COVER SHEET

An original, three copies, and a compact disc of this report (saved in PDF [preferred] or Microsoft Word 1997-2003 format) due March 15, 2011, to:

Department of Mental Health
Office of Multicultural Services
1600 9th Street, Room 153
Sacramento, California 95814

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CHECKLIST OF THE CULTURAL COMPETENCE PLAN REQUIREMENTS MODIFICATION (2010) CRITERIA

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- ☐ **CRITERION 2: UPDATED ASSESSMENT OF SERVICE NEEDS**
- ☐ **CRITERION 3: STRATEGIES AND EFFORTS FOR REDUCING RACIAL, ETHNIC, CULTURAL, AND LINGUISTIC MENTAL HEALTH DISPARITIES**
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Behavioral Health Services

Cultural Competence Plan Update
Fiscal Year 2025/2026

Orange County Health Care Agency Behavioral Health Services
Multicultural Development Program

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DIRECTOR'S MESSAGE

Greetings Department of Health Care Services,

We are pleased to submit the Fiscal Year 2025–2026 Cultural Competence Plan Update for Orange County's Behavioral Health Services (BHS). Our vision remains steadfast: to provide high-quality, equitable behavioral health services that meet the diverse needs of our communities. This update reflects our ongoing efforts to ensure that services are accessible, culturally and linguistically responsive, and centered on the individuals and families who rely on us the most.

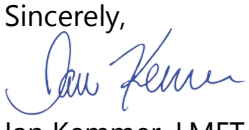
Over the past year, BHS has continued to align this work with countywide equity initiatives and statewide system changes as we respond to shifting community demographics and documented disparities in access, engagement, and outcomes. At the same time, we are preparing for the transition from the Mental Health Services Act (MHSA) to the Behavioral Health Services Act (BHSA), which will expand the focus on substance use disorders and on individuals at risk of or experiencing homelessness, justice involvement, and other forms of instability. Our goal is to move through this transition while preserving a clear focus on equity, inclusion, and culturally responsive care.

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

- Ensure the National CLAS Standards are implemented and monitored across programs and clinic levels.
- Support the Behavioral Health Equity Committee (BHEC) and its workgroups as true partners with community members, including leveraging these groups to promote community engagement meetings alongside the BHSA Office and other County partners.
- Further develop equity as a core component of all County work by reviewing policies, procedures, and operating practices, and by recruiting and retaining a highly qualified, bilingual and bicultural workforce at all levels of BHS.

Looking ahead, we will continue to rely on community voices—through Community Program Planning, the Behavioral Health Advisory Board, BHEC, cultural subcommittees, and our contracted partners—to shape priorities and guide improvements. We will use data, outcome measures, and staff and client feedback to monitor disparities and refine our approaches, with particular attention to communities that remain unserved or underserved. We remain committed to building and sustaining a behavioral health system in Orange County that is welcoming, culturally responsive, and equitable for all.

Sincerely,



Ian Kemmer, LMFT
Director of Behavioral Health Services

INTRODUCTION

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

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

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

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

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

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

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

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

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

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

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

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

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

Notes:

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

CRITERION 1: COMMITMENT TO CULTURAL COMPETENCE

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

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

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

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

Policies, Procedures, or Practices

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

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

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

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

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

Program Oversight and Compliance

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

Table 1.2 Program Oversight and Compliance Supporting Documents

Title	*Description*	*Source*
BHS Policies and Procedures	List of policies and procedures for operations and client care	https://www.ochealthinfo.com/about-hca/behavioral-health-services/bh-services/policies-and-procedures
Drug Medi-Cal Organized Delivery System	Levels of care, services, and resources	https://www.ochealthinfo.com/providers-partners/authority-quality-improvement-services-division-aqis/quality-assurance-18
HCA Organizational Chart	Leadership within organization	Appendix VII
Compliance Orientation, Education and Training	HCA Human Resources policies	https://www.ochealthinfo.com/sites/healthcare/files/2023-02/03.01.02_2023_Compliance_Orientation_Education_and_Training.pdf
Informing Materials for Mental Health Plan Consumers	Accountability policies and procedures	https://www.ochealthinfo.com/sites/hca/files/import/data/files/50869.pdf
Medi-Cal Consumer Rights Under the Orange County Mental Health Plan	Client care and rights	https://www.ochealthinfo.com/sites/hca/files/import/data/files/50870.pdf

Notes:

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

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

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

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

The Orange County Health Care Agency, Behavioral Health Services (BHS) is dedicated to promoting inclusion, equity, and active participation among diverse consumers, family members, stakeholders, and community representatives across the county in the planning and implementation of Mental Health Services Act (MHSA), and now Behavioral Health Services Act (BHSA), programs and services.

Commitment to Diversity and Inclusion - BHS recognizes and values the racial, ethnic, cultural, and linguistic diversity of Orange County. The agency is committed to ensuring that programs and services reflect the needs, strengths, and priorities of the diverse communities it serves. This commitment is demonstrated through culturally responsive practices, language access initiatives, and partnerships with community-based organizations that serve historically underserved populations.

Community Program Planning (CPP) Process - In accordance with MHSA/BHSA requirements, BHS implements an ongoing Community Program Planning (CPP) process that ensures meaningful stakeholder engagement in the development, implementation, and evaluation of MHSA/BHSA programs.

The CPP process includes:

- Community forums and stakeholder meetings held throughout the county, including sessions in multiple threshold languages such as Spanish, Vietnamese, and Korean.
- Partnerships with local cultural and faith-based organizations—such as Latino Health Access, OMID, Access California Services, Cambodian Family Services, Korean Community Services, and the Vietnamese Community of Orange County—to facilitate outreach and engagement among racial and ethnic communities.
- Interpretation and translation services to ensure full participation by individuals with limited English proficiency.
- Targeted outreach to communities experiencing mental health disparities, including refugees, LGBTQ+ individuals, and underserved youth populations.

    - Through these efforts, BHS actively solicits diverse input to local mental health planning and service development.

Integration of Community Feedback - Stakeholder input collected during CPP meetings directly informs identification of priorities, program planning, and quality improvement efforts. Community feedback has guided the expansion of culturally and linguistically appropriate programs, including:

- The Promotores de Salud initiative, which provides peer-based outreach and education to Latino communities.
- The Asian Pacific Islander (API) Mental Health Collaborative, which enhances access and reduces stigma among API populations.
- The Behavioral Health Equity Committee, which provides ongoing guidance on cultural responsiveness in service design and delivery.

Ongoing Engagement and Continuous Improvement - BHS ensures ongoing communication between the agency and community members through public postings of MHSA/BHSA updates, listening sessions, and advisory group participation. This continuous engagement allows BHS to implement real-time program adjustments and promote shared accountability between the agency and stakeholders.

Future Direction under the Behavioral Health Services Act (BHSA) - The Orange County MHSA Plan Update for FY 2025–26 highlights the transition toward the

BHSA Integrated Plan, which will replace the MHSA Three-Year Plan beginning July 1, 2026. The new Integrated Plan framework continues to emphasize community-driven planning, stakeholder participation, and equity-centered approaches to behavioral health service delivery.

Orange County is in the process of adopting the Integrated Care Coordination and Transformation Model (ICCTM) to guide community program planning activities. This year's Behavioral Health (BH) Integrated Plan development followed a twofold approach: it supported the identification of community priorities while also establishing baseline measures to assess progress as the ICCTM model is implemented. The ICCTM framework is grounded in Culturally and Linguistically Appropriate Services (CLAS) standards, intentionally embedding inclusivity and diversity at each stage of planning and implementation. In parallel, Orange County Behavioral Health Services (OC BHS) is coordinating and collaborating with Medi-Cal Managed Care Plans (MCPs) and Public Health to align priorities, planning efforts, and performance measures in support of developing an integrated Behavioral Health Services Act (BHSA) approach.

Through these sustained engagement practices, BHS ensures that consumers, family members, providers, County agencies, and community-based organizations work together to build a behavioral health system that reflects the diverse needs of Orange County residents.

Behavioral Health Services (BHS) Annual Plan Update: Integration, Engagement, and Equity

The OCHCA BHS continues to advance a vision of coordinated, equitable, and accessible behavioral health care. This Plan highlights BHS's ongoing efforts to integrate healthcare services across access points, ensuring individuals and families can navigate behavioral health resources with ease, especially during an era of transformative policy change leading toward implementation of the Behavioral Health Services Act (BHSA) Integrated Plan.

Purpose and Strategic Direction

The Annual Plan Update serves as a transparent tool to communicate progress, priorities, and policy alignment to community stakeholders, County leadership, and policymakers, while meeting the regulatory requirements of the MHSA and now BHSA.

Each program update describes successes, challenges, and opportunities for improvement, such as:

- Enhancing program evaluation and data-driven performance measurement across multiple domains.
- Expanding the use of technology in clinical care and service delivery.
- Strengthening workforce recruitment and retention efforts.
- Responding to state and federal policy changes that are reshaping behavioral healthcare in the public system.

Through these activities, BHS remains committed to a continuum of person-centered, community-informed, and culturally responsive services for all Orange County residents.

Continuous, Inclusive Community Program Planning (CPP) Engagement

The Community Program Planning (CPP) process is foundational to MHSA and continues to evolve into a continuous, year-round engagement practice. This model ensures that diverse community voices—including consumers, family members, providers, and partners—inform the development, implementation, and evaluation of BHS programs.

CPP Engagement Activities

CPP meetings are held monthly in both in-person and virtual formats and include a variety of community engagement opportunities, such as:

- Behavioral Health Advisory Board (BHAB) monthly meetings and study sessions.
- Planning Advisory Committee (PAC) sessions, featuring MHSA-related topics and subject matter experts.
- Behavioral Health Equity Committee (BHEC) and its population-specific subcommittees:
    - Spirituality
    - Deaf and Hard of Hearing
    - Black/African American
    - Latinx
    - Asian and Pacific Islander
    - LGBTQ+
    - Substance Use Disorder (pending formation)
- Contract Provider updates and OC Community Health Improvement Plan (OC CHIP) workgroups.

Attendance and participation are tracked through sign-in sheets, virtual attendance logs, and stakeholder surveys, which also document participation

among unserved, underserved, and inappropriately served populations in compliance with Welfare and Institutions Code (WIC) 5848.

Through these activities, BHS maintains two-way communication pathways that promote transparency, responsiveness, and continuous improvement in public behavioral health planning.

Culturally and Linguistically Congruent Approaches

BHS is deeply committed to cultural and linguistic congruence across all aspects of behavioral health policy, programming, and service delivery. This commitment is expressed through structural changes, policy alignment, and active partnerships designed to advance health equity and cultural responsiveness.

Office of Equity (OE)

To institutionalize cultural competence, BHS is establishing the Office of Equity (OE)., led by an Ethnic Services Manager (ESM), the OE will oversee implementation of Culturally and Linguistically Appropriate Services (CLAS) standards and guide systemwide efforts to ensure culturally sensitive and accessible services.

OE responsibilities include:

- Oversight of the Behavioral Health Equity Committee (BHEC) and subcommittees.
- Expanding subcommittee representation to include Veterans, Homelessness, and other priority populations.
- Coordinating translation and interpretation services for stakeholder engagement and public-facing materials.
- Integrating cultural competence into contracts, training curricula, and program evaluation frameworks.
- Participating in committees and planning groups to infuse equity and cultural humility into system decisions.

  Language regarding cultural competence and humility is embedded in all BHS contracts with community-based organizations and providers. The OE will also assist in developing, translating, and disseminating materials in threshold languages to ensure accessibility for limited-English proficient residents.

Additionally, BHS partnered with multiple organizations to promote OC Navigator and other resources at different community events. Some events that BHS participated in during 2024 included:

- 2024 Veteran Health & Wellness Summit
- 2nd Annual Children's Day Fun and Resource Fair
- 2nd Annual Recovery Happens Picnic
- 3rd Annual Community Well-Being Health Fair
- AASCSC Bountiful Harvest Community Health Fair
- Abrazar's Thriving and Vibing Community Block Party
- AccessCal Peace of Mind Conference
- Advance OC Mane Expressions Workshops
- Alianza Translatinx Hermosa Y Empoderada 2024 Event
- Anaheim Ducks Tabling Event: Native American Heritage Night
- Asian American Senior Citizens Services Center
  South County Chinese Mental Health Support Group
- Breastfeeding Health & Resources Fair
- CalOptima Health's Health & Wellness Event for Active Older Adults
- CalOptima's Back to School Event
- Chinese Mental Health Support Group-Connecting Thru Music
- Chinese Storytime
- Circulo Latino 2024
- Council on Aging Suicide Prevention Presentation for Older Adults
- Deaf and Hard of Hearing Career Fair
- Deaf and Hard of Hearing Opioid Forum
- Dia de Los Nino/Day of the Child Resource Fair
- Exploring the Impact of the Posada on Mental Health
- Fentanyl workshop and Naloxone training/distribution for LGBTQ Center
- Festival Dia de Muertos
- Festival of Tamales
- Homeless Service Providers Networking Fair
- Illustrating Your Pride! Youth Art Gallery Show
- International Children's Day,
- Juneteenth Festival
- Latino Health Access "From Sadness to Depression" Event
- Leisure World Seal Beach Golden Rain Foundation Clutter and Hoarding Discussion
- LGBTQ Center OC 2024 Youth Convening

- LHA Festival Dia de Muertos
- LHA Posada of Christmas
- Light Up Hope OC: Lanterns of Hope
- Mental Health and Wellbeing Promotion Multi-Provider Event, Blossoming Together, and the Hope Card Project
- Mental Health Stigma in Asian Community Coping Skills, Mindfulness, and Compassion
- NAMI OC: Laugh Rx - LGBTQ+ Workshop
- NAMI Walk 2024
- Norooz Clinic Foundation Unlocking Stigma Fair
- OC Black History Parade & Unity Festival
- OC Department of Education School Based Mental Health Summit
- OC PRIDE Event
- OC Public Safety & Re-Entry Conference - Juvenile Justice & Intervention Conference
- OCAPICA Community Wellness Fair
- Octoberfest 2024
- OMID Community Resource Fair
- Second Baptist Church Mental Health Fair
- Seniors Go Green-Egg Shell Arts and Crafts
- Sexual Assault Awareness Week Mental Health Resource Fair
- Shanti OC and Laguna Playhouse Art Workshop
- South Asian Network Community Town Hall
- South Coast Chinese Cultural Center Irvine Chinese School Year of the Dragon Lunar New Year Celebration
- Start Well Infant & Early Childhood Mental Health Gathering Conference
- Suicide Prevention Summit
- The Cambodian Family Khmer New Year Celebration
- Together for Teens - Igniting Your Authentic Self
- U.S. Vets 2nd Annual Art of Valor - Our Story Art Show
- UPLIFT Youth Foundation event
- Veteran's Day Breakfast
- Vietnamese American Cancer Foundation Mindfulness Coloring
- Villages of CA Mental Health Forum, Documentary Screening, and Panel Discussion
- Villages of California Cultura Cura Event
- Women Veterans in Higher Education Conference

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

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

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

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

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

The BHEC is expanding its efforts in meeting with community leaders, community-based organizations, clients, and family members, and will be working more closely with the Behavioral Health Advisory Board to address concerns in the community

and ensure that we are planning and implementing responsive services to our diverse communities. Additionally, BHEC is conducting outreach at various community events to raise awareness about the different workgroups and share opportunities to get involved.

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

The Orange County Health Care Agency, Behavioral Health Services (BHS) is dedicated to strengthening the skills, knowledge, and capacity of the behavioral health workforce and community-based organizations (CBOs) that provide essential services across the County.

Through comprehensive training, strategic partnerships, and continuous quality improvement, BHS ensures that providers and community organizations are equipped to deliver high-quality, equitable, and culturally responsive services to Orange County's diverse residents.

Capacity Building Through Partnership and Collaboration

BHS partners with a broad network of community organizations, nonprofit agencies, schools, and system partners to strengthen local infrastructure and improve coordination of care.

Collaboration through the Community Program Planning (CPP) process provides opportunities for shared learning, technical assistance, and leadership development.

BHS works closely with organizations such as Latino Health Access, Korean Community Services, and the Vietnamese Community of Orange County to enhance their capacity for outreach, service delivery, and community engagement.

Monthly BHS Contract Provider Updates, Townhall meetings, and Behavioral Health Operations trainings further strengthen partnerships by ensuring consistent communication, policy alignment, and professional development across the provider network.

Office of Equity and Workforce Development

The establishment of the Office of Equity (OE) underscores BHS's commitment to advancing workforce and organizational development through an equity-focused lens.

Led by an Ethnic Services Manager (ESM), the OE ensures that Culturally and Linguistically Appropriate Services (CLAS) standards are embedded across all programs and contracts.

The OE provides consultation, translation, and interpretation coordination for stakeholder and provider engagement activities and reviews training curricula to ensure cultural considerations are incorporated in all staff and provider education efforts.

The OE also works with the Behavioral Health Equity Committee (BHEC) and its seven population-specific subcommittees (Spirituality; Deaf and Hard of Hearing; Black/African American; Latinx; Asian and Pacific Islander; LGBTQ+; and Substance Use Disorder) to promote leadership development and skill-building within community groups that represent unserved and underserved populations.

Training and Technical Assistance for Providers and Community Partners

BHS prioritizes professional and organizational skill development through its Behavioral Health Training Services (BHTS) unit and its partnership with the Behavioral Health Training Collaborative (BHTC). Together, these teams deliver a wide range of evidence-based and community-focused trainings to County staff, contract providers, and the public.

Annual and Ongoing Cultural Competence Training

The County provides an annual Cultural Competence Training to all staff and contracted providers to promote delivery of culturally and linguistically appropriate services.

In addition, the Ethnic Services Manager (ESM) reviews all departmental training content to ensure that cultural, linguistic, and equity considerations are consistently integrated.

These trainings strengthen the capacity of providers to engage clients with cultural humility and awareness, and a list of qualifying "cultural development" trainings is included in Criterion 5 of this Plan.

Community and Workforce Trainings

Through BHTS and BHTC, BHS offers trainings designed to address diverse behavioral health topics and strengthen community skills, including:

- Suicide Prevention
- Anger Management
- Seasonal Anxiety and Depression
- Resilience and Hope
- Motivation and Goal Setting
- Mental Health First Aid (MHFA) – Adult & Youth
- Trauma-Informed Care
- Understanding Adverse Childhood Experiences (ACEs)
- Self-Care for Professionals
- Power of Self-Compassion
- Recognizing and Responding to Client Needs
- LGBTQ+ Awareness and Inclusion
- Improving Family Communication
- Multi-Cultural Mental Health Training
- Building Trauma-Informed School Communities
- Evidence-Based Clinical Practices
- Multi-part trainings supporting families and individuals living with mental illness

These courses not only enhance clinical competence but also promote collaboration and shared understanding between County staff, community organizations, and residents.

Mental Health First Aid (MHFA): Building a Skilled and Stigma-Free Community

A cornerstone of BHS's community training strategy is Mental Health First Aid (MHFA), an 8-hour, evidence-based course offered through the National Council on Mental Wellbeing.

BHTS and BHTC have formed an Orange County MHFA Trainer Cohort, expanding training opportunities for community agencies, schools, and the general public.

MHFA equips participants with the ability to:

- Recognize signs and symptoms of mental health or substance use challenges.
- Respond effectively to individuals in distress.
- Reduce stigma surrounding mental illness and promote open dialogue.
- Build awareness of local behavioral health resources and support pathways.

The revised MHFA curriculum places an even stronger emphasis on cultural relevance, diversity, and representation, with scenarios reflecting the experiences of Orange County's multicultural communities.

During FY 2022–23, BHTS and BHTC offered a total of 61 MHFA trainings (Adult and Youth curricula), training hundreds of community members, educators, and service providers. These trainings have proven instrumental in normalizing mental health conversations, especially within communities that historically experience stigma, systemic barriers, or cultural hesitation toward seeking care.

Organizational Empowerment and Data-Driven Capacity Building

BHS supports CBOs in developing skills related to data collection, program evaluation, and outcome measurement.

Through Community Engagement Meetings (CEMs) and the use of snapshot reports, BHS shares participant demographics, summarized feedback, and follow-up analyses with stakeholders to demonstrate how community input directly informs planning and service improvements.

BHS also provides technical assistance and evaluation support to help smaller organizations strengthen internal systems and demonstrate program effectiveness—key to sustaining funding and long-term impact.

Information Sharing and Continuous Learning

To promote cross-sector learning and professional growth, BHS employs multiple educational and communication platforms, including:

- The HUB Newsletter, connecting educators and community partners to school-based mental health initiatives, trainings, and resources.
- HCA and BHS Townhall meetings, which share agencywide updates, staff recognitions, and policy developments with internal and external partners.

These communication channels ensure transparency, promote continuous professional development, and strengthen the collaborative fabric of Orange County's behavioral health network.

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

- Interpretation services - HCA has contracted with CBO's that are fluent in specific threshold languages to expand our access to translation services.
- Expand services with language line, to include ASL. HCA has experienced that many interpreters are not as interested in supporting translation services for live events. In order to expand availability, OCHCA is modifying/expanding contracts, as approved by the OC Board of Supervisors.
- OCHCA has entered into a User agreement with Relias to expand access to Behavioral Health trainings via an ad on to the county online learning management system.
- Cultural Competency trainings are offered through vendors. OCHCA plans to develop a series of our own CCP trainings to be offered throughout the year that will address several topics.
- Workforce has been adjusting to the ever-evolving CPP process. Efforts to centralize and develop expertise in CPP is in process. To increase confidence and expertise, the ESM participated in a statewide learning collaborative to learn about the ICCTM model, grounding CPP in CLAS standards. In addition, other staff members have become more involved in the CPP process. Moving forward, HCA has contracted with a consultant who will cross train staff and community in the ICCTM model, guiding and coaching the team through implementation while developing policies and procedures for sustainability.
- Behavioral Health Transformation is helping to braid SUD services and processes throughout our system of care leading to the inclusion of SUD focused workgroups as part of BHEC.

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

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

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

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

There are no areas requiring technical assistance at this time.

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

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

The Orange County Health Care Agency, Behavioral Health Services (BHS) has a designated Ethnic Services Manager (ESM) responsible for ensuring that cultural competence principles are embedded throughout the behavioral health system of care. This position is central to promoting the development, implementation, and monitoring of culturally and linguistically appropriate services (CLAS) that address the diverse needs of Orange County's racial, ethnic, cultural, and linguistic communities.

Leadership and Organizational Structure

The Ethnic Services Manager functions as the County's Cultural Competence Officer and has direct access to the Behavioral Health Director, providing leadership, guidance, and oversight to ensure that all behavioral health programs reflect Orange County's commitment to diversity, equity, inclusion, and belonging. Following the retirement of the long-serving ESM in March 2022, an Acting Ethnic Services Manager was appointed to maintain continuity of responsibilities while

BHS completed a reorganization to formally integrate this role within the newly established Office of Equity (OE). *(See Appendix VII – Behavioral Health Services Re-organization Chart.)*

Responsibilities and Oversight

The ESM provides leadership across BHS divisions to ensure that cultural and linguistic equity is operationalized through policy, program planning, and service delivery.

Core functions include:

- Overseeing implementation of Culturally and Linguistically Appropriate Services (CLAS) standards.
- Coordinating cultural competency assessments and updating the Cultural Competence Plan in collaboration with MHSA/BHSA program leads.
- Advising County leadership and contract providers on strategies to eliminate behavioral health disparities and improve access for underserved populations.
- Supervising and providing guidance to the Behavioral Health Equity Committee (BHEC) and its population-specific subcommittees (Spirituality; Deaf and Hard of Hearing; Black/African American; Latinx; Asian and Pacific Islander; LGBTQ+; and Substance Use Disorder [pending]).
- Supporting workforce development initiatives, including cultural competence and humility trainings for County and contracted provider staff.
- Reviewing and updating program materials, policies, and communications to ensure linguistic accessibility and cultural alignment.

Integration Across the System of Care

Through the Office of Equity, the ESM works closely with MHSA/BHSA program leads, County departments, and contracted community-based organizations to advance cultural and linguistic equity.

The ESM provides input to all divisions—including Children and, Youth,; Adult and Older Adult; and Crisis & Acute Care; Forensics; and SUD services—ensuring that each integrates equity-driven principles into service design, community engagement, and quality improvement.

BHS also incorporates cultural competence expectations into all provider contracts, requiring training participation, culturally responsive outreach, and the use of interpretation and translation services in threshold languages (Spanish, Vietnamese, Korean, and others as needed).

Commitment to Continuous Improvement

BHS continues to uphold the responsibilities of the ESM through the Ethnic Services Manager, who collaborates with the OE, MHSA administration, and the BHEC to guide agencywide efforts in equity and inclusion.

The County remains committed to ensuring that the permanent Ethnic Services Manager position is filled under the reorganized structure, providing ongoing leadership to sustain cultural competence throughout the behavioral health system (See Appendix VII – Behavioral Health Services Re-organization Chart).

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

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

- Participate in the development and implementation of the Cultural Competence Plan, and coordination of the Cultural Competence Committee (CCC). In December of 2020 CCC members approved to change its name to Behavioral Health Equity Committee (BHEC).
    - Develop, implement, and ensure accuracy of verbal interpretation and written translation (transliteration) services and materials into the threshold languages as well as American Sign Language (ASL).
    - Participate in all aspects of Mental Health Service Act (MHSA) program implementation strategies as well as performing required system evaluation and reports to the state Department of Health Care Services (DHCS).
    - Develop, coordinate, and facilitate the implementation of the state Department of Health Care Services required Cultural Competency Plan.
    - Provide cultural competence consultation, evaluation, and training/education for the entire behavioral health system of care, including County and service contractors, to ensure service deliveries are

culturally and linguistically appropriate to the needs of the populations served and in compliance with local and state mandates.

- Identify local and regional cultural behavioral health needs of ethnically and culturally diverse populations as they influence County systems of care; make recommendations to department management.
- Maintain an on-going relationship with community organizations, planning agencies, and the community at large.
- Review and approve all staff trainings for culturally competent content.
- Oversee the Multicultural Development Program (MDP), which aims to promote behavioral health equity by enhancing culturally and linguistically appropriate, responsive, and inclusive behavioral health services for all ethnic and cultural groups through supportive services, training, education, research, and advocacy. The program provides and coordinates language services and cultural trainings. Additionally, it addresses mental health needs of the Deaf and Hard of Hearing community through consultation and training. In addition, consumer/peer supervision, culturally responsive and inclusive clinical consultation, culturally responsive and inclusive community research and advocacy are provided while identifying local and regional behavioral health needs of linguistically and culturally diverse populations as they impact County systems of care. MDP also assists in:

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

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

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

Within HCA BHS, the Multicultural Development Program is part of the Office of Equity, and is the unit dedicated to cultural competence activities. This unit coordinates requests for document translation, interpretation services, and leverages existing bilingual/bicultural staff across BHS. There are more than 496 bilingual staff available to provide interpretation services as needed. The MDP program currently consists of positions dedicated to interpretation and translation in Spanish and Vietnamese. MDP has access to additional staff who are able to assist with translation and interpretation services in Spanish, Arabic, Farsi, and Korean as part of their job responsibilities. The total budget for the MDP program for FY23/24 was set for $678,000. In addition to translations and interpretation, the Multicultural Development Program also ensures cultural considerations are addressed in each of the trainings provided. Also, MDP staff participate in community outreach efforts to support language and cultural needs.

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

As mentioned above, the current MDP budget allocated includes 3 Mental Health Professionals (1 coordinating the interpretation and translations services, 1 designated for Spanish interpretation and translations, 1 designated for Vietnamese interpretation and translation). Additionally, there is a Deaf Services Coordinator, and an ESM oversees the department.

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

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

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

3. **Outreach to racial and ethnic county-identified target populations;**
   The various workgroups under the BHEC have reached out to their respective communities and populations to engage in discussions and collaborations. Additionally, Prevention and Early Intervention funds the Outreach for Increasing Recognition of Early Signs of Mental Illness. These programs are intended to reach "potential responders," i.e., community members who are working with or likely to encounter individuals who are experiencing, or at elevated risk of experiencing, a mental health challenge. At-risk individuals can include, but are not limited to, PEI Priority Populations such as unserved and underserved racial/ethnic communities; immigrants and refugees; children and youth who are at risk of school failure and/or juvenile justice involvement; foster youth and non-minor dependents; individuals who have been exposed to trauma or are experiencing the onset of serious mental illness; the LGBTQ community; and those experiencing homelessness.

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

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

   The Behavioral Health Referral Line (OC-LINKS) consists of staff who are bi-cultural and bi-lingual in the threshold languages, ensuring access to community members with someone who can help them navigate the system in their preferred language. Calls are available in 7 languages other than English, and chat is available in Spanish.

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

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

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

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

   A bilingual pay differential (up to $0.90/hour) is paid to certified (tested) bilingual employees. 496 employees were paid a bilingual pay differential (as of October, 2025).

Number of Bilingual Staff, by Position, October 2025

	SPANISH	VIETNAMESE	KOREAN	FARSI	ARABIC	RUSSIAN	CHINESE	AMERICAN SIGN LANGUAGE	OTHER LANGUAGE	GRAND TOTAL
BEHAVIORAL HEALTH CLINICIAN I	70	7	1	1	1	0	1	0	1	82
BEHAVIORAL HEALTH CLINICIAN II	85	14	9	6	2	1	1	1	1	120
BEHAVIORAL HEALTH NURSE	1	0	0	0	0	0	0	0	0	1
CLINICAL PSYCHOLOGIST I	7	0	0	0	0	0	0	0	0	7
CLINICAL PSYCHOLOGIST II	6	2	2	0	0	0	1	0	0	11
COMMUNITY HEALTH ASSISTANT I	1	0	0	0	0	0	0	0	0	1
COMMUNITY WORKER II	4	0	0	0	0	0	0	0	0	4
COMPREHENSIVE CARE NURSE II	3	0	2	0	0	0	0	0	0	5
DATA ENTRY TECHNICIAN	0	1	0	0	0	0	0	0	0	1
HCA PROGRAM SUPERVISOR I	0	0	0	1	0	0	0	0	0	1
HCA PROGRAM SUPERVISOR II	0	1	0	0	0	0	0	0	0	1
HCA SERVICE CHIEF I	8	1	0	0	1	0	1	0	0	11
HCA SERVICE CHIEF II	12	3	0	1	0	0	0	0	0	16
HEALTH EDUCATION ASSOCIATE	2	0	0	0	0	0	0	0	0	2
HEALTH PROGRAM SPECIALIST	4	0	1	0	0	0	0	0	0	5
HEALTH SERVICES MANAGER	1	0	0	0	1	0	0	0	0	2
INFORMATION PROCESSING SPECIALIST	1	0	0	0	0	0	0	0	0	1
INFORMATION PROCESSING TECHNICIAN	4	0	0	0	0	0	1	0	0	5
MENTAL HEALTH SPECIALIST	55	10	0	1	1	0	0	1	2	70
MENTAL HEALTH WORKER II	15	1	0	0	0	0	0	0	0	16
MENTAL HEALTH WORKER III	5	0	2	0	0	0	0	0	0	7
OFFICE ASSISTANT	7	1	0	0	0	0	0	0	0	8
OFFICE SPECIALIST	63	3	0	0	0	0	1	0	0	67
OFFICE SUPERVISOR C	1	0	0	0	0	0	0	0	0	1
OFFICE SUPERVISOR D	3	0	0	0	0	0	0	0	0	3

Number of Bilingual Staff, by Position, October 2025

	SPANISH	VIETNAMESE	KOREAN	FARSI	ARABIC	RUSSIAN	CHINESE	AMERICAN SIGN LANGUAGE	OTHER LANGUAGE	TOTAL
OFFICE TECHNICIAN	12	2	0	0	0	0	0	0	0	14
PSYCHIATRIST	4	4	1	0	0	0	0	0	0	9
PSYCHIATRIST CONTRACT EMPLOYEE	1	1	0	0	0	0	0	0	1	3
PUBLIC HEALTH NURSE	1	0	0	0	0	0	0	0	0	1
RESEARCH ANALYST	1	0	0	0	0	0	0	0	0	1
SECRETARY III	1	0	0	0	0	0	0	0	0	1
SENIOR RESEARCH ANALYST	1	0	1	0	0	0	0	0	0	2
SR. COMPREHENSIVE CARE NURSE	0	1	0	0	0	0	0	0	0	1
STAFF ASSISTANT	4	1	0	0	0	0	0	0	0	5
STAFF SPECIALIST	6	2	2	0	0	0	0	0	0	10
SUPVG COMPREHENSIVE CARE NURSE	0	1	0	0	0	0	0	0	0	1
GRAND TOTAL										**496**

CRITERION 2: UPDATED ASSESSMENT OF SERVICES NEEDS

@CLAS Standard: 2

2-I: General Population

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

Table 1: Orange County's General Population Summary 2024

Demographic Characteristics of Orange County		
	Population	*Percent of Total Population**
Gender		
Male	1,568,875	49.5%
Female	1,601,560	50.5%
Other/Not Listed	---	<1%
Ethnicity		
American Indian/Alaska Native	4,997	0.1%
Asian/Pacific Islander	748,736	24.0%
Black/African American	50,600	1.6%
Hispanic/Latino	1,087,435	34.3%
White/Caucasian	1,136,486	35.8%
More than one race	124,947	3.9%
Age		
0-Less than 5 years	155,379	5%
5-9 years	166,960	5.3%
10-14 years	196,988	6.4%
15-19 years	208,887	6.6%
20-24 years	200,575	6.3%
25-34 years	441,480	14%
35-44 years	425,179	13.2%
45-54 years	410,233	13.2%
55-59 years	208,392	6.8%
60-64 years	206,138	6.3%
65 and older	482,317	15.5%
Total Population	*3,102,528*	

*Source: American Community Survey (ACS)** 2024, US Census*

*Percentages may not total to 100% due to rounding

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

2-II: Medi-Cal Population Service Needs

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

Table 2A: Medi-Cal Indicators for Calendar Year 2024 by Plan Type and Member Demographics

Jan 2024- Dec 2024	Mental Health Plan					Drug Medi-Cal-Organized Delivery System				
	Average Number of Members per Month[1]		*Members Receiving a Service*[2]		*Penetration Rate*	*Average Number of Members per Month*[1]		*Members Receiving a Service*[2]		*Penetration Rate*
Total[3]	***999,859***		***23,781***		***2.38%***	***604,035***		***6,843***		***1.13%***
Age	***N***	***%***	***N***	***%***	***%***	***N***	***%***	***N***	***%***	***%***
0-5 years	80,156	8.02%	689	2.90%	0.86%	79,944	13.23%	-	-	-
6-11 years	84,758	8.48%	3,142	13.21%	3.71%	84,642	14.01%	-	-	-
12-17 years	94,993	9.50%	6,837	28.75%	7.20%	94,986	15.73%	289	4.22%	0.30%
18-20 years	51,242	5.12%	1715	7.21%	3.35%	25,068	4.15%	161	2.34%	0.64%
21-64 years	548,876	54.90%	10,807	45.44%	1.97%	187,553	31.05%	6,254	91.39%	3.33%
65+ years	139,835	13.99%	591	2.49%	0.42%	131,842	21.83%	139	2.03%	0.11%
Gender	***N***	***%***	***N***	***%***	***%***	***N***	***%***	***N***	***%***	***%***
Male	463,455	46.35%	11,557	48.60%	2.49%	266,257	44.08%	4,461	65.19%	1.68%
Female	536,404	53.65%	12,224	51.40%	2.28%	337,778	55.92%	2,382	34.81%	0.71%
Race/Ethnicity	***N***	***%***	***N***	***%***	***%***	***N***	***%***	***N***	***%***	***%***
American Indian/Alaska Native	1,387	0.14%	60	0.25%	4.33%	583	0.10%	31	0.45%	5.32%
Asian/Pacific Islander	185,870	18.59%	1,675	7.04%	0.90%	109,982	18.21%	176	2.57%	0.16%
Black/African American	17,728	1.77%	730	3.07%	4.12%	9,951	1.65%	168	2.46%	1.69%
Hispanic/Latino	471,008	47.11%	11,420	48.02%	2.42%	304,781	50.46%	2,692	39.34%	0.88%
White/Caucasian	149,042	14.91%	4,419	18.58%	2.96%	77,510	12.83%	2,194	32.06%	2.83%
Another Ethnicity/Not Listed	174,825	17.48%	5,477	23.03%	3.13%	101,229	16.76%	1582	23.12%	1.56%

Table 2A: Medi-Cal Indicators for Calendar Year 2024 by Plan Type and Member Demographics, continued

Jan 2024- Dec 2024	Mental Health Plan					Drug Medi-Cal-Organized Delivery System				
	Average Number of Members per Month[1]		Members Receiving a Service[2]		Penetration Rate	Average Number of Members per Month[1]		Members Receiving a Service[2]		Penetration Rate
Primary Language	***N***	***%***	***N***	***%***	***%***	***N***	***%***	***N***	***%***	***%***
English	603,540	60.36%	15,440	64.93%	2.56%	337,117	55.81%	6,260	91.48%	1.86%
Arabic	4,998	0.50%	26	0.11%	0.52%	3,572	0.59%	< 11	< .01%	< .01%
Farsi	10,277	1.03%	44	0.19%	0.43%	7,386	1.22%	< 11	< .01%	< .01%
Korean	12,020	1.20%	49	0.21%	0.41%	8,693	1.44%	< 11	< .01%	< .01%
Mandarin	5,914	0.59%	33	0.14%	0.56%	4,355	0.72%	< 11	< .01%	< .01%
Russian[5]	4,070	0.41%	17	0.07%	0.42%	3,107	0.51%	< 11	< .01%	< .01%
Spanish	268,040	26.81%	5,388	22.66%	2.01%	179,717	29.75%	343	5.01%	0.19%
Vietnamese	80,598	8.06%	533	2.24%	0.66%	51,704	8.56%	13	0.19%	0.03%
Another Language/Not Listed	10,402	1.04%	2251	9.47%	21.64%	8,384	1.39%	218	3.19%	2.60%

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

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

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

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

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

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

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

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

Total Medi-Cal Members and Members Served in the Mental Health Plan and Drug Medi-Cal Organized Delivery System – Calendar Year 2024

Mental Health Plan (MHP)			***Drug Medi-Cal-Organized Delivery System (DMC-ODS)***		
Average Members per Month[1]	*Total Members Receiving a Service*[2]	*PR*	*Average Members per Month*[1]	*Total Members Receiving a Service*[2]	*PR*
999,859	***23,781***	***2.38%***	***604,035***	***6,843***	***1.13%***

PR = Penetration Rate

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

[2] *Total Members Receiving a Service is the unduplicated count of clients receiving at least one service during CY 2024 using claims data (i.e., 837 files).*

Mental Health: In calendar year (CY) 2024, the average number of people eligible for Specialty Mental Health Services per month was just under one million, and the overall penetration rate (PR) was 2.38%.

Substance Use: In CY 2024, the average number of people eligible for Drug Medi-Cal Organized Delivery System (DMC-ODS) services per month was just over 600,000, and the overall PR was 1.13%.

Disparities Analysis: Disparities in service utilization by age, gender, race/ethnicity, and primary language are described below. Disparities were defined as a subpopulation penetration rate that fell below the overall MHP penetration rate of 2.38% or the overall DMC-ODS penetration rate of 1.13% and reflect the need to increase and/or improve outreach and engagement for underserved populations.

Age

Mental Health: To better understand the pattern of MHP service delivery provided to Medi-Cal members across the life span, penetration rates were examined for six different age groups: 1) 0-5 years, 2) 6-11 years, 3) 12-17 years, 4) 18-20 years, 5) 21-64 years, and 6) 65+ years. In CY 2024, the adolescent group (12–17 years) had the highest PR at 7.20% and were the only age group not underserved. All other age groups fell below the overall PR of 2.38%, with the lowest rate (0.42%) observed among those ages 65 years and older.

Substance Use: For DMC-ODS, four age groups were examined: 1) 12-17 years, 2) 18-20 years, 3) 21-64 years and 4) 65+ years. In CY 2024, the adult group (21–64 years) had the highest penetration rate at 3.33% and was the only group not underserved. All other age groups had PRs well below the overall DMC-ODS rate of 1.13% (i.e., 0.11to 0.64%).

CY 2024	Mental Health Plan					Drug Medi-Cal-Organized Delivery System				
	Average Members per Month[1]		*Total Members Receiving a Service*[2]		*PR*	*Average Members per Month*[1]		*Total Members Receiving a Service*[2]		*PR*
Total[3]	***999,859***		***23,781***		***2.38%***	***604,035***		***6,843***		***1.13%***
Age	***N***	***%***	***N***	***%***	***%***	***N***	***%***	***N***	***%***	***%***
0-5 yrs	80,156	8.02%	689	2.90%	0.86%	79,944	13.23%	0	0.00%	0.00%
6-11 yrs	84,758	8.48%	3,142	13.21%	3.71%	84,642	14.01%	0	0.00%	0.00%
12-17 yrs	94,993	9.50%	6,837	28.75%	7.20%	94,986	15.73%	289	4.22%	0.30%
18-20 yrs	51,242	5.12%	1715	7.21%	3.35%	25,068	4.15%	161	2.34%	0.64%
21-64 yrs	548,876	54.90%	10,807	45.44%	1.97%	187,553	31.05%	6,254	91.39%	3.33%
65+ yrs	139,835	13.99%	591	2.49%	0.42%	131,842	21.83%	139	2.03%	0.11%

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

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

[2] *Total Members Receiving a Service is the unduplicated count of clients receiving at least one service during CY 2024 using claims data (i.e., 837 files).*

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

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

Gender

Mental Health: Females (2.28%) were slightly less likely to have received services than males (2.49%). The data did not capture non-binary identities.

Substance Use: Similarly, females were less likely to have received DMC-ODS services than males (i.e., 0.68%). The data did not capture non-binary identities.

CY 2024	Mental Health Plan					Drug Medi-Cal-Organized Delivery System				
	Average Members per Month[1]		Total Members Receiving a Service[2]		PR	Average Members per Month[1]		Total Members Receiving a Service[2]		PR
Total[3]	**999,859**		**23,781**		**2.38%**	**604,035**		**6,843**		**1.13%**
Gender	**N**	**%**	**N**	**%**	**%**	**N**	**%**	**N**	**%**	**%**
Male	463,455	46.35%	11,557	48.60%	2.49%	266,257	44.08%	4,461	65.19%	1.68%
Female	536,404	53.65%	12,224	51.40%	2.28%	337,778	55.92%	2,382	34.81%	0.71%

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

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

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

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

Race/Ethnicity

Mental Health: Hispanic/Latinos (47.1%) represented the largest group of Medi-Cal eligibles, followed by Asian/Pacific Islanders (18.6%) and those identifying with another race/ethnicity not listed (17.5%). Although Asian/Pacific Islanders were the second largest group of Medi-Cal eligibles, they were particularly underserved and had the lowest penetration rate at 0.90%. Hispanic/Latino clients were also underserved, with a PR of 2.04%.

Substance Use: Those identifying as Asian/Pacific Islander, Hispanic/Latino, or with more than one/another race represented over 85% of people eligible for DMC-ODS services yet had the lowest penetration rates (0.18% to 0.80%).

CY 2024	Mental Health Plan					Drug Medi-Cal-Organized Delivery System				
	Average Members per Month[1]		Total Members Receiving a Service[2]		PR	Average Members per Month[1]		Total Members Receiving a Service[2]		PR
Total[3]	**999,859**		**23,781**		**2.38%**	**604,035**		**6,843**		**1.13%**
Race/Ethnicity	**N**	**%**	**N**	**%**	**%**	**N**	**%**	**N**	**%**	**%**
American Indian/Alaska Native	1,387	0.14%	60	0.25%	4.33%	583	0.10%	31	0.45%	5.32%
Asian/Pacific Islander	185,870	18.59%	1,675	7.04%	0.90%	109,982	18.21%	176	2.57%	0.16%
Black/African American	17,728	1.77%	730	3.07%	4.12%	9,951	1.65%	168	2.46%	1.69%
Hispanic/Latino	471,008	47.11%	11,420	48.02%	2.42%	304,781	50.46%	2,692	39.34%	0.88%

White/Caucasian	149,042	14.91%	4,419	18.58%	2.96%	77,510	12.83%	2,194	32.06%	2.83%
Other/Not Listed[4]	174,825	17.48%	5,477	23.03%	3.13%	101,229	16.76%	1582	23.12%	1.56%

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

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

[2] Total Members Receiving a Service is the unduplicated count of clients receiving at least one service during CY 2024 using claims data (i.e., 837 files).

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

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

Primary Language

Mental Health: Service delivery was also examined according to the primary language spoken by the client. Eight primary languages were examined. The majority of Medi-Cal members (60.4%) and members served in the MHP (64.9%) reported English as their primary language. Non-English speakers continued to be underserved, particularly those who spoke Arabic, Farsi, Russian or any Asian language (i.e., 0.41 to 0.66%). Spanish-speakers (2.01%) experienced less pronounced service gaps than other non-English-speaking subpopulations, though they remained underserved.

Substance Use: Similar patterns were seen in the DMC-ODS. Over half (55.8%) of Medi-Cal members and nearly all of the members served (91.5%) reported English as their primary language. Penetration rates for Arabic, Farsi, Korean, Mandarin, Spanish, Vietnamese, and Russian-speaking individuals were all below 0.2%.

CY 2024	***Mental Health Plan***					***Drug Medi-Cal-Organized Delivery System***				
	Average Members per Month[1]		*Total Members Receiving a Service[2]*		*PR*	*Average Members per Month[1]*		*Total Members Receiving a Service[2]*		*PR*
Total[3]	***999,859***		***23,781***		***2.38%***	***604,035***		***6,843***		***1.13%***
Primary Language	***N***	***%***	***N***	***%***	***%***	***N***	***%***	***N***	***%***	***%***
English	603,540	60.36%	15,440	64.93%	2.56%	337,117	55.81%	6,260	91.48%	1.86%
Arabic	4,998	0.50%	26	0.11%	0.52%	3,572	0.59%	< 11	< .01%	< .01%
Farsi	10,277	1.03%	44	0.19%	0.43%	7,386	1.22%	< 11	< .01%	< .01%
Korean	12,020	1.20%	49	0.21%	0.41%	8,693	1.44%	< 11	< .01%	< .01%
Mandarin	5,914	0.59%	33	0.14%	0.56%	4,355	0.72%	< 11	< .01%	< .01%

Russian5	4,070	0.41%	17	0.07%	0.42%	3,107	0.51%	< 11	< .01%	< .01%
Spanish	268,040	26.81%	5,388	22.66%	2.01%	179,717	29.75%	343	5.01%	0.19%
Vietnamese	80,598	8.06%	533	2.24%	0.66%	51,704	8.56%	13	0.19%	0.03%
Other	10,402	1.04%	2251	9.47%	21.64%	8,384	1.39%	218	3.19%	2.60%

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

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

[2] *Total Members Receiving a Service is the unduplicated count of clients receiving at least one service during CY 2024 using claims data (i.e., 837 files).*

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

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

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

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

The Table 4 below compares Medi-Cal members served in the MHP to the total number of Orange County residents living at or below the 200% FPL, separated by whether or not they were enrolled in Medi-Cal. Results indicate that nearly one-quarter of Orange County residents are living at or below 200% of the FPL (764,000 compared to 3,077,000).

CY 2024	*Average Members per Month*[1]		*Members Receiving a Service*[2]		*County-Wide Estimated Population Living at or Below 200% FPL*[3]			
					Medi-Cal		*Non-Medi-Cal*	
	N	*%*	*N*	*%*	*N*	*%*	*N*	*%*
Gender								
Male	463,455	46.35%	11,557	48.60%	210,000	46.20%	153,000	49.50%
Female	536,404	53.65%	12,224	51.40%	244,000	53.60%	156,000	50.50%
Another/Not Listed	0	0.00%			0	0%	0	0%
Race/Ethnicity								
American Indian/Alaska Native	1,387	0.14%	60	0.25%	*	*	*	*
Asian/Pacific Islander	185,870	18.59%	1,675	7.04%	106,000	23.30%	77,000	24.90%
Black/African American	17,728	1.77%	730	3.07%	16,000**	3.5%**	*	*
Hispanic/Latino	471,008	47.11%	11,420	48.02%	236,000	51.90%	157,000	50.80%
White/Caucasian	149,042	14.91%	4,419	18.58%	81,000	17.80%	69,000	22.30%
Another Ethnicity/Not Listed	174,613	17.46%	5,477	23.03%	15,000**	3.3%**	*	*
Age								
0-5 years	80,156	8.02%	689	2.90%	34,000**	7.5%**	*	*
6-17 years	179,750	17.98%	9,979	41.96%	76,000	16.70%	16,000**	5.20%
18-64 years	600,118	60.02%	12,522	52.66%	289,000	63.50%	224,000	72.50%
65+ years	139,835	13.99%	591	2.49%	55,000	12.10%	67,000	21.70%
Total	**999,859**	**100%**	**23,781**	**100%**	455,000		309,000	

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

[2] Total Members Receiving a Service is the unduplicated count of clients receiving at least one service during CY 2024 using claims data (i.e., 837 files).

[3] California Health Interview Survey (2024). Counts are estimates.

** No data*

*** Statistically Unstable*

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

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

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

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

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

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

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

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

Gender

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

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

Race/Ethnicity

Medi-Cal Members: Among Medi-Cal members, Hispanic/Latinos and Asian/Pacific Islanders (API) were disproportionately represented among those living at or below 200% of the FPL (52.5% and 30.6%, respectively). In addition, only 7.6% of clients

who received MHP services in 2023 were Asian/Pacific Islander, indicating this population is particularly underserved among Medi-Cal members generally, as well as among members living at or below 200% of the FPL. While Hispanic/Latinos represented the largest proportion of clients served in the MHP (43.9%), this rate was slightly below the overall percent of Medi-Cal members who identified as Hispanic/Latino (46.9%) or Medi-Cal members who were living at or below 200% of the FPL (52.5%).

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

Age

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

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

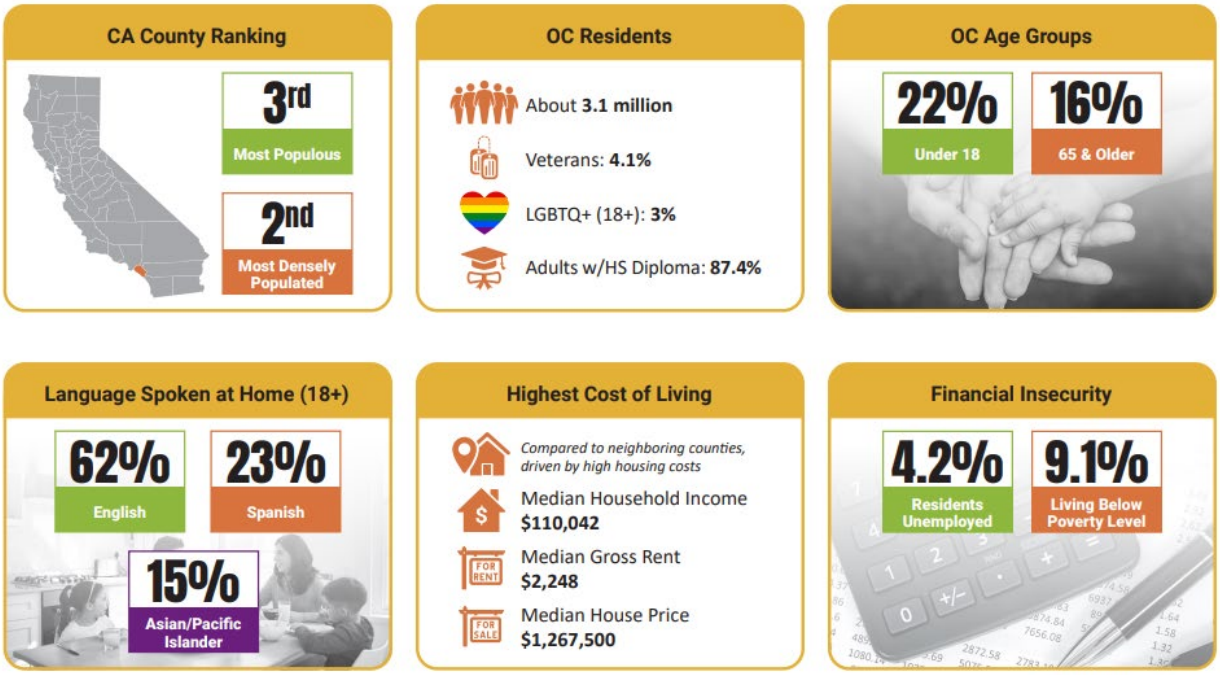
2-IV: MHSA Community Services and Supports (CSS) Population Assessment and Service Needs.

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

Tables 5 and 6 below were pulled from the most recent Mental Health Services Act (MHSA) Three Year Expenditure Plan Update (FY 2025 – 2026). Information presented discusses Orange County Population statistics, actual and proposed

budgets for MHSA funded programs (e.g., CSS and PEI), and estimated demographics of clients served by age, gender, and race/ethnicity.[1]

Table 5: Orange County Population Statistics



Source: NIH, PubMed, US Census

[1] Orange County Health Care Agency, Mental Health Services Act Three-Year Program Expenditure Plan, Fiscal Years 2025-26. Published Spring 2025. [https://www.ochealthinfo.com/sites/healthcare/files/2025-06/MHSA_2025-26_UpdatePlan_FINAL_BOS.pdf]

Table 6: MHSA CSS Fiscal Year 2023/2024

OC CENSUS

ORANGE COUNTY RESIDENTS BY DEMOGRAPHIC CHARACTERISTIC

Age	2022 ACS	Gender	2022 ACS	Race/Ethnicity	2022 ACS
0-9 yrs	10%	Female	50%	American Indian/Native Alaskan	<1%
10-19 yrs	13%	Male	50%	Asian/Pacific Islander	23%
20-29 yrs	13%	Transgender	<1%	Black/African-American	2%
30-39 yrs	14%	Genderqueer	<1%	Caucasian/White	36%
40-49 yrs	13%	Questioning/Unsure	<1%	Latino/Hispanic	34%
50-59 yrs	14%	Another	<1%	Two or more races	4%
60+ yrs	23%				

2022 Population: 3,135,755

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

CSS/MHSA

DEMOGRPAHIC CHARACTERISTICS OF PEOPLE SERVED IN FY 2023-24

Age	Estimated	Gender Identity	Estimated	Race/Ethnicity	Estimated
0-15 yrs	27%	Female	47%	American Indian/Alaskan Native	1%
16-25 yrs	20%	Male	58%	Asian	7%
26-59 yrs	47%	Transgender	< 1%	Black/African-American	5%
60+ yrs	6%	Genderqueer	< 1%	Hispanic/Latino	48%
		Questioning/Unsure	< 1%	Native Hawaiian/Pacific Islander	<1%
Served: 43,423		Another	< 1%	Middle Eastern / North African (MENA)	1%
				White	30%
				Another	8%
				Two or more	17%

Estimated demographic breakdowns for FY 2025-26 Annual Plan Update are based on individuals entered into the Electronic Health Record in FY 2023-24.

PEI/MHSA

INDIVIDUALS SERVED IN PEI PROGRAMS BY DEMOGRAPHIC CHARACTERISTIC

Age	Estimated	Gender Identity	Estimated	Race/Ethnicity	Estimated
0-15 yrs	8%	Female	57%	American Indian/Alaskan Native	1%
16-25 yrs	61%	Male	41%	Asian	12%
26-59 yrs	35%	Other	1%	Black/African-American	2%
60+ yrs	4%	Transgender	0%	Hispanic/Latino	58%
		Genderqueer	0%	Native Hawaiian/Pacific Islander	1%
		Questioning/Unsure	0%	Middle Eastern / North African (MENA)	1%
Served: 237,952		Another	2%	White	19%
				Another	6%
				Two or More	11%

Age reflects the age of the person served. These percentages do not reflect the expenditure breakdown, where programs that enroll adult caregivers and guardians in support of children and youth count as youth-focused programming. Participant data could not be unduplicated. These numbers do not reflect those reached through social media or large community events.

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

Age

The percentage of children (0-15 years old) in the CSS program at 27% is higher than what is reported in the Census, which is approximately 18%. The percentage

of Transitional Age Youth (16-25) in the CSS programs at 20% is higher than the 13% reported in the Census. Adults (26-59) served in the CSS were at 47%, which is comparable to the approximately 43% listed in the Census. As for the Older Adults (60+ years), they are greatly underrepresented in the CSS programs at 6%, compared to the 23% listed in the Census.

Gender

The proportion of females and males in the MHSA-CSS Unduplicated Clients Served vary from the county population. The county female population is at 50%, and accounts for 47% of the actual, unduplicated clients served so it is fairly comparable. The male population, at 50% is comparable to the actual, unduplicated clients served, which was 50%. The number of transgender, genderqueer, questioning/unsure, and other is similar between reported population in the Census and the clients served, which is <1% – however, this number is very low.

Race/Ethnicity

The percentage of Black/African Americans in the CSS programs is higher compared to their proportion of the county population (5.0% vs. 2%). The proportion of Asian/Pacific Islanders in CSS programs is lower compared to the Census (7% vs. 23%). The percentage of Latinos in CSS programs is also lower when compared to their proportion of the population 38.0% vs. 34.0%. The percentage of Caucasian is similar in CSS programs compared to their proportion of the county population (30% vs. 36.0%). Similarly, American Indian/Alaska Native is similar in CCS programs compared to the proportions reported in the Census (1%).

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

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

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

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

6. Access and Linkage to Treatment

The identified priorities include:

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

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

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

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

CLAS Standards: 1, 10 &14

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

The information and data provided throughout this Criterion comes from the MHSA Three-Year Program and Expenditure Plan Update (FY25/26)

(https://www.ochealthinfo.com/sites/healthcare/files/2025-06/MHSA_2025-26_UpdatePlan_FINAL_BOS.pdf)

Medi-Cal Target Population(s) with Disparities

The Orange County Medi-Cal population for Calendar Year 2024 includes 999,859 beneficiaries.

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

To begin, the population of White/Caucasian in Orange County is 36.4%. The population of Hispanic/Latino in Orange County is 34.2%. Yet, the Average Number of Medi-Cal Eligible members per Month for White/Caucasian is reported at only 14.9% whereas Hispanic/Latino is reported at 47.1%. Black/African American (1.6%) and Native American Average Number of Medi-Cal Eligibles per Month were close to comparable to the population in Orange County. For Asian Pacific American the population is 23% compared to Medi-Cal Eligible members per Month were 18.6%.

Asian and Pacific Islanders are underutilizing Medi-Cal services in Orange County. On average, 18.6% of Asian or Pacific Islander residents were eligible for Medi-Cal services, yet only 7% received an approved service, constituting a 0.9% penetration rate. Caucasians (3.0%) and Native Americans (4.3%) populations were served at higher percentages when compared to the Asian Pacific Islanders (1.0%) Medi-Cal eligible populations.

In terms of age, residents over 65 years of age are underutilizing services. Residents over 60 comprised 14% of the Medi-Cal eligible population, yet only 2.5% had an approved service. Older Adults (65+) had the lowest penetration rate of all age populations groups (4.2%). Children ages 0-5 had the second lowest penetration rate of all age populations groups (0.86%).

Spanish speakers comprised almost one-third of the Medi-Cal population (26.8%), but only 2% had an approved service. Similarly, those who spoke an Asian or Pacific Islander language made up 9% of the Medi-Cal population and only 1.63% had an approved service. However, it is important to note that Other language/Not Listed made up 1% of the Medi-Cal Members, but made up 9.4% of an approved service indicating a penetration rate of 21.6%

CSS Population with Disparities

Across all MHSA components, and specifically populations served by CSS, BHS has identified Latinx, Black/African American, Asian and Pacific Islander, LGBTQ+, DHH, immigrant/refugee, older adult, TAY, justice-involved, and housing-insecure populations as priority groups experiencing disparities in access, engagement, or outcomes.

Each of these groups is addressed through culturally and linguistically responsive programming, guided by the Office of Equity, the Behavioral Health Equity Committee, and adherence to CLAS Standards.

These efforts reflect Orange County's ongoing commitment to reducing behavioral health disparities and ensuring equitable access to quality, culturally congruent care across all MHSA and Medi-Cal services.

WET Population with Disparities

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

BHS employed 1,108 employees as of October, 2025 (noting there is currently a 11% vacancy rate). Disparities exist in the workforce with regards to gender and languages spoken. Of the 1,004 filled positions, 496 qualify for bilingual pay (47% of the current staff).

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

- Recruitment and Retention

- Pipeline Development
- Scholarships
- Stipends
- Loan Assumption Programs

WET addresses long-standing workforce shortages, underrepresentation of diverse professionals, and limited inclusion of individuals with lived experience in behavioral health careers. Through targeted programs, BHS develops and sustains a workforce that reflects Orange County's diversity, capable of providing equitable and effective care across all age groups, languages, and cultural backgrounds.

Target Populations with Identified Workforce Disparities

The WET component focuses on addressing disparities in service access and workforce representation affecting the following populations across Medi-Cal and MHSA components:

- **Latinx / Hispanic Communities** – Need for bilingual Spanish-speaking clinicians and culturally congruent care.
- **Asian and Pacific Islander (API) Communities** – Expansion of Vietnamese, Korean, and Mandarin-speaking providers and stigma-reduction efforts.
- **Black / African American Communities** – Increasing representation among behavioral health professionals and addressing systemic mistrust.
- **LGBTQ+ Populations** – Expanding gender-affirming and identity-inclusive training for staff and providers.
- **Deaf and Hard of Hearing (DHH)** – Ensuring access to ASL-trained professionals and interpreter support.
- **Refugee, Immigrant, and Undocumented Populations** – Building trauma-informed, culturally competent workforce capacity.
- **Veterans, Older Adults, and Transition-Age Youth (TAY)** – Strengthening workforce skills to meet complex, culturally influenced behavioral health needs.

WET Subcomponents and Strategies to Reduce Disparities

1. Workforce Staffing Support (WSS)

- Coordinates systemwide training and professional development.

- Conducts Consumer Employment Specialist (CES) trainings and consultations to help individuals with lived experience enter the workforce.
- Serves as liaison to the Southern Counties Regional Partnership (SCRP) to enhance recruitment and retention of bilingual and bicultural staff.
  FY 2023–24 Outcomes:
- 72 trainings provided to County and contract staff.
- 79 CES trainings and consultations delivered.
- 94 loan repayment awards issued to retain behavioral health professionals.

2. Training and Technical Assistance (TTA)

- Provides evidence-based and culturally informed trainings for BHS staff and community partners.
- Supports professional development with Continuing Education (CE/CME) credits and multicultural training topics.
  FY 2023–24 Outcomes:
- 162 trainings delivered to 5,945 attendees.
- 383 documents translated into Spanish, Vietnamese, Farsi, Korean, Arabic, and Simplified Chinese.
- 89 live interpretation sessions conducted.
- Training topics included *Breaking Down Binaries: Psychosis & the Transgender Community*, *Trauma-Informed Treatment*, and *LEAP (Listen–Empathize–Agree–Partner).*

Behavioral Health Equity Committee (BHEC):
Continued quarterly public meetings and community collaboration to promote CLAS implementation, increase participation among unserved groups, and guide MHSA equity initiatives.

3. Mental Health Career Pathways

- Expands career opportunities for consumers, family members, students, and community residents.

- Includes Recovery Education Institute (REI), Health Education Pathways Program (HEPP), and Leadership Development Program.
  FY 2023–24 Outcomes:
- 1,855 academic advisement sessions and 88 workshops provided through REI.
- 3 Peer Support Specialist trainings completed; 97% participant satisfaction.
- 251 high school and early college students participated in HEPP; 20 students placed in summer internships across BHS.
- Leadership Development and Behavioral Health Coaching programs in development.

4. Residencies and Internships

- Strengthens the behavioral health workforce pipeline through partnerships with local universities and clinical supervision programs.
  FY 2023–24 Outcomes:
- 27 graduate-level interns placed in BHS programs.
- 66 new clinical supervisors trained over two years.
- 11 trainings and networking events held, including *Affirmative Therapy*, *Play Therapy*, and *Trauma-Informed Treatment*.

5. Financial Incentive Programs (FIP)

- Provides loan repayment, stipends, and scholarships to retain and attract qualified, diverse staff.
  FY 2023–24 Outcomes:
- 94 staff and contract providers received loan repayment awards.
- 3 graduate student interns received $6,000 stipends.
- Program expanded to support psychiatrists and bilingual/bicultural clinicians.

Impact on Reducing Disparities

The WET component strengthens the County's ability to:

- Recruit and retain a **diverse, culturally competent workforce** reflective of community demographics.

- Train staff and providers to deliver linguistically accessible, trauma-informed, and culturally humble care.
- Integrate consumers and family members into the behavioral health workforce.
- Build educational and career pipelines for youth and underrepresented groups.
- Support professional retention through financial incentives and leadership development.

Through its WET initiatives, the County continues to reduce workforce disparities and advance CLAS Standards by developing a behavioral health system that values diversity, promotes equity, and ensures access to culturally and linguistically appropriate care.

Together, the WET programs and partnerships—Workforce Staffing Support, Training and Technical Assistance, Career Pathways, Internships, and Financial Incentives—carry forward MHSA's vision of a transformed, inclusive, and resilient public behavioral health workforce that meets the needs of all Orange County residents.

Target Populations within MHSA Components

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

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

BHSA

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

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

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

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

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

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

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

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

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

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

- Innovative approaches to Delivery of Care - The FSP Re-Boot concept will focus primarily on Program Performance and Performance Management that is implemented through real-time technical assistance with County staff and contracted providers.
- Full Service Partnership Re-Boot: Testing a Social Finance Approach to Improve Client Outcomes - The FSP Re-Boot concept will focus primarily on Program Performance and Performance Management that is implemented through real-time technical assistance with County staff and contracted providers.

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

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

BHS served 6,843 Medi-Cal Substance Use Disorder clients in Calendar Year 2024.

Of this population, disparities can be seen in the Youth/Young Adults and Older Adults. These populations were served at lower percentages when compared to their percentages as Medi-Cal beneficiaries. In contrast, the Caucasians and the American Indian/Alaska Native and Adult (21+) populations were served at significantly higher percentages than their percentage of Medi-Cal beneficiaries. Fewer Medi-Cal beneficiaries served were female compared to those who were Medi-Cal eligible (33.4% versus 55.9%). In contrast, 63.5% of Medi-Cal beneficiaries served were male, which was greater than their percentage of the Medi-Cal eligible population of 44.1%.

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

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

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

This process reflects the County's commitment to the National Culturally and Linguistically Appropriate Services (CLAS) Standards, particularly:

- **Standard 1:** Providing equitable, effective, and respectful quality care responsive to diverse cultural health beliefs and preferred languages.
- **Standard 10:** Conducting ongoing community needs assessments in collaboration with diverse stakeholders.
- **Standard 14:** Maintaining a strategic plan to advance culturally and linguistically appropriate services.

I. Data Sources and Analysis

To identify disparities, BHS conducted a review and analysis of multiple data sources, including:

- Medi-Cal and CSI data on service utilization, penetration rates, and outcomes disaggregated by race, ethnicity, language, age, and gender.
- CSS population assessments and MHSA evaluation reports identifying underserved and unserved populations.
- PEI program participant data from FY 2022–23 and FY 2023–24 on early intervention and prevention service engagement.
- Community stakeholder feedback from the Community Program Planning (CPP) process, including community forums, focus groups, and Behavioral Health Equity Committee (BHEC) subcommittees.
- Local demographic and health data from the Orange County Healthier Together initiative and the U.S. Census Bureau.

This comprehensive data review allowed BHS to compare community need versus service utilization, identifying populations that are underrepresented relative to their prevalence in the county.

II. Community Engagement and Stakeholder Consultation

Identification of PEI priority populations was grounded in ongoing stakeholder engagement.

Through the Community Engagement Meetings (CEMs), Behavioral Health Advisory Board (BHAB), BHEC, and cultural subcommittees, BHS collected direct feedback from consumers, family members, providers, and community representatives across Orange County's diverse regions.
Specific community partners that informed the identification process included:

- Latino Health Access, Korean Community Services, Vietnamese Community of Orange County, and other cultural organizations.
- Faith-based groups, LGBTQ+ advocacy organizations, and educational partners.
- Refugee and immigrant-serving agencies, veterans' groups, and organizations supporting Deaf and Hard of Hearing individuals.

Feedback from these stakeholders highlighted barriers to service access—including language, transportation, stigma, and lack of culturally aligned services—which directly informed the County's priority population designations.

III. Alignment with MHSA and PEI Framework

The identification of priority populations is aligned with the MHSA PEI statewide priority outcomes—Suicide Prevention, Stigma and Discrimination Reduction, Access and Linkage to Treatment, and Improving Timely Access for Underserved Populations—as well as with local MHSA goals for equity and access.

By comparing disparity indicators (service utilization, wait times, and outcomes) with community demographic data, BHS identified significant gaps in engagement among several key groups, including:

- Latinx/Hispanic communities
- Asian and Pacific Islander (API) subgroups
- Black/African American residents
- LGBTQ+ individuals
- Deaf and Hard of Hearing (DHH) individuals
- Immigrant and refugee populations
- Older adults and transition-age youth (TAY)

These populations were selected as PEI priorities because data showed lower service utilization rates, higher unserved/underserved representation, and greater stigma-related barriers to accessing early mental health support.

IV. Rationale for Designation of Target Populations

The rationale for identifying these specific populations is based on both quantitative disparities and qualitative evidence gathered through CPP and BHEC processes:

Evidence Source	Key Findings Supporting Disparity Designation
Medi-Cal and CSS Data	Lower penetration rates and fewer service encounters for Latinx, API, and DHH communities.
Community Feedback	Reports of stigma, fear of disclosure, and limited culturally appropriate outreach.
CPP and Focus Groups	Calls for increased bilingual staff, culturally specific programming, and trusted messengers.
BHEC and Equity Subcommittees	Identification of systemic barriers and the need for cultural adaptation of PEI models.
Provider Surveys	High demand for training in CLAS, trauma-informed, and culturally humble care practices.

These data sources converged to confirm the need to prioritize early intervention for racially, ethnically, culturally, and linguistically diverse groups disproportionately impacted by mental health challenges yet underrepresented in existing programs.

V. Continuous Evaluation and Improvement

The County continues to refine its identification process through ongoing monitoring, evaluation, and stakeholder feedback.

Annual updates to the PEI Evaluation Report, Community Program Planning summaries, and BHEC recommendations ensure that the target populations remain relevant and responsive to changing community demographics and emerging disparities.

This iterative, data-informed process ensures that PEI programs remain aligned with CLAS Standards, statewide equity goals, and Orange County's vision of a behavioral health system that promotes access, inclusion, and recovery for all communities.

Through the integration of quantitative data, community engagement, and cultural insight, Orange County BHS identified PEI priority populations with the highest disparities in behavioral health access and outcomes.

The process was grounded in stakeholder collaboration, CLAS compliance, and the MHSA guiding principles of inclusion, equity, and early intervention—ensuring that prevention and early intervention programs are responsive to the unique needs of the County's diverse populations.

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

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

Medi-Cal

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

Asian/Pacific Islanders (API) represent 18.6% of the Medi-Cal Eligible population yet the API Medi-Cal population served is 7%, therefore the API penetration rate is 0.9%.

For Latinos, there is a lack of access and service utilization in general, having a penetration rate at 2.4% and being the largest Medi-Cal beneficiary population at 48%.

Caucasians represented 14.9% of Medi-Cal beneficiaries and 18.6% of beneficiaries served by BHS. Caucasians have a penetration rate of 3%.

African Americans represented 1.8% of Medi-Cal beneficiaries and 3.1% of beneficiaries served by BHS. African Americans have a penetration rate of 4.1%.

Native Americans represented 0.1% of Medi-Cal beneficiaries and 0.3% of beneficiaries served by BHS. Native Americans have a penetration rate of 4.3%.

When examining the Medi-Cal population by age, Older Adults (65+) have the lowest penetration rate at 0.4%, followed by Children 0-5 at 0.9%, Adults (21 – 64) at 0.2%. Youth (12-17) have the highest penetration rate at 7.2%.

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

CSS Population:

API beneficiaries were the most disproportionately underrepresented.

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

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

WET Population:

As of October 2025, BHS had 496 staff who were paid bi-lingual pay differential. This represents about 44% of the BHS active workforce. Spanish speakers comprised almost one-fourth of the Medi-Cal population (26.8%) and 29.8% of the DMC-ODS yet represent 78% of the workforce who receive bi-lingual pay. BHS is working with HR to actively recruit bilingual staff in more threshold languages to better meet the needs of our beneficiaries.

BHS WORKFORCE Licensure/Classification	SPANISH	VIETNAMESE	KOREAN	FARSI	ARABIC	RUSSIAN	CHINESE	ASL	OTHER LANGUAGE	TOTAL
BEHAVIORAL HEALTH CLINICIAN I	70	7	1	1	1	0	1	1	1	82
BEHAVIORAL HEALTH CLINICIAN II	85	14	9	6	2	1	1	1	1	120
BEHAVIORAL HEALTH NURSE	1	0	0	0	0	0	0	0	0	1
CLINICAL PSYCHOLOGIST I	7	0	0	0	0	0	0	0	0	7
CLINICAL PSYCHOLOGIST II	6	2	2	0	0	0	1	0	0	11
COMMUNITY HEALTH ASSISTANT II	1	0	0	0	0	0	0	0	0	1
COMMUNITY WORKER II	4	0	0	0	0	0	0	0	0	4
COMPREHENSIVE CARE NURSE II	3	0	2	0	0	0	0	0	0	5
DATA ENTRY TECHNICIAN	0	1	0	0	0	0	0	0	0	1
HCA PROGRAM SUPERVISOR I	0	0	0	1	0	0	0	0	0	1
HCA PROGRAM SUPERVISOR II	0	1	0	0	0	0	0	0	0	1
HCA SERVICE CHIEF I	8	1	0	0	1	0	1	0	0	11
HCA SERVICE CHIEF II	12	3	0	1	0	0	0	0	0	16
HEALTH EDUCATION ASSOCIATE	2	0	0	0	0	0	0	0	0	2
HEALTH PROGRAM SPECIALIST	4	0	1	0	0	0	0	0	0	5
HEALTH SERVICES MANAGER	1	0	0	0	1	0	0	0	0	2
INFORMATION PROCESSING SPECIALIST	1	0	0	0	0	0	0	0	0	1
INFORMATION PROCESSING TECHNICIAN	4	0	0	0	0	0	1	0	0	5
MENTAL HEALTH SPECIALIST	55	10	0	1	1	0	0	1	2	70
MENTAL HEALTH WORKER II	15	1	0	0	0	0	0	0	0	16
MENTAL HEALTH WORKER III	5	0	2	0	0	0	0	0	0	7
OFFICE ASSISTANT	7	1	0	0	0	0	0	0	0	8
OFFICE SPECIALIST	63	3	0	0	0	0	1	0	0	67
OFFICE SUPERVISOR C	1	0	0	0	0	0	0	0	0	1

BHS WORKFORCE Licensure/Classification	SPANISH	VIETNAMESE	KOREAN	FARSI	ARABIC	RUSSIAN	CHINESE	ASL	OTHER LANGUAGE	TOTAL
OFFICE SUPERVISOR D	3	0	0	0	0	0	0	0	0	3
OFFICE TECHNICIAN	12	2	0	0	0	0	0	0	0	14
PSYCHIATRIST	4	4	1	0	0	0	0	0	0	9
PSYCHIATRIST CONTRACT EMPLOYEE	1	1	0	0	0	0	0	0	1	3
PUBLIC HEALTH NURSE	1	0	0	0	0	0	0	0	0	1
RESEARCH ANALYST	1	0	0	0	0	0	0	0	0	1
SECRETARY III	1	0	0	0	0	0	0	0	0	1
SENIOR RESEARCH ANALYST	1	0	1	0	0	0	0	0	0	2
SR. COMPREHENSIVE CARE NURSE	0	1	0	0	0	0	0	0	0	1
STAFF ASSISTANT	4	1	0	0	0	0	0	0	0	5
STAFF SPECIALIST	6	2	2	0	0	0	0	0	0	10
SUPVG COMPREHENSIVE CARE NURSE	0	1	0	0	0	0	0	0	0	1
ALL LANGUAGE TOTALS										**496**

PEI Population:

70% of our funding in PEI is allocated to prevention and early intervention strategies for children and youth (0-17 years old). 14% of the funding is allocated to strategies targeting the mental health needs of Older Adults (60+) who make up 23.2% of the population in Orange County.

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

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

Medi-Cal:

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

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

To address opioid related substance abuse disparities in Orange County, BHS continue to provide programing at various Substance Use Disorder outpatient clinics to provide Medication Assisted Treatment (MAT) for Medi-Cal beneficiaries.

CSS Plan:

The CSS component continues to prioritize equity, inclusion, and access for individuals with Serious Mental Illness (SMI) and Serious Emotional Disturbance (SED), particularly among racial, ethnic, cultural, and linguistic communities experiencing disproportionate barriers to care.

Key strategies and objectives within the CSS component are as follows:

Strategy / Objective	Action Steps	Timeline / Progress
1. Expand Culturally Responsive Full	- Maintain bilingual case managers and clinicians in FSP programs.	Ongoing; annual evaluation via MHSA outcomes.

Strategy / Objective	Action Steps	Timeline / Progress
Service Partnerships (FSPs)	- Offer culturally specific services through partner agencies (Latino Health Access, Multi-Ethnic Collaborative of Community Agencies, and API programs).	
2. Enhance Outreach and Engagement	- Utilize peer navigators, promotores, and faith-based liaisons to connect unserved / underserved populations to services. - Expand outreach in ethnic enclaves and rural South County.	Ongoing; expanded through FY 2025–26 MHSA updates.
3. Integrate Cultural Competence into Program Planning	- Conduct annual Community Program Planning (CPP) sessions with diverse community input. - Incorporate feedback into program modifications.	Year-round CPP process; monthly stakeholder meetings.
4. Address Linguistic Barriers and Accessibility	- Ensure all program materials, forms, and outreach are available in threshold languages. - Utilize American Sign Language (ASL) interpreters for Deaf/Hard of Hearing populations.	Continuous; monitored by the Office of Equity.
5. Expand Services for Specialized Populations	- Develop and sustain programs for Black/African American, API, Latinx, LGBTQ+, Veteran, and Older Adult populations. - Implement culturally relevant evidence-based practices such as *Trauma-Informed Care*, *Mental*	Ongoing; reviewed through BHEC and MHSA subcommittees.

Strategy / Objective	Action Steps	Timeline / Progress
	Health First Aid, and *Promotores de Salud* models.	
6. Strengthen Equity Infrastructure	- Support the Behavioral Health Equity Committee (BHEC) and subcommittees to provide recommendations on reducing disparities. - Expand representation of consumer and cultural groups in system-level planning.	Quarterly BHEC meetings; ongoing collaboration with Office of Equity.
7. Evaluate Disparity Reduction Progress	- Conduct annual analysis of CSS penetration rates, outcomes, and stakeholder satisfaction by race, ethnicity, language, and age.	Annual; reported in MHSA Plan Updates and CSS Evaluation Reports.

Through these combined Medi-Cal and MHSA CSS strategies, Orange County BHS is advancing equity, cultural humility, and language access across its behavioral health system.

By expanding bilingual services, strengthening culturally tailored outreach, and embedding CLAS principles into every level of care, the County continues to reduce disparities and ensure that all residents—regardless of race, ethnicity, culture, or language—have access to timely, effective, and culturally appropriate behavioral health services.

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

health need of all. The goal of all CSS programs is providing the necessary services and supports that help consumers achieve mental health and wellness and recovery goals.

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

CSS also provides the following programs to reduce the disparities:

- The Mobile **Crisis Assessment Team** (CAT) program serves individuals of all ages who are experiencing a behavioral health crisis. Clinicians respond to calls from anyone in the community 24 hours a day, 7 days a week year-round and dispatch to locations throughout Orange County other than inpatient psychiatric or skilled nursing facilities which are staffed to conduct such evaluations. The CAT also includes the Psychiatric Emergency Response Teams (PERTs), which consist of CAT clinicians who are stationed at police departments or ride along with assigned law enforcement officers to address behavioral health-related calls in their assigned cities or regionally.

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

County-contracted CSUs, our CAT teams and emergency department personnel.

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

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

- The **Peer Mentor and Parent Partner Support** program serves individuals who are living with a serious emotional disturbance (SED) or serious mental illness (SMI), may also have a co-occurring substance use disorder, and would benefit from the supportive services of a Peer Specialist. Peer Specialists may include peer or youth mentors and/or parent partners who work with participant's family members who would benefit from the supportive services of a parent mentor. Individuals referred to this program can receive support with linkage to services and/or with achieving one or more recovery goals. Program specializations include foster youth, parents, criminal-justice involved, ethnic communities, LGBTQ+, and Veterans/Military-Connected. Farsi, Mandarin, Spanish, and Vietnamese languages are available.

- Orange County funds three **Wellness Center** locations that serve adults 18 and older who are living with a serious mental illness and may have a co-occurring

disorder. Members are relatively stable in, and actively working on their recovery, which allows them to maximize the benefits of participating in Wellness Center groups, classes and activities. The Centers serve a diverse member base and Wellness Center West, in particular, has a unique dual track program that provides groups, classes and activities in English and monolingual threshold languages that meet the cultural and language needs of the population located in the city of Garden Grove. The predominant threshold language in the monolingual track is Vietnamese.

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

- The **Children and Youth Clinic Services** program serves youth under age 21 who meet the following eligibility criteria and their families/caregivers: Living with serious emotional disturbance (SED) or serious mental illness (SMI) and a) qualifies for Early and Periodic Screening, Diagnosis, and Treatment as part of having full-scope Medi-Cal; b) has a condition placing the child/youth at high risk for a mental health disorder due to the experience of trauma evidenced by scoring in the high-risk range under a trauma screening tool, child welfare or juvenile justice system involvement, or experiencing homelessness; c) requires medically necessary treatment services to address the child's mental health condition. Youth can be referred by community agencies, other mental health providers, pediatricians, SSA, school personnel, general community, families, etc.

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

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

- The **Outpatient Recovery** program is designed for adults ages 18 and older who are living with a serious mental illness and possible co-occurring substance use disorder. The program is operated at multiple locations throughout the county, with County-contracted locations referred to as Recovery Centers and County-operated locations referred to as Recovery Clinics. Individuals are referred to the program by Plan Coordinators in the Adult and Older Adult Behavioral Health (AOABH) Outpatient Clinics after all emergent mental health issues have resolved. This typically occurs within the first 3 to 6 months of being opened in an AOABH clinic. Individuals are referred to the contracted Recovery Centers after they have been in the AOABH outpatient system of care for one year and have remained out of the hospital or jail, are stable on their medication regimen and have consistently attended their appointments. The language capacities of the direct service providers include Arabic, Farsi, Korean, Mandarin, Spanish, and Vietnamese. The program specializes in serving ethnic communities, especially those recovering from SUD and trauma-exposed individuals.

Challenges

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

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

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

    - Project **Reaching Everyone Needing Effective Wrap (RENEW) FSP** provides services to children from birth to age 18 who are living with Serious Emotional Disturbance (SED). The program accepts referrals from the Outreach and Engagement teams, Crisis Assessment Team, general public, and County and contract clinics. Prominent among these referrals are children and youth who are homeless or at risk of homelessness. In addition to the treatment services provided to the children and youth, the parents frequently receive job assistance, especially when the needs of their child or youth with SED impact their ability to maintain employment.
    - Project **For Our Children's Ultimate Success (FOCUS) FSP** specializes in serving culturally- and/or linguistically isolated Asian-Pacific Islander youth living with SED or Serious Mental Illness (SMI), with a particular focus on the Korean and Vietnamese communities in the County. The program serves children and youth ages 0-25 and their families.
    - **Youthful Offender Wraparound** (YOW) FSP serves children and youth through age 25 who are experiencing SED/SMI and involved with the juvenile justice system. The program focuses on maintaining the gains the youth made while receiving services in custody and reintegrating the youth into the community. Learning how to obtain and maintain employment despite significant mental health issues is a particular focus of this FSP.
    - **Collaborative Courts (Girls and Boys Courts) FSP** program primarily works with the Juvenile Court to support youth through age 25 with SED/SMI who are in the foster care system and have experienced multiple placement failures. These youth face a considerable number of

problems and stressors and may require services well into early adulthood.

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

this group are children and youth with severe eating disorders. The target population for this program is youth through age 18 who are being seen primarily by Oncology, Endocrinology and Neurology services at a local hospital. Parents and siblings are an integral part of the treatment process, given the disruption to the family structure when the survival of one family member becomes the family's main focus. Many of these children and youth are Medi-Cal beneficiaries and MHSA funds serve as a match to the drawdown of federal funds.

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

    - **Support Transitional Age Youth (STAY) Process FSP serves TAY** who are living with SED or Serious Mental Illness (SMI) that is frequently complicated by substance use, almost all of whom are at some risk of homelessness. TAY are provided support and guidance to help them increase their abilities and skills essential to being self-sufficient adults.
    - **Project For Our Children's Ultimate Success (FOCUS) FSP** specializes in serving culturally and/or linguistically isolated Asian-Pacific Islander youth living with SED or SMI), with a particular focus on the Korean and Vietnamese communities in the County. The program serves youth through age 25 and their families.
    - **Youthful Offender Wraparound (YOW) FSP** serves youth through age 25 who are experiencing SED/SMI and involved with the juvenile justice system. The program focuses on maintaining the gains the youth made while receiving services in custody and reintegrating the youth into the community. Learning how to obtain and maintain employment despite significant mental health issues is a particular focus of this FSP.
    - **Collaborative Courts** (Girls and Boys Courts) FSP program primarily works with the Juvenile Court to support youth through age 25 with

SED/SMI who are or were in the foster care system and have experienced multiple placement failures. These youth face a considerable number of problems and stressors and may require services well into early adulthood.

- **Collaborative Courts** (Juvenile Recovery [formerly Drug] and Truancy) FSP works with Juvenile Recovery Court youth with SED/ SMI both while within the Court's prevue and after graduation when they are no longer on Probation. The goal of the program is to assist with alternative coping skills, educational opportunities and job training. This FSP also supports the Juvenile Court's Truancy Response Program, providing services to youth with SED/SMI. Many of these youth face multiple problems and stressors. This is often the first time they have come to the attention of the "helping system." Both parts of this FSP program serve children and youth up through age 25.
- The **Program of Assertive Community Treatment (PACT)** is the County-operated version of a Full-Service Partnership program. PACT utilizes the evidence-based Assertive Community Treatment model to provide comprehensive, "whatever it takes," field-based outpatient services to persons ages 16-25 who are living with serious emotional disturbance (SED) or serious mental illness (SMI). Individuals enrolled in the PACT may also have a co-occurring substance use disorder, experience social, cultural and/or linguistic isolation, and have had difficulty engaging with more traditional outpatient mental health services.

- The **Adult Full-Service Partnership (FSP)** programs provide intensive, community-based outpatient services which include peer support, supportive education/employment services, transportation services, housing, benefits acquisition, counseling and therapy, integration and linkage with primary care, intensive case management, 24/7 on-call response, crisis intervention and co-occurring disorder treatment. These programs strive to reduce barriers to accessing treatment by bringing treatment into the community. Adult FSP programs provide services in a linguistically and culturally competent manner to diverse, underserved populations in Orange County, which includes individuals who may have co-occurring substance use disorders. The target population for the Full-Service Partnership (FSP) programs includes adults who have a mental illness and are unserved or underserved and who may be homeless or at risk of homelessness, involved in the criminal justice system, or

are frequent users of inpatient psychiatric treatment. The adult FSP programs operating in Orange County each target unique populations:

- **Criminal Justice FSP** program serves adults who have current legal issues or experience recidivism with the criminal justice system.
- **General Population FSP** serves adults who live with a serious mental illness and who are homeless or at risk of homelessness. These individuals typically have not been able to access or benefit from traditional models of treatment.
- **Enhanced Recovery FSP** is a program that targets adults who are on LPS conservatorship and returning to the community from long-term care placements such as Institutions for Mental Disease (IMDs), and adults who have offenses and are referred by the Public Defender's Office to the Mental Health Court (Assisted Intervention Court).
- **Collaborative Court FSP** is a voluntary program for non-violent offenders who are referred through the Collaborative Court. The program works in collaboration with probation, the court team and judge, District Attorney's Office and the Public Defender's Office to provide treatment that re-integrates members into the community and reduces recidivism.
- **Assisted Outpatient Treatment FSP** serves adults who have been court-ordered to participate in assisted outpatient treatment and individuals who have voluntarily agreed to participate in treatment and are referred by the county Assisted Outpatient Treatment Assessment and Linkage Team.
- **Housing FSP** serves individuals who are living in permanent housing but struggling to maintain their housing and are at risk of becoming homeless.
- **FSP for Special Populations (new program)** is proposed as an expansion of the adult FSP program. The intention is to provide culturally congruent wraparound services for underserved populations, including but not limited to Veterans, Vietnamese, and Spanish speaking populations.
- The **Program of Assertive Community Treatment** (PACT) is the County-operated version of a Full-Service Partnership program. PACT utilizes the evidence-based Assertive Community Treatment model to provide comprehensive, "whatever it takes," field-based outpatient services to persons ages 18-59 who are living with serious emotional disturbance

(SED) or serious mental illness (SMI). Individuals enrolled in the PACT may also have a co-occurring substance use disorder, experience social, cultural and/or linguistic isolation, and have had difficulty engaging with more traditional outpatient mental health services.

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

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

- **Year-Round Emergency Shelter** (formerly called Short-Term Housing) serves adults with serious mental illness who may have a co-occurring substance use disorder, are experiencing homelessness and in need of immediate shelter. Individuals referred to the program are actively participating in services at Behavioral Health Services Adult and Older Adult County clinics including PACT or County-contracted outpatient clinic.

- Homeless **Bridge Housing** offers interim housing for adults who have been matched to a permanent housing opportunity. The program also serves adults experiencing homelessness who are in the beginning stages of obtaining permanent housing. Adults (including women with children) are eligible if they are homeless, are living with a serious mental illness, and may have a co-

occurring substance use disorder. Referrals for the Homeless Bridge Housing Services are accepted on an ongoing basis by Behavioral Health Services Adult and Older Adult Services Housing and Supportive Services. Participants can only be referred to the Homeless Bridge Housing Services if they are actively participating in treatment at a BHS outpatient clinic or a County contracted Full-Service Partnership (FSP). The Bridge Re-Entry program serves individuals exiting jail that are in need of shelter and permanent housing.

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

WET Plan:

The Orange County Health Care Agency, Behavioral Health Services (BHS) utilizes the Workforce Education and Training (WET) component of the Mental Health Services Act (MHSA) to build and sustain a diverse, culturally, and linguistically responsive behavioral health workforce.

The WET Plan directly supports disparity reduction by promoting recruitment, training, and retention of staff who reflect the racial, ethnic, cultural, and linguistic diversity of the Orange County community. The plan's implementation is guided by the Office of Equity (OE), the Ethnic Services Manager (ESM), and the Behavioral Health Equity Committee (BHEC) to ensure alignment with CLAS and equity priorities.

Strategy/ Objective	Actions Implemented	Timeline/ Progress
1. Diversify the Behavioral Health Workforce	- Recruit and retain bilingual/bicultural clinicians through targeted outreach, loan repayment, and scholarship incentives. - Collaborate with universities and training institutions to develop a culturally competent workforce pipeline.	Ongoing; expanded in FY 2025–26 under the BHSA Integrated Plan.
2. Strengthen Cultural and Linguistic Competence through Training	- Provide ongoing trainings on CLAS, cultural humility, trauma-informed care, and culturally responsive evidence-based practices. - Deliver translation, interpretation, and accessibility services (Spanish, Vietnamese, Korean, Farsi, Arabic, ASL).	Continuous; reviewed annually through WET and TTA reports.
3. Expand Pathways for Consumers and Family Members into the Workforce	- Operate the Recovery Education Institute (REI) to train consumers/family members in peer support and behavioral health career readiness. - Support Peer Support Specialist certification through CalMHSA.	Ongoing; FY 2023–24: 1,855 advisement sessions and 3 PSS trainings completed.
4. Develop Future Workforce through Internships and Residencies	- Partner with local universities for graduate-level internships and clinical residencies. - Offer structured supervision and professional development opportunities that embed cultural humility and recovery principles.	Ongoing; 27 graduate-level interns placed in FY 2023–24; expansion planned FY 2025–26.
5. Support Workforce Retention through Financial Incentives	- Implement loan repayment and tuition reimbursement through the Southern Counties Regional Partnership (SCRP) and County-funded programs.	FY 2023–24: 94 staff received loan repayment; program continues

Strategy/ Objective	Actions Implemented	Timeline/ Progress
	- Prioritize bilingual/bicultural staff and hard-to-fill clinical positions.	through FY 2025–26.
6. Build Career Pipelines for Underrepresented Populations	- Partner with Cal State Fullerton's Health Education Pathways Program (HEPP) to engage high-school and early-college students from diverse backgrounds. - Develop Leadership Development and Behavioral Health Coaching programs to prepare staff for advancement.	Mid-term (FY 2025–27): program development and launch in progress.
7. Integrate Equity in Workforce Planning and Evaluation	- Embed CLAS standards and equity objectives into all WET contracts and training evaluations. - Collect demographic data on staff participation in WET activities to monitor diversity outcomes.	Continuous; annual equity performance review and reporting to DHCS.

Through its WET Plan, Orange County BHS continues to reduce racial, ethnic, cultural, and linguistic disparities by cultivating a diverse, skilled, and culturally competent workforce.

By combining education, training, financial incentives, and community partnerships, WET ensures that the County's behavioral health professionals are prepared to deliver equitable, effective, and linguistically appropriate care to all residents—fulfilling the MHSA vision of a transformed, inclusive, and resilient public behavioral health system.

PEI Plan:

Prevention and Early Intervention (PEI) program services are envisioned to develop and implement strategies that stop mental illness from becoming severe and disabling, giving emphasis to improvement in timely access to services for

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

PEI also provides the following programs to reduce disparities:

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

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

These services include three components:

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

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

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

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

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

Intervention portion of the School-Based Behavioral Health Intervention and Support program will continue to be reported under the Early Intervention Program Category.

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

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

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

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

- **Outreach and Engagement for Homeless** provides field-based access and linkage to treatment and/or support services for those who are homeless and who have had difficulty engaging in mental health, housing, and other supportive services on their own. O&E staff identifies participants through street outreach and referrals from community members and/or providers.

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

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

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

- **Community Counseling and Supportive Service**s serves residents of all ages who have, or are at risk of developing, a mild to moderate behavioral health condition and have limited or no access to behavioral health services with face-to-face individual and collateral counseling, groups (i.e., psycho-educational, skill-building, insight oriented, etc.), clinical case management, and referral and linkage to community services.

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

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

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

Through ongoing implementation and evaluation, several key lessons have emerged that inform these new strategies:

1. **Cultural and Linguistic Responsiveness Must Be Systemic.**
   Disparity reduction requires more than individual program interventions; it must be institutionalized through equity-focused governance, policy, and resource allocation.
2. **Data Transparency Drives Accountability.**
   Disaggregating data continues to reveal previously unseen gaps in service utilization and outcomes, emphasizing the need for ongoing monitoring and data-driven decision-making.
3. **Community Co-Design Builds Trust.**
   Continuous collaboration with community partners, including through the Behavioral Health Equity Committee (BHEC) and CPP process, has shown that authentic engagement leads to higher participation and better program alignment.
4. **Language Access Is Foundational.**
   Interpretation, translation, and bilingual staff are not supplemental services—they are essential for equitable access to prevention, treatment, and recovery supports.

5. **Peer and Family Involvement Strengthens the System.**

   Consumers and family members bring lived experience that helps shape services to be more relatable, stigma-reducing, and recovery-oriented.

   Further, several Innovation projects address the current disparities across Orange County:

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

6. **PROGRESSIVE IMPROVEMENTS OF VALUED OUTPATIENT TREATMENT**

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

   The Progressive Improvements for Valued Outpatient Treatment (PIVOT) INN Project proposes to redesign the Orange County Behavioral Health Services system by piloting changes in behavioral health operations and programs that are in alignment with initiatives under Behavioral Health Transformation and the Behavioral Health Services Act (BHSA). The project was approved by the Mental Health Services Oversight and Accountability Commission (MHSOAC) in November 2024.

7. **PROGRAM GOAL(S) AND INTENDED OUTCOMES**

   This multi-component project will result in an overall system redesign that simultaneously addresses local areas of need identified through stakeholder feedback, prepares for the transition to BHSA and allows successful strategies to be integrated across the system of care. Each component will require its own evaluation plan and research team to track lessons learned. In addition, counties will have the opportunity to participate in PIVOT components that best align with their needs, resulting in multicounty and statewide learning opportunities.

8. DESCRIPTION OF SERVICES PIVOT

This includes five components, each with its own activities and learning objectives. These components, include: Full-Service Partnership (FSP) Re-Boot: Focuses on changing administrative processes and building the data infrastructure necessary to align county FSP programs with the new funding and program requirements under BHSA. This component also includes exploring

PIVOT includes five components, each with its own activities and learning objectives. These components, include:

- **Full-Service Partnership (FSP) Re-Boot**: Focuses on changing administrative processes and building the data infrastructure necessary to align county FSP programs with the new funding and program requirements under BHSA. This component also includes exploring the integration of mental health and Substance Use Disorder (SUD) services, and/or the development of an SUD FSP Program.

- **Integrated Complex Care Management for Older Adults**: Strives to develop a system of care for older adults living with co-occurring mental health and neurocognitive conditions who may also be homeless or at risk of homelessness.

- **Developing Capacity for Specialty Mental Health Plan Services with Diverse Communities**: Strives to develop the capacity of community-based organizations to become specialty mental health providers to ensure equitable access and advance community defined evidence based (CDEPs) practices.

- **Innovative, Countywide Workforce Initiative**: Proposes to address workforce shortages and increase access to services by exploring an alternative strategy to building a culturally competent and well-trained behavioral health workforce of professionals and paraprofessionals. Innovative Approaches to Delivery of Care: Seeks to create a more culturally responsive, inclusive, and efficient delivery of care, utilizing a User Experience model to gather input from consumers and their family members.

A detailed description of component activities is available in the Orange County PIVOT INN Project Proposal.

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

Building on the Criterion 2 population assessment and feedback from the Community Program Planning (CPP) process, the Orange County Health Care Agency, Behavioral Health Services (BHS) identified additional Prevention and Early Intervention (PEI) strategies to reduce behavioral health disparities among underserved racial, ethnic, cultural, and linguistic populations.

Through these new and emerging strategies, Orange County BHS continues to strengthen its Prevention and Early Intervention (PEI) system to better serve racially, ethnically, culturally, and linguistically diverse communities.

By expanding cultural navigation, community-driven prevention models, technology access, and data equity practices, BHS ensures that prevention and early-intervention services are inclusive, responsive, and grounded in community partnership—advancing the MHSA vision of wellness, recovery, and equity for all Orange County residents.

The transition from the Mental Health Services Act (MHSA) to the Behavioral Health Services Act (BHSA), effective July 1, 2026, will have a transformative impact on Orange County's Prevention and Early Intervention (PEI) programs. Under the BHSA, the current MHSA component structure—including Community Services and Supports (CSS), Prevention and Early Intervention (PEI), Innovation (INN), and Workforce Education and Training (WET)—will be replaced by two integrated funding categories:

1. Behavioral Health Services and Supports (BHSS): encompassing prevention, early intervention, treatment, and recovery services across the lifespan.
2. Housing Interventions Program (HIP): consolidating all housing-related funding streams.

As a result, PEI funding will no longer exist as a stand-alone category, and its goals and activities will be integrated throughout the broader BHSS continuum.

New and Emerging Strategies

To prepare for this shift, BHS is implementing several strategies to ensure PEI values—equity, prevention, early action, and community partnership—remain central within the BHSS framework:

3. Integration of Prevention Across the Continuum: Embed early intervention into all service areas, emphasizing outreach, wellness promotion, and timely access for unserved and underserved groups.
4. Equity-Driven System Redesign: Expand the role of the Office of Equity (OE) and Behavioral Health Equity Committee (BHEC) to ensure that racial, ethnic, cultural, and linguistic needs guide planning and evaluation.
5. Community Capacity Building: Establish micro-grants and partnerships with cultural, faith-based, and youth-serving organizations to continue community-led prevention work after PEI funding sunsets.
6. Data Modernization: Develop equity dashboards to track prevention outcomes by race, ethnicity, language, and gender identity within BHSS.
7. Youth and Family Engagement: Expand school-based and family-focused prevention programs consistent with BHSA's emphasis on early support for children and youth up to age 25.

Lessons Learned and Path Forward

The PEI experience has demonstrated that stigma reduction, cultural trust-building, and community co-design are essential for effective prevention. These lessons are being carried forward into the BHSA Integrated Plan to ensure prevention remains a systemwide philosophy, not a separate funding silo.

While the elimination of PEI funding represents a major structural change, it also provides an opportunity to embed prevention principles throughout the behavioral health system—linking early intervention, treatment, and recovery within one coordinated continuum. Orange County BHS will continue to uphold the MHSA vision of equitable, community-driven behavioral health care under the new BHSA Behavioral Health Services and Supports (BHSS) framework.

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

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

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

The Orange County Health Care Agency, Behavioral Health Services (BHS) has established a comprehensive process for planning, monitoring, and evaluating all strategies designed to reduce racial, ethnic, cultural, and linguistic disparities across Medi-Cal, MHSA (CSS, PEI, WET), and future Behavioral Health Services Act (BHSA) components. Monitoring is coordinated through the Office of Equity (OE), the Ethnic Services Manager (ESM), and the Behavioral Health Equity Committee (BHEC), with active participation from community stakeholders and contracted providers.

I. Monitoring Framework

BHS uses a multi-tiered framework to ensure progress toward disparity reduction goals:

1. **Annual Implementation Review**: Each MHSA component (CSS, PEI, WET) submits annual reports documenting implementation milestones, training totals, outreach activities, and service utilization by race, ethnicity, language, age, and gender.
2. **Quarterly Data Dashboards**: Program-level dashboards track key metrics such as penetration rates, participation in culturally specific programs, and staff demographic data to identify progress and gaps.
3. **Community Program Planning (CPP) Feedback Loop**: Monthly Community Engagement Meetings (CEMs) and quarterly BHEC meetings serve as ongoing forums to share updates, solicit input, and adjust strategies in real time. "Snapshot reports" summarizing stakeholder feedback and demographic data are presented at subsequent meetings to ensure transparency.
4. **Equity and CLAS Compliance Monitoring**: OE and ESM conduct regular reviews of contracts and training content to verify that CLAS Standards (1, 10, 14) are integrated into service delivery, outreach, and evaluation activities.
5. **Performance and Quality Improvement (PQI)**: Disparity-reduction strategies are incorporated into the BHS PQI process, including use of standardized outcome tools and client satisfaction surveys disaggregated by cultural group.
6. **Transition Readiness Monitoring for BHSA**: New tracking mechanisms are being established to ensure continuity of disparity-reduction goals as MHSA transitions to BHSA Behavioral Health Services and Supports (BHSS). Key milestones include:

- FY 2024–25: Develop equity dashboards and crosswalk current MHSA indicators to the BHSS structure.
- FY 2025–26: Integrate equity and prevention metrics into the BHSA Integrated Plan.
- FY 2026–27: Implement continuous evaluation under BHSS.

II. Status and Milestones of Implementation Efforts

Medi-Cal:

Equity data reviews through CalAIM and Whole Person Care reporting; CLAS compliance checks. Status – Ongoing, reviewed quarterly.

CSS: Annual analysis of FSP and outreach participation by race and ethnicity; stakeholder feedback through CEMs. Status – Ongoing, continuous.

WET: Workforce diversity and training participation data; SCRP loan repayment tracking. Status – Ongoing, annual WET report.

PEI: Demographic reporting on outreach and prevention activities; evaluation of stigma-reduction outcomes. Status – Ongoing, annual PEI Evaluation Report.

BHSA Transition: Development of integrated data dashboard and review of prevention and equity indicators within BHSS. Status – In progress, launch FY 2025–26.

III. Continuous Improvement and Reporting

Annual MHSA Plan Updates summarize outcomes and adjustments to disparity-reduction strategies. Community and provider input collected through CPP, BHEC, and townhall meetings directly informs quality improvement. Equity performance metrics are being expanded to ensure visibility and accountability within the upcoming BHSA Integrated Plan.

Through structured data review, stakeholder engagement, and continuous quality improvement, Orange County BHS maintains a living monitoring system that ensures identified disparity-reduction strategies are implemented, measured, and adapted in collaboration with the community. This approach provides a strong

foundation for transitioning from MHSA to BHSA while preserving a core focus on equity, inclusion, and culturally responsive behavioral health care.

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

BHSA has significantly changed the way data and outcomes are measured and reported in Orange County and at the State level. The MHSA funding specific-plan has been replaced with a new County Integrated Plan for Behavioral Health Services and Outcomes, which includes all local behavioral health funding and services, including Medi-Cal, and requires:

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

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

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

Orange County BHS will use a comprehensive set of mechanisms—including stratified penetration rate analysis, CQI dashboards, cultural competency workforce metrics, BHSA-aligned outcome indicators, and community-informed feedback—to measure and monitor the impact of its strategies on reducing disparities for the Medi-Cal, CSS, WET, and PEI populations.

Through these mechanisms, BHS ensures continuous evaluation of whether implemented strategies are successfully reducing disparities among API, Latino,

African American, Native American, Older Adult, youth, and non-English-speaking populations, and whether workforce capacity aligns with the cultural and linguistic needs of Orange County's diverse residents.

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

No technical assistance required at this time.

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

CLAS Standard: 13

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

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

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

In 2020, following the devastating inequities highlighted by the Coronavirus pandemic, as well as the murder of George Floyd, a Community Relations and Education (CoRE) sub-committee was formed to develop a governing structure for the CCC that puts equity at the forefront. The result was a change in the name from CCC to Behavioral Health Equity Committee (BHEC), and the Governing Structure document was finalized in December 2020.

BHEC's vision as defined by the Governing Structure states that: "*Our efforts are focused on the promotion of behavioral health equity for unserved and underserved racial and ethnic communities, as well as lesbian, gay, bisexual, transgender, questioning/queer and intersex (LGBTQI), Veterans, Deaf and Hard of Hearing and other cultural groups."* In accordance with the Governing Structure, a Steering Committee and several Work Groups were formed in the first quarter of 2021. At that time, the Director of Behavioral Health Services appointed Bijan Amirshahi, the ESM at the time, as the Co-Chair on its behalf and the community members of the Steering Committee elected Iliana Soto Welty as the community Co-Chair. In September 2021, Bijan Amirshahi stepped down from his position as Co-Chair (while still serving as the ESM), and Deana Helmy was appointed as his replacement. Deana served as the acting ESM after Bijan's retirement in March of 2022, and was hired as the ESM in May of 2024.

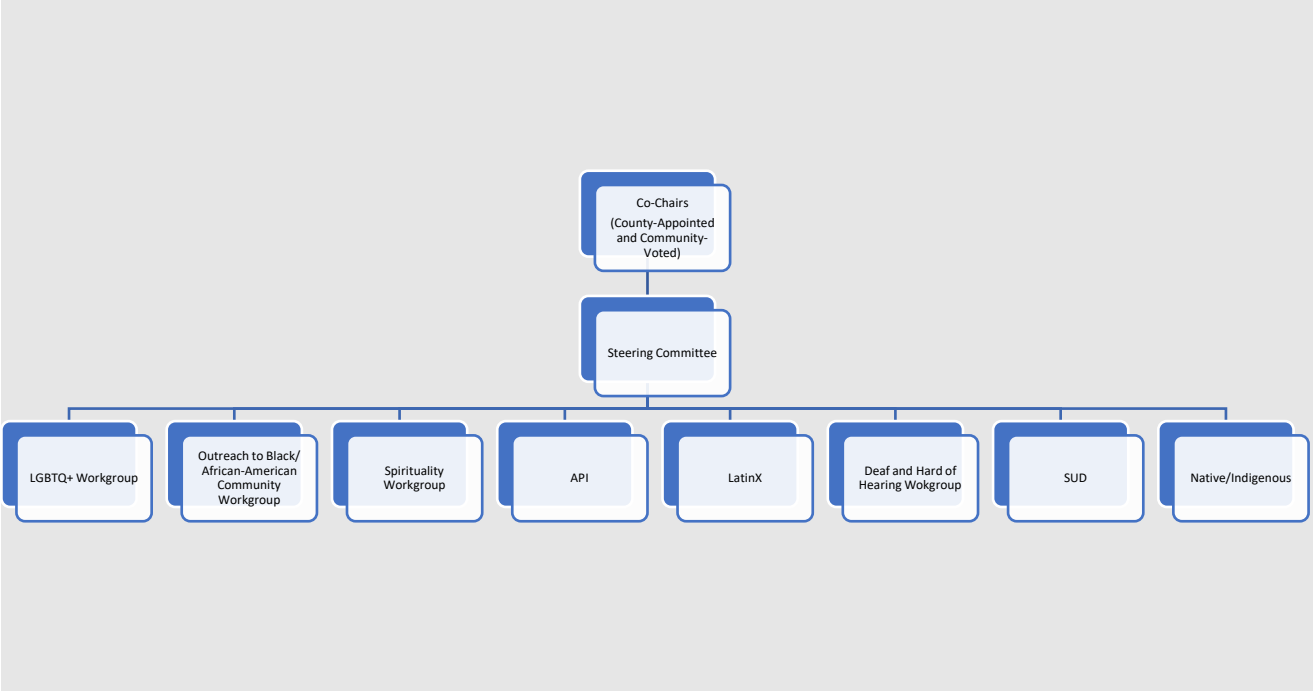
A copy of the Governing Structure as approved by BHS is included in Appendix II.

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

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

4-I-C: Organizational Chart

Current Organizational Chart of the Behavioral Health Equity Committee:



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

Behavioral Health Equity Committee Participants

First	Last	Organization
Adalid	Gutierrez	OHCHA - Behavioral Health Training Services
Al	Jabbar	D4 - Supervisor
Alan	Albright	OC Behavioral Health Advisory Board

First	Last	Organization
Alejandra	Dominguez	Abrazar Inc.
Alejandra	Capistran	NAMI OC
Alexandra	Merritt	OCHCA
Alexandra	Concepcion	Radiant Health Centers
Alicia	Carranza	OCHCA Tobacco Use Prevention Program
Ana	Vicuna	Phoenix House
Andrew	Parker	Work for County of Orange in HCA QMS
Annie	Medina	Pacific Clinics Recovery Education Institute
April	Thornton	Afro-American Community/ OCHCA
Arlene	Rosa	OCHCA
Belinda	McCleese	Deaf & Hard of Hearing Community
Brittany	Whetsell	OCHCA
Carolina	Nevarez	Mental Health Association of Orange County / Wellness Center West
Carolina	Ocampo Martinez	HCA CYS PACT
cheryl	downes	Seneca/ Ihope homeless outreach
Cheryl	Vargo	Kaiser Permanente
Christian	Downey	SUD, LGBTQIA+
Christine	Tran-Le	Older Adults
Claudia	Gonzalez de Griese	OC HCA
Connie J	Jones	NAN OC
Dalia	Oregel	Deaf
Daniel	Gibbs	OCHCA MHSA
Dayanna	Covarrubias	Casa de la Familia
Deana	Helmy	SAMENA, Spirituality - Muslim
Deb	Diaz de Leon	NAMI OC
Debbie	Acosta	Peer
Deepa	Shanadi	OCHCA
Donella	Cecrle	The Purpose of Recovery
Donna	Armfield Hume	Providence St. Joseph Hospital, Orange
Duan	Tran	Cal State Fullerton/ BHAB
Eileen	Duggleby	Voyagers Bible Church
Emmi	Monsour	N/A
Erika	Williams	Older adults- OCHCA
Fred	Williams	BHAB
Hanh-Thuc	Ullman	API
Heidi	Kim	AASCSC
Helen	Cameron	MHSA stakeholder

First	Last	Organization
Howard	Mirowitz	the Illumination Foundation (Board member)
Iliana	Welty	Mind OC
Janira	Perez	MOMS
Jeffrey	Vu	OCHCA
Jennifer	Friend	Phoenix House OC
Jesus	Gaona Perez	County of Orange - 4th District Supervisor
Joanie	Akkad	AOA Fullerton Pact
Joceline	Pérez	NA
Johnice	Williams	Outreach and Engagement for Blacks/African Americans
Karina	Rodriguez	Abrazar Inc
Katie	Tran	Advance OC
Katie	Tran	Asian/ Vietnamese/ Catholic
Kitty	Lee	OCHCA
Laura	Buscemi-Beebe	OC HCA. D/HH
Laura	De La Torre Baeza	SCTCA
Lei Portugal	Calloway	Telecare AOT/Care Court
Lenora	Burney	OCHCA
Lesa	Weinert	OCHCA
Linda	Smith	Community advocate
Lisa	Nguyen	Abrazar Inc.
Lloraley	Anguiano	Latin X/ OCHCA
Lorenzo	Contreras	SUD
Luis	Gonzalez	Office of Population Health and Equity
Luisa	Estanga	Abrazar Inc.
Luna	Lu	AASCSC
Luyen	Pham	OCHCA
Luz	Gunn	AASCSC
Mae	Alfaddaghi	MECCA
Marian	Kettler	OCHCA
Marie	Sanchez	MHA OC
Mario	Ortega	Abrazar Inc.
Mary	Barranco	CalOptima Health
Maryam	Jibaly	ICNA Relief
Maryam	Sayyedi	OMID
Maybelline	Racca-Salazar	TPOR
Megan	Fink	Phoenix House
Megan	Montrone	OCHCA

First	Last	Organization
Melissa	Struzzo	HealthRIGHT 360 SUD residential Treatment and Withdrawal Management
Michael	Mullard	HCA - Spirituality Workgroup
Michael	Fotion	Friendship Shelter
Michael	Arnot	CCOC
Michele	Cheung	OCHCA
Michelle	Harris	HCA/ CAT
Michelle	Smith	OCHCA-BHS
Michelle	Nieto Torres	MECCA
Michelle	Yang	Salvation Army
Min	Suh	OCHCA
Mychael	Blinde	MECCA
Nahla	Kayali	Access California Services
Nair	Shubha	SAAHAS
Nancy	Beltran	Goodwill of Orange County- Employment Works
Nathan	Green	Wellness Center South
Nichole	Duplesse	OCHCA
Omar	Guzman	Abrazar
Paige	Medina	MECCA
Pam	Presnall	MHA OC
Pamela	Estes	Boys & Girls Club of Laguna Beach, also serving Saddleback area
Pennie	Mack	Break Every Chain Foundation Incorporated
Princess	Osita-Oleribe	HEAAL
Priscilla	Gallardo	Native American
Rachel	Varisco	UCI
Raquel	Williams	Thrive Together OC
Rebecca	Freeman	RCBO
Rhiannon	Doscher	MECCA
Robynn	Zender	UCI
Rocio	Valencia	Mental health services for low income
Ryan	Yowell	OCHCA
Sabrina	Hermosillo	OCHCA
Saily	Gomez Batista	CHOC
Salina	Anderson	SCTCA
Salina	Anderson	Native American/ Indigenous
Sanaz	Mirbaha	OMID
Sara	Brown	First 5 Orange County
Sara	Kim	Council on Aging

First	Last	Organization
Sarah	Wareh	ICNA Relief
Sarah	De Bruyn	MECCA
Sarai	Arpero	Latina
Scott	Pham	Goodwill OC Mission Services
Shae	Harris	MECCA
Shubha	Nair	SAAHAS
Sohail	Eftekharzadeh	CCS/Pathways- Wellness Center Central
Steve	McNally	Orange County Behavioral Health Advisory Board (As an Individual)
Tammy	Wong	The Purpose of Recovery
Tania	Quevedo	ASL Interpreter
Tanji	Ewing	OCHCA
Teresa	Renteria	OCHCA/ Spirituality
Terri	Styner	OCHCA
Thuy	Nguyen	OCHCA
Thuy	Nguyen	API subgroup
Tracy	Rick	OCHCA
Tricia	Connolly	Woodglen Recovery Junction
Veronica	Briones-Montiel	DMC-ODS contractor
Virginia	Arvizu-Sanchez	Sacred Path Indigenous Wellness Center (Native population)
Wali	Hanifzai	Religious- Faith based (SAMENA)
Wenny	Nguyen	Didi Hirsch
Wesley	Shain	OC HCA/ LGBTQ+
Yennga Cecilia	Chau	Asian
Yichen	Wang	AASCSC
Zazareth	Roman	MECCA

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

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

The BHEC bylaws and governing structure, attached, highlight the role of BHEC as it pertains to the MHSA planning and stakeholder process, CCPR development, and communicating to the Director of Behavioral Health Services. Currently, the Office of Equity is being formed and will continue to collaborate and integrate with the

MHSA community planning process, as well as working closely with the client developed programs (wellness, recovery, and peer support programs).

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

The MHSA Coordinator and the BHEC Chair work together to ensure that the BHEC is involved in the community planning process, provides feedback to the MHSA Coordinator, and reviews the MHSA Plan. Moving forward, the MHSA Coordinator and the BHEC Chair will ensure community involvement and participation in the development of client-centered programs. Additionally, the CCPR incorporates feedback provided from the BHEC steering committee and workgroup members.

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

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

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

- **Human resources report;**
  Not applicable – there was no report requested by BHEC Committee
- **County organizational assessment;**
  In FY 2023/2024, the BHEC did not conduct a formal county organizational assessment. However, ongoing feedback from BHEC participants is used to inform the direction of BHEC.

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

CRITERION 5: CULTURALLY COMPETENT TRAINING ACTIVITIES

CLAS Standard: 4

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

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

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

In 2023/2024, 4,220 staff and contracted providers completed the annual cultural competence training.

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

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

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

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

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

5-II: Annual Cultural Competence Trainings

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

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

Cultural competence trainings were provided for staff, stakeholders, and community members on a variety of topics. Table 5.1 below is a chart that provides information on the cultural development trainings provided during FY 2023-24 (See Appendix IV for training descriptions and details). These topics helped to address the unique strengths and needs of clients from the diverse ethnic and cultural communities in Orange County.

Table 5.1 Name of Cultural Development Trainings, FY 2023-24[1]

	Total Trainings	*Number of Attendees*	*Combined Hours*	*Combined CEs Given*
2023 School-Based Mental Health Summit	1	79	5.0	5.0
2024 Emergency Medical Services Administrators Association of California (EMSAAC) Annual Pre-Conference CQI	1	47	4.5	4.5
Addressing Challenging Client Situations with Cultural Humanity	1	48	3.0	3.0
Breaking Down Binaries: Psychosis & the Transgender Community	2	34	4.0	4.0
Client Engagement Using A Recovery Perspective	1	46	1.5	1.5
Coping with the Journey of Mourning and Grief	1	84	6.0	6.0
Cultivating Competency-Based Clinical Supervision for New Clinical Supervisors	1	29	9.0	9.0
Cultural Competency 3.0 Training	1	412	1.0	0
Cultural Competency 4.0 Training	1	653	1.0	0
DBT Intensive PsychWire	1	8	5.0	5.0
Dialectical Behavior Therapy - Informed Interventions for Psychosis	1	92	1.5	0
Dialectical Behavioral Therapy-Informed Interventions for Psychosis In Depth	1	42	1.5	1.0
Dialectical Behavioral Therapy-Informed Interventions for Psychosis In Depth (recorded)	1	3	1.5	1.0
Exploring the Depths of Clinical Supervision	2	94	12.0	12.0
How to Maintain Ethical and Legal Boundaries While Using Technology in Your Mental Health Practice	2	91	12.0	12.0
Intersection Between Autism and Clinical High Risk for Psychosis (recorded)	1	3	1.0	1.0
Law and Ethics: Counter Transference, Self-Disclosure, and Therapist Self-Care	1	119	3.0	3.0
Law and Ethics: Cultural Humility, Tarasoff, and it's Progeny	1	116	3.0	3.0
LEAP Training (Listen - Empathize - Agree - Partner)	1	28	5.0	4.0

	Total Trainings	*Number of Attendees*	*Combined Hours*	*Combined CEs Given*
Medical Directors Leadership Series	4	85	9.0	9.0
Meeting of the Minds	1	80	5.0	5.0
Mental Health and Recovery Services MD/NP Series	3	92	8.0	6.0
Mini SIPS: A Brief Assessment for Psychosis-Risk with Transitional Age Youth	2	106	4.0	4.0
Mini SIPS: A Brief Assessment for Psychosis-Risk with Transitional Age Youth (recorded)	1	1	2.0	2.0
Neurobiology of Trauma: An Update on the Science of Trauma	1	80	3.0	3
Nutrition and Mental Health	4	38	8.0	8.0
Older Adult Mental Health Training for Professionals	1	106	2.5	2.5
Promoting Early Intervention for Psychosis: Conceptual and Empirical Basis to a Community Campaign for Latinxs	1	34	1.0	1.0
Promoting Early Intervention for Psychosis: Implementation, Evaluation, and Future Directions of a Community Campaign for US Latinos	1	14	1.0	1.0
Recent Traumatic Events Protocol (R-TEP) and Group Traumatic Events Protocol - An Advanced EMDR Training	1	19	12.0	12.0
Seeking Safety	4	84	20.0	20.0
Solution Focused Brief Therapy Training	1	118	11.0	11.0
Suicide Prevention and Intervention	4	0	24.0	24.0
The Moral Distress and Courage of Mandated Reporters	1	14	1.5	1.5
Tools for School-based Providers: Assessing Risk for Psychosis Youth	1	26	3.0	3.0
Tools for School-based Providers: Assessing Risk for Psychosis Youth (recorded)	1	1	3.0	3.0
Transgender and Gender Non-Conforming (TGNC) Health Summit: "Asi Soy Yo" Breakout Session	1	10	1.0	1.0
Trauma and Parenting: Creating a Safe Home Base	1	71	3.0	3.0

	Total Trainings	*Number of Attendees*	*Combined Hours*	*Combined CEs Given*
Trauma and Spirituality	1	59	3.0	3.0
Trauma Informed Strategies: A Neurodiversity-Affirming Approach	1	31	6.0	6.0
Trauma, Dissociation, and Psychosis: CBT and Other Approaches to Understanding and Recovery	1	58	3.0	3.0
Trauma-Informed Foundations	1	42	3.0	3.0
Unforgettable - Though Near or Far Conference	1	38	3.0	3.0
Veteran's Conference	1	158	8.5	8.5
Youth Mental Health First Aid (MHFA)	1	17	8.0	0
Total	***63***	***3,410***	***237.0***	***187.5***

Note: No CEUs were given for MHFA

[1]Source: Behavioral Health Training Services, Internal Data Tracking System (FY 23-24)

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

Table 5.2 Cultural Development Training Attendance by Participants' Professional Role, FY 2023-24

*Attendance by function**	*Total Number*
County Administrator/Manager	175
County Direct Service Provider	1060
County Support Staff	255
Community-Based Administrator/Manager	236
Community-Based Direct Service Provider	1411
Community-Based Support Staff	526
Total	***3,663***

**Some attendees reported multiple professional roles*

Source: Behavioral Health Training Services, Evaluation Form Data (FY 23-24)

Table 5.3 Cultural Development Training Attendance by Participants' Personal Role, FY 2023-24

*Attendance by function**	*Total Number*
Consumers	1298
Parents	715
Family Members	567
Community Member	605
Caregiver	715
Total	*3,900*

**Some attendees reported multiple personal roles*
Source: Behavioral Health Training Services, Evaluation Form Data (FY 23-24)

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

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

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

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

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

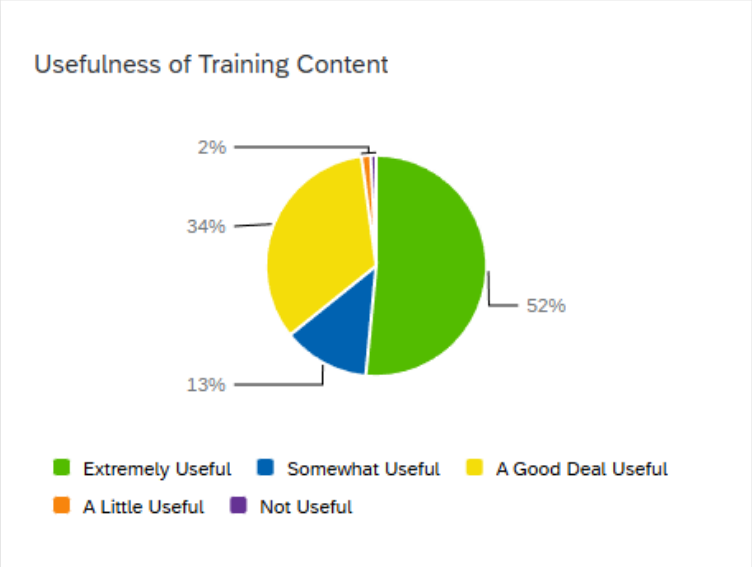
- Cultural and linguistic competency and quality of care

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

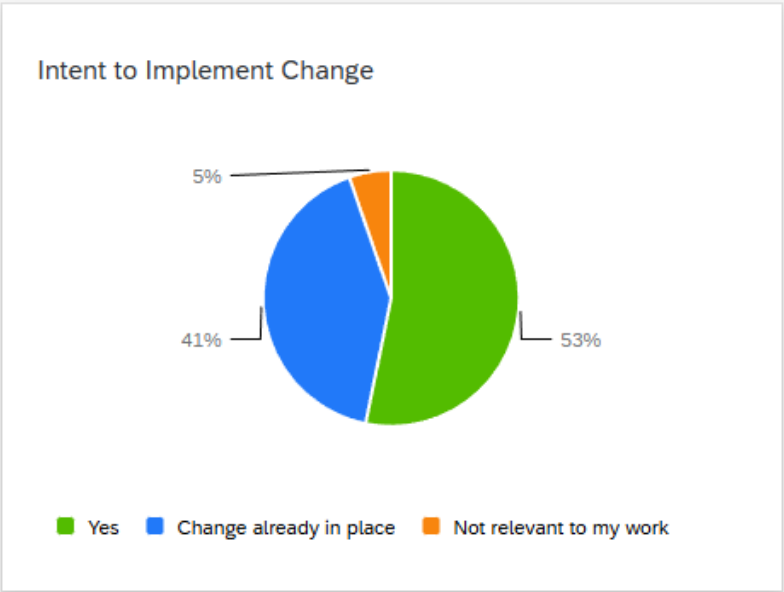
5-III-A: Training Report on the relevance and effectiveness of all cultural competence trainings, including the following:

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

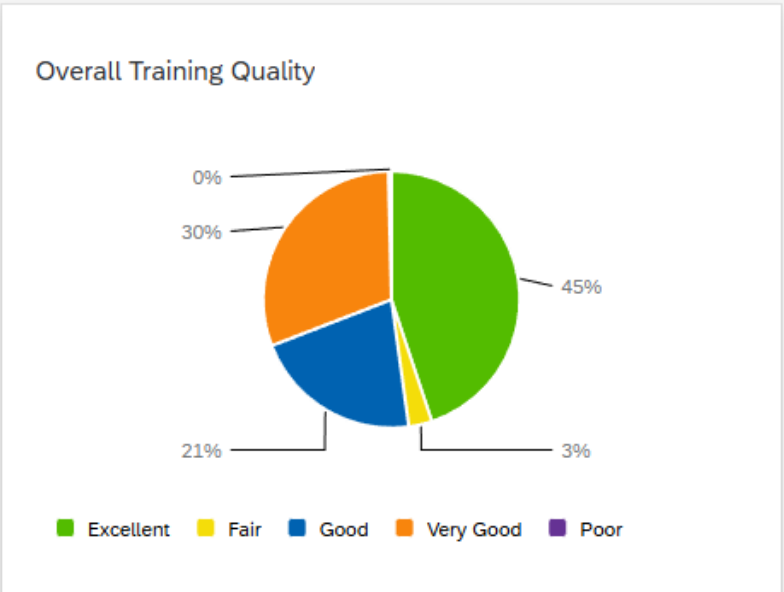
The annual cultural competence training is provided to both County- and Contract-operated staff. In 2023, a revised Cultural Competence training was launched and focused on culture identity, intersectionality, competency, humility, and linguistic competency. At the end of the training, participants were encouraged to take an online evaluation regarding their experiences. Overall, participants felt the educational objectives discussed during the training were useful. As a result of the training, the majority of participants who engaged in the FY 2023-24 training felt the content was extremely useful, with 34% stating it was a good deal useful and 13% stating it was a somewhat useful.



In examining staffs' intent to implement changes as a result of the training, 96% indicated they either had an intent to implement change (55%) or were already implementing changes (41%). This illustrates that the training provided additional insight into unconscious bias in the workplace.



While no Continuing Education (CE) units were provided, this training focused on understanding and identifying unconscious/implicit bias in the workplace. Of those who provided feedback for this training, 45% rated the overall quality of the training as excellent, 30% rated it as very good, 21% rated it as good, and 3% rated the training as fair.



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

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

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

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

Trainings that emphasize culture, identity, ethnicity, spirituality, or culturally responsive care.

- 2023 School-Based Mental Health Summit
- Addressing Challenging Client Situations with Cultural Humanity
- Breaking Down Binaries: Psychosis & the Transgender Community
- Cultural Competency 3.0 Training
- Cultural Competency 4.0 Training
- Intersection Between Autism and Clinical High Risk for Psychosis
- Law and Ethics: Cultural Humility, Tarasoff, and Its Progeny
- Promoting Early Intervention for Psychosis: Community Campaign for Latinxs
- Promoting Early Intervention for Psychosis: Implementation/Evaluation for US Latinos
- Transgender and Gender Non-Conforming (TGNC) Health Summit: "Asi Soy Yo"
- Older Adult Mental Health Training for Professionals
- Unforgettable – Though Near or Far Conference (culturally rooted grief/loss event)
- Veteran's Conference (population-specific cultural considerations)
- Trauma and Spirituality
- Trauma Informed Strategies: A Neurodiversity-Affirming Approach

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

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

1. **Family Focused Treatment:**

   Trainings centered on family systems, parenting, or child–caregiver roles.

- Trauma and Parenting: Creating a Safe Home Base
- Youth Mental Health First Aid (MHFA)
- Tools for School-based Providers (psychosis-risk in youth)*
- Mini SIPS: Psychosis-Risk with Transitional Age Youth*
  (*Also fits Navigating Multiple Agency Services; placed here due to youth/family focus.)

2. **Navigating Multiple Agency Services:**

   Trainings involving system interfaces, organizational leadership, supervision, medical–behavioral health collaboration, ethics, and interagency functioning.

- 2024 EMSAAC Annual Pre-Conference CQI
- Cultivating Competency-Based Clinical Supervision
- Exploring the Depths of Clinical Supervision
- Medical Directors Leadership Series
- Mental Health and Recovery Services MD/NP Series
- Meeting of the Minds
- How to Maintain Ethical & Legal Boundaries While Using Technology
- Law and Ethics: Countertransference, Self-Disclosure, Therapist Self-Care
- LEAP Training (Listen – Empathize – Agree – Partner)
- The Moral Distress and Courage of Mandated Reporters
- Tools for School-based Providers (also family-related)
- Mini SIPS assessments (also family-related)

3. Resiliency:

Trainings promoting recovery, coping, stabilization, trauma healing, DBT, psychosis recovery, safety, and therapeutic skill building.

- Client Engagement Using a Recovery Perspective
- Coping with the Journey of Mourning and Grief
- DBT Intensive PsychWire
- Dialectical Behavior Therapy–Informed Interventions for Psychosis
- Dialectical Behavioral Therapy–Informed Interventions for Psychosis (In Depth + recorded)
- Neurobiology of Trauma: Update on the Science
- Nutrition and Mental Health
- Recent Traumatic Events Protocol (R-TEP) & Group Traumatic Events Protocol
- Seeking Safety
- Solution Focused Brief Therapy
- Suicide Prevention and Intervention
- Trauma, Dissociation, and Psychosis: CBT and Other Approaches
- Trauma-Informed Foundations
- Meeting of the Minds (recovery-oriented; also fits category 3)

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

CLAS Standard: 3 & 7

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

BHS remains strongly committed to recruiting, retaining, and promoting a multi-cultural, highly skilled workforce. The following section provides information about recruitment and retention efforts of our behavioral health professionals that are in line with the Recovery-focused philosophy. At present, BHS has coordinated with OCHCA Human Resources Department to bring down the vacancy rate through coordained hiring events and other strategies. These strategies have worked increasingly well as the OCHCA BHS department has reduced the vacancy rate of approximately 27% in 2024 to approximately 11% as of October 2025.

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

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

Workforce Education and Training (WET) Component from the Mental Health Services Act Three Year Integrated Plan for Fiscal Years 2023/2026.

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

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

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

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

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

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

WET MHSA Legislative Goals

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

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

Designate a WET Coordinator:

- WET Coordinator designated.

Educate the workforce on incorporating the general standards:

- Training documented addressing these standards.
- Training evaluations.

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

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

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

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

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

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

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

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

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

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

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

- Documented meetings with diverse racial/ethnic populations

Establish regional partnerships:

- Participate in meetings.

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

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

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

BHS is working on collecting information on the ethnic make-up of its workforce. The information provided in Table 6.1 below lists the clinicians in our workforce (County clinicians and combined County and Contracted Clinicians) – while these numbers are from FY23/24, they show improvement from FY22/23.

The greatest disparity indicates the female workforce at 72.6% (County clinicians) and 75.8% (combined County and contracted clinicians). This is an overrepresentation of the 50.5% in the general population, and 51.8% of beneficiaries who received an approved service under the Mental Health Plan and 34.2% under the DMC-ODS. Male clinicians represent 27.4% of County clinicians and 24.1% (combined county and contracted clinicians), which is an underrepresentation of the 49.5% of males in the general Orange County population and the 47.6% of Medi-Cal beneficiaries who received an approved service under the Mental Health Plan and 65.2% under the DMC-ODS.

Table 6.1 Current Workforce by Gender Fiscal Year 2023/2024

	Total Population[1]		*County Wide Estimated Population Living at or Below 200% FPL (Medi-Cal Clients)*[2]		*Average Number of Medi-Cal Eligibles per Month*[3] *(Mental Health Plan)*		*Medi-Cal Beneficiaries who Received an Approved Service per Year*[4] *(Mental Health Plan)*		*Average Number of Medi-Cal (Mental Health Plan) Eligibles per Month*[3] *(DMC-ODS)*	*Medi-Cal Beneficiaries who Received and Approved Service per Year*[4] *(DMC-ODS)*		*BHS Workforce** (County Clinicians)	*BHS Workforce (County & Contracted Clinicians)*	
Total	3,170,435		454,000		999,859		23,781		604,035	6,843		759	1056	
Female	1,601,560		244,000		536,404		12,224		337,778	2,382		551	798	
Percentage of Female	50.5%		53.6%		53.7%		51.4%		55.9%	34.8%		72.6%		
Male	1,568,875		210,000		463,455		11,557		266,257	4,461		208	254	
Percentage of Male	49.5%		46.2%		46.4%		48.6%		44.1%	65.2%		27.4%	%	
Transgender Male to Female	-		-		-		-		-	-		1	1	
Percentage Transgender Male to Female	-		-		-		-		-	-				
Undisclosed Count	-	-	-	-	-	-	103	0.4%		13	0.2%	3	0%	0%

[1]*American Community Survey (ACS) 2025, US Census*

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

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

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

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

Not applicable

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

Recruitment

The Orange County WET component programs have experienced much success over the years, contributing to the development of a highly skilled workforce. However, some institutional barriers still exist, creating roadblocks for establishing integrated pathways to BHS employment. Orange County's vacancy rate showed that while there has been a slight improvement in the rate reported by the department, from approximately 18% in August 2023 to 11% currently.

Several factors contribute to these vacancies, including limited flexibility in work schedule; non-competitive and low pay; minimal pay differential for specialty skills (e.g., language competency); and slow hiring and human resources processes for potential candidates. These factors are extremely difficult to change within the existing County system, and many involve established processes that would take extensive resources and time to change.

The purpose of the hiring events is to lower the County of Orange vacancy rates for specifically difficult to hire positions which require a State Board of Behavioral Sciences license or pre-license requirement for these Behavioral Health Clinic I and II positions. Therefore, the County of Orange Human Resource department begin these events to provide on the spot job offers and to shorten the hiring process for these hard to fill positions.

Additionally, through the Progressive Improvements For Valued Outpatient Treatment (PIVOT) Innovation Project. This project seeks a Innovative, Countywide Workforce Initiative: Proposes to address workforce shortages and increase access to services by exploring an alternative strategy to building a culturally competent and well-trained behavioral health workforce of professionals and paraprofessionals as well as Innovative Approaches to Delivery of Care: Seeks to create a more culturally responsive, inclusive, and efficient delivery of care, utilizing a User Experience model to gather input from consumers and their family members.

A potential strategy to expand the workforce is through clinical internship programs. In the most recent MHSA 3-Year Plan, BHS identified the need to establish a centralized internship program that included paid internship positions;

an employee 20/20 program that would enable an employee time to complete training and/or educational requirements for a degree or certification; and streamlining the path from internship to employment. Despite these efforts, barriers exist that limit the success of the existing program, including but not limited to:

Competition amongst systems

For example, hospitals, education, criminal justice, and managed care plans all compete for the same qualified staff and interns.

- Limited ability to update minimum qualifications for entry level Behavioral Health Clinicians, including necessitating that applicants possess a Board of Behavioral Sciences (BBS) registration number prior to start date.

- Delays between graduation, hiring, and ability to start in BHS.

- Inability to establish the 20/20 program. In addition, there is not an established coordinated, countywide behavioral health pipeline and pathway to support the development of the larger provider network. These challenges result in workforce shortages that impact an individual's access to care. These challenges are not limited to the County, as the State continues to seek solutions to address this challenge with its recent behavioral health reform efforts. One of the tenets of BHSA is increasing access by building workforce infrastructure. BHSA will utilize 3% of its administrative funds on workforce investments to expand a culturally competent and well-trained behavioral health workforce to address behavioral health capacity shortages and expand access to services.

  This PIVOT component will take successful strategies from both internship and apprenticeship programs and utilize a third-party vendor as the "employer of record" to support payment of incentives for participating in the internship program. Because apprenticeships are longer than a typical internship, individuals participating in BHS internships will have the option to extend their paid learning opportunity beyond their educational requirement. A standard pay scale will be developed that incentives longevity 24 and continues to provide incentives during the period between graduation and the receipt of a BBS registration number that is required to qualify for regular county positions. Component activities and objectives include:

- Establish a multi-partner, countywide behavioral health workforce pipeline and pathway.
- Utilize third-party vendor to test alternative pathways to employment (e.g., apprenticeship program).
- Develop pathways that extend beyond traditional mental health clinician roles, including but not limited to substance use disorder counselors, all levels of peer specialists, community health workers, health and wellness coaches, and others.
- Provide option to extend paid learning beyond educational requirements.
- Develop a standard pay scale that incentivizes longevity.
- Provide incentives during period between graduation and receipt of a clinical registration number that is required to qualify for county clinical positions.

Through this PIVOT component, Orange County seeks to create a seamless pathway from paid internship to employment for diverse professionals and paraprofessionals. The activities in this component align with recent efforts in the Department of Health Care Access and Information (HCAI). In September 2024, HCAI proposed its initial plans for developing a data-driven statewide strategy to expand and diversify California's behavioral health workforce. The strategy will explore innovative solutions to improve financial incentives, compensation, recruitment, and retention. In addition, HCAI will explore the ability to offer flexible work schedules, develop career pathways, and reduce administrative barriers4. Where possible, Orange County will partner with/and or align its efforts with this statewide approach, as well as draw upon or share learnings from similar County workforce INN projects (i.e., San Diego County, Amador County).

BHS has a Peer Workforce Development Initiative (PWDI) that consults with the Director's Office to support and promote peer positions throughout BHS. Currently, there are 34 employed peer specialists (which include Mental Health Worker I, II and III (certified Peers), along with Community health Assistants. The PWDI began hiring and recruiting qualified peer workers in 2025. PWDI also supported the current Peer's CA State Certification process that allowed County

and County Contracted Peers to train and take the CA State Certification at no costs. Through these efforts, multiple County and County Contracted Peers passed and obtained their CA State Peer Certification. Further, the OCHCA BHS Crisis Department begin hiring Mental Health Worker III positions to assist with Crisis Assessment Team (CAT) responses. These Certified Peers are eligible to begin billing Medi-Cal for the eligible services and the County BHS CAT and Crisis Department continues to recruit and hire Certified Peers into our system of care.

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

The WET program experienced the following challenges for FY2023/2024:

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

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

- Coordinated with OCHCA Human Resources to hold targeted hiring events that provide on-the-spot job offers for hard-to-fill licensed and pre-licensed Behavioral Health Clinician positions, contributing to a vacancy reduction from ~27% (2024) to ~11% (2025).
- Implemented the MHSA Workforce Education and Training (WET) component to expand training opportunities for BHS and contract staff, promote hiring of a culturally diverse and bilingual workforce, and offer financial incentives (scholarships, stipends, loan assumption) to recruit and retain qualified staff.
- Conducted a workforce analysis and needs assessment with Southern California Regional Partnership (SCRP) partners to identify shortages, inform a new five-year WET plan, and prioritize recruitment/retention, pipeline development, and financial incentive strategies.

- Expanded and strengthened clinical internship pathways, including development of a centralized, paid internship model and a streamlined path from internship to employment, with the goal of building a sustainable, culturally responsive workforce pipeline.
- Launched the PIVOT Innovation Project to test alternative workforce models using a third-party "employer of record," create apprenticeship-style extended paid learning opportunities, develop a standardized pay scale that rewards longevity, and provide incentives during the period between graduation and BBS registration.
- Increased focus on hiring and retaining bilingual and bicultural staff and peers, including targeted recruitment for individuals who reflect the racial/ethnic, cultural, and linguistic characteristics of the communities served to improve penetration rates and trust in services.
- Implemented the Peer Workforce Development Initiative (PWDI) to recruit, train, and support peer specialists (including Mental Health Workers and Community Health Assistants), assist them in obtaining California State Peer Certification at no cost, and integrate certified peers into programs such as the Crisis Assessment Team (CAT) to expand culturally informed, recovery-oriented services.

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

There are no identified technical assistance needs at this time.

CRITERION 7: LANGUAGE CAPACITY

CLAS Standard: 5, 6 & 8

7-I: Increase Bilingual Workforce Capacity

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

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

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

In FY 2023/2024, BHS employed 496 bilingual employees, accounting for 44% of the workforce.

The majority of bilingual staff speak Spanish (78%), but other languages spoken by staff include:

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

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

Table: BHS Bilingual Staff by Language and Skill Level for FY 2023/2024 (*Updated October 2025)*

Title Description	SPANISH	VIETNAMESE	KOREAN	FARSI	ARABIC	RUSSIAN	CHINESE	AMERICAN SIGN LANGUAGE	OTHER LANGUAGE	TOTAL
BEHAVIORAL HEALTH CLINICIAN I	70	7	1	1	1	0	1	0	1	82
BEHAVIORAL HEALTH CLINICIAN II	85	14	9	6	2	1	1	1	1	120
BEHAVIORAL HEALTH NURSE	1	0	0	0	0	0	0	0	0	1
CLINICAL PSYCHOLOGIST I	7	0	0	0	0	0	0	0	0	7
CLINICAL PSYCHOLOGIST II	6	2	2	0	0	0	1	0	0	11
COMMUNITY HEALTH ASSISTANT I	1	0	0	0	0	0	0	0	0	1
COMMUNITY WORKER II	4	0	0	0	0	0	0	0	0	4
COMPREHENSIVE CARE NURSE II	3	0	2	0	0	0	0	0	0	5
DATA ENTRY TECHNICIAN	0	1	0	0	0	0	0	0	0	1
HCA PROGRAM SUPERVISOR I	0	0	0	1	0	0	0	0	0	1
HCA PROGRAM SUPERVISOR II	0	1	0	0	0	0	0	0	0	1
HCA SERVICE CHIEF I	8	1	0	0	1	0	1	0	0	11
HCA SERVICE CHIEF II	12	3	0	1	0	0	0	0	0	16
HEALTH EDUCATION ASSOCIATE	2	0	0	0	0	0	0	0	0	2
HEALTH PROGRAM SPECIALIST	4	0	1	0	0	0	0	0	0	5
HEALTH SERVICES MANAGER	1	0	0	0	1	0	0	0	0	2
INFORMATION PROCESSING SPECIALIST	1	0	0	0	0	0	0	0	0	1
INFORMATION PROCESSING TECHNICIAN	4	0	0	0	0	0	1	0	0	5
MENTAL HEALTH SPECIALIST	55	10	0	1	1	0	0	1	2	70
MENTAL HEALTH WORKER II	15	1	0	0	0	0	0	0	0	16
MENTAL HEALTH WORKER III	5	0	2	0	0	0	0	0	0	7
OFFICE ASSISTANT	7	1	0	0	0	0	0	0	0	8
OFFICE SPECIALIST	63	3	0	0	0	0	1	0	0	67

Title Description	SPANISH	VIETNAMESE	KOREAN	FARSI	ARABIC	RUSSIAN	CHINESE	AMERICAN SIGN LANGUAGE	OTHER LANGUAGE	TOTAL
OFFICE SUPERVISOR C	1	0	0	0	0	0	0	0	0	1
OFFICE SUPERVISOR D	3	0	0	0	0	0	0	0	0	3
OFFICE TECHNICIAN	12	2	0	0	0	0	0	0	0	14
PSYCHIATRIST	4	4	1	0	0	0	0	0	0	9
PSYCHIATRIST CONTRACT EMPLOYEE	1	1	0	0	0	0	0	0	1	3
PUBLIC HEALTH NURSE	1	0	0	0	0	0	0	0	0	1
RESEARCH ANALYST	1	0	0	0	0	0	0	0	0	1
SECRETARY III	1	0	0	0	0	0	0	0	0	1
SENIOR RESEARCH ANALYST	1	0	1	0	0	0	0	0	0	2
SR. COMPREHENSIVE CARE NURSE	0	1	0	0	0	0	0	0	0	1
STAFF ASSISTANT	4	1	0	0	0	0	0	0	0	5
STAFF SPECIALIST	6	2	2	0	0	0	0	0	0	10
SUPVG COMPREHENSIVE CARE NURSE	0	1	0	0	0	0	0	0	0	1
Total	**389**	**56**	**21**	**10**	**6**	**1**	**6**	**2**	**5**	**496**

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

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

Language assistance is offered to Orange County beneficiaries of Health Care Agency Services using a myriad of resources, both County- and Contract-operated. The Tables 7.1 through 7.6 examine the interpretation and translation services utilized during FY 2023-24. During this fiscal year, the Multi-Cultural Development Program provided interpretation and translation services in-house. Language Line, the contracted vendor, also provided document translation and interpretation services. Additionally, American Sign Language (ASL) services were contracted through a vendor called Accurate Communications, Inc.

Starting in November of 2017, Language Line began providing telephonic interpretation services to several behavioral health programs across Orange County. In FY 2023-24, this program facilitated 5,376 calls, which accumulated to roughly 1,747.8 hours of telephonic interpretations (see Table 7.1). Additionally, most telephonic interpretation services provided during FY 2023-24 were in Spanish, followed by Vietnamese, Korean, Mandarin Chinese, and Arabic (see Table 7.2). In FY 2023-24, out of the 5,376 total calls, roughly 97% were made in one of those languages.

Table 7.1 Total Number of Telephonic Interpretation Services Provided by Month, FY 2023-24

Month	Number of Calls	Minutes on Call	Facilitated Hours
July-23	383	7,006	116.7
August-23	396	7,583	126.4
September-23	432	7,475	124.6
October-23	536	10,865	181.1
November-23	437	8,230	137.2
December-23	369	6,862	114.4
January-24	430	9,299	155.0
February-24	483	9,022	150.4
March-24	526	10,613	176.9
April-24	477	9,938	165.6
May-24	523	9,965	166.1
June-24	384	8,009	133.5
Total	*5,376*	*104,867*	*1,747.8*

Source: Language Line Telephone Interpretation Report, FY 2023-24

Table 7.2 Top Five Telephonic Interpretation Requests, FY 2023-24

	Number of Calls	Minutes on Call	Facilitated Hours
Spanish	3,599	67,059	1,117.7
Vietnamese	769	15,162	252.7
Mandarin	356	8,040	134.0
Farsi	144	3,181	53.0
Korean	139	2,726	45.4
Total	*5,007*	*96,168*	*1,602.8*

Source: Language Line Telephone Interpretation Report, FY 2023-24

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

Table 7.3 Health Care Agency Programs to Request Telephonic Interpretation Services, FY 2023-24

	Number of Calls	Minutes on Call	Facilitated Hours
Children and Youth Services	1,958	10,735	678.9
MHSA - Community Supportive Services - Children	1,470	28,726	478.7
MHSA - Prevention and Early Intervention	669	8,751	145.9
MHSA – Community Supportive Services - Adults	697	14,073	234.6
Adult Mental Health Services - Outpatient/Crisis	397	9,058	151.0
Alcohol and Drug Use Services	149	2,802	46.7
Public Guardian	32	646	10.8
Adult Mental Health Services – Inpatient/Housing	2	21	0.3
Behavioral Health Services - Admin.	2	55	0.9
Total	*5,376*	*104,867*	*1,747.8*

Source: Language Line Telephone Interpretation Report, FY 23-24

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

Table 7.4 Hours for In-Person Interpretation Services, FY 23-24

	Number of Interpretations	Facilitated Minutes	Facilitated Hours
Requested by the Multi-Cultural Development Program			
American Sign Language	758	50,940	1,108
Requested by Health Care Agency Program(s)			
Vietnamese	11	2,154	35.9
Spanish	78	11,964	199.4
Khmer	1	225	3.75
Romanian	4	510	8.5
Korean	19	3,660	61
Arabic	3	360	6
Mandarin	6	720	12
Total	*880*	*70,533*	*1,434.6*

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

Source: WET Interpretations Database, FY 23-24 and Accurate Communications Inc. Invoices FY 23-24

**Source: MDP Log – FY 23-24*

In FY2023-24, the Multi-cultural Development Program utilized Accurate Communications Inc. for 193 ASL interpretation services which totaled 438 hours of service (see Table 7.5). Additionally, 276 ASL interpretation services were provided by Accurate Communications, Inc. for various program needs of the Health Care Agency totaling 670 hours of service (see Table 7.5).

Table 7.5 Contracted American Sign Language Services Total Number of Hours by Type of Event, FY 2023-24

	Total Number of Services	Facilitated Minutes	Facilitated Hours
Services Facilitated for the Multi-Cultural Development Program			
Meeting	14	840	52
Training	5	300	10
Other	193	10,440	376
Total	***482***	***11,580***	***438***
Services Facilitated for Health Care Agency Program(s)			
Behavioral Health Services	262	38,520	642
Other Services	14	840	28
Total	***276***	***39,360***	***670***

Source: Accurate Communications Inc. Invoices FY 23-24

The Multi-Cultural Development Program also helped with the creation and review of document translations (see Table 7.6). This included PowerPoint presentations, brochures, and surveys that were used across BHS. During FY 2023-24, 384 document translation requests were primarily made for Spanish, Vietnamese, Chinese, Korean, and Farsi.

Table 7.6 Document Translation Request by Threshold Language (Language Line), FY 2023-24[1]

	Total Number	Percent
Vietnamese	77	20%
Arabic	24	6%
Farsi	29	7%
Spanish	137	36%
Korean	35	9%
Other[3]	41	11%
Chinese[2]	41	11%
Total	***384***	100%

[1] All Canceled or No Reply Requests were removed from this analysis
[2] Includes Simplified Chinese/Mandarin or Traditional Chinese/Cantonese
[3] Other includes Braille, English, Hindi, Khmer, Japanese, Russian and Tagalog
Source: WET Interpretations Log Database, FY 23-24

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

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

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

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

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

- Drug Medi-Cal clients seeking Substance Use Disorder (SUD) services are directed to call the SUD Beneficiary Access Line at (800) 723-8641. Clients who speak a language other than English can call (855) 625-4657; TTY services are available at 714-834-2332.
- Incorporated CLAS Standards training and education into the OCHCA BHS New Employee Orientation for all new hires to understand and affirm our commitment to meeting the cultural and linguistic needs of our diverse clients.

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

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

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

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

BHS has a phone line that individuals may call to access support and services. **OC LINKS Information and Referral Hotline** (1-855-OC-LINKS/625-4657) is a 24-hour hotline for individuals to call or chat online with a clinical navigator at

www.ochealthinfo.com/oclinks. This is the behavioral health line for information, referral, crisis, and assessment. OC Links navigators serve at the Crisis Assessment Team dispatch as well.

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

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

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

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

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

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

Outlined in written materials provided to each client, it states that Orange County "is responsible to provide the people it serves with culturally and linguistically appropriate specialty mental health services." This means that all non-English or limited English-speaking persons have the right to receive services in their preferred language and can request an interpreter. If an interpreter is requested,

one must be provided at no cost and people seeking services do not have to bring their own interpreters. Verbal interpretation of a client's rights, benefits, and treatments is also available in one's preferred language. Information is provided in alternative formats if someone cannot read or has "visual challenges." The written materials are available in Orange County's seven threshold languages including Spanish, Vietnamese, Farsi, Korean, Arabic, Russian and Simplified Chinese as well as English.

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

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

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

Currently, there is no infrastructure in place for providing standardized feedback to the contract vendor and this is something that BHS is exploring.

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

The need to have multi-lingual and multi-cultural staff available at each of the clinic sites, along with proper training for each staff member on the availability of language services and how to utilize these services. OCHCA is also reinforcing trainings on best practices when working with and utilize interpreters.

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

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

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

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

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

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

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

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

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

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

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

To ensure BHS bilingual staff are linguistically proficient, they must pass a verbal and written exam. This is done through the Human Resources Department. The testing yields proficiency levels in reading, writing and speaking for the staff member.

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

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

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

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

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

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

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

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

Clients who do not met the threshold language criteria are appropriately linked to bilingual certified staff. If there is no staff available, BHS staff will utilize the Language Line to provide appropriate language services. Table 7.1 above shows evidence of telephonic interpretation services.

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

- **Prohibiting the expectation that family members provide interpreter services;**
- **A client may choose to use a family member or friend as an interpreter after being informed of the availability of free interpreter services; and**
- **Minor children should not be used as interpreters.**

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

CRITERION 8: ADAPTATION OF SERVICES

CLAS Standard: 12

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

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

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

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

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

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

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

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

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

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

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

8-II: Responsiveness of Mental Health Services

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

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

Beneficiary Informing Materials

English

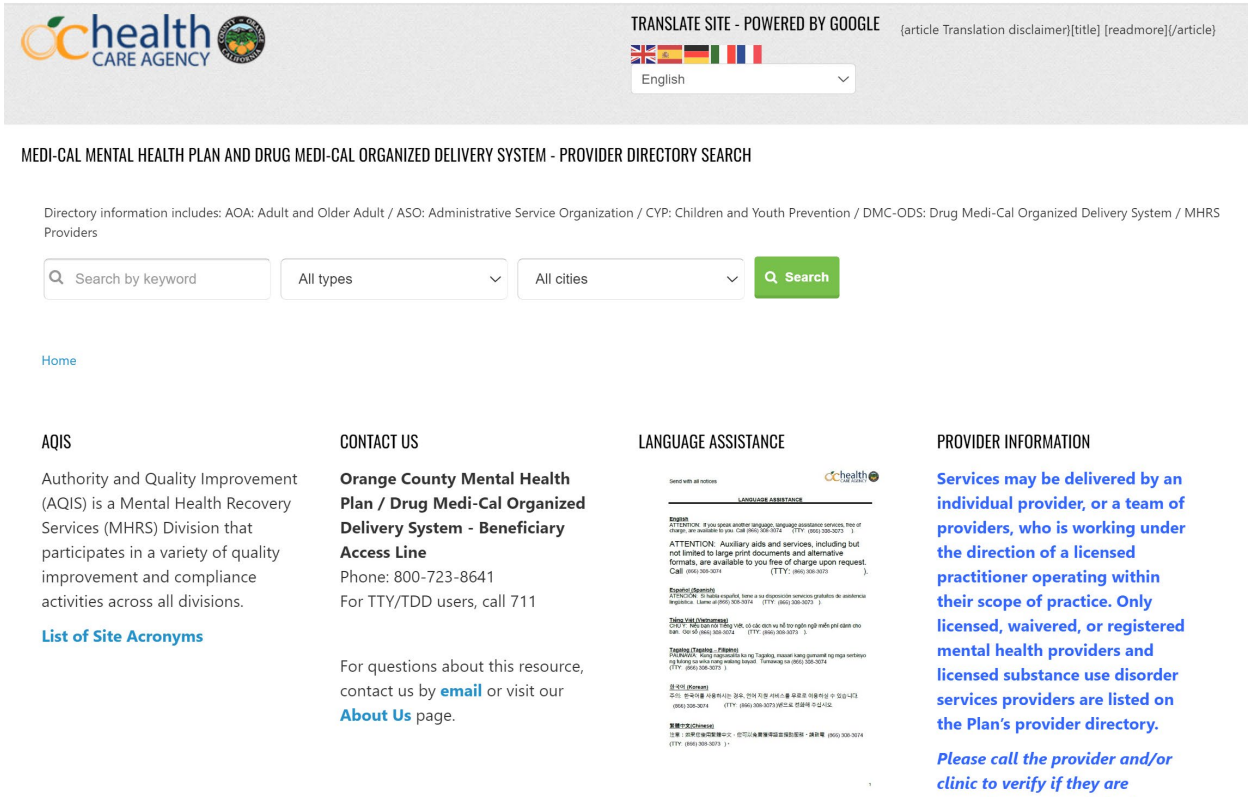
DMC-ODS Beneficiary Handbook

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

Audio Format (use Windows Media Player)

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

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



Provider Directory:

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

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

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

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

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

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

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

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

- Location, transportation, hours of operation, or other relevant areas;

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

- Locating facilities in settings that are non-threatening and reduce stigma, including co-location of services and /or partnerships, such as primary care and in community settings. (The county may include evidence of a study or analysis

of the above factors, or evidence that the county program is adjusted based upon the findings of their study or analysis.)

Transportation:

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

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

- Transportation is also a covered benefit under Medi-Cal.

Test Calls:

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

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

Family Resource Centers:

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

8-III: Quality of Care: Contract Providers

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

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

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

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

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

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

Below are some samples of contracts from BHS service areas:

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

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

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

8-IV: Quality Assurance Requirement

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

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

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

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

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

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

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

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

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

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

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

The beneficiary has several ways to file a grievance:

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

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

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

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

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

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

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

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

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

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

Grievance Process and CLAS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

APPENDIX I: POLICIES AND PROCEDURES GOVERNING CULTURAL COMPETENCE

Policy 02.01.01 - Cultural Competency

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

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

SUBJECT: Cultural Competency

PURPOSE:

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

POLICY:

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

SCOPE:

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

REFERENCES:

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

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

California Code of Regulations, Title IX, Chapter 11

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

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

Page 1 of 2

PROCEDURES:

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

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

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

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

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

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

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

Policy 02.01.02 - Meeting Beneficiary/Client Language Needs

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

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

SUBJECT: Meeting Beneficiary/Client Language Needs

PURPOSE:

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

POLICY:

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

SCOPE:

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

REFERENCES:

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

Department of Mental Health Information Notice No. 02-03

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

Dymally-Alatorre Bilingual Services Act 1973

PROCEDURE:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Policy 02.01.03 - Distribution of Translated Materials

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

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

SUBJECT: Distribution of Translated Materials

PURPOSE:

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

POLICY:

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

SCOPE:

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

REFERENCES:

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

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

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

FORMS:

Mental Health Plan Consumer Handbooks

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

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

Mental Health Plan Provider List

PROCEDURES:

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

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

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

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

Policy 02.01.04 - MHP and DMC-ODS Provider Directory

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

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

SUBJECT: MHP and DMC-ODS Provider Directory

PURPOSE:

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

POLICY:

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

SCOPE:

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

REFERENCES:

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

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

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

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

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

PROCEDURES:

I. Provider Directory Requirements

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

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

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

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

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

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

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

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

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

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

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

3. Telephone number(s);

4. Email address, as appropriate;

5. Website URL, as appropriate;

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

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

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

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

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

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

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

1. Type of practitioner, as appropriate;

2. National Provider Identifier number;

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

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

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

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

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

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

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

Policy 02.01.05 - Field Testing of Written Materials

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

	SIGNATURE	DATE APPROVED
Director of Operations Behavioral Health Services	Signature on File	9/21/16

SUBJECT: Field Testing of Written Materials

PURPOSE:

To ensure written materials for Behavioral Health Services (BHS) Mental Health Plan (MHP) have been field tested by consumers, family members or significant others to ensure comprehension.

POLICY:

Written materials provided to consumers, family members or significant others of the BHS MHP shall be field tested in the threshold languages to ensure comprehension.

Written materials include, but are not limited to:

- MHP Consumer Handbook
- MHP Provider List
- General Correspondence
- Beneficiary grievance and fair hearing materials
- Confidentiality and release of private health information
- MHP orientation materials
- SMHS education materials

SCOPE:

All County and County Contracted clinics providing Specialty Mental Health Services (SMHS) through BHS MHP.

REFERENCES:

State Department of Mental Health - Approved Cultural Competency Plan, 2010

SUBJECT: Field Testing of Written Materials

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

County of Orange, health Care Agency, BHS Cultural Competency Plan, Update, 2010

California Welfare and Institutions Code, Division 9, Part 3, Chapter 8.8, Article 5, 14684

FORMS:

Publication Field Test Feedback Sheet

PROCEDURE:

I. Each BHS Program is responsible for notifying the Multicultural Development Program (MDP) when new or altered forms and/or documents need translation.

II. MDP translates the forms or send to a contractor for translation into threshold languages.

III. Upon translation of forms, the MDP will, when available, have the document reviewed for accuracy of translation.

IV. Upon completion of translation, the MDP shall field test the document.

V. MDP staff shall coordinate obtaining assistance from consumers, family members, or significant others. Each shall participate in field testing the written material and compete a brief questionnaire documenting their ability to understand the written material.

VI. After feedback has been received, the MDP and Authority and Quality Improvement Services (AQIS) shall analyze the results of the submitted questionnaires and make appropriate changes if needed.

VII. Feedback regarding any recommended changes shall be given to the respective programs. Once changes have been implemented, the document shall be stamped "Field Tested and Approved by the Multicultural Development Program."

Policy 02.01.06 - Cultural Competence Committee

Health Care Agency **Behavioral Health Services** **Policies and Procedures**	Section Name: Sub Section: Section Number: Policy Status:	Client's Rights Cultural Competency 02.01.06 ☒New ☐Revised

	SIGNATURE	DATE APPROVED
Director of Operations Behavioral Health Services	Signature on File	10/12/16

SUBJECT: Cultural Competence Committee

PURPOSE:

To provide policy direction and procedural guidelines for the Cultural Competence Committee (CCC) of the Orange County Health Care Agency (HCA) Behavioral Health Services (BHS).

POLICY:

It is the policy of BHS to seek and incorporate input from the service providers and community representatives, consumers and families representing the diverse ethnic and cultural groups of Orange County into service design and implementation.

SCOPE:

The CCC will be reflective of the community, including county management level and line staff, consumers and family members from ethnic, racial, and cultural groups, providers, community partners, contractors, and other members as necessary.

The BHS CCC will function as a local forum for service providers and community representatives, consumers and families representing the diverse ethnic and cultural groups of Orange County.

The CCC will provide BHS with cultural competence related information, community feedback and recommendations regarding:

1. The functioning of local behavioral health service systems.
2. The mental health service needs of ethnic and cultural groups.
3. The provision by BHS of a collaborative process that is informed and influenced by community interests, expertise, resources and needs.
4. The establishment and maintenance of a meaningful dialogue with HCA BHS that addresses cultural and linguistic issues referenced from the active participation of cultural groups that are reflective of the community.

The CCC will be integrated within the Behavioral Health system, and:

1. Address cultural and linguistic competence; review the cultural competence plans of all BHS services and programs; and address the cultural competence issues at the county.

2. Provide reports to the BHS Quality Assurance/Quality Improvement Program, and an annual Report of CCC activities.

3. Provide input into the planning and implementation of services at the county.

4. Directly transmit recommendations to HCA executive level, and transmit concerns to the Behavioral Health Director.

5. Participate in and review county Mental Health Services Act (MHSA) planning and stakeholder process, and review county MHSA plans for all MHSA components.

6. Participate in and review client developed programs (wellness, recovery, and peer support programs).

7. Participate in revised Cultural Competence Plan Requirements (CCPR) (2014) development.

REFERENCES:

CCPR: http://www.dhcs.ca.gov/services/MH/Documents/CCPR10-02Enclosure1.pdf

National CLAS Standards: http://minorityhealth.hhs.gov/omh/browse.aspx?lvl=2&lvlid=53

County of Orange Health Care Agency, Behavioral Health Services, Cultural Competence Plan, 2010.

County of Orange Health Care Agency, Behavioral Health Services, Cultural Competence Plan, Updated 2015.

Cross, T.L., Bazron, B.J., Dennis, K.W. & Isaacs, M.R. (1989), Towards *a* culturally competent system of care. Washington, DC: Georgetown University Child Development Center, CASSP Technical Assistance Center.

National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care: A Blueprint for Advancing and Sustaining CLAS Policy and Practice. (April, 2013).

DEFINITIONS:

Definitions of terms which operationalize the aim and scope of the BHS Cultural Competence Committee:

Culture - The integrated pattern of human behavior that includes thought, communication, actions, customs, beliefs, values and institutions of a racial, ethnic, religious or social group.

Culture defines the preferred ways for meeting needs. Culture may include parameters such as age, county of origin, degree of acculturation, generation, educational level, family and household composition, gender identity and sexual orientation, health practices including the use of traditional healer techniques, linguistic characteristics—including language(s) spoken, written, or signed, perceptions of health and well-being and related practices, physical ability or limitations and cognitive ability or limitations, political beliefs, racial and ethnic groups, religious and spiritual characteristics, socioeconomic status, etc. (CLAS Standards, April 2013).

Cultural Competence - Cultural competence refers to the ability of organizations and individuals to work effectively in cross-cultural or multicultural situations. The emphasis is on the interaction/communication with diverse communities and among ethnic groups to assess their needs and effectively engage with them. Cultural competence is an evolving process, which at its core is "quality of care".

Organizational Cultural Competence - The existence of policies, procedures, practices, and organizational infrastructure to support the delivery of culturally and linguistically sensitive and appropriate health care services where "culture" is broadly defined.

Individual Cultural Competence - Set of congruent attitudes, knowledge, and skills that enable the person or individual to interact effectively in cross-sectional situations.

PROCEDURES:

I. The CCC will be represented by five categories of members to ensure that the various ethnic and cultural groups, and persons and providers with knowledge and experience can articulate their perspectives and concerns:

   A. Consumers;

   B. Family members;

   C. Community service providers;

   D. Local management staff of HCA BHS; and

   E. Community representatives.

II. The CCC will have a minimum of two members from each category that reflects the county's demographics of ethnic and cultural diversity.

III. The CCC and the Ethnic Services Manager (ESM) will assess CCC membership annually to ensure that all five categories are represented, and will actively work to suggest persons who can be of benefit to the ethnic and cultural community, and consumers of HCA BHS programs and services.

IV. The CCC members should live and/or work in the Orange County area.

V. The ESM will submit an annual report to the HCA BHS Director, indicating pertinent population trends and developments that should be represented in the CCC membership.

VI. At least annually, the Multicultural Development Program should offer new CCC members appropriate orientation and training regarding the objectives, policies and programs of HCA BHS.

VII. CCC membership will be inclusive to community members interested in participating. CCC members who have not attended for several meetings will be asked if they wish to continue their CCC membership.

VIII. The CCC Co-Chairs (ESM and appointed Co-Chair) report to the HCA BHS Director.

IX. CCC Goals:

A. To provide BHS with community perspectives in culturally competent program functioning and new and/or changed programs needed for county residents to assure optimal performance outcomes.

B. To review the cultural competence effectiveness of new BHS programs and services and proposed changes that impact the access to services for both county operated and county contracted programs.

X. Principles of CCC Formation and Cooperation:

A. The CCC shall consist of not less than 10 members, with at least two members representing each of the five categories of membership. New members should be recruited to ensure that each category is fully represented. While there is no fixed size limit on the number of members for the CCC, the CCC Co-Chairs can set limits for the size of each group to assure that each can function at optimal levels.

B. The CCC annual report to the BHS Director should include particular attention to the Committee's activities, projects, and accomplishments. In addition, problems, obstacles, needs, new issues, and changing priorities should be addressed that pertain to Cultural Competence.

C. The CCC is Co-Chaired by the ESM and a member of the committee. The Co-Chair will be nominated by the CCC and appointed by the ESM.

D. The ESM and CCC Co-Chair will function as a team, dividing responsibilities and activities in a complementary manner in order to promote full and complete discussion and deliberation by members and to increase CCC productivity and effectiveness.

E. The CCC will form sub-committees and task forces as appropriate and necessary each year for conducting cultural competency requirements and activities.

F. The CCC may adopt its own bylaws and procedures to facilitate its work, as long as there is no conflict with Departmental policy, County/State statutes, regulations and policies.

G. The CCC should participate in the Countywide MHSA Planning Committee to foster consensus on the planning strategies and directions to be taken by HCA BHS.

XI. CCC Meetings:

A. Meetings may occur as needed during the year, at places and times to be determined by the CCC, based on objectives, issues to be addressed and tasks to be accomplished.

B. All of the CCC general meetings are to be open to the public.

C. Brief minutes (including records of attendance, proposals, recommendations, etc.) shall be taken at every general and special meeting of the CCC. Each matter reported should reflect the consensus of the Committee as well as alternative perspectives. Copies of the minutes should be forwarded to the BHS Director and other BHS management staff, Co-Chairpersons of the CCC, the Mental Health Board, the Alcohol Drug Advisory Board and other staff as appropriate.

D. The ESM will encourage full and appropriate participation and involvement of all CCC members. Clerical support and services shall be made available as appropriate and needed to further the work of the CCC and its sub-committees.

E. The ESM, will take responsibility for providing the CCC with a range of appropriate, informational materials concerning HCA BHS, County and State guidelines, policies, procedures, evaluations and programs. The ESM will endeavor to assure that these and other materials are received by CCC's and distributed to members in a timely manner.

Policy 02.01.07 - Meeting Deaf and Hard of Hearing Language Needs at Key Points of Contact

Health Care Agency **Mental Health and** **Recovery Services** **Policies and Procedures**	Section Name: Sub Section: Section Number: Policy Status:	Client's Rights Cultural Competency 02.01.07 ☐New ☒Revised

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

SUBJECT: Meeting Deaf and Hard of Hearing Language Needs at Key Points of Contact

PURPOSE:

To ensure that all Deaf and Hard of Hearing Medi-Cal beneficiaries receiving services in Orange County Mental Health and Recovery Services (MHRS) within the Mental Health Plan (hereby referred to as Orange MHP) and Drug Medi-Cal Organized Delivery System (DMC-ODS) have access to linguistically appropriate services through staff or interpreters proficient in beneficiary's primary language, e.g., American Sign Language (ASL). This policy also applies to non-Medi-Cal clients receiving services within MHRS.

POLICY:

All MHRS beneficiaries/clients shall have access to linguistically appropriate services.

SCOPE:

This policy apply to all functions of MHRS County and County contracted programs involved in the linkage and treatment of beneficiaries/clients receiving services.

REFERENCES:

Code of Federal Regulations (CFR), Title 28, Part 35, ADA of 1990

California Code of Regulations (CCR), Title 9, Chapter 11, Section 1810.410 (a) (2) (b) (e) (3)

DMH Information Notice No. 02-03 Addendum for Implementation Plan for Phase II Consolidation of Medi-Cal Specialty Mental Health Services-Cultural Competence Plan Requirements

Dymally-Alatorre Bilingual Services Act 1973

PROCEDURE:

I. As defined in the Orange MHP and in the DMC-ODS, each service site is considered a key point of contact for Orange County.

II. Auxiliary aides must be made available to Deaf and Hard of Hearing beneficiaries/clients. Aides to be used will be determined in consultation with the beneficiary/client to determine what aide(s) is (are) the best fit. These aides may include but are not limited to the following:

A. Qualified sign language interpreter

B. Note takers

C. Screen readers

D. Written materials

E. Telephone handset amplifiers

F. Assistive listening systems or devices

G. Hearing aid-compatible telephones

H. Communication boards

I. Open or closed captioning, including real-time captioning

J. Video remote interpreting services (VRI)

K. voice, text and video-based telecommunication products and systems

L. Videotext displays

M. Description of visually presented materials

N. Exchange of written notes

O. Video relay services

P. Other effective methods of making orally delivered materials available to the Deaf and people who are hard of hearing.

III. For Non-Emergency Sign Language Interpreting Service, the MHRS County staff shall contact the MHRS contracted interpreting agency (current agency information available at HCA Forms under MHRS Forms-Language Service ASL Interpretation - Instructions) with requests for ASL interpreters during routine clinic hours. The Deaf Services Coordinator may be contacted for assistance with the request procedure if needed. A short notice fee will be applied by the contracting agency, if a request is made in less than 72 hours for non-emergency counseling services. County Contracted providers will need to contract with an interpreting agency to arrange for Non-Emergency Sign Language Interpreting Services.

IV. For Emergency Sign Language Interpreting Service when the primary MHRS contracted agency is unable to provide services or is unavailable, if the immediate need arises during the day, on a weekend, or after hours, the staff shall contact a secondary interpreting agency. (Secondary interpreting agency information available at HCA Forms under MHRS Forms-Language Service ASL Interpretation-Instructions). The Deaf Services Coordinator may be contacted for assistance with the request procedure during business hours, if needed. The higher fees are applied to all emergency cases. County Contracted providers will need to contract with an interpreting agency to arrange for Emergency Sign Language Interpreting Services.

V. Each key point of contact in MHRS shall be provided with a roster of linguistically proficient staff/interpreters throughout the Health Care Agency (HCA). This language roster shall be updated annually.

VI. Clinics with deaf or hard of hearing staff are familiar with and able to utilize Video Relay Services (VRS) in order to take calls or make calls to deaf or hard of hearing beneficiaries/clients in Orange County. Any caller using the deaf or hard of hearing's videophone numbers will be automatically connected to VRS.

VII. Initial access logs maintained at the service sites shall indicate whether an interpreter was needed and the response to offers of interpreting services.

VIII. Signage shall be posted at each MHRS County and County Contracted clinic indicating interpreting Services for the Deaf and Hard of Hearing are available free of charge to each beneficiary.

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

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

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

Policy 02.06.02 - Informing Materials for Mental Health Plan Beneficiaries/Clients and Intake/Advisement Checklist

Health Care Agency **Mental Health and** **Recovery Services** **Policies and Procedures**	Section Name: Sub Section: Section Number: Policy Status:	Client's Rights Informing Materials 02.06.02 ☐New ☒Revised	
	SIGNATURE	DATE APPROVED	
Director of Operations Mental Health and Recovery Services	Signature on File	2/22/2023	

SUBJECT:	Informing Materials for Mental Health Plan Beneficiaries/Clients and Intake/Advisement Checklist

PURPOSE:

To provide County of Orange Mental Health and Recovery Services (MHRS) beneficiaries/clients with appropriate informing materials and accurately document the provision of these materials as well as Advance Directives.

POLICY:

Required distribution of informing materials shall be documented so as to be easily audited. The Advance Directives shall be documented as required in CFR 42, Chapter 4.

SCOPE:

This policy applies to all beneficiaries/clients of the Orange County Mental Health Plan (MHP) and will be followed by all Mental Health and Recovery Services (MHRS) County and County Contracted staff providing Specialty Mental Health Services (SMHS).

REFERENCES:

MHRS P&P 02.06.01 Advance Directives

MHRS P&P 02.05.01 Notice of Privacy Practices

Title 42, Code of Federal Regulations (CFR),§422.128

FORM:

Health Care Agency Mental Health Plan (MHP) Intake/Advisement Checklist, F346-753

PROCEDURE:

I. All newly admitted beneficiaries/clients in the Mental Health Plan shall be given, at a minimum, the following materials:

A. Notice of Privacy Practices (NPP)

B. The Advance Directives Information Sheet (For adults only)

C. The MHP Beneficiary Handbook

D. MHP Provider Directory

II. If, at the time of admission, the beneficiary/client is unable to accept and utilize these materials due to the beneficiary/client's emotional condition, then the information shall be given as soon as the beneficiary/client is able to accept and utilize it.

III. These materials shall be available in the threshold languages in hard copy and in audio version.

IV. MHRS Staff shall provide the materials in the appropriate language and/or format to meet the beneficiary/client's needs.

V. MHRS Staff shall actively inquire of each newly admitted consumer whether the beneficiary wishes to have the informing materials in audio version. The response shall be documented on the MHP Intake/Advisement Checklist.

VI. Completion of the Mental Health Plan (MHP) Intake/Advisement Checklist:

A. The provision of the above materials shall be documented using the Mental Health Plan Intake/Advisement Checklist (Advisement Checklist).

B. The Intake/Advisement Checklist shall be completed each time a beneficiary is admitted for mental health services. MHRS Staff shall:

1. Inquire and document the language in which the beneficiary/client would like to receive the informing materials.

2. Offer or ask if the beneficiary/client would like to receive the informing materials in audio version and in their preferred language.

a) Have the beneficiary/client document by checking "yes" or "no" to this question.

3. For all MHP beneficiaries/clients, have the beneficiary/client/legal guardian check "yes" or "no" to the question to document receipt of each of the following informing materials:

a) The MHP Beneficiary Handbook

b) MHP Provider Directory

c) Notice of Privacy Practices (NPP)

d) Completed Receipt of the Notice of Privacy Practices

e) Car Seat Regulation

f) Offered Voter Registration (over 18 consumers or guardian)

VII. Advance Directives

A. All beneficiaries 18 years and older shall be provided with, and note the receipt of, the Advance Health Care Directives Information Sheet on the Intake/Advisement Checklist.

B. All beneficiaries/clients shall be informed that at any time they develop an Advance Directive or want to update the one on file, they can provide the revision and the MHRS staff shall place the update in the beneficiary's record (reference MHRS P&P 02.06.01 Advance Directives).

VIII. Signatures

A. Once the Intake/Advisement Checklist has been completed both the beneficiary/legal guardian and MHRS staff are to sign and date the Intake/Advisement Checklist and file in the beneficiary/client record.

Policy 03.01.03 - Trainings Specifically Pertaining to Cultural Competency

Health Care Agency	Section Name:	Human Resources
Behavioral Health Services	Sub Section:	Staff Development
Policies and Procedures	Section Number:	03.01.03
	Policy Status:	☐New ☒Revised

	SIGNATURE	DATE APPROVED
Director of Operations Behavioral Health Services	Signature on File	9/21/16

SUBJECT: Trainings Specifically Pertaining to Cultural Competency

PURPOSE:

The purpose of this policy is to establish a uniform method of reviewing the nature and adequacy of Behavioral Health Services (BHS) trainings that address cultural issues and to define class attendance requirements for all County and County Contracted BHS staff providing clinical care.

POLICY:

BHS trainings that address cultural issues shall be of the highest possible quality. Toward this end, the Multicultural Development Program shall provide review, feedback and consultation on all trainings that address cultural issues prior to the training date.

SCOPE:

This applies to all BHS County and County Contracted programs.

REFERENCES:

County of Orange Health Care Agency, Behavioral Health Services, Cultural Competency Plan Updated, 2010

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

California Welfare & Institutions Code Section 5600.2 (g)

California Welfare & Institutions Code Section 5600.9 (a)

National CLAS Standards, 2013

SUBJECT: Trainings Specifically Pertaining to Cultural Competency

PROCEDURES:

I. Proposed trainings that meet the criteria of addressing cultural issues shall be forwarded to the Multicultural Development Program for review and comment at least two months prior to the training event.

II. An outline and instructor vitae for the proposed course shall be submitted to the Multicultural Development Program for review.

III. The Multicultural Development Program shall review the materials and provide feedback to the training coordinator within three working days.

   A. Feedback shall include at a minimum suggestions, if any, regarding cultural content.

IV. The Multicultural Development Program shall provide consultation as needed to improve the quality of trainings that address cultural issues.

V. It is required that all BHS County and County Contracted staff will complete a mandatory annual cultural competence training.

GOVERNING STRUCTURE

BEHAVIORAL HEALTH SERVICES

Behavioral Health Equity Committee (BHEC)

GOVERNING STRUCTURE

I. Vision

Our efforts are focused on the promotion of behavioral health equity for unserved and underserved racial and ethnic communities, as well as lesbian, gay, bisexual, transgender, questioning/queer and intersex (LGBTQI), Veterans, deaf and hard of hearing and other cultural groups. Based on SAMHSA's Behavioral Health Equity[1] tips, key strategies will be focused on data, policy, quality, and communication:

a) **The *data strategy* utilizes available federal, state, county and community data to identify, monitor, and respond to behavioral health disparities.**

b) **The *policy strategy* promotes policy initiatives that strengthen the impact of BHS programs in advancing behavioral health equity.**

c) **The *quality practice and workforce development strategy* helps BHS to expand the behavioral health workforce capacity to improve outreach, engagement, and quality of care for unserved and underserved populations.**

d) **The *communication strategy* increases awareness and access to information about behavioral health disparities and strategies to promote behavioral health equity.**

The BHEC will further develop and make recommendations around these key strategies to be included in the Cultural Competency Plan annual update.

II. Role and Purpose

The BHEC seeks to impact and advise BHS policies and initiatives by:

a) **Strategically focusing on racial, ethnic, LGBTQI and other cultural groups in BHS programs**

b) **Using a data-informed quality improvement approach to address racial and ethnic disparities in BHS programs**

c) **Recommending that BHS policies, initiatives, and collaborations include emphasis on decreasing disparities**

d) **Proposing innovative, cost-effective training strategies to a diverse workforce**

The BHEC will satisfy the above role by conducting the following activities to promote increased cultural awareness, sensitivity and responsiveness in OC's behavioral health services:

a) **Culturally and linguistically appropriate services: The BHEC will advise Orange County Behavioral Health Services on ways to improve access and engagement with individuals who have Limited English Proficiency (LEP) and/or other communication needs.**

[1] https://www.samhsa.gov/behavioral-health-equity

b) **Trainings: The BHEC, through the Multicultural Development Program (MDP), works with Behavioral Health Training Services to create and coordinate trainings focused on cultural sensitivity, awareness and humility; and to ensure that other trainings include cultural considerations related to the subject of the training and that such considerations are included as one of the training objectives.**

c) **Leadership: The BHEC will work closely with the BHS leadership in promoting elimination of community health disparities and inequity in Behavioral Health Services.**

III. Operationalized Values

The BHEC will strive to work in a manner that is consistent with its values:

a. **Equity** – ***Attaining the highest level of behavioral health for all by addressing root causes of inequities.*** **The BHEC's membership, activities, and planning processes will be inclusive of the diverse communities in Orange County, especially those where data indicate to have disparities in health.**

b. **Inclusive** – ***Health includes physical, mental, spiritual, economic, environmental, and educational factors that contribute to it.*** **The BHEC's membership and planning processes will be inclusive of a broad range of perspectives representing the various factors that contribute to health.**

c. **Collaborative** –***requires a partnership between many entities including residents, health care providers, community-based organizations, faith-based organizations, schools, businesses, and government.*** **The BHEC will conduct its activities in a collaborative manner and actively engage community partners in working towards its shared vision and goals.**

d. **Multi-dimensional** – ***Culture must be understood at the individual, family, and system levels.*** **The BHEC will ensure that planning processes consider the various dimensions of culture.**

IV. Membership

a. **Representation: The BHEC is composed of individuals who are dedicated to cultural diversity and equity and come from a variety of backgrounds. The BHEC shall be a body representing a broad cross-section of interests and experiences. The BHEC does not limit membership from for-profit entities. Joining the BHEC as a means for solicitation or using meetings as a forum for solicitation is prohibited and may be cause for removal. The BHEC shall strive to include at minimum:**

i. **Representation from the following suggested organizations:**
   - **Orange County Health Care Agency, Public Health Services**
   - **Orange County Health Care Agency, Behavioral Health Services**
   - **Orange County Social Services Agency**
   - **Orange County Department of Education**
   - **Cal Optima**
   - **Children and Families Commission of Orange County**
   - **Orange County 211**

ii. **Representatives with the following expertise or perspectives:**
   - **Community based organizations**
   - **Outreach and engagement programs**
   - **Bilingual/bi-cultural**
   - **Black/African Americans**
   - **LGBTQI**

Veterans
Faith-based organizations
Community health center
Healthcare provider or other affiliation
Local government
Public safety
Transportation
Universities, colleges, and other research institutions
Advocacy organizations

iii. Individuals, including community members, who can represent perspectives of populations identified as having lived experience with the Behavioral Health system. Examples include, but are not limited to, persons with behavioral health conditions or family members of a person with a behavioral health condition.

iv. Other at-large members involved in assessing and/or promoting cultural diversity and equity

b. Term: There is no limit to the number of years a member may serve. Membership will be renewed based on members' interest and ability to serve every two years.

c. Selection: Individuals or representatives of organizations wishing to participate on the BHEC may request to join the BHEC as a voting member by submitting a written application. The application will be reviewed and voted upon by the BHEC Steering Committee. Applications approved by the BHEC Steering Committee will be forwarded via email to BHEC members for review prior to the next BHEC meeting. The BHEC will strive to come to consensus about approval of applications. When consensus cannot be reasonably reached, a vote of BHEC members will be conducted via email. Approved applicants will join the BHEC as a voting member at the first BHEC meeting after their application is approved.

d. Member Responsibilities: In order to complete these tasks, BHEC members have the following responsibilities:

i. Participate in scheduled meetings. Meetings will occur at least three times a year. Attendance to meetings will be monitored. The BHEC Steering Committee may contact members with excessive absences to discuss their interest and ability to serve on the BHEC.
ii. Commit to serving on at least one BHEC work group.
iii. Communicate information about the activities of the BHEC to the community and partners.
iv. Assist the BHEC in identifying resources to support the work of the BHEC.
v. Support BHEC activities, such as data collection, town halls, etc.

V. Officers

a. Co-Chairs: There shall be two Co-Chair positions. These shall be one **Behavioral Health Services Co-Chair** position filled by Ethnic Services Manager or a designated representative from Orange County Health Care Agency, Behavioral Health Services and one **Community Co-Chair**, selected by the BHEC from among the members unaffiliated with the County of Orange and its agencies.

b. Community Co-Chair Term: The term for the Community Co-Chairs shall run for two years from January to December.

c. Community Co-Chair Selection: The Community Co-Chair shall be selected by the BHEC by majority vote at the last scheduled BHEC meeting before the start of a new term, usually in December.

d. Officer Responsibilities:

i. **Behavioral Health Services Co-Chair:** The Ethnic Services manager or a representative of Orange County Health Care Agency, Behavioral Health Services shall serve as a permanent Co-Chair of the BHEC. In collaboration with the Community Co- Chair, the BHS Co-Chair will set meeting agenda; facilitate BHEC meetings; establish committees and ad-hoc work groups as needed. The BHS Co-Chair shall rotate the responsibilities of chairing individual meetings with the other BHEC Co-Chair.

ii. **Community Co-Chair:** The BHEC shall select a Co-Chair from members unaffiliated with the County of Orange agencies participating on the BHEC. The Community Co-Chair, in collaboration with the Behavioral Health Services Co-Chair, will set the meeting agenda; facilitate BHEC meetings; establish committees and ad-hoc work groups as needed. Each Community Co-Chair shall rotate the responsibilities of chairing individual meetings with the BHS Co-Chair.

VI. Voting

The BHEC will strive to govern by consensus. When consensus cannot be reasonably reached, official actions taken by the BHEC shall be adopted by a majority vote. Each individual member present, not by proxy, will have one vote.

VII. Meetings

The BHEC shall schedule meetings at least three times per year at the discretion of the BHEC Steering Committee. Meetings will be open to the public, but only members may vote.

VIII. Committees and Work Groups

a) **Steering Committee:** The BHEC Steering Committee will be charged with the general oversight of affairs of the BHEC including review and setting of the BHEC agenda and review and recommendation of BHEC member applications. Seats on the BHEC Steering Committee will be determined by the BHEC and may include Co-Chairs, representatives from each committee, and other individuals such as representation from the school districts, hospital, city government, and academic institutions and representation of specific populations.

b) **Work Groups:** The BHEC shall establish or identify work groups, or task forces as it deems necessary to accomplish its purpose and role. This may include establishing or designating work groups to implement strategies related to priorities identified in the Cultural Competence Plan.

c) **Suggested work groups:** Community Relations and Education; Spirituality; Outreach and Engagement to Black/African Americans, populations who speak in one of the threshold languages or have Limited English Proficiency (LEP) and or other communication needs; Veterans and Military; LGBTIQ

IX. Additional rules and procedures

The BHEC may establish any rules or procedures it so deems appropriate by consensus or majority action of the BHEC.

BY LAWS

Orange County Behavioral Health Equity Committee
BYLAWS

Adopted July 2021

ARTICLE I

Name

The name of this board shall be THE ORANGE COUNTY BEHAVIORAL HEALTH EQUITY COMMITTEE, hereinafter referred to as the "BHEC"

ARTICLE II

Section 1:

Authority and Purpose

The BHEC is authorized by the State of California through […] supporting Criterion #4 of the Cultural Competence Plan—

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

Rationale: A culturally competent organization views responsive service delivery to a community as a collaborative process that is informed and influenced by community interests, expertise, and needs. Services that are designed and improved with attention to community needs and desires are more likely to be used by patients/consumers, thus leading to more acceptable, responsive, efficient, and effective care (CLAS, Final Report).

Section 2:

In accordance with applicable federal and state statutory and regulatory requirements, the BHEC shall:

a. Act in an advisory capacity to the Director of Behavioral Health Services, hereinafter referred to as "Behavioral Health Services."
b. Review, evaluate and make recommendations regarding the community's mental health needs, services, facilities, and special problems, keeping the goals of the BHEC as priority.

c. Review and approve the procedures used to ensure diverse stakeholder involvement in all stages of the County's mental health planning process.
d. Provide an annual report to the Director of Behavioral Health Services
e. Develop the Cultural Competence Plan update and oversee its implementation by BHS

Section 3:

The BHEC seeks to impact and advise BHS policies and initiatives by:

a) Strategically addressing equity among racial, ethnic, LGBTQI and other cultural groups in BHS programs
b) Using a data-informed quality improvement approach to address racial and ethnic disparities in BHS programs
c) Recommending that BHS policies, initiatives, and collaborations include emphasis on decreasing disparities
d) Proposing innovative, cost-effective training strategies to a diverse workforce

The BHEC will satisfy the above role by conducting the following activities to promote increased cultural awareness, sensitivity, and responsiveness in OC's behavioral health services:

a) Culturally and linguistically appropriate services: The BHEC will advise Orange County Behavioral Health Services on ways to improve access and engagement with individuals who have Limited English Proficiency (LEP) and/or other communication needs.
b) Trainings: The BHEC, through the Multicultural Development Program (MDP), works with Behavioral Health Training Services to create and coordinate trainings focused on cultural sensitivity, awareness and humility; and to ensure that other trainings include cultural considerations related to the subject of the training and that such considerations are included as one of the training objectives.
c) Leadership: The BHEC will work closely with the BHS leadership in promoting elimination of community health disparities and inequity in

Behavioral Health Services – both county and contracted programs.

Section 4:

The BHEC will strive to work in a manner that is consistent with the following values:

a. **Equity** – *Attaining the highest level of behavioral health for all by addressing root causes of inequities.* The BHEC's membership, activities, and planning processes will be inclusive of the diverse communities in Orange County, especially those where data indicate to have disparities in health.
b. **Inclusive** – *Health includes physical, mental, spiritual, economic, environmental, and educational factors that contribute to it.* The BHEC's membership and planning processes will be inclusive of a broad range of perspectives representing the various factors that contribute to health.
c. **Collaborative** –*requires a partnership between many entities including residents, health care providers, community-based organizations, faith-based organizations, schools, businesses, and government.* The BHEC will conduct its activities in a collaborative manner and actively engage community partners in working towards its shared vision and goals.
d. **Multi-dimensional** – *Culture must be understood at the individual, family, and system levels.* The BHEC will ensure that planning processes consider the various dimensions of culture.

ARTICLE III

Membership

Section 1:

Representation: The BHEC is composed of individuals who are dedicated to cultural diversity and equity and come from a variety of backgrounds. The BHEC shall be a body representing a broad cross-section of interests and experiences. The BHEC does not limit membership from for-profit entities. Joining the BHEC as a means for solicitation or using meetings as a forum for solicitation is prohibited

and may be cause for removal. The BHEC shall strive to include at minimum:

i. Representation from the following suggested organizations:
   - Orange County Health Care Agency, Public Health Services
   - Orange County Health Care Agency, Behavioral Health Services
   - Orange County Social Services Agency
   - Orange County Department of Education
   - Cal Optima
   - Children and Families Commission of Orange County
   - Orange County 211

ii. Representatives with the following expertise or perspectives:
   - Community based organizations
   - Outreach and engagement programs
   - Bilingual/bi-cultural
   - Black/African Americans
   - LGBTQI
   - Veterans
   - Faith-based organizations
   - Community health center
   - Healthcare provider or other affiliation
   - Local government
   - Public safety
   - Transportation
   - Universities, colleges, and other research institutions
   - Advocacy organizations

iii. Individuals, including community members, who can represent perspectives of populations identified as having lived experience with the Behavioral Health system. Examples include, but are not limited to, persons with behavioral health conditions or family members of a person with a behavioral health condition.

iv. Other at-large members involved in assessing and/or promoting cultural diversity and equity

Section 2:

Term: There is no limit to the number of years a member may serve. Membership will be renewed based on members' interest and ability to serve every two years.

Section 3:

Selection: Individuals or representatives of organizations wishing to participate on the BHEC may request to join the BHEC as a voting member by submitting a written application. The application will be reviewed and voted upon by the BHEC Steering Committee. Applications approved by the BHEC Steering Committee will be forwarded via email to BHEC members for review prior to the next BHEC meeting. The BHEC will strive to come to consensus about approval of applications. When consensus cannot be reasonably reached, a vote of BHEC members will be conducted via email. Approved applicants will join the BHEC as a voting member at the first BHEC meeting after their application is approved.

Section 4:

Member Responsibilities: In order to complete these tasks, BHEC members have the following responsibilities:

i. Participate in scheduled meetings. Meetings will occur at least three times a year. Attendance to meetings will be monitored. The BHEC Steering Committee may contact members with excessive absences to discuss their interest and ability to serve on the BHEC.
ii. Commit to serving on at least one BHEC work group.
iii. Communicate information about the activities of the BHEC to the community and partners.
iv. Assist the BHEC in identifying resources to support the work of the BHEC.
v. Support BHEC activities, such as data collection, town halls, etc.

ARTICLE IV

Officers

Section 1:

a. **Co-Chairs:** There shall be two Co-Chair positions. These shall be one **Behavioral Health Services Co-Chair** position filled by the Behavioral Health Services Director or a designated representative from Orange County Health Care Agency, Behavioral Health Services and one **Community Co-Chair**, selected by the BHEC community members from among the members unaffiliated with the County of Orange and its agencies.

b. **Community Co-Chair Term:** The term for the Community Co-Chairs shall run for two years from January to December.

c. **Community Co-Chair Selection:** The Community Co-Chair shall be selected by the BHEC by majority vote of BHEC community steering committee members at the last scheduled BHEC meeting before the start of a new term, usually in December.

d. **Officer Responsibilities:**

   i. **Behavioral Health Services Co-Chair:** The Ethnic Services manager or a representative of Orange County Health Care Agency, Behavioral Health Services shall serve as a permanent Co-Chair of the BHEC. In collaboration with the Community Co- Chair, the BHS Co-Chair will set meeting agenda; facilitate BHEC meetings; establish committees and ad-hoc work groups as needed. The BHS Co-Chair shall rotate the responsibilities of chairing individual meetings with the other BHEC Co-Chair.

   ii. **Community Co-Chair:** The BHEC shall select a Co-Chair from members unaffiliated with the County of Orange agencies participating on the BHEC. The Community Co-Chair, in collaboration with the Behavioral Health Services Co-Chair, will set the meeting agenda; facilitate BHEC meetings; establish committees and ad-hoc work groups as needed. Each Community Co-Chair shall rotate the responsibilities of chairing individual meetings with the BHS Co-Chair.

Section 2:

Meetings: Meetings will be co-led by the Co-Chairs with Co-Chairs alternating in facilitating agenda items and jointly developing the agenda prior to the meeting. A consensus process will be used for making decisions as illustrated in Exhibit A. In the event a decision cannot be reached through this process, then a deliberative discussion will be conducted using Rosenberg's Rules of Order as published by the California League of Cities.

Community members will have opportunities to attend quarterly steering committee meetings and participate through polls/chat, and provide public comments as directed by Co-Chairs.

ARTICLE V

Committees

The Co-Chairs shall appoint members of standing committees, such as ad hoc,task force, work group, or other entities as necessary to carry out the responsibilities of the BHEC.

Section 2:

There shall be a Steering Committee comprised of the Co-Chairs, Committee Chairpersons, and others as appointed by the Co-Chairs. The Steering Committee shall carry out any responsibilities delegated to it by the BHEC and act in emergencies in any way it deems necessary when there is not time for the entire BHEC to act.

Section 3:

Committee chairs or their delegates shall report to the BHEC at least once a month.

ARTICLE VI

Meetings

Section 1:

General meetings shall be held each month, the time and place to be announced prior to adjournment of the preceding meeting.

Section 2:

Special meetings may be held by giving 48-hour notice to all members at the call of the Co-Chairs or of a majority of the BHEC.

Section 3:

All meetings will be open to the public as much as possible.

Section 4:

A simple majority of the BHEC shall constitute a quorum and a vote of a simple majority of that quorum shall constitute a vote of the BHEC when a decision cannot be reached by consensus through the process outlined in Exhibit A.

Section 5:

All general meeting Agenda items which require a vote of the BHEC must be submitted to the Chairperson one (1) week in advance of the meeting.

ARTICLE VII

Adoption and Amendment

Section 1:

These Bylaws and amendments thereto shall be recommended to the BHEC by the Steering Committee.

Section 2:

Amendments to the bylaws may be introduced and voted upon by the BHEC at a regular meeting so long as such amendments are e-mailed to all members at least one (1) week in advance of the meeting.

APPENDIX III: SAMPLE OF TRAINING EVALUATION FORM

Cultural Competence 3.0 Online Training Survey

Orange County Health Care Agency
MHSA Office Division
Behavioral Health Training Services

Training:	**Cultural Competency Training 3.0 - Addressing Unconscious Bias in the Workplace**
Presenter(s):	Various
Date:	Ongoing
Time:	Ongoing
CE or CME Credits:	None

[Adjust instructions as needed depending on if CEs/CMEs are being given]
Instructions: This year's training fulfills the State of California's requirement for a Cultural Competency training to be completed by each County- and Contract-operated BHS staff member. To receive credit for this online training, please complete the mandatory evaluation form. Your input, which shall remain anonymous, will help us determine the effectiveness of this training and improve training program quality. Following the evaluation, you will be directed to a credit documentation form and will then be able to access the certificate.

1. **How much did you learn as a result of this training? [For trainings where CEs are not provided, change 'CE program' to 'training']**
   ☐ 1- Very Little ☐ 2 ☐ 3 ☐ 4 ☐ 5- Great Deal

2. **How useful was the content of this training for your practice or other professional development? [For trainings where CEs are not provided, change 'CE program' to 'training']**
   ☐ 1- Not Useful ☐ 2 ☐ 3 ☐ 4 ☐ 5- Extremely Useful

3. **Do you intend to make changes or apply what you have learned from this training?**
   ☐ Yes ☐ Change already in place ☐ Not relevant to my work

4. **What changes do you intend to make, if any?**
   _____

5. **What barrier(s) do you expect to encounter in your attempts at change? *Please select all that apply.***
   ☐ No barriers ☐ Not ready to make changes ☐ No time to apply/practice new changes
   ☐ Change is not possible in current condition/system ☐ Other (please specify): _____

6. **Educational trainings should be free of marketing or sales of products or services. This type of *bias* is defined as the promotion or sale of products or services that serves one's professional or financial interests. How much bias was presented during this educational training?**
   ☐ None ☐ Very Low ☐ Low ☐ Moderate ☐ High ☐ Very high

7. **What was most useful and/or helpful to you with this training? *Please select all that apply.* [PRE-RECORDED TRAININGS]**
   ☐ The training was easy to follow ☐ The training information ☐ The length of the training
   ☐ The resources provided ☐ Other (please specify) _____

8. **Please rate the quality of today's training: [REQUIRED]**

	Poor	Fair	Good	Very Good	Excellent	N/A
The information discussed during the training.	☐	☐	☐	☐	☐	☐
The training promotional material was informative and accurate (e.g., flyers).	☐	☐	☐	☐	☐	☐
Visuals aids (e.g., slides, handouts, videos, pictures).	☐	☐	☐	☐	☐	☐
Audio/Sound used during the training.	☐	☐	☐	☐	☐	☐

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PLEASE ALSO COMPLETE THE REVERSE SIDE. Thank you.

The location of the training met my needs.	☐	☐	☐	☐	☐	☐
The location where I took the training was comfortable and accessible.	☐	☐	☐	☐	☐	☐
The overall quality of this training.	☐	☐	☐	☐	☐	☐

9. **Based on your experience(s) today, please select how much you agree or disagree with the following statements regarding the quality of the training: [PRE-RECORDED TRAININGS]**

	Strongly Disagree	Disagree	Agree	Strongly Agree	N/A
Delivery of information was clear.	☐	☐	☐	☐	☐
The training was engaging/kept my interest.	☐	☐	☐	☐	☐
The online training clearly outlined presenter/staff contact information in case there were follow-up questions.	☐	☐	☐	☐	☐
Information was presented in a fair and balanced manner.	☐	☐	☐	☐	☐
Information presented was current.	☐	☐	☐	☐	☐
Information presented was accurate.	☐	☐	☐	☐	☐
The training was easy to navigate (going from one section of the training to another, being able to go back, if needed).	☐	☐	☐	☐	☐
Enough time was provided to reflect on the topics that were presented.	☐	☐	☐	☐	☐
The presenter(s) communicated knowledge of the subject.	☐	☐	☐	☐	☐

10. **Based on my experience(s) with this training: [REQUIRED]**

	Strongly Disagree	Disagree	Agree	Strongly Agree	N/A
I would recommend this training to someone I know.	☐	☐	☐	☐	☐
The staff treated me with courtesy and respect during this training.	☐	☐	☐	☐	☐
Overall, I am satisfied with this training.	☐	☐	☐	☐	☐

11. **Please provide any comment(s) about your experience and/or suggestions for this training.**

_____

PARTICIPANT INFORMATION

1. **Of the Behavioral Health (BH) personal or community roles listed below, which ones do you best identify with? *Please select all that apply.***

- ☐ Advocate for BH clients/services
- ☐ Consumer of BH services
- ☐ Community Member / General Public
- ☐ Caregiver of someone with a BH condition
- ☐ Parent of someone with a BH condition
- ☐ Other Family Member of someone with a BH condition
- ☐ I do not identify with any of these roles

2. **BHTS would like to know why you are attending today's training. Of the licensed or unlicensed occupations listed below, which ones were you seeking professional development for? *Please select all that apply.***

- ☐ Physician (MD)
- ☐ Registered Nurse (RN)
- ☐ Psychologist
- ☐ LCSW
- ☐ LMFT
- ☐ LPCC
- ☐ Case Manager
- ☐ CADC/CATC/RAS
- ☐ Intern
- ☐ Peer Support Worker
- ☐ Faith-based Partner
- ☐ School Counselor
- ☐ Teacher
- ☐ Unlicensed Staff (e.g., Associates)
- ☐ Other Licensed Staff
- ☐ Not a Service Provider

AGE

3. **What is your age?**

☐ 18-25 years ☐ 26-59 years ☐ 60+ years ☐ Decline to State

RACE / ETHNICITY *(Please select ALL of the race and ethnicity categories you identify with.)*

4. **What is your race/ethnicity?**

- ☐ American Indian / Alaska Native
- ☐ African / African American / Black
- ☐ Asian
- ☐ Pacific Islander
- ☐ Latino / Hispanic
- ☐ White / Caucasian
- ☐ Decline to State
- ☐ Other (please specify): _____

LANGUAGE – PRIMARY / PREFERRED

5. **What is your primary language?**

- ☐ Arabic
- ☐ Cantonese
- ☐ Korean
- ☐ Tagalog
- ☐ Armenian
- ☐ English
- ☐ Mandarin
- ☐ Vietnamese
- ☐ ASL
- ☐ Farsi
- ☐ Russian
- ☐ Other _____
- ☐ Cambodian
- ☐ Khmer
- ☐ Spanish
- ☐ Decline to State

GENDER INFORMATION *(Please select ONE that best describes you.)*

6. **What is your current gender identity?**

☐ Male ☐ Female ☐ Transgender ☐ Genderqueer / Non-Binary ☐ Decline to State
☐ Questioning or unsure of gender identity ☐ Another gender identity _____

Community & Agency Staff Training (WET) Evaluation Form

Training: Cultural Competency Training 3.0 – Follow Up Form

1. **Please enter your name (precisely with Last, First) as it will appear on the Certificate of Completion (example: Luna, Bella) [REQUIRED]**

2. **What is your supervisor's name (Last, First)? [REQUIRED]**

3. **What is your supervisor's email address? [REQUIRED]**

4. **Are you currently employed by a County Agency or a Community-Based Organization/Contractor (Please select ONE)? [REQUIRED]**
   - ☐ County Agency **[Complete Question 2-5 as applicable, then Skip to Question 8]**
   - ☐ Community-Based Organization/Contractor **[Skips to Question 6]**
   - ☐ I do not work for a County Agency or a Community-Based Organization/Contractor **[Skips to Question 8]**

5. **[IF *COUNTY* IS SELECTED]: At which County Agency do you currently work? [REQUIRED]**
   - ☐ Orange County CEO
   - ☐ District Attorney
   - ☐ Sheriff-Coroner
   - ☐ Office of Independent Review
   - ☐ Probation
   - ☐ Interim Public Defender
   - ☐ Child Support Services
   - ☐ Health Care Agency
   - ☐ OC Community Resources
   - ☐ Social Services Agency
   - ☐ John Wayne Airport
   - ☐ OC Public Works
   - ☐ OC Waste & Recycling
   - ☐ Assessor
   - ☐ Auditor-Controller
   - ☐ Clerk-Recorder
   - ☐ Treasurer-Tax Collector
   - ☐ Clerk of the Board
   - ☐ County Counsel
   - ☐ Internal Audit
   - ☐ OC Ethics Commission
   - ☐ Registrar of Voters
   - ☐ Other

6. **[IF *HEALTH CARE AGENCY* IS SELECTED]: In which HCA Department do you currently work? [REQUIRED]**
   - ☐ Executive Office
   - ☐ Administrative Services
   - ☐ Mental Health & Recovery Services
   - ☐ Public Health Services
   - ☐ Regulatory / Medical Health Services
   - ☐ Correctional Health Services

7. **[IF *BEHAVIORAL HEALTH SERVICES* IS SELECTED]: What is the name of your division and program? [REQUIRED]**

Name of your Division (e.g., CYBH, P&I)	Open-ended response
Name of your Program (e.g., CAT, CCSS)	Open-ended response

8. **[IF *COUNTY* IS SELECTED]: What is your role within your program? [REQUIRED]**
   - ☐ Manager/Supervisor
   - ☐ Administrative Staff
   - ☐ Direct Service Provider
   - ☐ Office/Support Staff

9. **[IF *COMMUNITY-BASED ORGANIZATION/CONTRACTOR* IS SELECTED]: What is the name of the Agency/Program you work for? [REQUIRED]**

   Open-ended response

10. **[IF *COMMUNITY-BASED ORGANIZATION/CONTRACTOR* IS SELECTED]: What is your role within your Agency/Program? [REQUIRED]**
    - ☐ Manager/Supervisor
    - ☐ Administrative Staff
    - ☐ Direct Service Provider
    - ☐ Office/Support Staff

By clicking the statement below, I attest to having viewed/completed: **[REQUIRED]**

- All 14 micro-learnings through Cornerstone Cares
- TED Talk by Verna Myers
- Implicit Association Test
- Article Titled "How to Identify and Mitigate Unconscious Bias in the Workplace"

☐ I understand and agree to the statements above.

APPENDIX IV: LIST OF CULTURALLY COMPETENT TRAININGS

Training Title	Date(s)	Training Description
2023 School-Based Mental Health Summit by Multiple Presenters	August 23, 2023	The summit will provide school-based mental health professionals with effective counseling interventions and evidence-based mental health strategies to support their work with students. Learn specific methods and techniques to apply across all tiers of school-based mental health supports directly from the experts. These sessions will focus on promoting mental health and well-being, while identifying and responding to the emerging needs of students. Research has shown that providing mental health services in a school-based setting can improve access, improve academic performance, reduce stigma and allow for early identification of mental health issues. This summit will help build capacity and support your efforts with students.
2024 Emergency Medical Services Administrators Association of California (EMSAAC) Annual Conference by Multiple Presenters	May 29 & 30, 2024	The EMS Administrators' Association of California (EMSAAC) cordially invites California's EMS leaders and professionals to join us for the EMSAAC Annual Conference 2024. EMSAAC continues to lead the way in creating conferences that are meaningful and exciting to attend. This year's theme, "O-Ohana" is a Hawaiian word for "Do Meaningful Work" embodies the concept that puts EMS professionals to work everyday to do the valuable life-saving work that we are called to do. The theme lays down the foundation for a broad variety of subject matter to interest all levels of prehospital care personnel and managers including ambulance providers, fire department personnel, military and law enforcement partners, EMS agency personnel, ED nurses, physicians and emergency preparedness coordinators, and all of you who provide life-saving EMS services to your communities. The conference includes lectures, panel discussions and opportunities to network with current leaders and innovators in EMS as well as preview new and upcoming equipment, products and services.

Training Title	Date(s)	Training Description
2024 Meeting of the Minds Mental Health Conference by Multiple Presenters	April 26, 2024	The Meeting of the Minds Mental Health Conference brings together a full spectrum of behavioral health community in Orange County to raise awareness, enhance skills, increase cultural diversity, and reduce stigma. The conference provides opportunities for attendees to network, develop new alliances, and to improve care for individuals impacted by mental illness.
Addressing Challenging Client Situations with Cultural Humility by Rosana Trivino-Perez, LCSW	May 23, 2024	Substance use disorders (SUD) are pervasive and chronic conditions that can impact the lives of any person regardless of ethnicity, race, culture, religious preference, sexuality, gender, or any other individual or group factor. Learning how to approach each individual who asks us for help with humility and a willingness to accept those individual differences is crucial to providing effective treatment for successful outcomes. This training will help participants define cultural humility and begin to raise awareness of the cultural factors that can have an impact on treatment retention and outcomes. Using the most current data and incorporating real world clinical examples, the interactive training will demonstrate the importance of incorporating cultural humility into daily clinical practice.
Breaking Down Boundaries: Psychosis and the Transgender Community by Maggie Mullen, LCSW	December 14, 2023	Experiences of significant mental health issues are common amongst the transgender and gender nonconforming (TGNC) community as a result of discrimination and bias in their environment. This training will explore the overlap between experiences of severe mental illness such as psychosis and people of trans experience. Specifically, we will focus on understanding how minority stress contributes to the development of psychosis, the role of gender-affirming care, and strategies for self-advocacy and cultivating resilience.
Client Engagement Using a Recovery Perspective by Giselle Rocha, Ph.D.	October 3, 2024	This training explores ways to enhance client engagement. The recovery-mindset and trauma-informed practice are emphasized. Tools from Motivational Interviewing and the Transtheoretical

Training Title	Date(s)	Training Description
		Model are discussed. Participants will be able to practice the concepts that are presented through vignettes and role playing to begin to gain confidence in working with substance-involved individuals.
Coping with the Journey of Mourning and Grief by Deborah Silveria, Ph.D.	February 22, 2024	In this workshop, participants will learn about the different types of grief and mourning and an overview of four major theories of how people grieve: Kubler Ross, Worden, Rando and Berger. Cultural and social identity considerations that impact grieving will also be reviewed. Participants will be able to identify the psychological and psychophysiological factors contributing to grief and mourning. Using ICD-11 and DSM-5, participants will be able to differentiate between normal grief and mourning and complicated bereavement and depression. The current and projected impact of Covid-19 on mental health, taking into consideration culture and premorbid conditions, will be presented. Participants will learn practical tools for assisting consumers in their grief process through cultural awareness, humility, and sensitivity, (using the ASK model) in building resiliency during periods of mourning. Participants will learn self-care strategies for clinicians to protect them from burnout and build vicarious resilience.
Cultivating Competency-Based Clinical Supervision for New Clinical Supervisors by Multiple Presenters	August 9 & 10, 2023	This 9-hour training, in addition to the standard 6-hour training, will meet the requirements of the BBS for new supervisors. In this presentation, new supervisors will learn the following: Supervisory Excellence model; the use of the SCRP Core Competencies in evaluation of supervisees; ways to structure a clinical supervision session; elements of Trauma-Informed Clinical Supervision; ways of managing the supervisor/supervisee relationship including the repair of ruptures; a case conceptualization model; LGBTIQ+ affirmative practices; and the use of transference and countertransference in clinical supervision. Time will be provided for vignettes, role plays, videos and other types of learning experiences.

Training Title	Date(s)	Training Description
Cultural Competency 3.0 Training	July 2023	This training provides an overview of a culturally responsive approach to incorporate into service attitudes and interactions with clients. The concepts of culture, race, ethnicity, and diversity, as well as stigma and self-stigma, are discussed. The training also demonstrates the influence of unconscious thought on our judgment as it relates to stereotyping and racism. Strategies are also provided to recognize diversity and embrace the uniqueness of other cultures beyond the mainstream American culture.
Cultural Competency 4.0 Training	Ongoing	This training provides an overview of a culturally responsive approach to incorporate into service attitudes and interactions with clients. The concepts of culture, race, ethnicity, and diversity, as well as stigma and self-stigma, are discussed. The training also demonstrates the influence of unconscious thought on our judgment as it relates to stereotyping and racism. Strategies are also provided to recognize diversity and embrace the uniqueness of other cultures beyond the mainstream American culture.
DBT Intensive with PsychWire by PsychWire	July 11, 2023	Our DBT Intensive learning pathway has been designed specifically for existing clinical teams (teams are groups of four-to-eight providers), all of whom are committed to working together to help each other deliver effective treatment. This comprehensive learning experience equips participant teams with not only the practical knowledge of DBT, but also guidance on how to effectively apply DBT in their respective treatment settings.
Dialectical Behavior Therapy – Informed Interventions for Psychosis by Maggie Mullen, LCSW, DBT-LBC	Ongoing	In this "DBTp in Depth" training, we will explore the four modules of DBT skills (distress tolerance, emotional regulation, mindfulness, and interpersonal effectiveness) and strategies to reduce emotion dysregulation in people experiencing psychosis. There will be an emphasis on skill building interventions derived from DBT, rather than a strict adherence to DBT treatment protocol that is customary for DBT programs. This

Training Title	Date(s)	Training Description
		interactive two-part presentation will introduce you to DBT skills adapted for psychotic experiences through discussion, case examples, and practical tools.
Dialectical Behavior Therapy In Depth Training by Maggie Mullen, LCSW, DBT-LBC	January 11, 2024	In this "DBTp in Depth" training, we will explore the four modules of DBT skills (distress tolerance, emotional regulation, mindfulness, and interpersonal effectiveness) and strategies to reduce emotion dysregulation in people experiencing psychosis. There will be an emphasis on skill building interventions derived from DBT, rather than a strict adherence to DBT treatment protocol that is customary for DBT programs. This interactive two-part presentation will introduce you to DBT skills adapted for psychotic experiences through discussion, case examples, and practical tools.
Exploring the Depths of Clinical Supervision by Multiple Presenters	May 23, 2024	This 6-hour clinical supervision training is intended for current clinical supervisors who seek to improve their clinical supervision skills and knowledge of competency-based clinical supervision. Time will be allotted to focus specifically on best practices regarding clinical assessment and intervention skills within the context of clinical supervision. Through this training, clinicians will review and update knowledge of the supervisory alliance, multi-cultural supervision, and legal and ethical issues. Interpersonal Process Recall and Deliberate Practice will be presented as useful models of clinical supervision that can assist in developing cognitive complexity and ability to think at a more relativistic level about their clients. Finally, updates from the Board of Psychology and Board of Behavioral Sciences will be reviewed and discussed.
How to Maintain Ethical and Legal Boundaries While Using Technology in Your Mental Health Practice by Dr. Melissa J. Westendorf	November 2 & 9, 2023	The challenges you face are clear…If you are going to be successful in your practice, you need to adapt to your clients' growing expectations of your technological competence. The problem is, technology is the most likely way you'll get caught up in a legal and ethical nightmare! This presentation will focus on the changing landscape

Training Title	Date(s)	Training Description
		of mental health and will discuss the ethical and legal compliance related to technology in mental health practice. Additionally, the presentation will explore how school-based professionals can maintain boundaries in social media, email and texting. Lastly, this presentation will provide ethical scenarios for participants to discuss and review.
Intersections Between Autism and Clinical High Risk for Psychosis by Jason Schiffman, Ph.D.	Ongoing	Schizophrenia and autism spectrum disorders have been historically linked, and even today are found to have substantial overlap in symptomatology. This presents challenges for clinical diagnosis and intervention, and points to a need for further research as a foundation that will enable clinicians to reliably delineate the common and distinct features of both disorders. This presentation will cover an overview of the current state of research in the field, including its historical context, the prevalence of this co-morbidity, working theories of the association, the overlap in diagnostic criteria, challenges in assessment, implications of co-morbidity, tips for clinical assessment and treatment, and a discussion of case-studies.
Law and Ethics: Counter Transference, Self-Disclosure, and Therapist Self-Care by Pamela Harmell	April 10, 2024	This workshop addresses therapist responsibility to ensure patient welfare in all aspects of practice. Participants will learn to deal with ethical dilemmas related to 4/10/24 training will include the topics of: (1) Counter transference (2) therapist self-disclosure (3) therapist self-care.
Law and Ethics: Cultural Humility, Tarasoff, and it's Progeny by Pamela Harmell	April 11, 2024	This workshop addresses therapist responsibility to ensure patient welfare in all aspects of practice. Participants will learn to deal with ethical dilemmas related to the topics of: (1) Cultural Humility; (2) Tarasoff and its progeny. Literature updates, along with relevant Codes of Ethics and current expert opinion will be included in all areas of discussion. This program overviews the current research findings and knowledge that inform the practice of ethical and legal practice.
LEAP Training (Listen-Empathize-Agree-Partner) by Jim Fix, Psy.D.	April 23, 2024	This course is designed to help participants address the number one reason people with severe mental illness (SMI) refuse help – anosognosia, the lack of

Training Title	Date(s)	Training Description
		awareness. Participants will be introduced to the LEAP ® (Listen-Empathize-Agree-Partner) method, an evidence-based communication approach that creates trusting and collaborative relationships that lead to engagement of treatment and services — including medication, psychotherapy, psychosocial programs, peer support, supervised housing, and to cooperate with people who are trying to help with their recovery.
Medical Directors Leadership Series by Multiple Presenters	April 10, 2024 April 17, 2024 June 12, 2024	The Medical Director Leadership Series (MDLS) is designed to empower experienced and emerging leaders by providing strategic insights, innovative solutions, and a collaborative platform to address and surmount these multifaceted challenges. Through MDLS, behavioral health leaders can confidently navigate the complexities of their roles, ensuring the delivery of quality behavioral health services while staying ahead of industry advancements.
Mental Health and Recovery Services MD/NP Series by Multiple Presenters	January 10, 2024 July 12, 2023 November 8, 2023	BHS Regularly Schedules Series: Updates and Training for MDs and NPs. This is a regularly scheduled series (RSS) designed to provide crucial program updates to Mental Health & Recovery Services (MHRS) to MD and NP staff. This time will also be used to provide other practice oriented trainings on subjects to be determined later— including such topics as implicit bias, cultural conciderations, and specific populations.
Mini SIPS: A Brief Assessment for Psychosis-Risk with Transitional Age Youth by Elizabeth Martin Bailey, Ph.D.	October 3, 2023	The program will provide an overview of psychosis and psychosis-risk syndromes. It will include a focused training of the Mini-Structured Interview for Prodromal-Risk Syndromes (Mini-SIPS), a brief assessment of psychosis-risk. There will also be a discussion of self-report assessment instruments and assessment best practices. The presentation will be geared to mental health care professions.
Neurobiology of Trauma: An Update on the Science of Trauma by Gabriella Grant, M.A.	November 28, 2023	Neurobiology shows that traumatic events affect the brain at the time of the event and over the lifespan. Once the neurobiology of trauma is understood, through a user-friendly approach, staff and agencies can better understand client reactions, better understand how to minimize re-

Training Title	Date(s)	Training Description
		traumatization and triggering interaction, and know how to use neurobiology to create safety and connection.
Nutrition and Mental Health by Dr. Kristen Allott	September 28, 2023 October 5, 2023 October 12, 2023 October 19, 2023	This presentation will provide participants with the information and tools necessary to have conversations with students and other school community members about the importance of food on mood. Participants will learn how food timing can determine whether we are in our "responsive brain" or our "reactive brain" as well as the impact of food on learning, emotional regulation, and decision-making. Participants will be given an opportunity for experiential learning.
Older Adult Mental Health Training for Professionals by Multiple Presenters	December 4, 2023	The holiday season can be hard for seniors. This training will offer an overview to help aging professionals and caregivers debunk common myths that lead to ageism and discrimination of older adults, recognize common mental health needs, identify signs of crisis for clinical referrals, and access appropriate resources to support older adults.
Promoting Early Intervention for Psychosis: Conceptual and Empirical Basis to a Community Campaign for Latinxs by Steven R. Lopez, Ph.D.	July 19, 2023	Given the barriers that underserved communities face when seeking care for early psychosis, participants will review the importance of community outreach campaigns to promote coordinated care. Because coordinated specialty services are so critical to care, this presentation addresses how to help underserved ethnic and linguistically underrepresented groups access services early in the course of psychotic disorders. And finally, participants will learn the importance of psychosis literacy and how to provide evidence to support its efficacy and effectiveness.
Promoting Early Intervention for Psychosis: Implementation, Evaluation, and Future Directions of a Community Campaign for US Latinos by Steven R. Lopez, Ph.D.	August 16, 2023	Participants will review the importance of community outreach and coordinated care, specifically as it relates to the La CLAve campaign. Participants will also learn to describe the campaign designed for the Spanish-speaking Latinx community, utilize skills to enhance psychosis literacy, and describe the findings of the La CLAve campaign. This presentation addresses how to help

Training Title	Date(s)	Training Description
		improve services for underserved ethnic and linguistically underrepresented groups early in the course of treatment.
Recent Traumatic Events Protocol (R-TEP) and Group Traumatic Events Protocol – An Advanced EMDR Training by Deborah Silveria, Ph.D.	October 3 & 4, 2023	The Recent Traumatic Episode Protocol (R-TEP) and Group Traumatic Episode Protocol (G-TEP) are part of a comprehensive approach to Early EMDR Intervention (EEI). These approaches can also be used successfully by EMDR practitioners for clients who are not ready to receive the full 8-Phase Protocol due to high levels of emotional distress. Workshop participants will learn how to apply R-TEP and G-TEP principles for early intervention in emergent trauma situations, and with clients experiencing high levels of emotional distress including those with complex trauma and dissociation. Participants will identify and apply key features, procedures, and concepts of both R-TEP and G-TEP as well as demonstrate their use through active participation within the workshop practicum setting. Participants will learn how to adapt both protocols for online tele-health formats. All clinicians trained in EMDR, especially those on the BHS Disaster Response Team should attend this training.
Seeking Safety by Multiple Presenters	Ongoing	Seeking Safety is an evidence-based, present-focused counseling model to help people attain safety from trauma and/or substance use issues. It can be conducted in group and individual modalities. It is a treatment model that directly addresses both trauma and addiction, but without requiring clients to delve into their trauma narrative (the detailed account of disturbing trauma memories), thus making it relevant to a very broad range of clients and easy to implement. Seeking Safety is highly flexible and has been successfully applied in various clinical settings to a wide variety of patients (e.g., women, men, adults, adolescents, prisoners, war veterans, outpatients, inpatients, inner-city patients, suburban patients, minorities).

Training Title	Date(s)	Training Description
Solution Focused Brief Therapy Training by Johnny S. Kim, Ph.D., LCSW	December 5 & 6, 2023	Help support students with Solution Focused Brief Therapy strategies, to address a number of concerns including behavioral and emotional issues, academic problems, social skills, and dropout prevention. This training introduces attendees to the solution-focused brief counseling as an evidence-based brief model that was developed to provide a strengths-based alternative to traditional problem-focused services. Research has shown that using this modality in school settings can be an effective intervention used to help students reach their goals, reduce the intensity of negative feelings, manage their conduct problems, and improve relationship problems.
Suicide Prevention and Intervention by Deborah Silveria, Ph.D.	Multiple Dates	In this workshop participants will learn techniques and obtain tools for assessing suicidal risk among consumers, with cultural awareness, humility, and sensitivity. They will learn crisis intervention techniques that allow them to practice to the standard of care. Evidence based therapies for working with suicidal clients will be discussed and self-care for clinicians to protect them from burnout with this population will also be discussed.
The Moral Distress and Courage of Mandated Reporters by Dr. Sarah Golomb	September 20, 2023	This virtual presentation will focus on key influences behind the role of a mandated reporter. The historical and current legal and ethical foundations will be reviewed, as well as commonly cited barriers to reporting. Participants will have an opportunity to reflect on their previous practices while preparing for future challenges. Resource guides and sample checklists will be shared in conjunction with suggested action steps.
Tools for School-Based Providers: Assessing Risk for Psychosis in Youth by Jason Schiffman, Ph.D.	November 22, 2023	The program will provide an overview of psychosis and psychosis-risk syndromes, followed by issues regarding assessment and intervention. It will include a primer on the use of the SIPs and the PRIME Screen, and touch on assessment best practices, and use of existing screening instruments. The entire presentation will be tailored to the needs of schools to provide services for those at risk for psychosis in schools.

Training Title	Date(s)	Training Description
Transgender and Gender Non-Conforming (TGNC) Health Summit: "Asi Soy Yo" Breakout Session by Jonathan Gomez, MD	July 28, 2023	The Transgender and Gender Non-Conforming Health Summit focuses on providing healthcare professionals with the latest information on HIV and STD prevention and care for TGNC individuals. The summit covers a range of topics, including epidemiology, prevention strategies, treatment options, and best practices for gender affirming and culturally competent care. The event offers an opportunity to share knowledge and network with peers, while also highlighting the unique health disparities and barriers faced by TGNC individuals in accessing healthcare. Healthcare professionals will gain the skills and knowledge necessary to provide inclusive, culturally responsive, and affirmative care to their TGNC patients.
Trauma and Parenting by Gabriella Grant	January 23, 2024	This training provides a framework to enhance parenting safety. A research-based overview, it focuses on safety, child abuse law, casework practice and the interaction between parenting and the impact of trauma and disaster on both the child and parent. It considers emerging research into the intergenerational transmission of trauma as well as practice approaches to help parents increase both physical and emotional safety with their interactions with their children.
Trauma and Spirituality by Gabriella Grant	May 21, 2024	This training explores the research showing spirituality as an evidence-based practice for trauma recovery. The information provides ethical guidelines for publicly funded employees to bring safety to spiritual practices, as determined by the client. The second part of the training looks at spiritual abuse as a unique traumatic exposure that might get missed in the publicly funded system: how to report, how to support and how to connect survivors to safe groups and peers.
Trauma Informed Strategies: A Neurodiversity-Affirming Approach by Kelly Krueger & Sabrina Thakur	April 18, 2024	In this workshop, participants will learn to define neurodiversity and implement neurodiversity-affirming approaches to working with students. They will identify the unique needs of neurodivergent students both in classrooms and in school based mental health settings. This workshop

Training Title	Date(s)	Training Description
		will review fundamental principles of interpersonal neurobiology and brain development to establish a foundational understanding of how to address behaviors on school campuses. Participants will engage in experiential learning to learn neurodevelopmentally informed strategies to address trauma on both a systemic level and within counseling sessions.
Trauma, Dissociation, and Psychosis: CBT and Other Approaches to Understanding Recovery by	February 21, 2024 and February 28, 2024	Numerous studies now provide strong evidence that psychosis can be an understandable reaction to trauma, abuse, and other adverse experiences. This seminar is designed to help you understand how this reaction occurs, and to help you learn skills which will allow you to support people in changing those reactions and in turning toward recovery. Dissociation has been identified as a factor that can mediate between adverse experiences and psychosis. You will learn how to frame dissociation as a normal response to traumatic stress which can, when extreme or misinterpreted, develop into psychosis. Then, we will explore how methods drawn from diverse sources such as CBT, the Hearing Voices Movement, mindfulness, and psychodynamic approaches can help people regain perspective and personal power. These approaches offer people a chance to ultimately heal their internal splits rather than remaining stuck in endless efforts to suppress disturbing experiences.
Trauma Informed Foundations by Gabriella Grant	May 15, 2024	This training provides line staff, managers and administrators with six key elements of a trauma-informed program. Based on the core values of SAMHSA's TIP 57, it incorporates the 2001 "Using Trauma Theory to Design Service Systems" framework. A written statement of commitment is developed to be applied on the agency-level. Additional resources are provided to assess and transform agencies to become more trauma-informed. Appropriate for all levels of staff.
Unforgettable – Though Near or Far Conference by Multiple Presenters	August 1, 2023	Focus on older adult related care and resources for Asian Americans. Typically, an underserved population in mental health support, older adults

Training Title	Date(s)	Training Description
		and their families, especially those facing financial and cultural hardships, are in need of better services and resources for care. Since our elderly are unforgettable, no matter how near or far mentally and physically they may be, the conference invites those interested in learning more about our communal role in elderly support and care. The conference is composed of 3 different workshops to redefine compassionate care for our Asian elders and address strategies to increase public knowledge and support for those facing Alzheimer's and dementia, mental health challenges, and caregiving impacts.
Veterans Conference by Multiple Presenters	October 31, 2023	The Veteran Health and Wellness Summit provides an opportunity to engage in active dialogue with colleagues on how best to address the needs of our Veterans and Military families while seeking collaboration and innovative responses to address and support those needs. We intend to accomplish this goal by discussing ways we continued to work together to help our Veterans and their families this past year, what worked, what didn't work and how we continue to build and strengthen community and collaboration as providers as well as within the veteran community itself. Our goal is to promote a collaborative community of care whose goal is to provide continuity of care for our Veterans and their families both in and out of the VA Healthcare System. No one agency can do it all by themselves.
Youth Mental Health First Aid by Michael J. Mullard, Ph.D., LCSW and Margery Arnold	August 14, 2023	Youth Mental Health First Aid teaches you how to identify, understand and respond to signs of mental illness and substance use disorders in youth. This 6-hour training gives adults who work with youth the skills they need to reach out and provide initial support to children and adolescents (ages 6-18) who may be developing a mental health or substance use problem and help connect them to the appropriate care. The training covers common signs and symptoms of mental illness and substance use, as well as how to interact with a child or adolescent in crisis and connect them with help.

APPENDIX V: NOTICE OF DISCRIMINATION

NOTICE OF NONDISCRIMINATION

AFFORDABLE CARE ACT (ACA) 45 CFR 92 SECTION 1557

The Orange County Health Care Agency complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Orange County Health Care Agency does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Orange County Health Care Agency:

- Provides free aids and services to people with disabilities to communicate effectively with us such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English such as:
  - Qualified interpreters
  - Information written in other languages

Let our staff know if you need these services.

If you have any difficulty obtaining these services, believe you have been discriminated against, or wish to file a grievance related to any of these services or policies, you can file a grievance in person or by mail, fax or email at the contact information listed directly below. Kelly K. Sabet, Civil Rights Coordinator at Orange County Health Care Agency, is available to help you as needed.

Orange County Health Care Agency
Attn: Kelly K. Sabet, Civil Rights Coordinator, Office of Compliance
405 W. 5th Street, Santa Ana, CA 92701
714-568-5787, 711 (TTD), 714-834-6595 (Fax)
officeofcompliance@ochca.com

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf , or by mail or phone at:
U.S. Department of Health and Human Services
200 Independence Avenue, SW Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at www.hhs.gov/ocr/office/file/index.html.

APPENDIX VI: INTERPRETATION SERVICES AVAILABLE

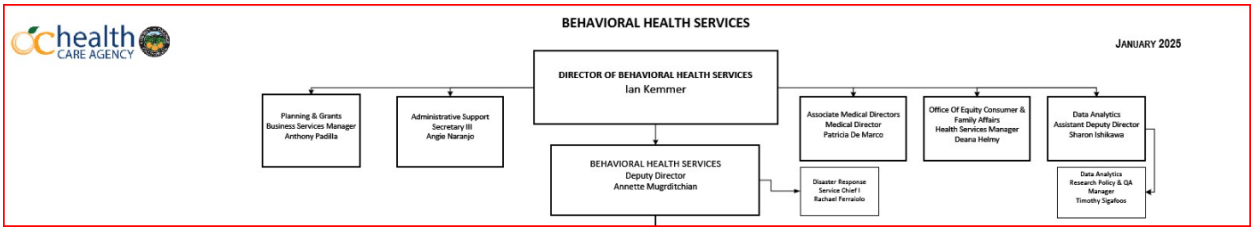
INTERPRETATION SERVICES AVAILABLE

You have the right to an interpreter at no cost to you. Ask at the front desk.

Arabic	لك الحق في الحصول على مترجم فوري بدون تحمل أي رسوم من تجاهك. اسأل في مكتب الاستقبال.
Armenian	Դուք իրավունք ունեք անվճար թարգմանչի ծառայություն ստանալ: Հարցրեք գրանցման սեղանի մոտ:
Cambodian	លោកអ្នកមានសិទ្ធិទទួលបានអ្នកបកប្រែផ្ទាល់មាត់ម្នាក់ដោយឥតគិតថ្លៃ។ សូមសាកសួរនៅតុទទួលភ្ញៀវ។
Cantonese	您有權免費獲得一位口譯人員。請在前臺諮詢。
Farsi	شما این حق را دارید که بطور رایگان از خدمات یک مترجم استفاده کنید. در مورد این خدمات از کارکنان جلوی دفتر یا پشت پیشخوان جویا شوید.
Hindi	आपको निःशुल्क दुभाषिया प्राप्त करने का अधिकार है। फ्रंट डेस्क पर पूछताछ करें।
Hmong	Koj muaj cai tau txais ib tug kws txhais lus pub dawb. Nug ntawm lub rooj ua haujlwm nyob sab ntawm xub thawj.
Japanese	あなたには無料で通訳者のサービスを受ける権利があります。フロントデスクにお尋ねください。
Korean	당신은 통역사를 무상으로 이용할 권리가 있습니다. 프론트 데스크에 문의하세요.
Lao	ທ່ານມີສິດມີລ່າມແປພາສາໂດຍບໍ່ເສຍຄ່າ. ຖາມຢູ່ໂຕະຕ້ອນຮັບ.
Mandarin	你有权利免费获得翻译服务。请问前台。
Punjabi	ਤੁਹਾਡੇ ਕੋਲ ਬਿਨਾਂ ਕਿਸੇ ਖ਼ਰਚ ਦੁਭਾਸ਼ੀਏ ਦੀ ਮਦਦ ਲੈਣ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਇਸ ਬਾਰੇ ਫਰੰਟ ਡੈਸਕ ਤੇ ਪੁੱਛੋ।
Russian	Вы имеете право на получение бесплатных услуг переводчика. Спросите на стойке регистрации.
Samoan	E iai lau aiia tatau mo se fa'amatalaupu e leai se totogi. Fesisli i le tagata oi le laulau i luma.
Spanish	Usted tiene el derecho a un intérprete sin costo alguno para usted. Pregunte en la recepción.
Tagalog	Mayroon kang karapatan sa isang tagapagsalin nang walang bayad. Magtanong sa front desk.
Thai	คุณมีสิทธิเป็นล่ามได้โดยที่คุณไม่ต้องมีค่าใช้จ่าย สอบถามได้ที่แผนกต้อนรับ
Vietnamese	Quý vị có quyền yêu cầu một thông dịch viên miễn phí. Xin hỏi ban tiếp tân.

**Translation services are also available in other languages, free of charge.
If another language is needed, please inquire at the front desk.

APPENDIX VII: BEHAVIORAL HEALTH SERVICES RE-ORGANIZATION CHART



APPENDIX VIII: ACCESS CRITERIA FOR SPECIALTY MENTAL HEALTH SERVICES

Policy 01.03.06

Health Care Agency **Mental Health and** **Recovery Services** **Policies and Procedures**	Section Name: Sub Section: Section Number: Policy Status:	Care and Treatment Access 01.03.06 ☒New ☐Revised

	SIGNATURE	DATE APPROVED
Director of Operations Mental Health and Recovery Services	Signature on File	9/14/2022

SUBJECT: Access Criteria for Specialty Mental Health Services

PURPOSE:

To describe the County of Orange Mental Health Plan (hereby referred to as Orange MHP) access criteria for Medi-Cal beneficiaries residing in Orange County to comply with the California Advancing and Innovating Medi-Cal (CalAIM) initiative to address beneficiaries' needs across the continuum of care, ensure that all Medi-Cal beneficiaries receive coordinated services, and improve health outcomes.

POLICY:

Orange County Health Care Agency (OCHCA) adheres to California state regulations and guidelines for providing access to Specialty Mental Health Services (SMHS) in accordance with California Advancing and Innovating Medi-Cal (CalAIM) initiative.

SCOPE:

The provisions of this policy are applicable to all County and County contracted staff providing SMHS throughout the Orange MHP.

REFERENCES:

Behavioral Health Information Notice (BHIN) 21-073 Criteria for beneficiary access to Specialty Mental Health Services (SMHS), medical necessity and other coverage requirements

Early and Periodic Screening, Diagnostic, and Treatment | Medicaid

The ICD 10-CM Updates and Information

Welfare and Institutions Code (WIC) §14184.402

DEFINITIONS:

Specialty Mental Health Services (SMHS) - Medi-Cal mental health services available to children, youth, and adults. SMHS include medically necessary services to correct or ameliorate impairments and mental illnesses or conditions available through the Medi-Cal Early and

Periodic Screening, Diagnostic and Treatment (EPSDT) benefit. This benefit is available to beneficiaries under the age of 21 who are eligible for full scope Medi-Cal. These services may include crisis counseling, individual/group/family therapy, medication management, targeted case management, psychological testing, psychiatric inpatient hospitalization, and recovery services.

Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT) - The federally mandated Medi-Cal benefit that entitles full-scope Medi-Cal-covered beneficiaries less than 21 years of age to receive any Medi-Cal service necessary to correct or ameliorate a defect, mental illness, or other condition, such as a substance-related disorder, that is discovered during a health screening.

Involvement in Child Welfare System - The beneficiary has an open child welfare service case, or the beneficiary is determined by a child welfare service agency to be at imminent risk of entering foster care but able to safely remain in their home or kinship placement with the provision of services under a prevention plan, or the beneficiary is a child whose adoption or guardianship occurred through the child welfare system. A child has an open child welfare services case if: a) the child is in foster care or in out of home care, including both court-ordered and by voluntary agreement; or b) the child has a family maintenance case (pre-placement or post-reunification), including both court-ordered and by voluntary agreement. A child can have involvement in child welfare whether the child remains in the home or is placed out of the home.

Juvenile Justice Involvement - The beneficiary (1) has ever been detained or committed to a juvenile justice facility, or (2) is currently under supervision by the juvenile delinquency court and/or a juvenile probation agency. Beneficiaries who have ever been in custody and held involuntarily through operation of law enforcement authorities in a juvenile justice facility, including youth correctional institutions, juvenile detention facilities, juvenile justice centers, and other settings such as boot camps, ranches, and forestry/conservation camps, are included in the "juvenile justice involvement" definition. Beneficiaries on probation, who have been released home or detained/placed in foster care pending or post-adjudication, under probation or court supervision, participating in juvenile drug court or other diversion programs, and who are otherwise under supervision by the juvenile delinquency court and/or a juvenile probation agency also meet the "juvenile justice involvement" criteria.

Homelessness - The beneficiary meets the definition established in section 11434a of the federal McKinney-Vento Homeless Assistance Act.15 Specifically, this includes (A) individuals who lack a fixed, regular, and adequate nighttime residence (within the meaning of section 103(a)(1) of the Act); and (B) includes (i) children and youths who are sharing the housing of other persons due to loss of housing, economic hardship, or a similar reason; are living in motels, hotels, trailer parks, or camping grounds due to the lack of alternative adequate accommodations; are living in emergency or transitional shelters; or are abandoned in hospitals; (ii) children and youths who have a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings (within the meaning of section 103(a)(2)(C)); (iii) children and youths who are living in cars, parks, public spaces, abandoned buildings, substandard housing, bus or train stations, or similar settings; and (iv) migratory children (as such term is defined in section 1309 of the Elementary and Secondary Education Act of 1965) who qualify as homeless for the purposes of this subtitle because the children are living in circumstances described in clauses (i) through (iii).

Trauma Screening Tools - The trauma screening tools referenced are screening measures that have been approved by DHCS to aid in determining whether a beneficiary has met the access criteria. MHPs are not required to implement screening tool(s) until DHCS issues additional guidance regarding approved trauma screening tool(s) for the purposes of SMHS access criteria.

Medical Necessity or Medically Necessary –

- Pursuant to Welfare and Institutions Code section 14184.402(a), for individuals 21 years of age or older, a service is "medically necessary" or a "medical necessity" when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain as set forth in Welfare and Institutions Code section 14059.5.

- For individuals under 21 years of age, a service is "medically necessary" or a "medical necessity" if the service meets the standards set forth in Section 1396d(r)(5) of Title 42 of the United States Code. This section requires provision of all Medi-Cal coverable services necessary to correct or ameliorate a mental illness or condition discovered by a screening service, regardless of whether such services are covered under the State Plan. Services that sustain, support, improve, or make more tolerable a mental health condition are considered to ameliorate the mental health condition are thus medically necessary and covered as Early Periodic Screening, Diagnostic, and Treatment (EPSDT) services.

- Services provided to a beneficiary must be medically necessary and clinically appropriate to address the beneficiary's presenting condition.

PROCEDURE:

I. Criteria for Adult Beneficiaries to Access the SMHS Delivery System

A. For beneficiaries 21 years of age or older, SMHS shall be provided for beneficiaries who meet both of the following criteria in 1 and 2 below:

1. The beneficiary has one or both of the following:

a) Significant impairment, where impairment is defined as distress, disability, or dysfunction in social, occupational, or other important activities.

b) A reasonable probability of significant deterioration in an important area of life functioning. AND

2. The beneficiary's condition as described above in 1 is due to either of the following:

a) A diagnosed mental health disorder, according to the criteria of the current editions of the Diagnostic and Statistical Manual of Mental Disorders (DSM) and the International Statistical Classification of Diseases and Related Health Problems (ICD).

b) A suspected mental disorder that has not yet been diagnosed.

II. Criteria for Beneficiaries under Age 21 to Access the SMHS Delivery System

A. Beneficiaries under 21 years of age shall be provided all medically necessary SMHS required pursuant to Title 42 U.S.C.§1396d(r). Covered specialty mental health services shall be provided to enrolled beneficiaries who meet either of the following criteria in 1 or 2 below.

1. The beneficiary has a condition placing them at high risk for a mental health disorder due to experience of trauma evidenced by any of the following: scoring in the high-risk range under a trauma screening tool approved by the department, involvement in the child welfare system, juvenile justice involvement, or experiencing homelessness. OR

2. The beneficiary meets both of the following requirements in a) and b) below:

a) The beneficiary has at least one of the following:

i) A significant impairment

ii) A reasonable probability of significant deterioration in an important area of life functioning

iii) A reasonable probability of not progressing developmentally as appropriate.

iv) A need for SMHS, regardless of presence of impairment, that are not included within the mental health benefits that a Medi-Cal managed care plan is required to provide. AND

b) The beneficiary's condition as described in 2 above is due to one of the following:

i) A diagnosed mental health disorder, according to the criteria of the current editions of the Diagnostic and Statistical Manual of Mental Disorders (DSM) and the International Statistical Classification of Diseases and Related Health Problems (ICD).

ii) A suspected mental health disorder that has not yet been diagnosed.

iii) Significant trauma placing the beneficiary at risk of a future mental health condition, based on the assessment of a licensed mental health professional.

3. If a beneficiary under age 21 meets the criteria as described in 1 above, the beneficiary meets criteria to access SMHS. It is not necessary to establish that the beneficiary also meets the criteria in 2 above.

III. Additional Coverage Requirements

A. Criteria for a beneficiary to access the SMHS delivery system (except for psychiatric inpatient hospital and psychiatric health facility services) set forth above shall not be construed to exclude coverage for, or reimbursement of, a clinically appropriate and covered mental health prevention, screening, assessment, treatment, or recovery service under any of the following circumstances:

1. Services were provided prior to determining a diagnosis, including clinically appropriate and covered services provided during the assessment process.

2. The prevention, screening, assessment, treatment, or recovery service was not included in an individual treatment plan.

3. The beneficiary has a co-occurring substance use disorder.

B. All Medi-Cal claims, including SMHS claims, are required to include a CMS approved ICD-10 diagnosis code.

APPENDIX IX: ACCESS CRITERIA FOR DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM

Policy 01.03.07

Health Care Agency **Mental Health and** **Recovery Services** **Policies and Procedures**	Section Name: Sub Section: Section Number: Policy Status:	Care and Treatment Access 01.03.07 ☐New ☒Revised

	SIGNATURE	DATE APPROVED
Director of Operations Mental Health and Recovery Services	Signature on File	1/30/2023

SUBJECT: Access Criteria for Drug Medi-Cal Organized Delivery System

PURPOSE:

To describe the County of Orange Drug Medi-Cal Organized Delivery System (DMC-ODS) access criteria for Medi-Cal beneficiaries residing in Orange County to comply with the California Advancing and Innovating Medi-Cal (CalAIM) initiative to address beneficiaries' needs across the continuum of care, ensure that all Medi-Cal beneficiaries receive coordinated services, and improve health outcomes.

POLICY:

Orange County Health Care Agency (OCHCA) adheres to California state regulations and guidelines for providing access to DMC-ODS in accordance with California Advancing and Innovating Medi-Cal (CalAIM) initiative.

SCOPE:

The provisions of this policy are applicable to all County and County contracted staff providing DMC-ODS and Substance Use Disorder (SUD) services throughout Orange County.

REFERENCES:

Behavioral Health Information Notice (BHIN) 23-001 Drug Medi-Cal Organized Delivery System (DMC-ODS) Requirements for the Period of 2022 – 2026

Behavioral Health Information Notice (BHIN) 21-071 Medical Necessity Determination and Level of Care Determination Requirements for Drug Medi-Cal (DMC) Treatment Program Services

The ICD 10-CM Updates and Information

Welfare and Institutions Code (WIC) §14184.402

Welfare and Institutions Code § 14059.5

Title 42 of the United States Code § 1396d(r)(5)

Page 1 of 4

DEFINITIONS:

Medical Necessity or Medically Necessary –

- Pursuant to Welfare and Institutions Code section 14184.402(a), for individuals 21 years of age or older, a service is "medically necessary" or a "medical necessity" when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain as set forth in Welfare and Institutions Code section 14059.5.

- For individuals under 21 years of age, a service is "medically necessary" or a "medical necessity" if the service meets the standards covered under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) mandate.

PROCEDURE:

I. Criteria for Adult Beneficiaries to Access the DMC-ODS

A. For beneficiaries 21 years of age or older, DMC-ODS services shall be provided for beneficiaries who meet one of the following criteria in 1 and 2 below:

1. Have at least one diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM) for Substance-Related and Addictive Disorders, with the exception of Tobacco-Related Disorders and Non-Substance Related Disorders, OR

2. Have had at least one diagnosis from the DSM for Substance- Related and Addictive Disorders, with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders, prior to being incarcerated or during incarceration, determined by substance use history.

B. Narcotic Treatment Programs (NTPs) conduct a history and physical exam by an LPHA pursuant to state and federal regulations. This history and physical exam done at admission to a NTP qualifies for the purpose of determining medical necessity under the DMC-ODS.

II. Criteria for Beneficiaries under Age 21 to Access the DMC-ODS

A. Beneficiaries under 21 years of age shall be provided all medically necessary DMC-ODS services required pursuant to Title 42 U.S.C.§1396d(r).

B. Federal EPSDT statutes and regulations require States to furnish all Medicaid-coverable, appropriate, and medically necessary services needed to correct and ameliorate health conditions, regardless of whether those services are covered in the state's Medicaid State Plan.

C. Consistent with federal guidance, services need not be curative or completely restorative to ameliorate a mental health condition, including substance misuse and SUDs.

D. Services that sustain, support, improve, or make more tolerable substance misuse or an SUD are considered to ameliorate the condition and are thus covered as EPSDT services.

III. Level of Care Determination

A. In addition to being medically necessary, all SUD treatment services provided to a DMC-ODS beneficiary must be clinically appropriate to address that beneficiary's presenting condition.

B. In accordance with Welfare and Institutions Code (WIC) §14184.402(e), providers must use the criteria adopted by the American Society of Addiction Medicine (ASAM) to determine the appropriate level of SUD treatment service for DMC-ODS beneficiaries.

1. However, a full assessment utilizing the ASAM criteria is not required for a DMC-ODS beneficiary to begin receiving covered and reimbursable SUD treatment services; an abbreviated ASAM screening tool may be used for initial screening, referral, and access to clinically appropriate services.

2. These requirements for ASAM Level of Care assessments apply to NTP clients and settings.

C. For DMC-ODS beneficiaries 21 and over, a full assessment using the ASAM Criteria shall be completed within 30 days of the beneficiary's first visit with a licensed professional of the healing arts (LPHA) or registered/certified counselor.

D. For DMC-ODS beneficiaries under 21, or for adults experiencing homelessness, a full assessment using the ASAM criteria shall be completed within 60 days of the DMC-ODS beneficiary's first visit with an LPHA or registered/certified counselor.

E. If a DMC-ODS beneficiary withdraws from treatment prior to completing the ASAM assessment and later returns, the time period starts over.

1. The assessment time period re-sets in cases where the Episode of Care (EOC) has been closed, as open EOC must follow established timelines.

IV. Additional Coverage Requirements

A. Consistent with WIC §14184.402(f), clinically appropriate and covered SUD prevention, screening, assessment, treatment, and recovery services are covered and reimbursable Medi-Cal services even when:

1. Services are provided prior to determination of a diagnosis or prior to determination of whether DMC-ODS criteria are met, as described above.

2. Services are provided during the assessment process and if is later determines through the assessment that the beneficiary does not meet criteria for DMC-ODS services.

3. The prevention, screening, assessment, treatment, or recovery services were not included in an individual treatment plan; or

4. The beneficiary has a co-occurring mental health condition.

    a) Reimbursement for covered DMC-ODS services provided to a beneficiary who meets DMC-ODS criteria and has a co-occurring mental health condition shall not be denied as long as DMC-ODS criteria and requirements are met.

B. All Medi-Cal claims, including DMC-ODS claims, are required to include a CMS approved International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM), or current version, diagnosis code.

APPENDIX X: TEST CALL PROCEDURE FOR MONITORING ADMINISTRATIVE SERVICE ORGANIZATION (ASO) ACCESS QUALITY AND COMPLIANCE

Policy 06.02.01

Health Care Agency **Mental Health and** **Recovery Services** **Policies and Procedures**	Section Name: Sub-section Name: Section Number: Policy Status:	Quality Improvement Access 06.02.01 ☐New ☒Revised

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

SUBJECT: Test Call Procedure for Monitoring Administrative Service Organization (ASO) Access Quality and Compliance

PURPOSE:

To establish a Policy and Procedure for monitoring the Administrative Service Organization (ASO)'s compliance to County of Orange Mental Health Plan (MHP) (hereby referred to as Orange MHP) Access Line requirements.

POLICY:

The Orange MHP will monitor the ASO in order to assure that the ASO is complying with the MHP's Access Line regulations.

SCOPE:

The procedure is applicable to the ASO.

REFERENCES:

California Code of Regulations, Title 9, Chapter 11, Section 1810.405(d)

California Code of Regulations, Title 9, Chapter 11, Section 1810.405(f)

DEFINITIONS:

Test calls to the MHP's ASO are made in order to test the Orange MHP's Access Line in the following areas:

- Responsiveness of the Access Line 24-hours a day, seven days a week;
- Access to afterhours care;
- Knowledge and helpfulness of the access line staff; and

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- Recording of the call on the Telephone Access Log. Calls made in threshold languages are to test response capability to non-English languages.

PROCEDURE:

I. Once per quarter the Adult and Older Adult (AOA) ASO contract monitor will arrange, with the assistance of Authority and Quality Improvement Services (AQIS), to make a minimum of four test calls.

II. AOA will maintain a desk procedure for test calls to the ASO and provide a worksheet and call scenarios for test callers to utilize in order to monitor the ASO's Access Line for access, quality, and compliance. AQIS will collaborate with AOA to modify procedures per State requirements and as needed.

III. Worksheets will be compiled and the results in the form of a Test Call Summary will be shared at the Quality Improvement ASO quarterly management meetings with a request for ASO follow-up and correction.