Relias online training system
QII	1/6/2020	Cultural Competency with	4 hr.	Direct Service:	Relias Online

Training Event	Date of Training	Description of Training	Frequency and Duration	Attendance by Function	Presenter
		IA+ Individuals and the Community		19	training
QII	2/10/2020	Respecting Cultural Diversity in Persons with IDD	60 min	All Staff	Relias Online training
QII	2/10/2020	Respecting Cultural Diversity in Persons with IDD	60 min	Direct service: 13	Relias Online training
Supervisor training	5/5/2020 delayed Covid	Increase understanding of CC practices to reduce eliminate racial/ethnic health disparities	2 hr.	All Leadership staff	HHS- PIQA Manager/ESM
Introduction to a Framework for Confronting Racism in Behavioral Health	8/20/2020	Confronting Racism in Behavioral Health	One Time	All Direct Staff/ Leadership/ PIQA Manager	CIBHS
Systemic Racism and Structural Racialization	8/27/2020	Examining the Impact on Behavioral Health Disparities	One Time	All Direct Staff/ Leadership/ PIQA Manager	CIBHS
Implicit Bias	9/3/2020	Recognizing Its Harmful Impact and Taking Actions to Counter Unconscious Bias	One Time	All Direct Staff/ Leadership	CIBHS

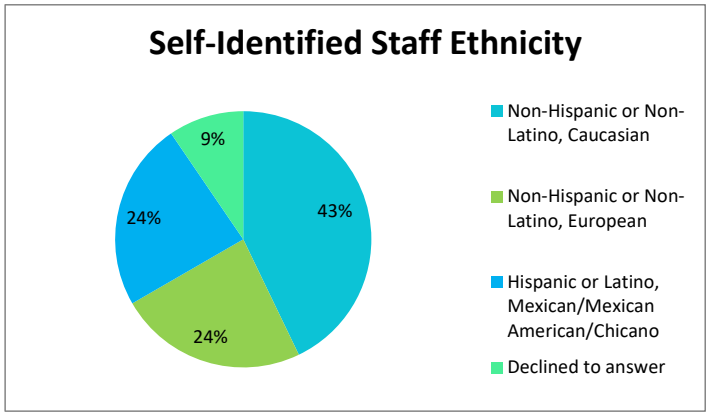
Training Event	Date of Training	Description of Training	Frequency and Duration	Attendance by Function	Presenter
The Role and Responsibilities of Health and Behavioral Health Leaders	9/10/2020	Addressing Systemic Racism to Eliminate Behavioral Health Disparities	One Time	All Direct Staff/ Leadership/ PIQA Manager	CIBHS
Bilingual Staff Interpreter Training	05/05/2021	Best practices in interpreting for public service	40 hours 10, 4 hour sessions	All Bilingual Staff BH: 2	Chatterbox, Inc. Contractor
Civil Rights Division 21	06/30/2021	Civil Rights Law and Implicit Bias	4 hr./ annually	All Direct Staff/Leadership	UC Davis
Ethics	07/13/2021	Confidentiality and Professional Boundaries	4 hr./ annually	All Direct Staff/Leadership	UC Davis

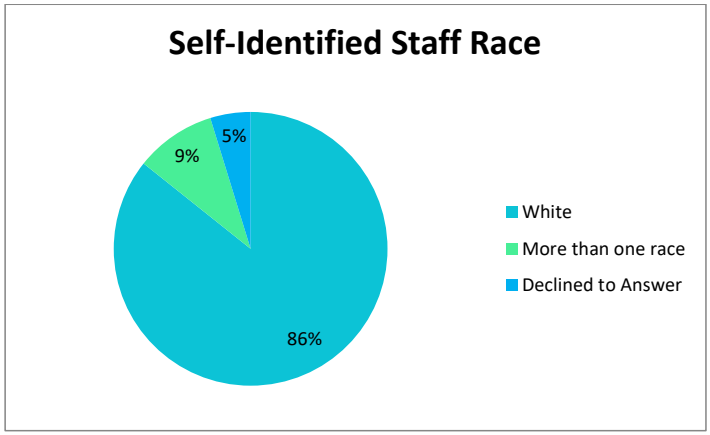
COMMITMENT TO GROWING A MULTI-CULTURAL WORKFORCE (CRITERON 6 & 7)

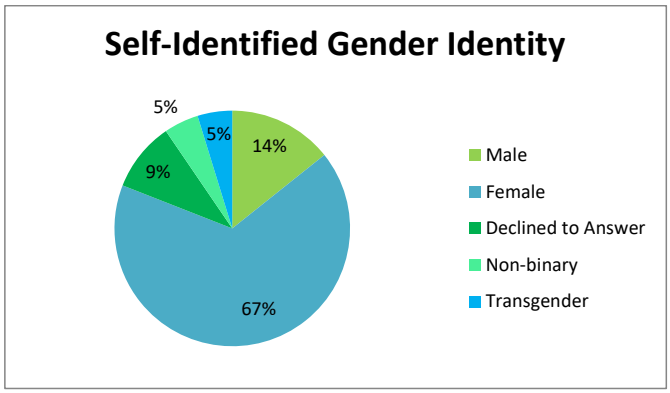
We are fortunate to have American Indian/Native American, Latinx and Peer staff and have experienced an improved ability to provide outreach and engagement to these communities. Given our population figures, we could use additional staff presence in American Indian/Native American and Latinx. The difficulty of identifying and hiring staff for these underserved populations is even greater given 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. We are fortunate at this time to have two bilingual employees in Behavioral Health, one as the front office manager and another as a clinician on our Child & Family Team. The Spanish-speaking staff has been willing to go above and beyond and help meet the needs of our Spanish-speaking population regardless of what program they enter services. In addition, the Equity Group has made a commitment to identify pathes to leadership in the organization that encourages diverse staff to not only enter the organization but to promote to positions of leadership.

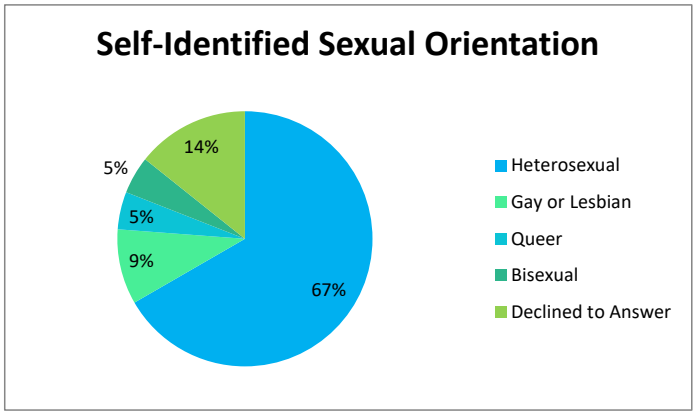
Staff and Service Assessment

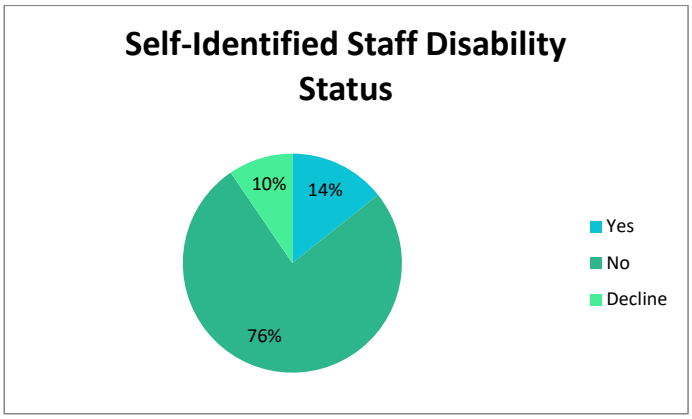
This year we sent out a Survey Monkey poll to all Behavioral Health staff asking them to self-identify with the demographic information. We asked the same questions that we ask our clients in MHSA programs and we received 21 responses out of 32 total staff. Our results are displayed in the charts below:






Self-Identified Gender Identity
5%
5%
14%
9%
67%
Male
Female
Declined to Answer
Non-binary
Transgender


Self-Identified Sexual Orientation
14%
5%
5%
9%
67%
Heterosexual
Gay or Lesbian
Queer
Bisexual
Declined to Answer


Self-Identified Staff Disability Status
10%
14%
76%
Yes
No
Decline

Our goal is to have a staff that is representative of our population in Inyo County. Although we would like to increase our number of Native American staff, we have become more diverse in respect to language access as well as gender and sexual orientation. The ability to provide services in Spanish as well as a qualified interpreter in the front office will increase access to our Latinx population. We are excited to look at data in the future to see the impact. Having staff that identify with LGBTQIA+ and that have the skill and ability to provide competent services, both individual and group, in this area has been great addition to our service array.

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

We have one associate marriage and family therapist (AMFT) that is fluent in Spanish and can read and write in the Spanish language and has attended the interpreter basic training. Our front office manager is fluent in Spanish and can read and write in the Spanish language and has been trained as a healthcare interpreter.

Director's Remarks

Formatted: Font: 11 pt, Bold, Font color: Accent 1

ICHHS-BH recognizes that our commitment to be a culturally sensitive and diverse organization must ~~be continuously~~be continuously nourished and renewed. We will celebrate small steps but never lose sight of the fact that we must champion these efforts on a continuous basis. –We will look for ways to listen to our community, using data and narratives, to hold ourselves accountable. This cultural competency plan is one way for us to track our efforts and to identify ways to continuously improve our services and support wellness in our community.