Sonoma County Department of Health Services, Behavioral Health Division
Cultural Competency Plan
FY '20-21

An original, three copies, and a flash drive of this report (saved in PDF) due December 20, 2020 to:

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Plan and Network Adequacy Branch
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CHECKLIST OF THE 2010 CULTURAL COMPETENCY PLAN REQUIREMENTS CRITERIA

√ CRITERION 1: COMMITMENT TO CULTURAL COMPETENCE

√ CRITERION 2: UPDATED ASSESSMENT OF SERVICE NEEDS

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

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

√ CRITERION 5: CULTURALLY COMPETENT TRAINING ACTIVITES

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

√ CRITERION 7: LANGUAGE CAPACITY

√ CRITERION 8: ADAPTATION OF SERVICES

Criterion 1: Commitment to Cultural Competence

Sonoma County's Department of Health Services, Behavioral Health Division (DHS-BHD) is committed to meeting the cultural and linguistic needs of our community, for all individuals from racial, ethnic, cultural and linguistically diverse backgrounds. Not just to attain Health equality but to ensure Health equity for the thousands of community members seeking services. This endeavor is reflected in our mission, philosophy, policies, procedures, and practices throughout our mental health system.

Most importantly, DHS-BHD strives to develop strategic plans based on local data and community engagement. The identification of behavioral health disparities, vulnerable populations, emerging trends, and barriers to services is an ongoing process improvement plan that involves a complex arrangement of examining systemwide data, consumer satisfaction and feedback, assuring regulatory compliance and balancing budgets.

Holding true to the MHSA values of a system that is consumer and family member driven, focused on wellness and resiliency and a philosophy in which recovery is possible, the delivery of culturally competent and linguistically appropriate services is possible.

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

1. Mission Statement;
2. Statements of Philosophy;
3. Strategic Plans;
4. Policies and Procedure Manuals;
5. Other Key Documents (Counties may choose to include additional documents to show system-wide commitment to cultural and linguistic competence);

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

A. Provide a copy of the county's CSS plan that describes practices and activities that demonstrate community outreach, engagement, and involvement efforts with identified racial, ethnic, cultural, linguistic, and other relevant small county cultural communities with mental health disparities.

Mental Health Services Act (MHSA) has provided Sonoma County the opportunity to enhance new partnerships and to strengthen continuing partnerships with community-based organizations and has supported inclusion of the voices of more consumer, family members, and unserved and underserved populations in the planning and implementation of mental health activities, programs, and services. As a consequence, Sonoma County residents now have a more accessible, integrated, comprehensive, and compassionate mental health system of care. At the foundation for the development of this system of care, Sonoma County continues to be driven by the following MHSA Guiding Principles:

- **Community collaboration**: Individuals, families, agencies, and businesses work together to accomplish a shared vision
- **Cultural competence**: Adopting behaviors, attitudes, and policies that enable providers to work effectively in cross-cultural situations
- **Client and family driven system of care**: Adult clients and families of children and youth identify needs and preferences that result in the most effective services and supports
- **Focus on wellness, including recovery and resilience**: People diagnosed with a mental illness are able to live, work, learn, and participate fully in their communities
- **Integrated service experiences**: Services for clients and families are seamless; clients and families do not have to negotiate with multiple agencies and funding sources to meet their needs

DHS-BHD has established a system and structure for a community-engaged planning process as a basis for developing the Three-Year Program and Expenditure Plans and inclusive actions taken under MHSA governance. This structure is anchored with an MHSA Steering Committee *(MHSA Steering Committee Membership: Attachment A)* and includes the Cultural Responsiveness Committee, the Community Program Planning Process Committee, the Behavioral Health Department Stakeholder Group, and the Mental Health Board. Furthermore, additional outreach and engagement is made through related, but independent community committees and advisory councils, such as First 5 Sonoma and Health Action. The California Code of Regulations, Title 9 states that counties must ensure that stakeholders reflecting the diversity of the demographics of the county, including, but not limited to, geographic location, age, gender, and race/ethnicity, have the opportunity to participate in the CPP process (CCR § 3300).

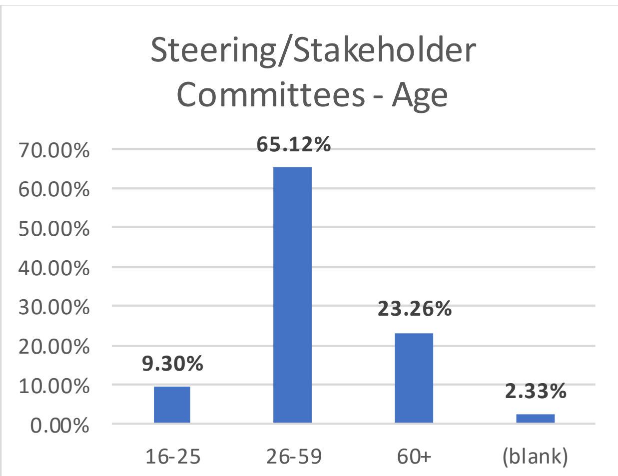
The commitment to an open and inclusive process is seeded throughout the MHSA committees that are convened by the Sonoma County Department of Health Services, Behavioral Health Division. The following guiding principles are adhered to in membership and practice:

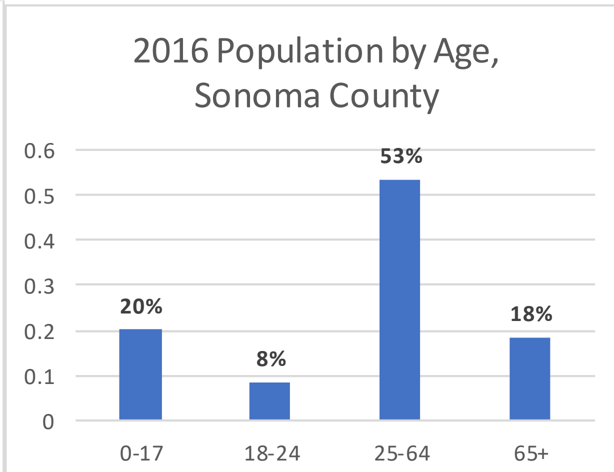
- Inclusive and representative
- Transparent and easy for all participants to understand
- Collaborative and in partnership with consumers, families and the community
- Broad participation from diverse groups throughout Sonoma County
- Culturally Competent

B. A one-page description addressing the county's current involvement efforts and level of inclusion with the above identified underserved communities on the advisory committee.

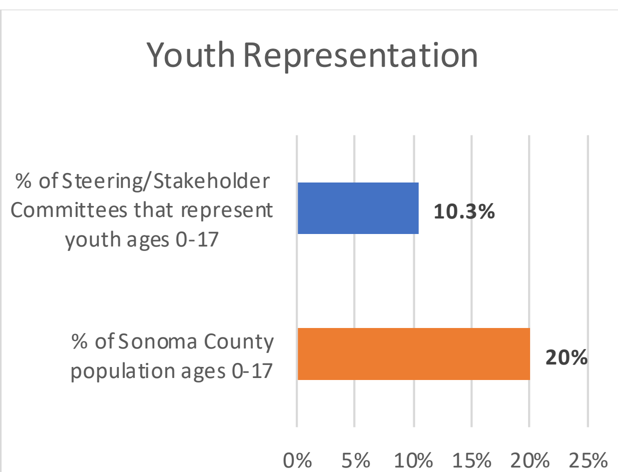
As noted in the section preceding, DHS-BHD works with stakeholders through established MHSA Steering Committee, Cultural Responsiveness Committee and the Community Program Planning Committee. In addition, DHS-BHD has various ad hoc interactions with the peer community, community at-large, industry groups such as Health Action Sonoma, law enforcement, First Five and other coalitions throughout the year. DHS-BHD has consciously monitored the representation of committee stake holders against the county's demographic make-up. The following charts provide some comparisons.

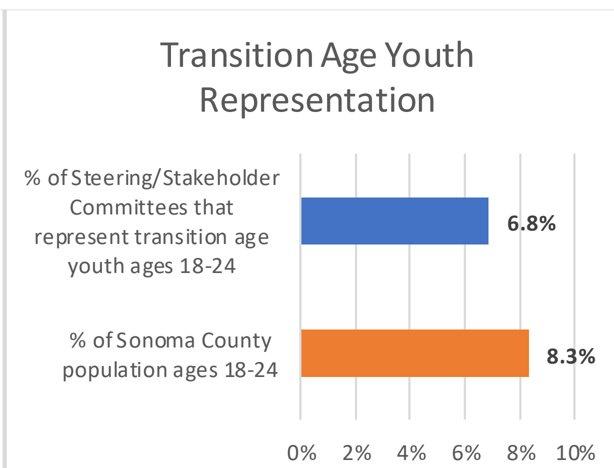
Age



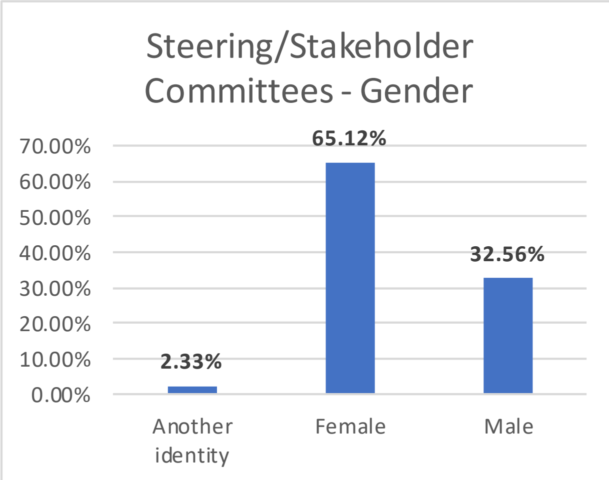


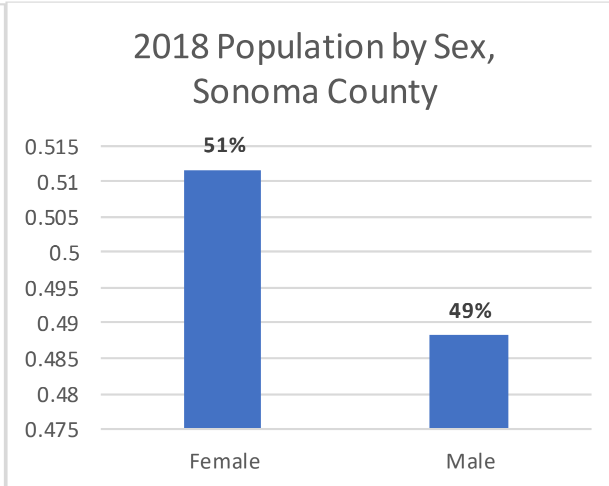
Note the age grouping are not defined the same and the Steering Committee/Stakeholder Committees do not include 0-15 years.



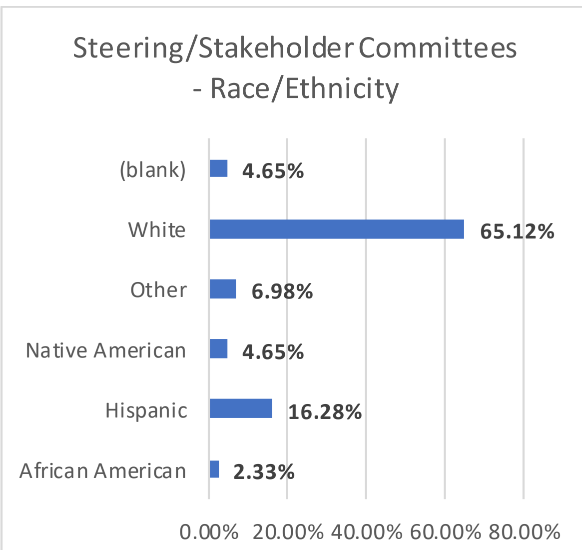


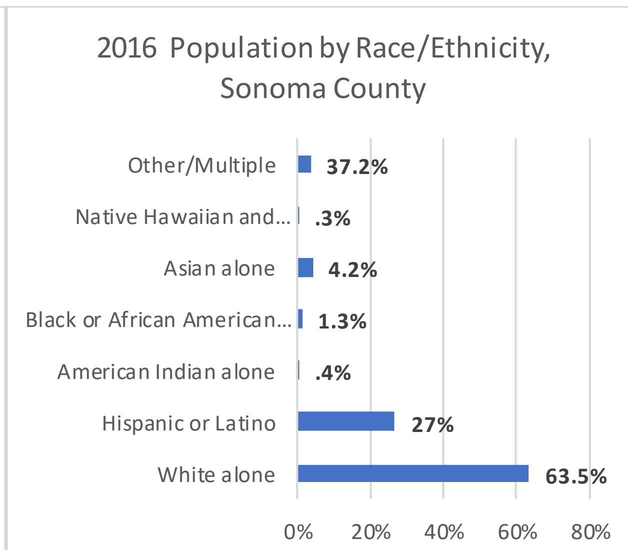
Gender



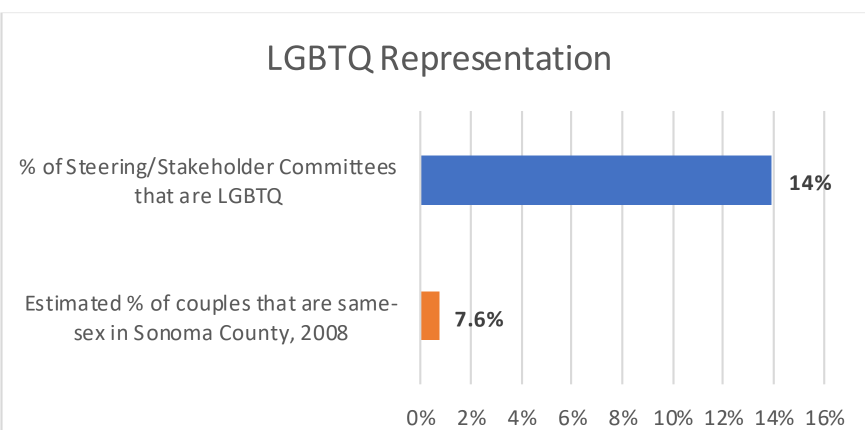


Race/Ethnicity





LGBTQ+



Description of the Stakeholder Community Planning Process (CPP)

The Sonoma County Behavioral Health Division (BHD) Division partners with the community to ensure each plan and update is developed with local stakeholders with meaningful input and involvement on mental health policy, program planning, implementation, monitoring, quality improvement, evaluation, and budget. BHD uses a variety of opportunities and processes to seek stakeholder input to ensure full community participation. BHD continues to use traditional (meetings, forums, etc.) and non-traditional (one-on-one and small group discussion) approaches for engaging the community about the planning process and seeking input from the community about the Update. BHD takes special care to meet with and receive input from historically underserved communities in ways identified as appropriate by these groups and individuals. BHD used the following methods to educate and seek input from the public about the MHSA Annual Update.

Existing and ongoing opportunities for update of accomplishments, opportunity for community stakeholder input and discussion with the public. These include the following:

Meeting Name	Stakeholder Group	Meeting Occurrence
Early Childhood Mental Health Collaborative Partners	0-5 aged children	Quarterly Meetings
Greater Bay Area Mental Health & Education Workforce Collaborative	All Stakeholders	Quarterly meeting
Mental Health Board meeting (monthly)	All Stakeholders	Monthly Meetings
Mental Health Services Act Steering Committee	Consumers/Healthcare/Mental Health/Social Services provider/Veterans/Peers/ Family Members/Law Enforcement/Criminal Justice/Housing/TAY	Quarterly meetings
Mental Health Services Act Stakeholder Committee	All Stakeholders	Biannual meetings
Prevention and Early Intervention (PEI) Older Adult Collaborative meeting	Older Adults	Quarterly Meetings
Petaluma Health Care District – Community Health Initiative for Petaluma Area	Healthcare/Mental Health/Social Services provider/Veterans/Peers and Family Members	Monthly Meetings
Russian River Area Resources and Advocates (monthly)	Homeless and Geographically Isolated	Monthly
Crisis Intervention Training (CIT)	Law Enforcement	Twice a year Spring and Fall
Quality Management Committee	All Stakeholders	Monthly

Sonoma County Behavioral Health Division also publishes an MHSA Newsletter, featuring relevant MHSA news, information, and events. A hard copy version of the newsletter is produced every 2-3 months and is shared with a variety of community groups and stakeholders, including the Mental Health Board, the Board of Supervisors, Behavioral Health program managers, and contractors. An archive of the newsletter PDFs is available on the MHSA website. An email version of the newsletter is produced and sent out every 2-3 months. People can subscribe to the email newsletter via the MHSA website.

In 2019, the MHSA Steering Committee established an ad hoc Innovation Committee to develop and implement a process to solicit applications for projects supported by MHSA Innovation funds. The robust process resulted in five community-based projects, one focuses on the Latinx and Spanish Speaking community, one on older adults and one on TAY (Transitional Age Youth). BHD will continue to engage stakeholders in preparation for the for the upcoming MHSA PEI (Prevention and Early Intervention) Request for Proposal (RFP) in 2021.

In 2020, BHD re-convened the Cultural Responsiveness Committee (CRC), currently with 13 members representing people with lived experience/family members, Spanish speakers, Latinx, Native Americans, LGBTQ+, Veterans, Seniors, TAY, people with disabilities and those with cultural diversity expertise. *(Cultural Responsiveness Committee Membership: Attachment B)*. The Cultural Responsiveness Committee will be tasked with reviewing the findings from the Cultural Assessment Tool administered to mental health staff and findings from the Consumer Perception Survey administered to BHD clients. These data findings along with community input, other community reports and utilization reports will be utilized to identify staff training needs, recommend system and policy changes, and other workforce development needs. The CRC will work closely with the Community Program Planning Process Committee (CPP) to assure outreach and engagement with diverse community members, especially those that are the hardest to reach.

The upcoming solicitation for PEI contracts will be a focus in early 2021. Both CRC and the MHSA Steering committees will be engaged in the planning and implementation of the solicitation and CRC members will be invited to volunteer on an evaluation panel to rate incoming proposals submitted by community organizations. This will assure community representatives can apply a cultural lens to the process.

C. Share lessons learned on efforts made on the items A and B above and any identified county technical assistance needs. Information on the county's current MHSA Annual Plan may be included to respond to this requirement.

The primary lesson learned from reviewing the efforts in community outreach, engagement, and involvement is that the County must continue to get input from stakeholders to provide opportunities for engagement that stakeholders find meaningful. This year the MHSA Steering committee developed a Community Program Planning Subcommittee. This subcommittee is aiding us in involving stakeholders in the development of significant projects including the PEI RFP process and design and how to engage stakeholders during and after stakeholder meetings.

Currently, DHS-BHD has three priority areas of improvement:

1) Increase services for Latinx and Spanish Speaking community members;
2) Continued focus on increasing bilingual (Spanish) and bicultural workforce; and
3) Hiring the Ethnic Services Manager/Workforce Education and Training Coordinator.

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.

Detail who is designated the county's CC/ESM responsible for cultural competence and who promotes the development of appropriate mental health services that will meet the diverse needs of the county's racial, ethnic, cultural, and linguistic populations.

Currently, the Mental Health Services Coordinator, Melissa Ladrech, LMFT, is also the Ethnic Services Manager (ESM) and Workforce Education and Training (WET) Coordinator. This assignment of combining MHSA coordination and oversight with CC/ESM and WET responsibilities under one staff person does not provide adequate resources to identify and implement strategies to address racial, ethnic, cultural and linguistic mental health disparities.

Earlier this calendar year, the Sonoma County Department of Health Services initiated a recruitment for an ESM/WET Coordinator. This position is to focus up to 50% of their time on WET and a minimum of 50% to the duties as ESM. These duties are described below. It is anticipated that the WET/ESM position will be filled in March 2021 and will have direct access to the Behavioral Health Director.

The ESM position will be responsible for promoting the development of appropriate behavioral health services that will meet the diverse needs of the county's racial, ethnic, cultural, and linguistic populations. The ESM will be responsible for continuously moving BHD towards quality and equitable care as it relates to racial, ethnic, and cultural populations served by both county-operated and contracted behavioral health programs.

The ESM will advocate and take a leadership role in the development and implementation of policies, programs, practices and services that address the cultural and linguistic needs of all communities in the County. Furthermore, the ESM will work collaboratively with the recently hired Sonoma County Equity Officer who oversees the County's independent Office of Equity. The alignment with the Office of Equity will provide additional support to the ESM in improving workforce representation, operational policies and procedures, consumer access and culturally responsive services.

The ideal candidate will have at least four years of experience in Behavioral Health and possess a Master's degree or higher. He/she will be an ethical and dependable individual who is committed to equity with a high standard of quality patient care and service delivery. Additionally, the ideal candidate will also possess knowledge, experience, skills, and abilities in the following competencies:

- Education and experience involving cultural disparities, and effective culturally competent services and resources;
- Develop and implement policies and procedures to meet the Cultural Competence Plan requirements;
- Interpret data accurately and apply relevant data to achieve the desired results especially as it pertains to cultural development trainings, programs, and goals;
- Research new and existing laws, regulations and research dealing with ethnic and cultural disparities, and effective culturally competent services and resources;
- Remain current and up to date on all State and regional correspondence involving culturally competent mental health and substance use disorder services and issues;
- Convene and engage stakeholders to set priorities, identify and mobilize resources to continuously improve cultural relevancy of behavioral health services;
- Manage and coordinate all aspects of interpretation/translation services, including all threshold languages; and
- Develop, implement and ensure accuracy of verbal interpretation and written translation services and materials into the threshold languages, as well as American Sign Language.

The Sonoma County CC (Cultural Competency)/ESM uses the California Behavioral Health Directors Association (CBHDA) April 2016 *Framework for Advancing Cultural, Linguistic, Racial & Ethnic Behavioral Health Equity in County and Local Behavioral Health Services* as the basis for the implementation of CC-ESM responsibilities.

FY 20-21 Goals	Details	Activities
I. Maintain members and facilitate meeting of the Cultural Responsiveness Committee (CRC)	Currently, the CRC meets monthly. It is anticipated that the committee will continue to meet monthly for the second and third quarter of FY 20-21. The committee will revisit the frequency of meetings based upon workload as determined by goals and priorities.	Virtual CRC meetings have been conducted in Oct and Nov of 2020 with 13 members representing BHD County employees, peer providers, MH contractors. Members represent the diversity of Sonoma County as Latinx, LGBTQ+, peers, TAY, Native American, and Seniors.
II. Collect and analyze data to identify achievements and areas of need in building a system that is culturally responsive to the	Data sources have been identified that inform staff training, recruitment and hiring needs, system access and quality of services to underserved individuals. These data findings to be	Administer staff Cultural Competence surveys to identify training needs; Utilize the Capacity Assessment conducted every three-years for service access and utilization; create a system of monitoring staff

communities of Sonoma County	discussed with the CRC to develop recommendations.	recruitment and hiring in areas of highest need.
III. Oversee a staff training program to reduce racial, ethnic, cultural and linguistic mental health disparities and on the topics identified in the last staff Cultural Competence survey.	Five culturally responsive trainings are planned for FY 20-21: • Understanding LGBTQIA+ Clients and Meeting Their Needs • Access to Mental Health Services for All: Interpreter Services, Materials, and Resources • Peer Recovery Panel Discussion • Local Latinx Populations and Their Challenges: Indigenous Communities, Immigration and Needed Resources • Examining Our Implicit Bias	The staff Cultural Competence surveys will be administered in December of 2020 to identify training needs for the next 2 years; Attend Quality Improvement Steering Committee (QIS) to provide guidance to Training Committee to incorporate cultural competency in system-wide training; Attend and recommend training to enhance knowledge and skills promoting equity; Attend regional and statewide meetings with other ESM and other advisory groups to develop strategies and increase tools in meeting CCP goals and job duties.
IV. Advocate for and promote a multi-lingual and diverse workforce	Monitoring the recruitment and hiring of a diverse workforce that is representative of the county's demographics. Provide for equitable access and culturally responsive services. Monitoring the number of bi-lingual staff in threshold language(s) is a key metric.	Establish staffing goals in bi-lingual staffing in threshold language of Spanish; work in coordination with the County Office of Equity to leverage resources for workforce development and engagement of diverse community members.
V. Assure that Public Access – materials, interpreter services	Educational and outreach materials are vetted by the communities to be served and translated in threshold language(s) to ease access barriers to MH system. The County maintains a qualified list of interpreter service providers available to staff.	Maintain a library of bi-lingual consumer materials; work with CRC to identify additional materials that may need modifications/translation; provide regular training on accessing language line and other interpreter services.
VI. Responsible for development and implementation of Cultural Competency Plan (CCP) for DHS-BHD	The ESM shall participate in the review and development of planning, policy, compliance and evaluation of system and services to affect change and improvement to equity measures.	Attend Quality Improvement Steering Committee (QIS) and Quality Management Policy Committee (QMP) to assist in development of CCP and recommend actions for policy and practice adaptations.

IV. Identify budget resources targeted for culturally competent activities

A. Evidence of a budget dedicated to cultural competence activities which may include, but not be limited to the following:

1. Budget amount spend on Interpreter and translation services;

Currently, Sonoma County BHD has $166,192 budgeted for interpreter and translation services. The following chart documents active contracts in place for language providers, including live real time translation and services for translating materials.

	Phone	Translation	In Person	Video	Language Restrictions	Service Notes
Communique			x		ASL only	
Linguabee			x	x	ASL only	
CTS Language Link	x	x	x	x		Needs at least 24 hours response time for translation
Telelanguage	x			x		
Sonia Pacheco	x		x		Spanish Only	Weekend service must be pre-arranged
Language People	x	x	x	x		
Gray Highlander		x			Spanish Only	Email communication is preferred
Interpreters Unlimited	x	x	x	x		
Nubilla Padilla		x			Spanish Only	
Lazar & Associates		x				Needs at least 24 hour response time
Alison Trujillo		x			Spanish Only	
International Contact	x There is a department 60-minute monthly minimum	x	x	x		Department will need to call to set up an account for phone service for use.

2. Reduction of racial, ethnic, cultural, and linguistic mental health disparities in administration;

Within the FY 2020-21 budget for the Sonoma County Behavioral Health Division, a total of $5,487,980 has been allocated to reducing disparities and increase equity system-wide. The following three charts itemize those allocations:

Budget Allocation Description	FY 20-21
Personnel: .50 FTE Ethnic Services Manager/.50 FTE Workforce, Education and Training (WET) Coordinator (salary and benefits)	$169,000
Personnel: Support staff	$35,178
Cultural Competency Activities Oversight	$41,557
Kawahara Associates, Inc. – Sonoma County Reducing Disparities Projects	$24,375

3. Budget amount allocated towards outreach, community engagement and prevention to racial and ethnic county-identified target populations;

Organization/Priority Population	FY 20-21
Latino Service Providers/Latinos	$85,000
Sonoma County Indian Health Project/Native Americans	$20,919
Positive Images/LGBTQQI	$101,995
Community Baptist Church Collaborative /African Americans	$144,410
West County Health Services /LGBTQQI	$248,149
Sonoma County Behavioral Health Division: Whole Person Care/Homeless	$3,328321
West County Community Services: Peer Education and Training	$139,000
Santa Rosa Junior College: PEERS for TAY, Stigma Reduction and Suicide Prevention	$200,000

4. Budget for culturally appropriate mental health clinical services

Organization/Priority Population	FY 20-21
Sonoma County Indian Health Project/Native Americans	$81,040
Council on Aging/Seniors	$83,951
On The Move, Nuestra Cultura Cura/Latinx (pending Mental Health Oversight and Accountability Commission (MHSOAC)approval)	$278,071
Human Services Department, CCERP/Older Adults (pending MHSOAC approval)	$319,866
Buckelew and UC Davis, Early Psychosis Learning Healthcare Collaborative Network/ TAY Spanish Speaking Community	$187,148

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

The County of Sonoma has personnel policies that provide for a differential pay increase above the employee’s base hourly rate if the position requires at least 10% of the employee’s work time to be used in a bilingual capacity. The current policy states that the employee shall be entitled to an additional $1.15 per hour premium.

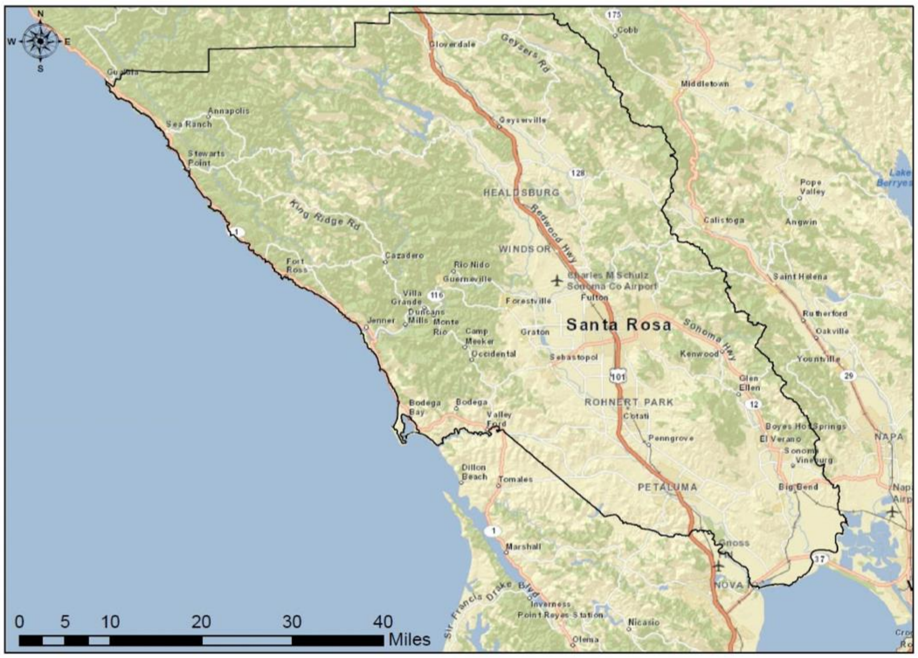
Criterion 2: Updated Assessment of Service Needs

A population assessment is necessary to identify the cultural and linguistic needs of the County and to determine/confirm emerging population(s) of need. This assessment is also critical in designing, and planning for the provision of culturally responsive and effective mental health services. A majority of the following data has been gleaned from the 2019-20 MHSA Capacity Assessment and MHSA FY 2020-23Three-Year Program and Expenditure Plan,.

I. General Population

A. Provide a description of the county's general population by race, ethnicity, age, gender, and other relevant small county cultural populations. The summary may be a narrative or as a display of data (other social/cultural groups may be addressed as data is available and collected locally). If appropriate, the county may use MHSA Annual Update Plan data here to respond to this requirement.

Sonoma County has a population of 499,942 people across a region of 1,576 square miles.[1] While most residents in the County have economic security, about 10% of the population have an income below the Federal Poverty Level (FPL).[2] With the high cost of living in the County, there are likely additional residents without the ability to meet their basic needs (i.e., food, clothing, shelter, transportation, health care, etc.). One in four County residents (122,962) were enrolled in Medi-Cal in 2018 with an income at or below 138% FPL.[3] These residents rely on the County for support with a number of social services and health care needs, including mental health services for individuals with serious mental illness.



Santa Rosa, the County's most populous city with 177,586 people, is home to over one-third of county residents, the County seat, and the Behavioral Health Division (DHS-BHD) main campus.[4] Beyond Santa Rosa, the main population centers are Petaluma (population 61,917) and Rohnert Park (population 43,753) to the south, and Windsor to the north (population 27,849).[5] Sonoma is geographically dispersed with limited public

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[1] U.S. Census Bureau. (2018). *Quick Facts, Sonoma county, California*. Retrieved from https://www.census.gov/quickfacts/fact/table/sonomacountycalifornia

[2] U.S. Census Bureau. (2018). *Quick Facts, Sonoma County, California*

[3] California Department of Health Services (2018). *Medi-Cal Enrollees and Beneficiaries Served in CY 2018 by Race/Ethnicity.*

[4] U.S. Census Bureau. (2018). *Quick Facts, Santa Rosa city, California*. Retrieved from https://www.census.gov/quickfacts/fact/table/santarosacitycalifornia/

[5] U.S. Census Bureau. (2018). *Quick Facts, Petaluma city, California; Rohnert Park city, California; Windsor town, California.* Retrieved from https://www.census.gov/quickfacts/fact/table/petalumacitycalifornia,rohnertparkcitycalifornia,windsortowncalifornia/

transit and bicycle and pedestrian infrastructure. It can therefore be challenging for individuals living in more rural areas and those without a personal vehicle. This is particularly true for residents enrolled in Medi-Cal and can make it difficult to access services.

In 2018, 87% of residents identified as White with 27% identifying as Hispanic or Latinx, the County's largest minority population.[6] The County's poverty rates vary significantly by ethnicity with disparities affecting the Latinx community in particular. While Hispanic or Latinx residents were about a quarter of the population, this group accounts for over 40% of Sonoma County's Medi-Cal beneficiaries in 2018.[7]

The County is also home to five federally recognized Native American tribes, including the Cloverdale Rancheria of Pomo Indians of California, the Dry Creek Rancheria Band of Pomo Indians, the Federated Indians of Graton Rancheria, the Kashia Band of Pomo Indians of the Stewarts Point Rancheria, and the Lytton Band of Pomo Indians.[8] Native Americans make up just over 2% of the County's total population and about 1% of Medi-Cal beneficiaries.[9]

Over 25% of Sonoma households speak a language other than English at home, of which about 19% speak Spanish – the County's only threshold language.[10] About 11% of residents speak English less than "very well," suggesting possible linguistic isolation for this population.[11] Additionally, there are an estimated 38,500 undocumented residents in the County.[12] Individuals that are undocumented and/or linguistically isolated may experience unique challenges accessing medical, transportation, and social services. If services are limited by language, it can reduce access as well as the quality of services available – particularly for individuals with lower levels of income.

The County's major industries include agriculture, healthcare, hospitality, and manufacturing. The top employers are Kaiser Permanente, Sutter Medical Center of Santa Rosa, St. Joseph Health System, and Graton Resort & Casino.[13] \

Like many California counties, Sonoma was severely affected by the economic recession that began in 2008 and unemployment rates were impacted by COVID and the statewide/county Shelter-in-Place orders issued March 17, 2020. The unemployment rate in Sonoma County was 6.2% in October 2020, down from a revised 7.2% in September 2020, and above the year-ago estimate of 2.4%.[14]

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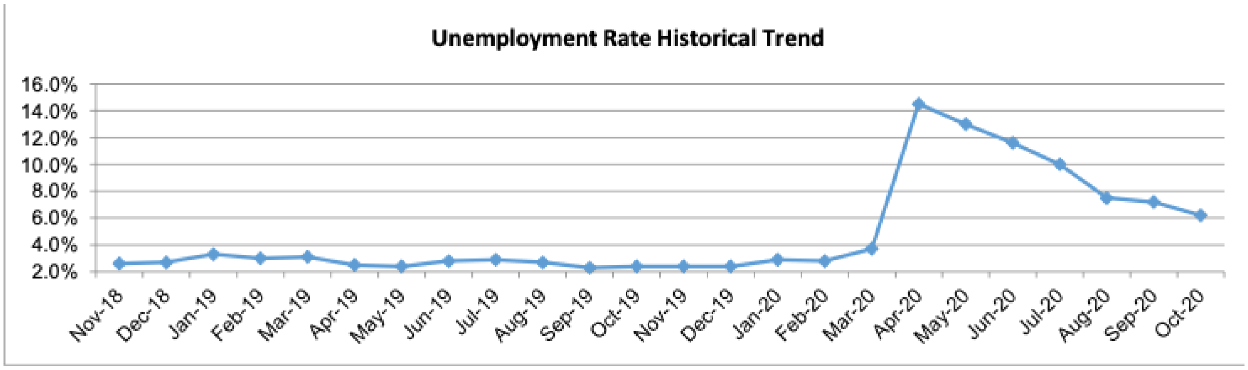
[6] U.S. Census Bureau. (2018). *Quick Facts, Sonoma county, California*.
[7] California Department of Health Services (2018). *Medi-Cal Enrollees and Beneficiaries Served in CY 2018 by Race/Ethnicity.*
[8] County of Sonoma. (2019). *Tribal affairs*. Retrieved from http://sonomacounty.ca.gov/CAO/Public-Reports/Legislative-Program/Tribal-Affairs/
[9] U.S. Census Bureau. (2018). *Quick Facts, Sonoma county, California*. Retrieved from https://www.census.gov/quickfacts/fact/table/sonomacountycalifornia
[10] U.S. Census Bureau, American Fact Finder. (2018). *Occupied housing units, 2013-2017 American Community Survey 5-year estimates*. Retrieved from https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_17_5YR_B25106&prodType=table
[11] U.S. Census Bureau. (2018). *Selected social characteristics on the United States, California.* Retrieved from https://data.census.gov/cedsci/table?d=ACS%205-Year%20Estimates%20Data%20Profiles&table=DP02&tid=ACSDP5Y2017.DP02&y=2017&g=0400000US06_0500000US06097&lastDisplayedRow=146
[12] Hayes, J. & Hill, L. (2017). *Undocumented immigrants in California.* Retrieved from https://www.ppic.org/content/pubs/jtf/JTF_UndocumentedImmigrantsJTF.pdf
[13] County of Sonoma. (2019). *Industry sectors*. Retrieved from http://sonomaedb.org/Why-Sonoma-County/Industry-Sectors/
[14] State of California, Employment Development Department. (November 2020). *Santa Rosa MSA (Sonoma County), Industry Employment & Labor Force.* https://www.labormarketinfo.edd.ca.gov/cgi/databrowsing/localAreaProfileQSResults.asp?selectedarea=Sonoma+County&selectedindex=49&menuChoice=localAreaPro&state=true&geogArea=0604000097&countyName=



Yet, just over 9% of County residents live in poverty, about half of California's rate of 19%.[15] The median household income is $71,796.[16]

COVID-19 has also disproportionately affected the Latinx/Hispanic community in 2020. The Latinx community represents 71% of the COVID-19 cases recorded while being 27.3% of the county's population. The combined economic and health impacts of COVID on the Latinx population has not yet been fully realized.

While many Sonoma residents have bounced back after the recession, rising housing costs continue to be a key driver of economic instability. Over 50% of Sonoma County residents who rent their homes and over 30% of residents who own their homes experience housing-cost burden (i.e., spend 30% or more of their household income on rent or mortgage).[17] Historic chronic underbuilding of housing created a disparity between supply and demand and limited the growth potential of the County's economy.[18] Housing costs and underbuilding have the greatest impact on individuals and families with less financial security or who are experiencing home instability, furthering disparities already present.

Housing availability in Sonoma was negatively impacted by the 2017 Sonoma Complex Fires and the recent 2019 Kincade Fire. The Complex Fires burned over 112,000 acres, destroyed over 5,000 homes, and took 24 lives. One in six households reported lost wages or employment and one in ten households reported an increase in housing or rent costs as a direct result of the fires.[19] Approximately 2.5% of Sonoma's total housing units were lost in the fires, leading the County to require a total of 26,000 new units by 2020 to account for employment growth, fire losses, and overcrowding.[20] The County was better-prepared for the Kincade Fire and, fortunately, it was less impactful. However, the fire burned over 77,000 acres, forced almost 200,000 people to evacuate, and affected the County for weeks.[21]

The fires also had enduring mental health impacts across the County. The Sonoma community experienced individual and collective trauma, with 40% of households

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[15] U.S. Census Bureau. (2018). *Quick Facts, Sonoma county, California*.
[16] U.S. Census Bureau. (2018). *Quick Facts, Sonoma county, California*.
[17] U.S. Census Bureau. (2018). *Quick Facts, Sonoma county, California*.
[18] Beacon Economics. (2018). *Sonoma county complex fires: Housing and fiscal impact report*. Los Angeles, CA: Thornberg, Kleinhenz, & Meux.
[19] Epidemiology and Assessment Unit. (2019). *2018 Sonoma county rapid needs assessment*. [PowerPoint slides].
[20] Beacon Economics. (2018).
[21] Alexander, K. (2019, November2). Sonoma's Kincade Fire was different – no one died. Here's why.

reporting traumatic experiences such as being separated from a family member or suffering a significant disaster-related illness or injury.[22] Some experienced quality of life changes associated with post-traumatic stress disorder, depression, and anxiety. Fifty-nine percent of households reported at least one family member experienced anxiety and/or fear and 24% reported at least one family member experienced depression or hopelessness.[23] Vulnerable populations, such as individuals enrolled in Medi-Cal and those with a serious mental illness, are disproportionately impacted by these events as they add to their cumulative trauma. The County saw an increase in the number of people seeking mental health assistance as a result of the fires, many for the first time. Sonoma County BHD deployed over 120 staff to provide services, resources, and act as Disaster Workers, and the County was subsequently awarded disaster relief grants and funds to support mental health assistance and training activities.[24]

In fiscal years 2017-2018 and 2018-2019, Sonoma Department of Health Services, including BHD, faced a significant budget deficit. [25] To address the issue, the Sonoma DHS-BHD engaged in a system redesign, a hiring freeze and general reduction in staff levels, program cuts, and the elimination of some MHSA contracts.[26] The scope and various levels of care provided in the mental health continuum within the County was impacted, unfortunately during a time of higher need in the County. Moving forward the County intends to more conservatively estimate revenues and expenditures in the MHSA expenditure plans, and the DHS budget more broadly, to account for financial shortfalls and ensure sufficient funds exist to pay for planned programming.

II. Medi-Cal population service needs (Use current CAEQRO data if available.)

California External Quality Review Organization (CalEQRO), BHC (Behavioral Health Concepts), reports that Sonoma County's average monthly unduplicated number of Medi-Cal enrollees by Race/Ethnicity during Calendar Year 2017 are as follows:

Race/Ethnicity	Average Monthly Unduplicated Medi-Cal Enrollees	% Enrollees
White	46,153	35.6%
Latino/Hispanic	53,672	41.4%
African-American	2,438	1.9%
Asian/Pacific Islander	4,899	3.8%
Native American	1,675	1.3%
Other	20,760	16.0%
Total	**129,596**	**100%**

22 *San Francisco Chronicle*. Retrieved from https://www.sfchronicle.com
23 Epidemiology and Assessment Unit. (2019).
24 Epidemiology and Assessment Unit. (2019).
25 Sonoma County DHS-BHD. (2019). *MHSA 2018-2019 Plan Update & Annual Update for 2016-2017*. Sonoma, CA.
26 Sonoma County DHS-BHS. (2019).

The total for Average Monthly Unduplicated Medi-Cal Enrollees is not a direct sum of the averages above it. The averages are calculated independently.

California's Department of Health Care Services (DHCS) Information Notice 13-09 reports Spanish as a threshold language for Sonoma County. DHCS defines "Threshold Language" as a language identified as the primary language, as indicated on the Medi-Cal Eligibility Data System (MEDS), of 3,000 beneficiaries or five percent of the beneficiary population, whichever is lower, in an identified geographic area, per Title 9, CCR Section 1810.410 (a)(3).

A. Summarize the following two categories by race, ethnicity, language, age, gender, and other relevant small county cultural populations:

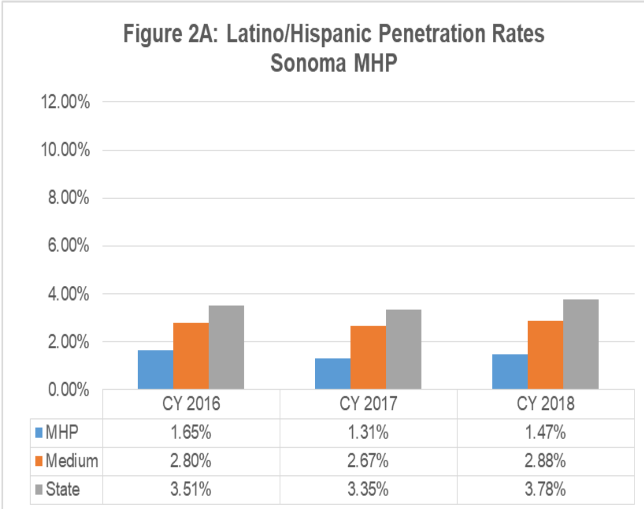
1. The county's Medi-Cal population (County may utilize data provided by DMH. See the **Note** at the beginning of Criterion 2 regarding data requests.)

Table 1: Medi-Cal Enrollees and Beneficiaries Served in CY 2018 by Race/Ethnicity Sonoma MHP

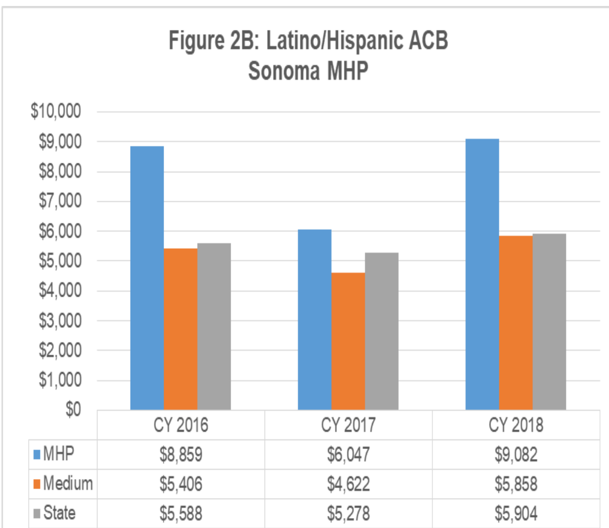
Race/Ethnicity	Average Monthly Unduplicated Medi-Cal Enrollees	% Enrollees	Unduplicated Annual Count Beneficiaries Served	% Served
White	41,314	33.6%	1,730	49.5%
Latino/Hispanic	51,906	42.2%	765	21.9%
African-American	2,197	1.8%	117	3.3%
Asian/Pacific Islander	4,228	3.4%	71	2.0%
Native American	1,456	1.2%	40	1.1%
Other	21,864	17.8%	775	22.2%
Total	**122,962**	**100%**	**3,498**	**100%**

The total for Average Monthly Unduplicated Medi-Cal Enrollees is not a direct sum of the averages above it. The averages are calculated independently. Source: Sonoma County MHP 2019-20 External Quality Review Performance Measures Behavioral Health Concepts, Inc.

2. The county's client utilization data



Sonoma BHD has not seen an improvement of utilization of services by the Latinx population, which is growing in the county. The chart to the left indicates that Sonoma County is lower than the average in similar size counties and lower than statewide averages. Over the same time period from 2016 – 2018, Sonoma BHD has allocated larger budgets to serve the Latinx population as compared to similar size counties and statewide averages.



A. 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.

According to the most current Community Health Needs Assessment (CHNA), Sonoma County residents and stakeholders perceive the need for an increase in accessible mental health services, including preventative care and screening. It was also noted that stigma remains an issue surrounding mental health and mental health treatment and may prevent some residents from seeking care. Socioeconomic and other upstream factors may affect access to care, and it should not be assumed that access issues represent a lack of available services.

Within Sonoma County, attention to mental health has increased in recent years, and was ranked as an issue of high concern in the most recent CHNA. Sonoma Residents have a high risk for suicide, with 14.00 per 100,000 county residents dying as a result of suicide (2015-17). This number is notably higher than the rate of suicide deaths for

California residents, which is 10.312 per 100,000 residents for the same time period. Additionally, an estimated 15.2% of Sonoma County residents have reported experiencing poor mental health, defined as problems with mental health, emotions, nerves, or use of alcohol and drugs. There are distinct differences in this prevalence when looking at various demographic groups.

Age

Mental health challenges vary distinctly by age group. The bullets below provide a summary of available data from Lucille Packard Foundation for Children's Health (kidsdata.org) on mental health challenges for Older Adults, Adults, and Youth in Sonoma County.

Children and Youth

- 19.4% of Sonoma County high school students (2011-2012 and 2012-2013 school years) report having seriously considered suicide in the past year
- 48 youth aged 13-20 were hospitalized in Sonoma County in 2014 due to self-inflicted injuries
- 5 children aged 5-14 were hospitalized in Sonoma County in 2014 due to self-inflicted injuries
- Children aged 5-14 in Sonoma County are hospitalized for mental health issues at a rate of 2.7 per 1,000
- Youth aged 15-19 in Sonoma County are hospitalized for mental health issues at a rate of 11.6 per 1,000

Adults (Sonoma County CHNA 2016)

- 19.6% of Sonoma County adults 18-59 report needing help for emotional/mental health problems or use of alcohol or drugs, higher than the statewide average of 16.1%

Older Adults (Sonoma County CHNA 2016)

- 10.5% of older adults in Sonoma County, aged 60 and higher, report needing help for mental health issues, higher than the statewide average of 7.4%

Race/Ethnicity

Sonoma County is less racially and ethnically diverse than the State of California as a whole. The vast majority of Sonoma County residents identify as either white or Hispanic, and available demographic data on other groups remains limited.

- 64.8% of white survey respondents in Sonoma County rate their mental health, which includes stress, depression and problems with emotions, as "very good" or "excellent"
- 44.6% of Hispanic respondents survey respondents rate their mental health, which includes stress, depression and problems with emotions, as "very good" or "excellent"

Housing Status

Homelessness remains a high priority issue for Sonoma County residents. Even more so, in the wake of the Sonoma Complex fires that occurred on October 8th 2017 and burned over 112,000 acres, destroyed over 5,000 homes with the loss of 23 lives.

Despite widespread concerns about the ongoing effects of the 2017 fires, the 2019 Point-in-Time Homeless Count shows that the number of people experiencing homelessness in Sonoma County has declined by 7% during the past year - from 2,951 in 2019 to 2,745 in 2020. This is a positive trend including a 2% decrease the year prior. This decrease is significant considering the aftermath of the 2017 wildfires. However the 2020 Homeless Count was conducted in February 2020, prior to COVID-19 shelter-in-place orders and subsequent economic impacts on businesses and employment. It is unclear how the pandemic may have contributed to the numbers of homeless in the community since then. But Sonoma County Supervisors have accelerated efforts to support those dealing with the region's high housing costs including authorizing wage replacement for residents who have access to the fewest resources and who test positive for COVID-19.

In order for Sonoma County to have a more accurate analysis of people who are unsheltered in Sonoma County, the count was conducted for the first time in 2020 using a mobile app that relays real-time data and pinpoints exact geo locations for individuals being counted. The 2020 county demonstrates that some of the most dramatic decreases appeared in homeless subpopulations which the Department of Housing and Urban Development identified as key to ending homelessness overall. Subpopulations of individuals experiencing homelessness include: Individuals experiencing chronic homelessness, homeless families with children, Transition-Age-Youth and veterans.

California continues to fund a wide range of programs to alleviate the homeless crisis. The state's emphasized funding for subpopulations, alongside Sonoma County's focus on high-risk populations of individuals experiencing homelessness has had positive results in decreasing homelessness overall.

- 562 individuals experiencing chronic homelessness were identified, a 16% reduction from 675 in 2019.
- 79 families with a total of 233 individuals were found, almost all of them in emergency shelter. This is a decrease of 9%, from 87 families in 2019, and a continued overall decrease in families from a high mark of nearly 200 families in 2013.
- 52 unaccompanied children and 297 TAY were counted, for a total of 349 - a decrease of 47% from 657 in 2019.
- In 2020, 139 veterans were counted, a reduction of 34% from 210 in 2019.

Significant investments in rapid rehousing and permanent housing solutions have also been key to the decrease in homelessness from 2019 to 2020. It should be noted that the Point-In-Time count took place after the declaration of the emergency on the Joe Rodota Trail, in which over $11 million was injected into housing solutions resulting in 104 placements: 60 placements into Los Guilicos Village, 35 shelter placements, four residential substance use treatment placements, and five other housing placements.

The MHSA Peer Housing Needs Survey was conducted in September 2017.

Sonoma County Department of Health Services Behavioral Health Division (BHD) worked with Harder Company Community Research (Harder Company) to conduct a housing needs assessment survey. The survey aims to provide BHD with the information it needs to better understand the housing needs of its clients. The survey findings will also be used to help inform the County's application for No Place Like Home funding. The No Place Like Home program provides financing for County's to acquire, design, build, and/or restore permanent supportive housing for individuals living with a serious mental illness who are homeless, chronically homeless, or at-risk of chronic homelessness. The survey aimed to explore the following questions:

- What are the housing needs of BHD clients? How many BHD clients are homeless, have unstable housing, and/or are unsatisfied with their housing?
- What types of barriers do BHD clients experience when attempting to secure housing?
- What types of housing would BHD clients like to have access to?

To ensure the survey was useful to BHD and reflective of the clients BHD serves, Harder Company worked closely with a group of peer leaders to draft the survey. Survey input was also provided by BHD program managers and BHD staff. The survey was conducted between September 14, 2017 and December 29, 2017 and administered across 14 BHD programs with a total of 558 surveys collected. Paper surveys were administered to BHD clients and were either completed by clients independently or with a case manager, program staff member, or peer leader. All surveys were administered in English.

It is important to note that during the data collection period (October 2017), Sonoma County experienced the worst wildfires in the history of the State of California. These fires were incredibly destructive, burning over 140,000 acres and destroying over 7,000 structures. Not only were BHD staff overseeing emergency shelters, but many were also directly impacted by the fires and/or assisting clients impacted by the fires. As such, survey data collection was on hiatus for most of October and November. While the original target was to reach 80 percent of BHD clients, given the events and capacity of BHD staff, survey administration was extended through the end of December with approximately 40 percent of BHD clients surveyed. It is also important to note that the survey itself was not updated to include specific questions about the fire. While open-ended responses allowed clients to include any information about if/how the fires impacted their housing, none of the surveys we received after the fire included responses from clients indicating they had been displaced due to the fires.

Economic Status

While many of Sonoma County's residents are socioeconomically secure, 11.7% of county residents reported annual incomes below Federal Poverty Level in 2015. According to the 2013 Sonoma County Community Health Needs Assessment, "Given the high cost of living in Sonoma County, it is generally accepted that an annual income under 200% of FPL ($21,660 for an individual) is inadequate to meet basic needs for food, clothing, shelter, transportation, health care and other necessities." There appear to be notable disparities in reported mental health between those living with incomes below 200% of the FPL, and those with higher incomes.

- Among respondents living under 200% of FPL, 40.2% report "excellent" or "very good" mental health as compared with 71.2% of those with higher incomes. (26)
- Among those living below 200% of FPL, over 30% report only "fair" or "poor" mental health. (27,24)

Education

There appear to be similar disparities regarding level of education and mental health.

- Among Sonoma County adults with the highest education levels (college graduate or above), 72% report excellent/very good mental health (28)
- 28.6% of those without a high school degree report excellent/very good mental health (29)
- Over 30% of those without a high school degree report fair/poor mental health (30)

The 2013-2016 Sonoma County Community Health Needs Assessment can be found at the following link:
http://www.sonomahealthaction.org/content/sites/sonoma/cnha_2016/Sonoma_CHNA_FINAL_Report.pdf.

III. 200% of Poverty (minus Medi-Cal) population and service needs.

A. Summarize the 200% of poverty (minus Medi-Cal population) and client utilization data by race, ethnicity, language, age, gender, and other relevant small county cultural populations.

The following tables are made available by the CA Department of Health Care Services. These tables demonstrate mental health and alcohol and other drug prevalence estimates. These tables are available to all California counties. To review the complete report, follow the following link:

https://www.dhcs.ca.gov/provgovpart/Documents/CaliforniaPrevalenceEstimates.pdf

Estimates of Need for Mental Health Services for Sonoma County – SMI Definition Children and Youth in Households below 200% poverty			
Total Pop	Cases	Pop	Percent
Total Population	8,858	105,332	8.41
Youth Total	2,553	29,326	8.7
AGE			
00-05	982	11,292	8.7
06-11	839	9,625	8.71
12-17	732	8,409	8.71
GENDER			
Male	1,274	14,524	8.77
Female	1,279	14,902	8.64
ETHNICITY			
White - NH	748	8,570	8.73
African American - NH	63	702	9.04
Asian - NH	92	1,073	8.6
Pacific Islander - NH	6	69	8.83
Native - NH	22	241	9.12
Other - NH	0	0	0
Multi - NH	84	955	8.82
Hispanic	1,537	17,716	8.68

Estimates of Need for Mental Health Services for Sonoma County – SMI Definition Adults in Households below 200% poverty			
Total Pop	Cases	Pop	Percent
Total Population	8,858	105,332	8.41
Adult Total	6,305	76,006	8.71
AGE			
18-20	172	5,374	3.2
21-24	646	9,005	7.17
25-34	1,612	15,730	10.25
35-44	1,437	11,862	12.12
45-54	1,253	10,669	11.75
55-64	707	9,261	7.63
65+	477	14,104	3.38
GENDER			
Male	2,331	34,176	6.82
Female	3,974	41,830	9.5
ETHNICITY			
White - NH	3,869	42,589	9.08
African American - NH	140	1,446	9.66
Asian - NH	100	2,850	3.49
Pacific Islander - NH	7	151	4.47
Native - NH	89	766	11.64
Other - NH	0	0	0
Multi - NH	148	1,690	8.78
Hispanic	1,952	26,515	7.36
MARITAL STATUS			
Married	1,575	26,175	6.02
Sep/Wid/Div	2,594	24,469	10.6
Single	2,153	25,362	8.42
EDUCATION			
Grades 00-11	2,154	26,976	7.98
HS Graduate	3,541	40,124	8.82
College Graduate	610	8,906	

B. Ranking the highest to the lowest rates of estimated illness among racial groups is as follows:

For Adults 18+:

Estimates of Need for Mental Health Services for Sonoma County – SMI Definition Adults in Households below 200% poverty			
Total Pop	Cases	Pop	Percent
Total Population	8,858	105,332	8.41
Total Adult (18+)	6,305	76,006	8.71
ETHNICITY			
Pacific Islander - NH	7	151	4.47
Asian - NH	100	2,850	3.49
Hispanic	1,952	26,515	7.36
Multi - NH	148	1,690	8.78
White - NH	3,869	42,589	9.08
African American - NH	140	1,446	9.66
Native - NH	89	766	11.64

C. Provide an analysis of disparities as identified in the above summary. This can be a

According to the data cited above, Native Americans, African Americans and multi-racial populations are disproportionately represented in estimated need.

IV. MHSA Community Services and Supports (CSS) population assessment and service needs

A. From the county's approved CSS plan, extract a copy of the population assessment and summarize population and client utilization data by race, ethnicity, language, age, gender and other relevant small county cultural populations.

The following data was extracted from our mental health and substance use disorders data systems. Mental Health Medi-Cal Beneficiary data for client utilization data by race, ethnicity, language, age, and gender and other factors:

By Age	Count of Clients	%age
0-17	1319	37.03%
18-64	2265	59.36%
65+	189	3.61%
Grand Total	3773	100.00%

By Race	Count of Clients	%age
Alaskan Native	1	0.03%
American Indian	74	2.01%
Asian Native	1	0.03%
Black/African-American	202	5.44%
Cambodian	10	0.28%
Chinese	13	0.29%
Filipino	11	0.25%
Guamanian	4	0.11%
Hawaiian	10	0.28%
Japanese	5	0.14%
Korean	7	0.19%
Laotian	14	0.37%
No Entry	364	10.13%
Other Asian	27	0.74%
Other Race	655	17.86%
Samoan	3	0.08%
Vietnamese	5	0.14%
White	2367	61.64%
Grand Total	3773	100.00%

By Language	Count of Clients	%age
Cambodian	1	0.03%
Cantonese	5	0.14%
English	3403	90.05%
Farsi	2	0.06%
French	1	0.03%
Hebrew	2	0.06%
Ilocano	2	0.06%
Japanese	2	0.06%
Lao	6	0.15%
Mandarin	1	0.03%
No Entry	75	2.10%
Other Non-English	20	0.30%
Other Sign Language	1	0.03%
Russian	1	0.01%
Samoan	1	0.03%
Spanish	225	6.23%
Tagalog	1	0.03%
Unknown / Not Reported	23	0.61%
Vietnamese	1	0.03%
Grand Total	3773	100.00%

By Ethnicity	Count of Clients	%age
Cuban	3	0.08%
Mexican/Mexican American	624	17.13%
No Entry	982	26.76%
Not Hispanic	1897	48.86%
Other Hispanic/Latino	125	3.40%
Puerto Rican	8	0.22%
Unknown	134	3.54%
Grand Total	3773	100.00%

Sexual Orientation	Count of Clients	%age
Bisexual	22	0.61%
Declined To State	133	3.13%
Gay (male)	15	0.42%
Heterosexual / Straight	441	11.87%
Lesbian (female)	6	0.15%
No Entry	3136	83.27%
Transgender	11	0.31%
Unsure / Questioning	9	0.25%
Grand Total	3773	100.00%

By Gender	Count of Clients	%age
Female	1768	46.91%
Male	2001	53.00%
Transgender (F to M)	1	0.03%
Transgender (M to F)	1	0.01%
Unknown	2	0.06%
Grand Total	3773	100.00%

Employment	Count of Clients	%age
Competitive job market 20-35 hrs a week	92	2.52%
Competitive job market 35 hrs + a week	54	1.50%
Competitive job market less thn 20 hrs a wk	64	1.72%
Full-time homemaking responsibility	10	0.28%
Job training, full-time	5	0.14%
No Entry	197	5.36%
Not in the labor force	714	17.56%
Part-time school/job training	44	1.18%
Rehabilitative work, 20 to 35 hrs a week	9	0.23%
Rehabilitative work, less 20 hrs a week	9	0.23%
Rehabilitative work,35 hrs or more week	1	0.03%
Resident/Inmate	7	0.20%
Retired	30	0.68%
School, full-time	941	26.39%
Unemployed, actively seeking work	155	4.25%
Unemployed, not actively seeking work	1105	29.19%
Unknown	313	8.10%
Volunteer Work	23	0.46%
Grand Total	3773	100.00%

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.

Based on the data above, it would appear that 20% of the clients served are Mexican, Mexican American or other Latinx ethnicity. The gap in declaration of race with over 17% declaring "other race" need clarification, but assuming those of Latinx background may have selected that option. 20% of Latinx client utilization is lower than representation in Sonoma County demographics, thus this data also validates the need for more outreach, culturally responsive services for the Latinx population. Older adults, 65+ are also underrepresented. Notable employment findings include almost 30% who are unemployed and not actively seeking work, 17% not in the labor force and 26% who are in school.

V. Prevention and Early Intervention (PEI) Plan: The process used to identify the PEI priority populations

A. Describe which PEI priority population(s) the county identified in their PEI plan and describe the process and rationale used by the county in selecting them. PEI Plan sections should be used to respond to priority populations identified by the county.

Most recently, the FY 2020-23 MHSA Work Plan Summaries for the Integrated Plan for PEI prioritized the following populations:

- Latinx/Hispanic
- African Americans
- Native Americans
- LGBTQ+ youth and
- Older Adults

These culturally underserved groups were identified and validated through a variety of data sources, including the 2019 Sonoma County Capacity Assessment and FY 2020-23 MHSA Three-year Program and Expenditure Plan; 2018 EQRO data reports; documented meetings with stakeholders, MHSA Steering Committee, Mental Health Board and Health Action Chapters.

Criterion 3: Strategies and Efforts for Reducing Racial, Ethnic, Cultural, and Linguistic Mental Health Disparities

I. List the target populations with disparities your county identified in Medi-Cal and all MHSA components (CSS, WET, and PEI)

A. Briefly describe the process and rationale the county used to identify and target the population(s) (with disparities) in its PEI population.

In March of 2019, 25 individuals were selected to serve on the MHSA Steering Committee. The MHSA Steering Committee members represent diverse populations, age groups, and historically underserved populations throughout the geographical regions of Sonoma County. The initial committee meetings provided in-depth training on MHSA history, regulations, current programs and the FY 19-20 Expenditure Plan. In 2019, the MHSA Steering Committee formed two subcommittees that focused on a solicitation process for Innovation Projects and the support for a community engagement plan to gather data for the Capacity Assessment as a basis for the FY 2020-2023 MHSA Three-Year Planning Process. The Capacity Assessment validated the populations most at-risk and in need of PEI services:

- Native Americans
- Latinx
- LGBTQ+

II. Then list disparities in each of the populations (Medi-Cal, CSS, WET,and PEI).

Latinx Community (Medi-Cal, CSS, WET and PEI)

The County has had a low Latino penetration rate in clinical services for the past several years. The County is working towards improving the Latino penetration rate and increasing both access to mental health services for Latino clients and improving the cultural responsiveness of services for Latino clients.

The FY 2020-23 MHSA Three-Year Program and Expenditure Plan cites an overrepresentation of Latinx/Hispanic individuals enrolled in Medi-Cal and treatment service utilization data that indicates an imbalance of representation, both in the youth and adult age groups.

Sonoma County Latinx/Hispanic Population Compared to Medi-Cal Enrollment and Consumers of BHD in 2019

Sonoma County Latinx/Hispanic Population	Percent of Population
In County	27%
Medi-Cal	42%
Consumers	23%
Adult Consumers	13%
Youth Consumers	36%

While the County offers some behavioral health services for the Latinx/Hispanic community, opportunities were limited. The table below lists the percent of various Sonoma County population groups identified as Hispanic or Latinx. There is a notable contrast in the youth and adult populations served. **Latinx/Hispanic consumers made up just over a tenth of adult consumers while they made up over one third of youth consumers.** Interestingly, over 21% of consumers served by the Adult Access Team identified as Hispanic, almost double the proportion of Sonoma's broader consumer population. It is unclear why these individuals were not connected to subsequent services.

Latinx/Hispanic youth, on the other hand, were overrepresented in a variety of programs. They made up 45% of episodes in general outpatient programs (e.g. therapy, medication support, etc.), 44% of episodes in youth FSP program, and 42% of episodes in youth justice programs compared to 35% in the general youth DHS-BHD population. There may be greater services available for Latinx/Hispanic youth or they may be more likely to access services due to less barriers either from language or stigma.

"She happens to speak Spanish and now provides those services in Spanish, but she's not actually trained to do so."
– Community Member

Both consumers and providers noted difficulties accessing or supplying services in Spanish. While about one fifth of consumers identified as Hispanic, very few services were offered in Spanish. Many reported a need for a greater quantity and variety of high-quality services in Spanish that accept consumers regardless of citizenship status. Stakeholders noted that the lack of culturally competent and bilingual staff resulted in the Hispanic community accessing a lower level of care than others or being deterred from accessing care altogether. For example, when monolingual Spanish-speakers tried to access counseling services oftentimes they were only offered education or wellness opportunities due to the lack of in-county bilingual clinicians. Service limitations were particularly true for undocumented residents, who had limited access to facilities that were often over capacity and inconsistent in quality. Limited services in Spanish and culturally relative to Sonoma's Latinx/Hispanic population may have led to increased use of higher-level services. During fiscal year 2018-2019, a high proportion of Latinx consumers went to the CSU, though slightly less than consumers overall. While accessing the appropriate level of care may have been a problem for this community, Sonoma is working to address this issue. The County is currently exploring a possible MHSA Innovation project that would create culturally-specific interventions for the Latinx/Hispanic population.

"We have the bilingual staff that…do [the] program…because they speak Spanish, not because they have the mental health training." – Provider

Native American Communities (PEI, WET, Medi-Cal)

The Native American population has access to the Sonoma County Indian Health Project (SCIHP), a Community Health Center that provides behavioral health, medical, dental and other wellness related services predominantly to Native Americans in Sonoma. However, SCIHP is underutilized, likely due to mental health stigma within the target population and limited culturally specific programs in remote geographic areas. As with the Latinx/Hispanic community, this could be leading Native American individuals with behavioral health needs to over rely on crisis services, as the majority of Native American consumers went to the CSU in fiscal years 2018-2019. As mentioned previously, Native American consumers were also overrepresented in locked long-term residential treatment. In fiscal year 2018-2019 they made up 7% of program episodes compared to only 2% of the MHSA population.

Stakeholders also emphasized **challenges finding comfortable, culturally/socially appropriate services for LGBTQ+ and Native American consumers**. Further engagement of the MHSA values of community collaboration and culturally competency specific to these communities could support deeper integration of relative services into Sonoma's behavioral health system.

LGBTQ+ Youth and Young Adults (PEI, WET, CSS, Medi-Cal)

A recent survey conducted by a local nonprofit, Positive Images focused on learning more from the community of LGBTQ+ youth (14 – 18 years) and young adults (18 – 30 years). The sample of over 100 respondents disclosed that up to 24% reported being nonbinary or transgender. This population continues to report that they are challenged with finding both healthcare and mental health services that supports them in their identity and in meeting their health needs. 68% of the respondents reported that they had utilized mental health services in the past year. Furthermore, this population reported that 79% had received a diagnosis of depression, 77% of anxiety, 41% of PTSD, and 26% of ADD/ADHD. The most striking finding was that 25% had called the suicide hotline at least once in their life, and 4% had called more than three times in their life.

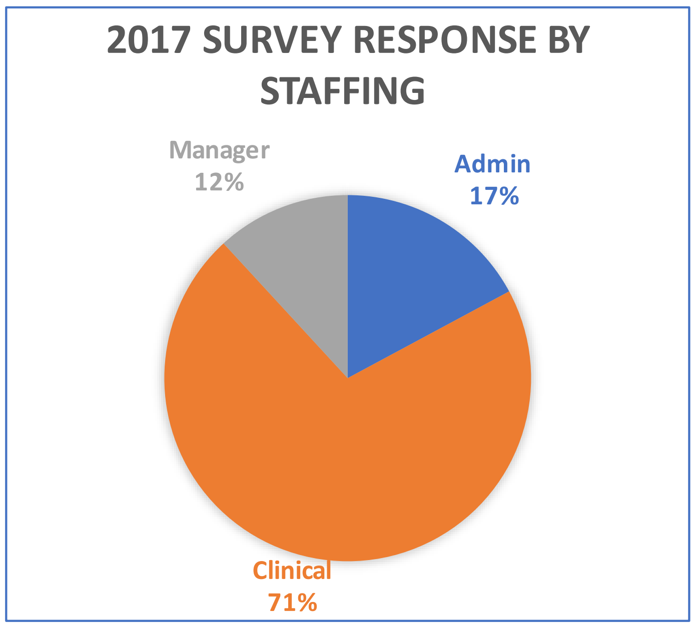
IV. Then discuss how the county measures and monitors activities/strategies for reducing disparities.

Sonoma County Behavioral Health Division (BHD) Division uses a community driven Continuous Quality Improvement (CQI) model as part of our community planning process. Continuous Quality Improvement is the complete process of identifying, describing, and analyzing strengths and problems, and then testing, implementing, learning from, and revising solutions. Sonoma County BHD staff and managers monitor performance outcomes with contractors, working with them to make necessary adjustments in real time, in the effort to realize more effective programs, services, and activities.

Every three years, a division-wide **Cultural Responsiveness (CR) Survey** is conducted to identify disparities, assess cultural responsiveness needs of the staff and provide insight into future training and system planning (reflected in the Workforce Education and Training Plan) for the Sonoma County Department of Health Services – Behavioral Health Division. Three levels of staff are requested to take the survey to address differing scopes of work and interactions with the communities served: Management, Clinical and Administrative staff.

The following standardized tools are utilized:

- California Brief Multicultural Competence Scale (CBMCS)
- Contra Costa County Mental Health Division Cultural Competency Assessment Tool
- Sonoma County Mental Health Administrative Staff Cultural Assessment Tool



Survey administration for 2020 is presently underway (released December 2, 2020), thus this plan will include the results from the 2017 CR Survey report.

In 2017, 75.6% Response (324 Surveys distributed; 245 Surveys returned)

- 42 Admin Responses
- 174 Clinical Responses
- 29 Manager Responses

FINDINGS FOR ADMINISTRATIVE STAFF

BHD Administrative/Clerical staff report feeling most comfortable in the area of communication with people who are different from them, particularly in displaying an open, non-fearful attitude toward said differences. They report feeling comfortable seeking support from supervisors for cultural issues. Administrative/Clerical staff know what to do when someone comes to the front desk who speaks a different language and report having access to written notices in multiple languages for interpreter services.

BHD Administrative/Clerical staff report feeling least comfortable with phone interpretive services. Some of these responses may be due to the survey questions referencing the old Language (People) Line rather than the current CTS Language Line. Staff report concern about the timeliness of interpretive services when the need is immediate. Additionally, a significant portion of Administrative/Clerical staff report needing support/training on how to make non-English appointment reminders.

Administrative/Clerical staff identified several questions as not applicable to their job duties. This suggests a need to revise the survey tool itself to be more relevant to job scope. The distinguishing factor between these questions was a focus on direct client services. This suggests a need to delineate results between program support staff and administrative support staff.

In sum, BHD Administrative/Clerical staff communicate comfortably cross-culturally, utilize supervision support, and respond effectively to in-person client interpretation needs. They would benefit from training around phone interpretive services and non-English appointment reminders. They identified an issue with the timeliness of urgent interpretive needs. Lastly, they indicated several questions with limited relevance for their job focus, suggesting the need for survey revision of those questions.

FINDINGS FOR CLINICAL STAFF

BHD Clinical Staff report their highest strengths in the area of Cultural Sensitivity, particularly in the use of their communication skills. They are aware of how their own values and institutional barriers affect their clients. BHD Clinical Staff also scored high in the area of Cultural Awareness, particularly relating to awareness of dominant culture privilege. They report high self-awareness of their own cultural background, experiences, and reactions. In terms of specific client populations, Clinical Staff report their highest degree of comfort in assessing the mental health needs of women and persons from very poor socioeconomic backgrounds.

Clinical Staff report their highest need for development in the area of Cultural Knowledge, specifically relating to identifying culturally relevant assessment tools, critiquing multicultural research, and discussing differences within/among ethnic groups. Additional areas for development include knowledge of acculturation models and ability to discuss research regarding mental health issues in culturally diverse populations. Of note were the number of hand-written comments in this section of the survey, stating that these questions were not applicable to the respondent’s current work. In terms of specific client populations, BHD Clinical Staff report highest need for training in assessing the mental health needs of LGBTQ-identified individuals.

In sum, BHD Clinical Staff show highly effective communication skills and self-awareness of personal values and institutional barriers which affect their clients. They could benefit from further development of skills regarding the critique and application of research and assessment tools in diverse populations; however, there is some question as to the relevance of this domain. As to specific populations, Clinical staff are highly comfortable assessing the mental health needs of women and persons from poor socioeconomic backgrounds. They could benefit from training in assessing the needs of LGBTQ-identified individuals.

FINDINGS FOR MANAGEMENT STAFF

BHD Management staff report highest confidence in the Consumer Grievance process, the working relationships with CBOs, and the cultural sensitivity of the reception area staff. Of note, the Community Outreach and Engagement efforts of the division received the highest marks of all the domains, specifically for creating strong ties to community partners and building knowledge of the community served.

Management staff report greatest concern about our work environment reflecting diverse populations served, involving diverse groups in the decision-making process at all levels of staffing, and providing training on the impact of immigration issues. The lowest-scoring domains are as follows: Education & Training; Governance, Systems, Policy Development; Human Resources & Development. Specific training is requested in the areas of immigration, supervision of multicultural workforce, and assessing cultural proficiency in the performance evaluation process. Additionally, the single largest factor in the suggestions for improvement category was Training Requests, particularly in the areas of cultural differences, assessment, awareness, specific populations, interpreters, and cultural skills.

As to HR and Systems Level, the results were largely mixed, with greatest concern expressed around hiring/retaining diverse staffing and involving diverse staff at all levels of decision-making. Of note is a fairly low score in the domain of Service Delivery on the specific item of incorporating practices and treatment modalities from the diverse populations served.

Several items scored a high incidence of the “Don’t Know” response, indicating a need for more information in these areas. The largest gap in knowledge appears to be in the Human Resources & Development domain, specifically in what types of culturally diverse media a position might be advertised. Additionally, there is an unknown in how the organization handles cultural conflicts between staff. Other unknowns center around interpreters, hands-on coaching, and explicit contractual agreements to serve specific sub-groups.

In sum, BHD Management staff are confident in the Community Outreach and Engagement efforts of the division. They rely upon strong relationships with community partners and express appreciation for the cultural skills of the reception-area staff. SCBH Management staff wish to be more inclusive of a multi-cultural perspective in the decision-making process at all levels. They request specific training regarding immigration issues and supervision of cultural conflicts. Lastly, there appears to be a knowledge gap around Human Resource Development as well as interpreter training and hands-on coaching opportunities for staff.

In January 2020, the Behavioral Health Division released the **MHSA FY 2016-2019 Capacity Assessment Report.** Within that report, underserved populations were identified as the Latinx/Hispanic community, LGBTQ+ community members and Native American community members.

In addition, the Behavioral Health Division administers the **Consumer Perception Survey** every May and November. The goal of the survey is to collect data for the federal National Outcome Measures (NOMs) required by the Substance Abuse and Mental Health Services Administration (SAMHSA). Receipt of federal Community Mental Health Services Block Grant funding is contingent upon the submission of this data.

The Department of Health Care Services (DHCS) has contracted with the California Institute for Behavioral Health Solutions (CIBHS) to scan and process the submitted forms and aggregate the data, once the counties have mailed the surveys. There is a focus on four consumer populations:

- Adults
- Older Adults
- Youth
- Family/Parents of Youth

Overall, 463 Consumer Perception Surveys were collected in calendar year 2019 for Sonoma County Behavioral Health. The number of surveys collected in 2019 decreased from 2018; however, this decrease is due to the missing November dataset resulting from Kincade Fire. Had the November survey administration proceeded with the same volume as the May administration, then overall response volume would have increased substantially, especially for Older Adults. The response rate from clients/family of Hispanic/Latino ethnicity remained strong representing 32% of survey respondents. The following are significant findings indicating a need in cultural competency in service delivery:

- Adult clients identifying as Transgender/Gender Fluid/Other Gender scored below the satisfaction threshold on all domains, whereas Transgender/Gender Fluid youth reported scores below threshold for Outcomes and Functioning only;
- Clients identifying as Native American, Asian and Black saw significant improvement in scores from the previous year, however the age group of older adults showed persons of Latinx, Asian, Pacific Islander and Other Ethnicity reported low satisfaction rates for Outcomes, Social Connectedness, and Functioning domains;
- Clients indicating Unknown ethnicity showed scores below the satisfaction threshold on Outcome, Social Connectedness, and Functioning domains; and
- American Indian/Alaskan Native youth the mean scores on almost all domains were low.

In addition to the Cultural Responsiveness Survey, BHD administers the Consumer Perception Survey twice annually. The goal of this survey is to collect data for the federal National Outcome Measures (NOMs) required by the Substance Abuse and Mental Health Services Administration (SAMHSA). Receipt of federal Community Mental Health Services Block Grant funding is contingent upon the submission of this data.

Counties are required to conduct the survey and submit data per §3530.40 of Title 9 of the California Code of Regulations. Section 3530.40 of Title 9 of the California Code of Regulations requires that semi-annual surveys be conducted (May and November). However, in November 2019, we were unable to collect survey results due to county-wide evacuations during the Kincade Fire.

The Department of Health Care Services (DHCS) has contracted with the California Institute for Behavioral Health Solutions (CIBHS) to scan and process the submitted forms and aggregate the data, once the counties have mailed the surveys. There are a total of four surveys for consumer populations:

- Adults
- Older Adults
- Youth
- Family/Parents of Youth

The surveys contain items in the form of statements that consumers rate. These responses are aggregated into the following categories:

Adults and Older Adults	Youth and Family
General Satisfaction	General Satisfaction
Perception of Access	Perception of Access
Perception of Participation in Treatment Planning	Perception of Participation in Treatment Planning
Perception of Quality and Appropriateness	Perception of Outcomes of Services
Perception of Outcomes of Services	Perception of Social Connectedness
Perception of Social Connectedness	Perception of Cultural Sensitivity
Perception of Functioning	Perception of Functioning

In 2018, a total of 128 respondents completed the survey.

Consumer Population	Items Scored	Survey Participants
Older Adult	36	23
Adult	36	231
Youth	26	81
Family/Parents of Youth	26	128

Of the survey participants, 32% were Latinx, representative of the general population. Some of the more significant findings were the low ranking for satisfaction for the nonbinary gendered population (both youth and adult), older adults, and for Native American youth.

Nonbinary Youth

Results by Gender

Satisfaction Domain	Male (n=27)	Female (n=41)	Other (n=4)
General Satisfaction	3.98	4.14	4.13
Perception of Access	3.88	4.28	4.00
Perception of Participation in Treatment Planning	3.74	4.09	4.00
Perception of Outcomes of Services	3.86	3.78	3.46
Perception of Social Connectedness	4.04	4.07	4.00
Perception of Cultural Sensitivity	4.15	4.33	4.19
Perception of Functioning	3.85	3.78	3.58

Nonbinary Adults

Results by Gender

Satisfaction Domain	Male (n=117)	Female (n=98)	Other (n=3)
General Satisfaction	4.19	4.19	3.06
Perception of Access	4.17	4.09	3.56
Perception of Participation in Treatment Planning	4.14	4.26	2.83
Perception of Quality and Appropriateness	4.12	4.25	3.31
Perception of Outcomes of Services	3.95	3.97	3.10
Perception of Social Connectedness	3.92	3.94	2.67
Perception of Functioning	3.96	3.94	3.06

Older Adults by Ethnicity

Results by Ethnicity

Satisfaction Domain	White n=15	Latinx n=3	AIAN n=0	Asian n=1	Black n=2	NHI/OPI n=1	Other n=4	Unknown n=1
General Satisfaction	4.41	4.67	N/A	4.00	4.83	4.33	4.50	4.50
Perception of Access	4.23	4.67	N/A	3.33	4.50	4.00	4.38	4.33
Perception of Participation in Treatment Planning	4.23	4.17	N/A	4.00	4.50	4.50	3.88	5.00
Perception of Quality and Appropriateness	3.98	4.63	N/A	3.63	4.50	3.67	4.32	4.78
Perception of Outcomes of Services	3.69	3.07	N/A	3.13	4.25	3.00	2.80	4.88
Perception of Social Connectedness	3.53	3.58	N/A	2.50	4.25	3.00	3.38	4.75
Perception of Functioning	3.53	3.27	N/A	3.00	4.40	3.20	3.25	4.60

Youth by Ethnicity: Native American

Results by Ethnicity

Satisfaction Domain	White n=32	Latinx n=38	AIAN n=11	Asian n=3	Black n=7	NHI/OPI n=1	Other n=22	Unknown n=6
General Satisfaction	4.25	4.14	3.59	4.17	4.11	4.83	4.01	4.06
Perception of Access	4.20	4.29	3.59	3.67	4.00	4.50	3.95	4.50
Perception of Participation in Treatment Planning	4.07	4.05	3.53	3.78	3.93	4.33	3.84	3.78
Perception of Outcomes of Services	3.87	3.76	3.47	3.72	3.57	4.83	3.66	3.95
Perception of Social Connectedness	4.42	4.15	3.82	3.72	4.27	5.00	4.27	4.00
Perception of Cultural Sensitivity	4.44	4.26	4.40	4.67	4.63	4.34	4.48	4.47
Perception of Functioning	3.89	3.74	3.38	3.72	3.60	4.83	3.66	3.93

Finally, BHD collects data on system access for non-English speaking consumers/beneficiaries as described on pages 52-53 of this report and utilization data collected through the electronic health records.

V. Share what has been working well and lessons learned through the process of the county's development and implementation of strategies that work to reduce disparities (within Medi-Cal, CSS, WET, and PEI).

Latinx Community

Latino Service Providers (LSP) was founded in 1989 by Latino leaders in education, government, and the social service sectors. LSP is currently comprised of over 1,600 members from neighborhood and community groups, mental health programs, public and private health service providers, education, law enforcement, immigration and naturalization agencies, social service agencies, community-based organizations, city and county governments, criminal justice systems, and the business community. The mission of LSP is to serve and strengthen Latinx families and children by building healthy communities and reducing disparities in Sonoma County. LSP's vision is a community where Latinos are fully integrated by having equal opportunities, support, and access to services in the pursuit of a higher quality of life.

To reduce disparities among the Latinx community, the specific focus of this program is to utilize a networking model among community providers to exchange information about activities and resources that will promote economic stability and educational success; increase access to healthcare, mental health, housing, and legal services and resources; reduce the stigma associated with behavioral/mental health issues; and to address other areas of interest for families throughout Sonoma County.

In the fall of 2019, the County started to collaborate on a new MHSA Innovation Project, Nuestra Cultura Cura: A community-based Social Innovations Lab. The county has worked closely with local CBOs On the Move and La Plaza Latinx. This project specifically focuses on the unique, cultural needs of the Latinx community surrounding mental health, as a means to raise awareness, reduce stigma and increase access to mental health support.

La Plaza is set apart from traditional mental health programs by pairing clinical, therapy-based services with traditional mental health practices and cultural experiences that empower the Latinx community to recognize their own ability to heal. By providing a welcoming, cultural approach, La Plaza creates a bridge for Latinx community members to access clinical services when needed. As a specific Innovations project, the Nuestra Cultura Cura Social Innovations Lab and its prototype strategies will create and promote a welcoming setting that will reduce mental health stigma, create appropriate, culturally-based wellness activities and provide a bridge to a variety of mental health resources. The county received technical assistance and feedback from the Mental Health Services Oversight and Accountability Commission on the project in September of 2020. The County anticipates initiating the 30-day public review as a component of our local Community Program Planning process in November of 2020 and implementing the project in the second quarter of 2021.

African American Community

The Community Baptist Collaborative is focused on reducing mental health disparities the African American population by increasing protective factors, building community and decreasing mental health stigma. Projects include:

- Village Project: A weekly program for children ages 8-13 using a faith- based curriculum that focuses on character building.
- Saturday Academy: A weekly program that features topics of importance to youth of the church and the community.
- Rites of Passage: An eight-month program predominantly for youth ages 14-18. This program uses adult mentors (civic and community leaders, elected officials, etc.) to provide youth with life skills to assist with a successful transition into adulthood.
- Safe Harbor Project: Facilitated by African American peers that represent an at-risk population to assist people in dealing with ‘life-disrupting’ events, and to provide education, support and referral using music therapy, gardening, etc.

Native American Community

The purpose of the Aunties and Uncles Project is to reduce mental health disparity in the local Native American communities by increasing access to mental health services by:

- Mental health stigma reduction and decreasing suicide through a “Community Defined Evidence Practice” of Culture as Prevention.

- Provides community-based awareness campaigns and community wellness gatherings to reinforce intergenerational relationships as a protective factor.
- Providing youth mentoring and tutoring to improve academic performance and cultural enrichment for Native American youth who are at risk.

LGBTQ+ Youth Community

Positive Images (PI) is an agency in Sonoma County serving the unique needs of lesbian, gay, bi- sexual, transgender, queer, plus (LGBTQ+) youth ages 12 to 24. For the past 25 years, Positive Images has provided programs and services that help youth, service providers and the public develop positive, healthy, life affirming, and accepting behaviors and views of personal expression of gender identity and sexual preference. These services include:

- Engage youth in programs, activities and services that increase resiliency and reduce risk
- Educate youth, schools, and service providers to reduce stigma and increase acceptance
- Train healthcare providers, school personnel and other community groups about LGBTQ+ issues and building understanding of working with this community

Older Adult Collaborative

The Older Adult Collaborative (OAC) is comprised of the primary senior services agencies in Sonoma County and is led by the Sonoma County Human Services Department – Adult & Aging Services Division. The community based, non-profit members serving older adults in their respective communities are:

- Council on Aging (COA)
- Petaluma People Services (PPSC)
- West County Community Services (WCCS)

The OAC utilizes Healthy IDEAS (Identifying Depression and Empowering Activities for Seniors), a prevention and early intervention evidence-based model, to reduce depression and suicide among older adults throughout Sonoma County by:

- Administration of a depression screening by both licensed experience professionals and peer/volunteers who are supervised by licensed professionals
- Referral of case managed clients to counseling and psychotherapy for those older adults identified as at risk for depression

Despite the challenges faced by County over the past three years (budget crisis, firestorms, COVID), BHD has managed to gain ground on re-establishing the MHSA Steering Committee and corresponding community engagement in community planning, relevant committees and changes in cultural responsiveness of service delivery in PEI, WET, CSS and Medi-Cal. This community engagement is the primary key that provides diverse experiences and perspectives shaping processes and decision-making.

Furthermore, engaging community members provides for a level of accountability and momentum that could not be achieved if the County were working in isolation. Adopting a Community-Based Participatory Research practice is challenging but rewarding and sustainable. For example, it may not be possible for BHD to hire a workforce that is equally representative of the community in gender, ethnicity, age, life experience. But engaging a diverse community constituency to serve in various capacities within the mental health system is an achievable goal.

Criterion 4: Client/Family Member/Community Committee: Integration of the Committee with the County Mental Health System

I. The county has a Cultural Competence Committee, or similar group that addresses cultural issues, has participation from cultural groups, that is reflective of the community, and integrates its responsibilities into the mental health system.

A. If so, briefly describe the committee or other similar group (organizational structure, frequency of meetings, functions, and role). If the committee or similar group is integrated with another body (such as a Quality Improvement Committee), The so inclusive committee shall demonstrate how cultural competence issues are included in committee work.

In FY 18-19, the County's Behavioral Health Division experienced a number of challenges including a budget crisis followed by changes in leadership of the division and within MHSA oversight and coordination. This included the reassignment of the ESM, resulting in an interruption of the existing Cultural Responsiveness Committee (CRC). Upon assigning the MHSA Coordinator the ESM responsibilities in August of 2019, the CRC reconvened on October 11, 2019. However, momentum to rebuild the CRC was again interrupted by the evacuations and Public Safety Power Shutoffs of Pacific Gas and Electric utilizes in response to the Kincaid Fire that burned 77,758 acres. Meetings of the CRC were put on hold as the MHSA Coordinator prepared for the DHCS MHSA Review in February of 2020.

In January 2020, a community outreach and engagement process was conducted to recruit new membership for the Cultural Responsiveness Committee. The County received 20 applications in the first quarter of 2020. In March 2020, twelve new members were selected from the applicants based on diversity, experience and representation of unserved/underserved populations. This increased the representation of those with lived experience and the diverse populations of TAY, Latinx, LGBTQ+, and Native Americans. In total, 18 individuals from the community and the Division of Behavioral Health make up the membership of the CRC. The first meeting of the CRC scheduled for April 2020 was cancelled with the March shelter-in-place orders due to the COVID pandemic. Adjusting to a virtual platform, the renewed CRC held orientation meetings in October and November of 2020. The committee currently plans to meet monthly.

Immediate work planned includes the review of the 2017 Cultural Responsiveness (CR) Survey findings, administration and review of 2020 CR Survey findings, analysis and development of recommendations for additions to the CR Survey. Based on these findings, workforce education and training plans will be developed and system change recommendations will be developed for implementation in 2021-22.

The Cultural Responsiveness Committee (CRC) will participate in developing the Cultural Competence Plan. Each committee of the Quality Management Program regularly collaborates with the Cultural Responsiveness Committee, receiving reports from or participating in the development and submission of reports to those committees. The ESM will collaborate with the Quality Management Program in areas regarding Cultural Competency planning and implementation of county services. The future ESM/WET Coordinator will assure that recommendations are directly transmitted to the executive level of the organization including the Behavioral Health Director. The ESM participates in local community meetings relevant to the CCP.

The Sonoma County CRC works closely with the Quality Management Program to ensure compliance to the Cultural Competence Plan and include recommendations in its CCP implementation and development. The Mission of the Division of Behavioral Health Services Quality Management Program is to monitor and promote improvement of clinical services by reviewing, monitoring and reporting on clinical data gathered as measured against prevailing standards of the industry, State and Federal guidelines, and evidence-based practices. Through this review and reporting, the Quality Management Program staff recommends implementing certain methods, techniques and best practices to assure the highest clinical practices are adopted and the reimbursement process is accurate.

The Quality Management Program is designed to assure all beneficiaries and stakeholders that the processes for obtaining services are fair, efficient, cost-effective, and produce results consistent with the belief that people with mental illness and Substance Use Disorders can recover.

The Division's practitioners, providers, consumers and family members and other stakeholders are active participants in the planning, design, and execution of the Quality Management Program. Stakeholders participate in collaboration with QM committees described below, or through various sub-committees or through particular quality management activities.

As such, the Quality Management Program is divided into committees: The Quality Management Policy Committee, the Quality Improvement Steering Committee, and the Quality Improvement Committee. Each Committee has specific responsibilities, activities and oversight. Each Committee reports to or provides direction to the other committees. The Cultural Responsiveness Committee will meet regularly and track their activities so that projects, activities and policy issues are reported to the QM committees to ensure compliance.

The Policies, procedures, and practices that assure members of the Cultural Responsiveness Committee will be reflective of the community including county management level, line staff, clients, family members from ethnic, racial, and cultural groups, providers, community partners, contractors and other members as necessary.

The Quality Management Committees are:

- Quality Management Policy Committee (QMP)
- Quality Improvement Steering Committee (QIS)
- Quality Improvement Committee (QIC).

Each Committee has specific responsibilities, activities and oversight. The Cultural Responsiveness Committee interacts with and receives input from each committee at various levels of the CRC Committee's projects or plan implementation.

Quality Improvement Committee (QIC)

The purpose of QIC is to oversee and be involved in quality improvement activities including policy issues; review and evaluate results of QI activities; institute needed QI actions; and follow- up of QI processes. Furthermore, QIC is one venue for community participation of the MHSA Community Planning Process. QIC members identify community issue related to mental illness resulting from lack of community services and supports, including any issues identified during the implementation of MHSA; analyze the mental health needs in the community; and identify and re-evaluate priorities and strategies to meet those mental health needs.

The areas of responsibility for the QIC are to; monitor and review consumer relations/outcomes; develop and review an annual QI work plan; review data and work plan activities; and monitor performance improvement projects, including the Cultural Responsiveness Committee.

Quality Improvement Steering Committee (QIS) The purpose of QIS is to ensure that quality improvement activities are effectively implemented throughout the Division. QIS functions as the central organizing body for the Division. QIS receives direction from and provides recommendations to QIP, gives guidance to and receives information and recommendations from QIC. QIS is responsible for reviewing and making recommendations regarding Consumer Satisfaction/Outcomes data and reviewing general documentation and other quality improvement issues as the need arises.

Quality Management Policy Committee (QMP)

The purpose of QMP is to provide the overall policy direction regarding quality of care issues relevant to the whole Division. While each committee communicates and informs all other committees, QMP gives overall direction to the other Committees to analyze, review and make recommendations regarding issues raised in the course of reviewing training, quality improvement or compliance activities.

QMP establishes reviews and approves recommended policies, training issues, form versions, provider-credentialing issues, and policy issues related to the Division including quality Improvement activities. QMP sets policy regarding issues raised in compliance/utilization reviews, including under and over-utilization and reviews beneficiary grievances, appeals, fair hearings, expedited fair hearings, provider appeals and clinical records review, as well as access and service authorizations.

B. If so, briefly describe how the committee integrates with the county mental health system by participating in and reviewing MHSA planning process.

The Cultural Responsiveness Committee (CRC) will be kept appraised of MHSA planning processes and in 2020-21, members will be involved in the planning, solicitation and review of MHSA PEI funded contracts. Furthermore, during the appropriate cycles, the CRC will be engaged in annual MHSA Program Updates and the MHSA Capacity Assessment and corresponding MHSA Three-year Program and Expenditure Plan.

Criterion 5: Culturally Competent Training Activities

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

A. The county shall develop a three-year training plan for required cultural competence training that includes the following: (The county may submit information from the county's WET plan provisions for training. The county shall describe how training efforts are integrated and can reasonably be expected to create and maintain a culturally competent workforce).

1. Steps the county will take to provide required cultural competence training to 100% of their staff over a three-year period.

Sonoma County Department of Health Services, Behavioral Health Division is updating their policy and procedure on Workforce Education and Training: Mandatory Training. This policy establishes a procedure that identifies mandatory training requirements and related tracking processes for DHS/BHD staff. (*See Attachment C)*

2. How cultural competence has been embedded into all trainings.

All trainings are required to have at least one specific cultural competence goal. Staff report on their perceptions of how well the presenter(s) achieved that goal on each evaluation.

3. A report list of annual training for staff, documented stakeholder invitation. Attendance by function to include: Administration/Management; Direct Services, Counties; Direct Services, Contractors, Support Services; Community Members/General Public; Community Event; Interpreters; Mental Health Board and Commissions; and Community- based Organizations/Agency Board of Director, and if available, include if they are clients and/or family members.

The following charts document the cultural competency training offered in the past year:

DATE	***TITLE***	***Hours***	***PRESENTER(S)***	***AUDIENCE***
Jan 11, 2019	Mi Futuro	All day		*16-30 year olds*
May 1, 2019	Staff Development: LGBTQ Mental Health Training	2.0	Jessie Hankins, LGBTQ Connections Jessica Carrol, Positive Images	*Required Training for All Staff, including clerical and administration*
May 17, 2019	Older Adult Depression: An Integrated Approach to Improving Outcomes through Collaborative Care	3.0	Ladson Hinton, MD; UC Davis Patrick Arbore, Ed.D., Center for Elder Suicide Prevention Todd Finnemore, Psy.D.; West County Health Centers	*Open to Behavioral Health Professionals*
Jun 5, 2019	Staff Development: Recovery in Action, a Peer Perspective	2.5	Sean Bolan, Wellness and Advocacy Center Sean Kelson, Interlink Self-Help Center Kate Roberge, Goodwill Susan Standon, Advocate/Consultant	*Recommended for all SCBH Staff*
Mar 11, 2020	Staff Development" Behavioral Health and Culture"	2.0	Yatiel Owens, MSW Jessica Hetherington, SSWII	*Mandatory for all Staff*
May 6, 2020 Canceled Due to Covid-19	Understanding LGBTQI + Community and Working with Clients	2.0	Jessica Carrol, Positive Images	*Mandatory for all Staff*
June 3, 2020 Canceled Due to Covid-19	Peer Recovery Panel	2.0	Kate Roberge, Goodwill Peer Services	*Mandatory for all Staff*

B. Annual cultural competence trainings topics shall include, but not be limited to the following:

1. Cultural Formulation;
2. Multicultural Knowledge;
3. Cultural Sensitivity;
4. Cultural Awareness; and
5. Social/Cultural Diversity (Diverse groups, LGBTQ, SES, Elderly, Disabilities, etc.).
6. Interpreter Training in Mental Health Settings
7. Training Staff in the Use of Mental Health Interpreters

FY '20-21 Cultural Behavioral Health Trainings

DATE	***TITLE***	***TIME***	***PRESENTER(S)***	***AUDIENCE***
March 2021	Understanding LGBTQI + Community and Meeting Their Needs	2.0	Jessica Carrol, Positive Images	*Mandatory for all Staff*
May 2021	Access to Mental Health Services for All: Interpreters, Materials and Resources	1.0	WET Coordinator and TBD	*Mandatory for clerical staff only*
May 2021	Peer Recovery Panel	2.0	Kate Roberge, Goodwill Peer Services	*Mandatory for all Staff*
Aug 2021	Local Latinx Populations and Their Challenges: Indigenous Communities, Immigration and Needed Resources	2.0	Lupe Navarro, Latino Service Providers; Javi Rivera, Nuestra Cultura Cura; Nubia Padilla, Humanided	*Mandatory for all Staff*
Oct 2021	Examining Our Implicit Bias	2.0	TBA	

In addition to the posted trainings above, DHS-BHD has a monthly manager' meeting where every other month an additional 30 minutes are added to the agenda to discuss issues related to Diversity, Equity and Inclusion (DEI).

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

A. Evidence of an annual training on Client Culture that includes a client's personal experience inclusive of racial, ethnic, cultural, linguistic, and relevant small county cultural communities. Topics for Client Culture training are detailed on page 18 of the CCPR (2010) from DMH Information Notice 10-02. The training plan must also include, for children, adolescents, and transition age youth, the parent's and/or caretaker's, personal experiences with the following:

1. Family focused treatment;
2. Navigating multiple agency services; and
3. Resiliency.

Every year, Sonoma BHD conducts a training with a diverse panel of Peers (Individuals with lived MH experiences). This panel is diverse in gender, ethnicity, age, ability and other factors that influence the person's experience. A more concerted effort needs to be made to outreach to the Latinx community and increase TAY representation on this panel. Future guidance given to panelists will ask them to share their experiences in accessing treatment, navigating multiple agencies, quality of treatment including client-centered and family-focused approaches, and their ability to increase resiliency for greater positive outcomes.

Required trainings held in the past were responsive to both staff surveys and input from community providers. Peer panels and Latinx focused staff development has been a mainstay of the annual training plan(s). Examples and evidence of those trainings are documented via flyers *(See Workforce Development and Training Flyers: Attachment D* and sign-in sheets maintained by the WET Coordinator.

Criterion 6: County's Commitment to Growing a Multicultural Workforce: Hiring and Retaining Culturally and Linguistically Competent Staff

I. Recruitment, hiring, and retention of a multicultural workforce from, or experienced with, the identified unserved and underserved populations

County standard advertising for recruitments includes the following outlets that target Latinos:

- LaVoz - newpaper specific to Sonoma County's Spanish speaking community
- Press Democrat/La Prensa – Leading local newspaper with Spanish language companion
- Los Cien, Sonoma County – influential organization for Latinx equity
- Hispanic Chamber of Commerce of Sonoma County – Latinx Business association
- Latino Service Providers - nonprofit with bilingual (Spanish) electronic newsletter

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

The Workforce Education and Training program supports the mission of the Sonoma County Behavioral Health Division to promote recovery and wellness of Sonoma County residents. BHD embraces a recovery philosophy that promotes the ability of a person with mental illness and/or substance use disorders to live a meaningful life in a community of his or her choosing, while striving to achieve his or her full potential. The principles of a recovery-focused system include:

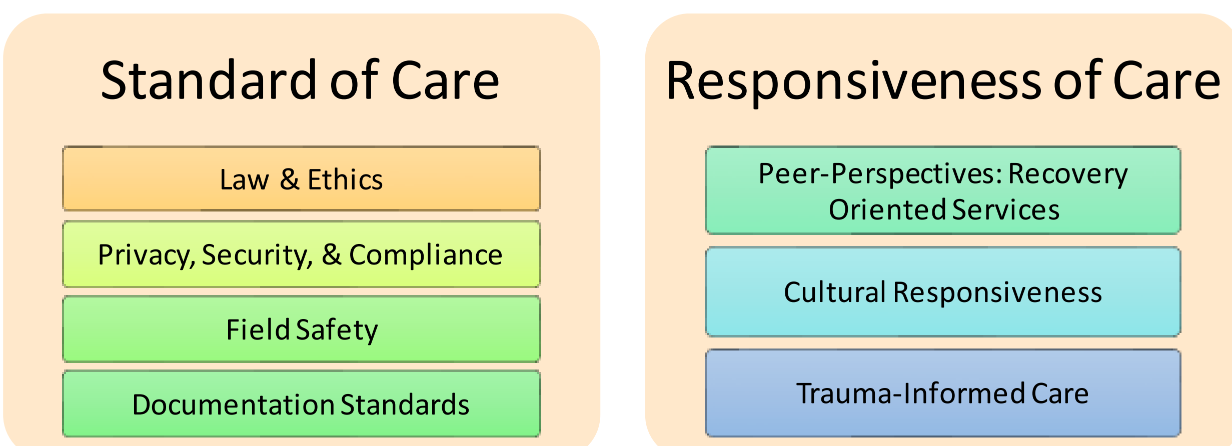
- Self-direction
- Individualized and person-centered care
- Empowerment and shared decision-making
- Holistic approach that encompasses mind, body, spirit, and community
- Strengths-based
- Peer-support
- Focus on respect, responsibility, and hope

BHD fosters a collaborative approach by partnering with clients, consumers, family members, and the community to provide high quality, culturally responsive services.

BHD Workforce Education and Training goals are:

- To provide staff with high quality education and training that promotes and endorses the mission of the Behavioral Health Division.
- To contribute to the development and maintenance of a culturally competent workforce, including individuals with client and family member experience who are capable of providing client- and family-driven services that promote wellness, recovery, and resilience.
- To teach and promote evidence-based and evidence-informed practices leading to measurable, values-driven outcomes in support of the Quality Improvement Workplan for the Behavioral Health Division.
- To encourage career development and increase job satisfaction by supporting the growth and refinement of a skillful workforce.
- To create and promote community outreach and training opportunities that encourage community stakeholder collaborations and facilitate forums for discussion and education around locally relevant behavioral health topics and needs.

In response to the QI Work plan and the Cultural Competence Plan, the Staff Development Training Series provides annual trainings on a core set of skills to support staff in refining their competency in legal issues, cultural awareness, and current interventions. The following topics are featured in this series:



B. Compare the WET Plan assessment data with the general population, Medi- Cal population, and 200% of poverty data. **Rationale:** Will give ability to improve penetration rates and eliminate disparities.

- The WET Plan assessment is in agreement with known shortages of Spanish-speaking, culturally diverse providers.
- In addition, the plan calls for increasing the number of mental health consumers in the public mental health system workforce.

C. Provide a summary of targets reached to grow a multicultural workforce in rolling out county WET planning and implementation efforts.

The Workforce Education and Training program addressed the following Domains:

- System Level Support
- Career Pathways
- Skill Development: Evidence-Based Practices
- Community Collaboration
- Workforce Diversification

WET Domain Components

System Level Support

Accreditation

Supporting the continuing education of the licensed clinical staff is vital to maintaining a skillful workforce with current and relevant practice. Accordingly, the Workforce Education and Training Coordinator is responsible for obtaining and maintaining accreditation to provide continuing education units (CEUs) for multiple clinical specialties. The accreditation process establishes and monitors Course Content, Instructor Qualifications, Course Evaluation, and Records Management. Presently, BHD has obtained and maintains accreditation through the Board of Registered Nursing (BRN) and the California Association of Marriage and Family Therapists (CAMFT) for the following license types:

BRN

- Licensed Vocational Nurse (LVN)
- Licensed Psychiatric Technician (LPT)
- Registered Nurse (RN)
- Public Health Nurse (PHN)
- Nurse Practitioner (NP)
- Psychiatric Nurse Practitioner (PNP)

CAMFT

- Licensed Clinical Social Worker (LCSW)
- Licensed Marriage and Family Therapist (LMFT)
- Licensed Professional Clinical Counselor (LPCC)

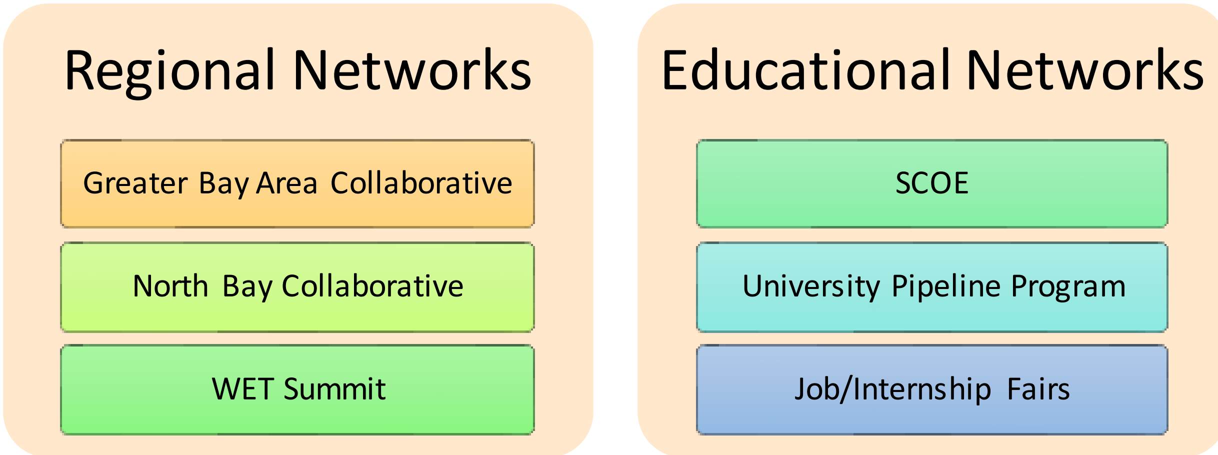
The Workforce Education and Training Coordinator has completed application for accreditation through the California Consortium of Addiction Programs and Professionals (CCAPP) to provide continuing education units to Substance Use Disorders Services (SUDS) staff. Accreditation is expected April 2017. Once obtained, BHD will be able to provide CEUs for the following certification types:

CCAPP

- Registered Alcohol Drug Technician (RADT)
- Certified Alcohol Drug Counselor I (CADC-I)
- Certified Alcohol Drug Counselor II (CADC-II)
- Licensed Advanced Alcohol Drug Counselor (LAADC)
- Licensed Advanced Alcohol Drug Counselor Supervisor (LAADC-S)

Regional Collaboration

The WET Coordinator participates in several networks and collaborations to stay current with best-practices and innovative ideas regarding workforce development. Additionally, the WET Coordinator monitors the OSHPD website for funding opportunities to support WET programs.



Quality Improvement

On an annual basis, the WET Coordinator, Quality Assurance and Performance Improvement Section Manager and QI Manager will meet to review the continuing education goals for the following purposes:

- To align with the mission of Sonoma County Behavioral Health Division
- To update course content to reflect current best-practices and evidence-based approaches in the field of Mental Health treatment
- To assess cultural sensitivity and relevance of training subjects
- To support new or adjusted outcomes and goals of the Quality Improvement Workplan

The WET Coordinator is responsible for maintaining current information regarding regulatory changes affecting continuing education. This includes monitoring the Knowledge Base underlying Training Content, checking the Instructor Qualifications, analyzing the Course Evaluation data, and maintaining the program records.

Knowledge Base

The WET Coordinator provides information to support the methodological, theoretical, research, and/or practice knowledge basis for the course content. This includes best-practices, theoretical models, and research citations that identify the established concepts.

Instructor Qualifications

Instructors must demonstrate expertise and knowledge in the specific content area of the course. Such expertise will be demonstrated by certification or experience in their specialty field. For Peer-Provider trainings, lived experience will substitute for academic/clinical experience. In congruence with the Sonoma County Behavioral Health Division mission, instructors are required to integrate issues of recovery, wellness, best-practice, and cultural sensitivity into their teaching.

Course Evaluation

Responses on the course evaluation forms are entered into the training database from which a statistical report is generated for review. Evaluation reports are reviewed by the training committee to identify content issues, presentation issues, and other identified areas of need. Suggested future topics and speakers from the evaluation forms are recorded in the training database and worked into the annual training curriculum where appropriate.

D. Share lessons learned on efforts in rolling out county WET implementation efforts.

- BHD has only increased the number of bilingual and bicultural staff minimally and continues to be challenged by the competition among the county's healthcare system.
- Staff diversity training has been well received with solid attendance.

E. Identify county technical assistance needs.

DHS-BHD does not have any identified TA needs at this time.

Criterion 7: Language Capacity

I. Increase bilingual workforce capacity

A. Evidence of dedicated resources and strategies counties are undertaking to grow bilingual staff capacity, including the following: (Counties shall document the constraints that limit the capacity to increase bilingual staff.)

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

Continuous efforts are made by the County to recruit and retain bilingual and bicultural staff to more accurately reflect the diversity of Sonoma County, specifically focused on the Latinx and Spanish speaking community. A significant development worth noting is the establishment of a countywide Office of Equity on August 20, 2020. The Interim Director of this Office will be focusing on the development of new policies, programs and legislation that will unseat racial inequities. The Behavioral Health Division has engaged in an initial meeting with the Equity Officer to establish a working relationship that seeks the same outcomes, including diversifying the BHD workforce to reflect the community that it serves and ultimately improves the quality of services for non-English speakers.

The County offers a pay differential of $1.15 per hour when a position is deemed essential in requiring a Spanish language skill. Over 35 positions are filled in BHD currently, staffing the three categories of Management, Administrative and Clinical.

Another strategy employed by BHD is to engage in promoting mental health careers for bi-lingual Latinx individuals. The MHSA WET Coordinator allocates time to support the annual Mi Futuro Symposium to engage Latinx high school and junior college student populations and expose them to health/mental health careers and pipeline programs. This annual program draws (prior to COVID) over 300 local students from various regions in the County to interact with professionals from nonprofits, health clinics and hospital systems. Students have responded positively to this event and resources, including financial support continues to grow. This year, 2020-21, Mi Futuro is being offered on-line with a speaker series kicking off Dec 9, followed by 10 additional workshops featuring a different healthcare professional in Sonoma County who will share their story about their career pathway. *(See Increasing Bi-Lingual Capacity – Mi Futuro: Attachment E)*

Career Ladders

The WET Coordinator will support the development of promotional opportunities with career tracks to support a Grow-Your-Own Model from entry-level intern/student through Supervisory Leadership. This includes formalizing an Internship & Traineeship program, expanding the Peer-Provider program, and providing management-level training specific to the supervision of clinical interns and peer providers.
Specific career ladders are as follows:

Medical

- LVN
- LPT
- Phlebotomist (proposed specialty)
- RN/PHN
- NP/PNP
- PA/MD

Clinical

- Trainee/Student Intern
- Clinical Intern (MFTi, ASW, PCCi)
- Licensed Clinician (LMFT, LCSW, LPPC)
- Clinical Specialist

Substance

- AODS Assistant
- AODS Counselor
- AODS Specialist

Non-Licensed

- Client Support Specialist
- Senior Client Support Specialist

Peer Provider

- Peer Support Specialist
- Consumer Education Coordinator
- Consumer Relations Coordinator

Internship & Traineeship

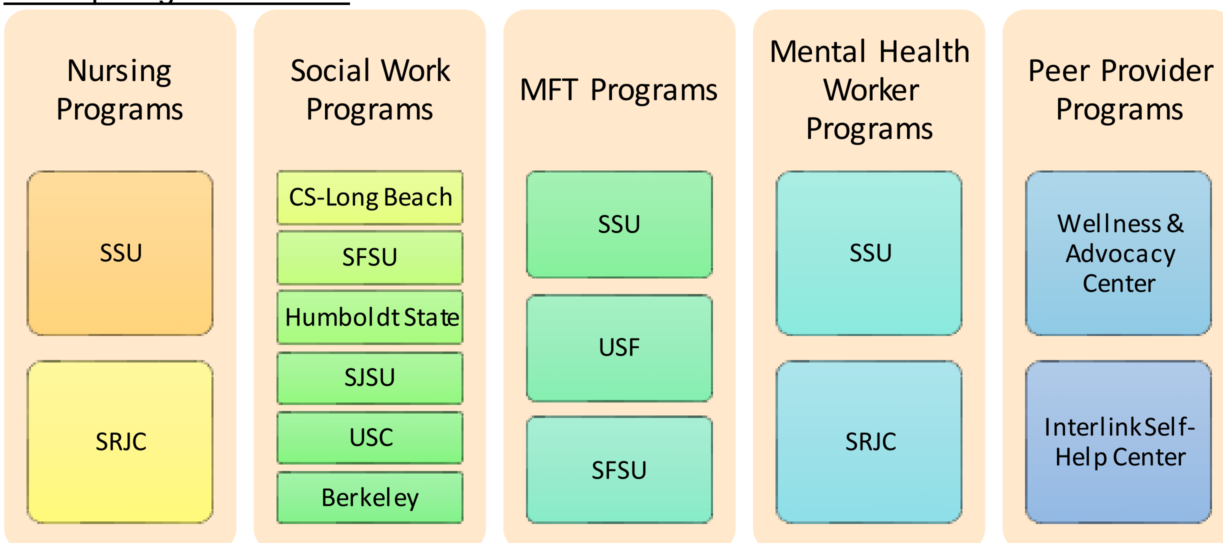
In support of a more skillful clinical workforce, BHD is formalizing the Internships and Traineeship program to assist staff in obtaining clinical licensure and to develop pipeline programs with participating universities. This includes a Licensure Support Program, Group Clinical Supervision, and Educational Outreach Events. Presently, 9 new MOU's are in process with local and regional universities.

Pipeline Program

The purpose of the pipeline program is to cultivate interest in healthcare careers, particularly in hard-to-fill areas with high-risk populations. Additionally, the pipeline program preserves diversity in the workforce and reduces health disparities for the consumers. The WET Coordinator plans and participates in several community career events at both the high school and college level. Particular focus is given to encouraging Latino and bi-lingual students to consider Behavioral Health as a career option.

Career & Internship Fairs
The WET Coordinator, in collaboration with the Community Intervention Program, engages in outreach through internship and career fairs at Santa Rosa Junior College, Sonoma State University, and University of San Francisco.

Participating Universities



Clinical Licensure Exam Support
The WET Coordinator partnered with the Therapist Development Center and with the Association for Advanced Training in the Behavioral Sciences (AATBS) to provide discounted test-prep materials for BHD Interns. Additionally, the WET Coordinator will develop and facilitate a monthly Test-Prep Support Training.

Group Clinical Supervision
BHD will formalize the clinical supervision process to offer on-going group supervision to clinical interns. Managers, Specialists, and the WET Coordinator will rotate facilitation duties to ensure maximum exposure to a variety of clinical styles.
WET Coordinator also supports the Cultural Responsiveness Committee in providing culturally relevant trainings to County staff and the community.
Another strategy to increase representation of the community served, is to employ and engage peers with lived experience from the community. The WET Coordinator partners with the Consumer Relations Coordinator and the Consumer Education Coordinator to support Peers in the workforce and expand peer-employment opportunities for people with lived-experience. The Peer Relations Program is collaborating with the WET Coordinator to bring WISE (Workforce Integration Support

and Education) training to the management team in order to facilitate best-practices in integrating peers into the workforce. The WET Coordinator also participates in the Workforce Co-Learning Collaborative (WCC) to develop curriculum for management training of peers in the workforce. In support of peer-support career pathways, the WET Coordinator participates as a trainer in the peer-support programs and facilitates cross-training opportunities between the Peer-Run Self-Help Centers (Wellness Center, Interlink, Petaluma Peer Recovery Project, Russian River Empowerment Center) and Sonoma County Behavioral Health.

Bilingual/Bi-Cultural Staffing	Peer-Provider Integration
• LSP • Mi Futuro • CRC	• WISE • WCC • Cross-Training

2. Updates from Mental Health Services Act (MHSA), Community Service and Supports (CSS), or WET Plans on bilingual staff members who speak the languages of the target populations.

As of February 2020, the Behavioral Health Division (BHD) had 36 positions filled by bi-lingual Spanish speaking staff in management, administrative, and clinical positions.

Staffing Category	Number of Bi-lingual staff
Management	2
Administrative	11
Clinical	23

Furthermore, BHD has an open recruitment for bi-lingual individuals to fill the following positions: Office Assistant II (both regular and extra-help), Senior Office Assistant (both regular and extra-help), and Extra-help Alcohol and Other Drug Services Counselor.

3. Total annual dedicated resources for interpreter services in addition to bilingual staff.

In addition to the staffing referenced above, BHD has contracts in place to provide interpreter services for non-English speaking consumers.

	Phone	Translation	In Person	Video	Language Restrictions	Service Notes
Communique			x		ASL only	
Linguabee			x	x	ASL only	
CTS Language Link	x	x	x	x		Needs at least 24 hours response time for translation
Telelanguage	x			x		
Sonia Pacheco	x		x		Spanish Only	Weekend service must be pre-arranged
Language People	x	x	x	x		
Gray Highlander		x			Spanish Only	Email communication is preferred
Interpreters Unlimited	x	x	x	x		
Nubilla Padilla		x			Spanish Only	
Lazar & Associates		x				Needs at least 24 hour response time
Alison Trujillo		x			Spanish Only	
International Contact	x There is a department 60-minute monthly minimum	x	x	x		Department will need to call to set up an account for phone service for use.

II. Provide services to persons who have Limited English Proficiency (LEP) by using interpreter services.

A. Evidence of policies, procedures, and practices for meeting clients' language needs, including the following:

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

Within the BHD Beneficiary Handbook, Sonoma County has an acknowledgement of nondiscrimination and a corresponding policy addressing access to services in languages other than English and formats that are accessible to people with different abilities.

Sonoma County BHD has a 24-hour phone line that is answered by a live person.

The BHD policy is to utilize a bilingual staff member to provide interpretation services whenever needed. If staff are unavailable the BHD uses other resources to provide interpretation. These other resources include:

- CTS Language Link
- Individual contracts for Cambodian
- CA RELAY TDD

OTHER LANGUAGES AND FORMATS

To request Mental Health Services call the Access Team at 1-800-870-8786 or (707) 565-6900.

Other Languages

You can get this Beneficiary Handbook and other materials for free in other languages. Call Sonoma County Behavioral Health (SCBH). The call is toll free: 1-800-870-8786.

Other Formats

You can get this information for free in other auxiliary formats, such as Braille, 18-point font large print, or audio. Call SCBH. The call is toll free: 1-800-870-8786.

Interpreter Services

You do not have to use a family member or friend as an interpreter. Free interpreter, linguistic, and cultural services are available 24 hours a day, 7 days a week. To get this handbook in a different language or to get interpreter, linguistic, and/or cultural help, call SCBH. The call is toll free: 1-800-870-8786.

NONDISCRIMINATION NOTICE

Discrimination is against the law. SCBH follows state and federal civil rights laws. SCBH does not unlawfully discriminate, exclude people, or treat them differently because of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation.
SCBH provides:

- Free aids and services to people with disabilities to help them communicate better, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact SCBH between Mondays through Fridays: 8am – 5pm. Or, if you have difficulty hearing or speaking, please call TYY: 711.

2. Least preferable are language lines. Consider use of new technologies such as video language conferencing as resources are available. Use new technology capacity to grow language access.

Sonoma BHD does not solely rely on language lines, though that is one tool to support access to individuals who are non-English speaking. In addition, BHD has interpreter services on contract and is always seeking to hire a diverse multi-lingual staff to serve the community.

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

Sonoma County BHD, Mental Health Policy No: MHP-8 Linking Non-English Speaking Beneficiaries to Behavioral Health Services and Use of Interpreters provides the protocols to implement language access at no cost, 24-hours, seven days a week. Furthermore, multi-lingual signage is provided at all BHD county lobbies and at the entryways to contract providers.

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

Contained in the Sonoma County Mental Health Plan Beneficiary Handbook provided to all consumers/beneficiaries is a multi-lingual notice informing them of their right to access services in their primary language, free of charge. This notice is located on the first two pages of the handbook.

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

Sonoma County DHS-BHD conducts an annual system review of performance metrics with respect to client ethnicity and preferred language. The FY 2019-20 Performance Metrics and Ethnic Services Summary Report examines the following:

- Access to Services
- Timeliness of Service Delivery
- Distribution of Services
- Outcomes of Services.

Data for the report is taken from ACD (Automatic Call Distribution) 24-hour call line, the Access Initial request for Services Database, and the Electronic Health Record. Below is a chart of initial access by month for all languages requested in 2019:

Month of Call	English	Spanish	ASL	Thai	Vietnamese	Total
July	256	11				**267**
August	289	14	1			**304**
September	267	20			1	**288**
October	222	24				**246**

November	232	17				**249**
December	224	13	1			**238**
January	286	14				**300**
February	271	11				**282**
March	202	15	1			**218**
April	182	7	1	1		**191**
May	203	12				**215**
June	178	14			1	**193**
Total	**2812**	**172**	**4**	**1**	**2**	**2991**

In addition, the Adult and Youth Access teams staff the 24/7 call line with bilingual staff. But in the event that a bilingual staff member is not available for call backs or screenings, the Language Line is available to provide telephonic interpretation services. Utilization of the Language Line for Access purposes is as follows:

Month of Call	Spanish	Vietnamese	Thai	Total
July	35			**35**
August	36			**36**
September	14	1		**15**
October	39	5		**44**
November	17	2		**19**
December	16			**16**
January	19			**19**
February	11			**11**
March	12			**12**
April	14		1	**15**
May	15			**15**
June	8			**8**
Total Utilization	**236**	**8**	**1**	**245**

Although these charts indicate first point of contact, data is collected on all interactions throughout the system, including reasons for call, disposition of call, appointments for assessments and intake, attendance rate by preferred language, and retention rate by threshold language (Spanish) and ethnicity (Latinx).

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

In 2019-20, the number of calls taken by the Language Line diminished as bi-lingual staffing and availability increased. This is an obvious cause and effect, that the more bi-lingual staffing is available, the less reliance on the Language Line is needed. The goal of maintaining bilingual staffing is challenged by the fact that the BHD is in direct competition for a bilingual workforce with other health systems such as Kaiser Permanente, Sutter Health, St. Joseph's Health and the community clinics throughout Sonoma County. Thus it has been the interest of all providers to support the healthcare/mental health career pathways with such efforts as Mi Futuro and post-secondary programs offered by the Santa Rosa Junior College and Sonoma State University.

E. Identify county technical assistance needs. (DMH is requesting counties identify language access technical assistance needs so that DMH may aggregate information and find solutions for small county technical assistance needs.)

At this time, there are no technical assistance needs identified.

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

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

As noted in earlier in this document, Sonoma County DHS-BHD Mental Health Policy No: **MHP-8 Linking Non-English Speaking Beneficiaries to Behavioral Health Services and Use of Interpreters** provides the protocols to implement language access at no cost, 24-hours, seven days a week. In addition, information for all language access is found on the first pages of the Beneficiary Handbook given to all consumers/beneficiaries. Finally, **Mental Health Policy No: MHP-21** Required Informing Materials and Translation of written Documents (Rev. 5-20-19), posters are required to be prominently displayed in the lobbies of BHD offices and posted by contractors providing mental health services to Medi-Cal beneficiaries. *(See MHP-21, Required Informing Materials and Translation of Written Documents – Attachment F)*

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

As noted in Section II., Item C above, all incoming calls taken in non-English languages are recorded. The following series of charts indicate continuity in call disposition, intake and assessments. The immediate chart below depicts the call disposition by preferred language of the caller. At the point of initial call, ethnicity of the caller is unknown, so analysis of potential ethnic disparities in call disposition is not possible at this point in the process.

Call Disposition	English	Spanish	ASL	Thai	Vietnamese	Total
Initiate Clinical Screening	779	82	2		1	**864**
Caller Declined Screening	104	5				**109**
Request for Referral	628	27		1		**656**
Request for Access Information	304	17				**321**
Grievance	3					**3**
Current Client	80	1				**81**
Other Insurance: Not Medi-Cal/Medi-Care	115	3				**118**
Medical Emergency: Transferred 911	1					**1**
Crisis Call: Transferred CSU	140	7				**147**
Unable to Reach Caller	380	20				**400**
Other	278	10	2		1	**291**
Total	**2812**	**172**	**4**	**1**	**2**	**2991**

Overall, 28.89% of calls resulted in clinical intake. However, the percentages of walkins that resulted in intake are much higher. The following chart includes walk-in requests as well as calls and email/fax referrals.

By Preferred Language

Month of Intake	English	Spanish	Other	Total
July	115	7		**122**
August	130	2	1	**133**
September	103	9	3	**115**
October	103	6		**109**
November	97	2		**99**
December	102	8		**110**
January	105	11	3	**119**
February	116	9		**125**
March	102	14	1	**117**
April	84	3	1	**88**
May	97	6		**103**
June	60	8		**68**
Total	**1214**	**85**	**9**	**1308**

The **Ethnic Services Summary Report FY 2019-20** continues to document disposition of intake, number of assessments completed or reason for not conducting an assessment through appointments made and kept and retention of non-English speaking consumers/beneficiaries. *(See Ethnic Service Summary Report FY 2019-20: Attachment G)*

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

As of February 2020, the Behavioral Health Division (BHD) had 36 positions filled by bi-lingual Spanish speaking staff in management, administrative, and clinical positions.

Staffing Category	Number of Bi-lingual staff
Management	2
Administrative	11
Clinical	23

Because the competition for attracting and retaining skilled workers has increased significantly particularly in the areas of law enforcement, health professionals and for bilingual candidates, Sonoma County provides bilingual pay to certified bilingual staff working in specific, bilingual designated positions. In order to receive this premium, staff must meet the established job qualifications and who also meet the County's bilingual certification requirements. For those who meet those requirements and speak a necessary language, such staff receive a “bilingual premium” ranging from $0.90 per hour to $1.15 per hour, paid on all hours worked.

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

As noted earlier, Sonoma County BHD has $166,192 budgeted for interpreter and translation services with active contracts in place for language providers, including live real time translation and services for translating materials.

	Phone	Translation	In Person	Video	Language Restrictions	Service Notes
Communique			x		ASL only	
Linguabee			x	x	ASL only	
CTS Language Link	x	x	x	x		Needs at least 24 hours response time for translation
Telelanguage	x			x		
Sonia Pacheco	x		x		Spanish Only	Weekend service must be pre-arranged
Language People	x	x	x	x		
Gray Highlander		x			Spanish Only	Email communication is preferred
Interpreters Unlimited	x	x	x	x		
Nubilla Padilla		x			Spanish Only	
Lazar & Associates		x				Needs at least 24 hour response time
Alison Trujillo		x			Spanish Only	
International Contact	x There is a department 60-minute monthly minimum	x	x	x		Department will need to call to set up an account for phone service for use.

As stated in **Mental Health Policy No: MHP-21**, the Mental Health Plan Quality Assurance Manager will initiate review and authorization of all translated materials. This review is conducted by at least two independent bilingual staff prior to distribution of the document(s). Edits may be made by the Quality Assurance staff.

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

A. Policies, procedures, and practices 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.

As noted earlier, the Beneficiary Handbook and corresponding policies clearly provide for language access through bilingual staffing, language interpreters or utilizing the Language Line (last resort) for all aspects of the continuum of care. In addition, materials translated into the threshold language of Spanish are available to all staff.

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.

The MHP maintains a policy to ensure that all client and MHP contact providers link non-English speaking clients to culturally and linguistically competent mental specialty mental health services regardless of language spoken. Sonoma County's Mental Health Policy No: MHP – 8: Linking Non-English Speaking Beneficiaries to Behavioral Health Services and Use of Interpreters addresses this issue.

C. Policies, procedures, and practices that comply with the following Title VI of the Civil Rights Act of 1964 (see page 27) requirements:

1. Prohibiting the expectation that family members provide interpreter services;
2. 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
3. Minor children should not be used as interpreters.

Sonoma County's Mental Health Policy No: MHP – 8: Linking Non-English Speaking Beneficiaries to Behavioral Health Services and Use of Interpreters clearly states the three policy positions above.

V. Required translated documents, forms, signage, and client informing materials

A. Culturally and linguistically appropriate written information for threshold languages, including the following, at minimum:

1. Member service handbook or brochure;
2. General correspondence;
3. Beneficiary problem, resolution, grievance, and fair hearing materials;
4. Beneficiary satisfaction surveys;
5. Informed Consent for Medication form;
6. Confidentiality and Release of Information form;
7. Service orientation for clients;
8. Mental health education materials, and
9. Evidence of appropriately distributed and utilized translated materials.

As noted, Sonoma County has determined Spanish as the threshold language for the County. The Mental Health Plan Member Service Handbook is published in English and Spanish and kept on file for regular review, updating and access by staff on a common computer drive. In addition, consumers/beneficiaries can access all documents in English and Spanish on the County's website: https://sonomacounty.ca.gov/Health/Behavioral-Health/Medi-Cal-Informing-Materials/ *(See Mental Health Plan Member Service Handbook table of contents: Attachment H)*

B. Documented evidence in the clinical chart, that clinical findings/reports are communicated in the clients' preferred language.

BHD conducts a quarterly chart audits and is required to include one chart for a client who prefers Spanish (threshold language) for services.

C. Consumer satisfaction survey translated in threshold languages, including a summary report of the results (e.g., back translation and culturally appropriate field testing).

Each year, Sonoma County Department of Health Services, Behavioral Health Division (DHS-BHD), administers the Consumer Perception Survey in May and November. This survey is offered in English and Spanish. The goals of this survey are to collect data for the federal Nation Outcome Measures (NOMs) required by the Substance Abuse and Mental Health Services Administration (SAMHSA). Receipt of federal Community Mental Health Services Block Grant funding is contingent upon the submission of this data. The Consumer Perception Survey is a state issued and controlled survey, and the BHD cannot change labels, age categories or wording of questions. The Quality Improvement Manager led the BHD staff, QIC and CRC through a review of 2019 findings. In 2019, the survey was administered only once due to Kincade Fire, resulting in a lower overall response rate. The data is only from one administration of the survey conducted in June 2019. However, worth noting is the Latinx and LGBTQ+ response rate was higher than in past years.

The Consumer Perception Survey measures general satisfaction, perception of access, perception of participation in treatment planning, perception of quality and appropriateness (cultural sensitivity for youth), perception of outcomes of services, perception of social connectedness, and perception of functioning. Age groups surveyed include youth, family/parents of youth, adults and older adults.

The analysis of the survey looks at the various domains of consumer perception on a scale of 1-5 (5 being the best/highest) A Satisfaction Threshold of 3.5 has been established as a standard measure for "acceptability". An average score above 3.5 is "good" and an average score below 3.5 "needs improvement. Findings are presented by gender and ethnicity in all age groups.

The 2019 summary findings of the Consumer Perception Survey highlights areas worth noting for service delivery improvements, implications for staff training, and/or policy changes.

- Adults by gender: Nonbinary gender indicates an average score of perception in all domains are under the acceptable threshold. Lots of work to do.
- Adults by ethnicity is OK, except "undeclared ethnicity".
- Older adult by gender is improvement from last year, but results for females close to threshold in areas of Social Connectedness and Functioning, males are low in perception of functioning only. May introduce skill-based training to help older adults.
- Older adult by ethnicity has areas of improvement for social connectedness and functioning in all groups, with exception of Black/African Americans who did

above average in all domains. Though sample size was too small (N=1), also did poorly in perception of access.

- Youth by gender – Non-binary youth reported average below threshold in outcomes of services and functioning.
- Youth by ethnicity were low for almost all domains for the American Indian/Alaskan Natives.
- Parents/family of nonbinary gendered children reported below threshold in general satisfaction, outcomes and functioning.
- Parents/family by ethnicity also reported low in outcomes and functioning for AIAN.

In addition, the County uses the Performance Outcomes Survey for additional information on whether consumer outcomes are achieved.

D. Report mechanisms for ensuring accuracy of translated materials in terms of both language and culture (e.g., back translation and culturally appropriate field testing).

The standard practice for Sonoma County BHD is to have translated documents proof-read by at least two bilingual staff to ensure accuracy and accessibility.

E. Report mechanisms for ensuring translated materials are at an appropriate reading level (6th grade). Source: Department of Health Services and Managed Risk Medical Insurance Boards.

To monitor readability and access for those needing an appropriate reading level, documents are proofed by utilizing Word options in the software to show readability statistics. This application will provide a Felsch-Kincaid Grade Level for the selected content.

Criterion 8: Adaptation of Services

I. Client driven/operated recovery and wellness programs

A. List client-driven/operated recovery and wellness programs and options for consumers that accommodate racially, ethnically, culturally, and linguistically specific diverse differences.

Sonoma County is seeking to build on four client-driven/operated recovery and wellness programs provided under the auspices of West County Community Services:

- Wellness and Advocacy Center – Santa Rosa
- Interlink Self-Help Center – Santa Rosa
- Petaluma Peer Recovery Program – Petaluma
- Russian River Empowerment Center – Guerneville

In addition, Positive Images, a LGBTQ+ youth and young adult MHSA PEI funded program utilizes a peer-based and peer-led socio-educational model with support groups, social activities, community education and activism.

The value of peer-led and peer-engaged programming cannot be understated and has been highlighted in the FY 2020-23 MHSA Three-Year Program and Expenditure Plan.

II. Responsiveness of mental health services

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, non-traditional mental health provider.

As required, Sonoma County provides a Provider Directory to all new clients which has descriptive information regarding types of services available, populations served, and/or linguistic capabilities. Sonoma County Behavioral Develop contracts with a number of community-based organizations who provide non-traditional mental health services.

Agency/Organization	Interpretation & Translation	Disparities Reduction	Outreach & Engagement	Culturally Appropriate Mental Health Services
Latino Service Providers/Latinx		X	X	X
Sonoma County Indian Health Project/ Native Americans		X	X	X
Positive Images/LGBTQ+		X	X	X
Community Baptist Church Collaborative/African Americans		X	X	X
Santa Rosa Community Health Centers/Communities of Color		X	X	X
Alliance Health Center/Latinx	X	X	X	X
West County Health Services/LGBTQII		X	X	X
Alexander Valley Health Center/Latinx	X	X		

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.

Sonoma County BHD provides each beneficiary/consumer with the DHCS required Guide to Medi-Cal Mental Health Services either in English or Spanish. Also, both documents can be found on the County's website: https://sonomacounty.ca.gov/Health/Behavioral-Health/Medi-Cal-Informing-Materials/

C. Counties have policies, procedures, and practices to inform all Medi-Cal beneficiaries of available services under consolidation of specialty mental health services.

Sonoma BHD has established MHP-21, Required Informing Materials and Translation of Written Documents on March 31, 2017 with update on May 20, 2019. This policy states that BHD and its contracted providers will provide to all beneficiaries written informing materials that are critical to obtaining Specialty Mental Health Services at the first face-to-face contact and/or upon request. In addition, informing materials will be displayed in the lobbies of all county-owned/operated programs and contract provider programs. *(See MHP-21: Attachment F and Flyer for Public Notice of Language Access: Attachment I)*

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:

1. Location, transportation, hours of operation, or other relevant areas;

BHD's Access team is located within the main Behavioral Health Campus at The Lakes business complex in Santa Rosa. Clinical services, including crisis and peer services are co-located and centralized to provide easier access. In addition, a main bus line has a stop in front of BHD complex. This Behavioral Health Campus is located in the southern section of Santa Rosa and is close to the heart of the Latino community, known as Roseland, where many Medi-Cal beneficiaries reside. This area is also accessible to many parts of Sonoma County given its proximity to the major highways. Due to the various public health orders in 2020, is utilizing virtual clinical services in addition to in-person services.

Hours of operations are generally 8a – 5p, Monday through Friday with five Full-Service Partnership that provide services beyond those hours, as needed, including weekends.

2. 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);

All county-owned facilities have disabled access. Many locations have upgraded their waiting rooms to be more clients- and culturally-friendly and inviting.

3. 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.)

As part of the MHSA planning process, in order to provide more services to Latino population, it was decided to co-locate services as much as possible with the community health centers (FQHCs and Sonoma County Indian Health Project). In addition, BHD has a variety of community-based nonprofits that provide an array of prevention, early intervention and clinical services in locations that are accessible to the populations intended to be served and in an appropriate cultural setting.

III. Quality Assurance

A. 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.

Prominently displayed in the Beneficiary Handbook and on the County's DHS-BHD website is a statement of Client Rights and guidelines to file a grievance in English and Spanish. BHD records all Medi-Cal Beneficiary grievances and appeals filed through the fiscal year. In FY 2019-20, a total of 84 grievances were filed resulting in 72 cases resolved, 16 cases referred (to the source of grievance) and 4 cases were pending at the close of the fiscal year. Grievances and appeals are reviewed by the Quality Management Policy Committee (QMP) and determine if trends and patterns warrant a policy review or development, training implications, provider credentialing review or other quality improvement concerns.

Attachment A: MHSA Steering Committee Membership 2020

First Name	Last Name	Industry	Representing
Claudia	Abend	Community	Consumer, Family member
Mechelle	Buchignani	Law Enforcement	
Jessica	Carroll	MH, Social Services	Consumer, LGBTQ+
Sophie Marie	Clifford	Substance Abuse	Consumer, Latina, LGBTQ+
Mandy	Corbin	Education	Family Member
Christy	Davila	Social Services	
Angie	Dillon-Shore	0-5	LGBTQ
Cynthia	Kane Hyman	Education	
Ozzy	Jimenez	Businessman	LGBTQ, Latino
Erika	Klohe	Health, MH, Foundation	Family Member
Claire	McDonell	Education	Family Member, TAY
John	Mackey	Healthcare	Veteran
Shannon	McEntee		Consumer, TAY
Mike	Merchen	Law Enforcement	Family Member
Allison	Murphy	0-5	Family Member
Ernesto	Olivares	Social Services	Latino
Matt	Perry	Probation	
Ellisa	Reiff	Disabilities	
Kate	Roberge	MH, Disabilities, Workforce	Consumer, Peer
Kurt	Schweigman	Healthcare, MH	Native American
Kathy	Smith	Mental Health Board	Family member
Susan	Standen	Self-employed, MH peers	Consumer
Angela	Struckmann	Social Services	Family Member
Katie	Swan	Mental Health	Family Member, LGBTQ+, TAY
Sam	Tuttelman	Community	Family member
Carol Faye	West	Peer	Consumer, Family member
7 Consumers, 11 Family members, 5 LGBTQ+, 3 Latinx, 1 Native American, 3 TAY			

Attachment B: Cultural Responsiveness Committee Membership 2020

Name	Agency	Representation
Maxwell Anderson	Positive Images	LGBTQ+, TAY, Lived Experience
Susan Castillo	DHS-BHD	Latinx, Compliance, Continuous Improvement
Betzy Chavez	Hanna Boys Center	Latinx, Education
Monte Cimino	Petaluma People Services	Family member, Older Adults,
Dean Hoaglin	Sonoma County Indian Health Project	Native American, Family Member, Veteran
Miguel Loeza	Seneca Family of Agencies	Bi-lingual, Latinx
Denisse Mendoza	Side by Side	Bi-lingual, Latinx
Lisa Nosal	DHS-BHD	Compliance, Continuous Improvement
Lauren Reed	DHS-BHD	LGBTQ+
Melissa Struzzo	DHS-BHD	Substance Abuse
Katie Swan	Buckelew Programs	LGBTQ+, Family member, Disabilities
Saraisabel Virgen	Latino Service Providers	Bi-lingual, Latinx, Lived Experience, TAY
Liana Whisler	DHS-BHD	Law enforcement, LGBTQ+

Attachment C: Workforce Education and Training: Mandatory Training Procedure (DRAFT)

COUNTY OF SONOMA
DEPARTMENT OF HEALTH SERVICES
BEHAVIORAL HEALTH DIVISION: MENTAL HEALTH SERVICES

<u>Workforce Education and Training Mandatory Training Procedure</u>

PURPOSE:
To establish a procedure that identifies mandatory training requirements and related tracking processes for Department of Health Services (DHS) Behavioral Health Division (BHD).

PROCEDURE:

I. The Workforce, Education and training (WET) Team and the Quality Improvement Steering (QIS) Committee with the guidance of Division Management Team (DMT), determines which trainings are mandatory and which staff are required to attend. The BHD Workforce, Education and Training team administers and monitors attendance of the mandatory trainings.
   a. Prior to a mandatory training the WET team compiles a list of staff that are required to attend the mandatory training. The list of staff required to attend is retained in the file established for the specific training.
   b. The WET team informs all required staff about the mandatory training and provides registration information.
   c. All staff who are identified and invited to the training must register.
   d. All trainings must be recorded.
   e. All required attendees must sign in and sign out at the beginning and end of the training. Staff must use actual times of entrance and exit of training.
   f. Training materials, including the recordings and sign in/out sheets will be saved in the corresponding training folder.
   g. Within 2 weeks of the training, the WET team compares the list of staff required to attend the training to the list of staff that attended the training. Any staff that were required to attend the training that are not on the attendance list are placed on a Non-Attended list.
   h. Within 4 weeks of the training the WET team contacts each individual on the Non-Attendance list and carbon copies their manager. The WET team provides the individuals on the Non-Attendance list the location of the video recording of the training, training materials, distance learning test and instructions for submitting the test to the WET team located in the Share Drive: S:\BH\STAFF\TRAINING.
   i. Within 8 weeks of the training the individuals on the Non-Attendance list are required to review the training video and materials and take the distance learning test. The individual then submits the distance learning test to the WET team.
   j. The WET team scores the test. In order to pass the test, staff must have a score of 70% or greater. Once the score is achieved, they are removed from the Non-Attendance list.
   k. If the individual does not pass the test, they are instructed to review materials and retake the test until they pass.
   l. The WET team records the date the test was passed on the Non-Attendance list.
   m. After 8 weeks from the date of training, individuals who remain on the Non-Attendance list will be reported to DMT to identify next steps.
   n. If the individual is eligible for continuing education units (CEUs), the individual must request CEUs when the test is submitted along with the name of their licensure board and their license number.

Attachment D: Workforce Development and Training Flyers

sonoma county
DEPARTMENT OF HEALTH SERVICES
BEHAVIORAL HEALTH DIVISION

Sonoma County Behavioral Health Division

Staff Development Training

** **Required Training for all Staff** **

(including clerical and administrative)

2.0 CEUs provided for LCSWs, LMFTs, LPCCs, RNs, and CADC

"Cultura Cura, The Power of Cultural Arts, Testimonio and Comunidad to Address UndocuTrauma in Latino Communities"

Recognizing the growing need to capitalize on the cultural wealth of our communities to support their mental health and well being, this workshop focuses on how the use of the arts, testimonios and building community creates a temascal of safety for Latino communities suffering from trauma of immigration fears, separation of families and isolation in communities due to racism and inequities. This presentation creates a new narrative for the use of the cultural arts in mental health and builds the healing powers of cultura.

June 6, 2018

Wednesday, 8:30am – 10:30am

Finley Center, Person Auditorium

2060 W. College Ave

Santa Rosa | CA 95404

Dr. Belinda Hernandez Arriaga,

Assistant Professor at the University of San Francisco

Counseling Psychology Department

CEU Certificates awarded at the end of the session.

Contact: Melissa Totz at Melissa.Totz@sonoma-county.org for more information, ADA requests, or grievances.

Sonoma County Behavioral Health Division

Staff Development Training

**** Recommended for All Staff ****

2.5 CEUs provided for LCSWs, LMFTs, Registered Associates, LPCCs, LEPs, RNs, and AODS Counselors

Staff Development:

"Recovery in Action, a Peer Perspective"

This training is an opportunity for clinicians and other mental health professionals to broaden their understanding of recovery, and to gain the tools needed to put these concepts into practice. Participants will be provided with the information necessary to start replacing current practices with a more consumer-driven approach to service provision.

June 5, 2019

Wednesday, 8:30am – 11:00am
Finley Center, Person Auditorium
2060 W. College Ave
Santa Rosa | CA 95401

Presenters:

Sean Bolan, Program Manager, Wellness and Advocacy Center, Goodwill Redwood Empire
Sean Kelson, Program Manager, Interlink Self-help Center, Goodwill Redwood Empire
Kate Roberge, Peer Education Coordinator, Goodwill Redwood Empire
Susan Standen, Peer Mental Health Advocate/Consultant

CEU Certificates awarded at the end of the session.

Contact: Melissa Totz at Melissa.Totz@sonoma-county.org for more information, ADA requests, or grievances.

Course meets the qualifications for 2.5 hours of continuing education credit for LMFTs, LCSWs, and LPCCs as required by the California Board of Behavioral Sciences.

th Division is approved by the California Association of Marriage and Family
lucation for LMFTs, LCSWs, & LPCCs. Sonoma County Behavioral Health

Sonoma County Behavioral Health Division

Staff Development Training

** **Mandatory Training for all Staff ** (including clerical and administrative)**

2.0 CEUs provided for LCSWs, LMFTs, LPCCs, RNs, and CADC "Uncommon Reality:

Talking with People about Visions and Voices."

This training will cover practical tips and strategies for talking and listening to clients who have experiences outside the common reality.

March 7, 2018

Wednesday, 8:30am - 10:30am

Finley Center, Person Auditorium

2060 W. College Ave

Santa Rosa | CA 95404

Peer Panel:

Sean Kelson, Manager, Interlink Self-Help Center

Susan Standen, Peer Mental Health Advocate/Consultant

Kate Roberge, Consumer Education Coordinator, Goodwill

Amy Breckenridge, Consumer Affairs Coordinator, Goodwill

CEU Certificates awarded at the end of the session.

Contact: Melissa Totz at Melissa.Totz@sonoma-county.org for more information, ADA requests, or grievances.

Course meets the qualifications for 2.0 hours of continuing education credit for LMFTs, LCSWs, and LPCCs as required by the California Board of Behavioral Sciences.

The Sonoma County Behavioral Health Division is approved by the California Association of Marriage and Family Therapists to sponsor continuing education for LMFTs, LCSWs, & LPCCs. Sonoma County Behavioral Health

Attachment E: Increasing Bi-Lingual Capacity – Mi Futuro

Healthcare & Career Exploration for Youth

Virtual Mi Futuro in Healthcare Career Pathways Speaker Series!

Kick-off: Wednesday, December 9 | 12:40 PM - 1:10 PM
Career Pathway: Certified Nursing Assistant (CNA)
Speaker: Musetta Perezarce, RN, Mi Futuro co-founder

Event #2: Wednesday, December 16 | 12:40 PM - 1:10 PM
Career Pathway: Family Medicine Resident
Speaker: Cherriese Thompson M.D.

Registration required before receiving zoom link!

Scan QR Code to register or email us:
mifuturonorcal@gmail.com

Attachment F: BHD Policy Required Informing Materials and Translation of Written Documents

COUNTY OF SONOMA
DEPARTMENT OF HEALTH SERVICES
BEHAVIORAL HEALTH DIVISION: MENTAL HEALTH SERVICES

ISSUE DATE: 03/31/2017 REVISION DATE: 05/20/2019 APPROVED BY: William J [signature] Behavioral Health Services Director	POLICY NO: MHP-21 POLICY NAME: **Required Informing Materials and Translation of Written Documents** REFERENCE/AUTHORITY: 1. Code of Federal Regulations, Title 42, §438.10 2. Code of Federal Regulations, Title 45, §92.8 3. California Code of Regulations, Title 9, Chapter 11, §1810.360 and §1810.410 4. Department of Health Care Services (DHCS), Mental Health Substance Use Disorders Services Information Notice NO.: 18-020 and 18-043 5. DHCS-Sonoma County Behavioral Health Mental Health Plan Contract 17-94619 6. 81 Federal Register Volume 81, Issue 96 31375, Nondiscrimination in Health Programs and Activities

POLICY:

The Sonoma County Behavioral Health Division (SCBH) and its contracted providers will provide to all Medi-Cal beneficiaries served by the Sonoma County Mental Health Plan (MHP) written informing materials that are critical to obtaining Specialty Mental Health Services (SMHS). Informing materials will be provided to Medi-Cal beneficiaries at the first face-to-face contact and upon request. Additionally, informing materials will be displayed in the lobbies of all MHP county-owned/operated programs and contracted provider programs. Electronic versions of informing materials will be available on the SCBH website.

Informing materials will be available in Sonoma County's threshold languages and upon request, alternative formats will be available to beneficiaries at no cost and in a format that the beneficiary can easily understand. Upon request, oral and alternative interpretation of informing materials will be provided; this includes the availability of auxiliary aids and services, such as TTY/TDY and American Sign Language. Language Assistance Taglines and a Non-Discrimination Notice shall be included in all informing materials, and posted in MHP county-owned/operated programs and contracted provider programs.

Definitions:
Sonoma County's *threshold languages* are English and Spanish. This means that these languages have been identified as the primary language of either 3,000 Medi-Cal

beneficiaries or 5% of the beneficiary population, whichever is lower, in the County geographic area. Thus, all written informing materials are available in English and Spanish.

Informing materials include, but are not limited to, program literature that is critical to assisting beneficiaries in accessing mental health services, explain the beneficiary problem resolution and fair hearing process, and identify beneficiary rights and protections.

Alternative formats for written materials include, but are not limited to, large print or oral interpretation/audio format. The MHP readily has large print formats available and other formats (e.g., audio, braille) will be provided upon request.

Language Assistance Taglines is a notification explaining the availability of written or oral translation and includes the toll-free and TTY/TDY telephone number of the MHP's customer service unit. This notification is written in English, large-print (18-point font), and the top 16 non-English languages spoken by individuals with Limited English Proficiency.

Non-Discrimination Notice is a notification that the MHP must comply with non-discrimination and accessibility requirements.

PROCEDURE:

I. Informing Materials Provided to all Medi-Cal Beneficiaries

The following documents must be provided to beneficiaries at the first face-to-face contact with them and upon request:

A. *Guide to Medi-Cal Mental Health Services Handbook*
B. *Sonoma County MHP Provider Directory*
C. *HIPAA Provider's Notice of County Privacy Practices*
D. *Client Rights and Grievance/Appeal Process and Form*-with County addressed envelope
E. *Your Right to Make Decisions About Medical Treatment-Advanced Directive* brochure (adult service providers only)
F. *Early & Periodic Screening, Diagnosis & Treatment Including Therapeutic Behavioral Services* brochure (for providers of youth - up to age 21 years)

NOTE: An acknowledgement of receipt must be obtained from all beneficiaries who are offered the identified informing materials (Use MHS 115–Consent for Treatment).

II. Informing Materials Postings for Medi-Cal Provider Lobbies

The following documents must be readily available in the lobbies of all Medi-Cal certified provider sites:

A. *Guide to Medi-Cal Mental Health Services Handbook*
B. *Sonoma County Mental Health Plan Provider Directory*
C. *HIPAA Provider's Notice of County Privacy Practices*
D. *Client Rights and Grievance/Appeal Process and Form* with County addressed envelopes
E. *Your Right to Make Decisions About Medical Treatment-Advanced Directive* brochure (adult service providers only)
G. *Early & Periodic Screening, Diagnosis & Treatment Including Therapeutic Behavioral Services* brochure (for providers of youth - up to age 21 years)
F. *Free Language Assistance Services* (Taglines)
G. *Point to Your Language*
H. *Consumer Notification of Licensing Boards*
I. *Mental Health Patients' Rights* Poster (for Residential Treatment and other 24-hour treatment facilities)
J. *Request for Change of Service Provider*
K. *Non-Discrimination Notice*

III. Translation of Written Materials

SCBH staff and contractors will provide to Medi-Cal beneficiaries, informing materials in Sonoma County's threshold languages (English and Spanish) and in Large print (18-point font) format.

When applicable, SCBH staff will also ensure that other SCBH documents are translated into threshold languages, or provided in alternative formats upon request. For this purpose, SCBH contracts with a language interpretation and translation service (See policy *MHP 08-Linking Non-English Speaking Beneficiaries to Mental Health Services and Use of Interpreters*).

A. Requests for written translation of formal SCBH documents are to be e-mailed to the Mental Health Plan Quality Assurance Manager (MHP-QA Manager) for review and authorization.
    i. Less formal document translation, such as a single letter to a client during the course of treatment, may be translated by SCBH bilingual staff without going through the MHP-QA Manager (SCBH maintains a list of bilingual staff).
        a. In these cases, review of the document by at least one other bilingual staff person is recommended before distribution of the document.
B. Either the contracted language service or the identified bilingual staff person provides translation into Latin American Spanish, the type of Spanish that is most relevant to the County's Spanish-speaking clients.
C. To ensure both accuracy of translation and cultural appropriateness, upon receipt of a translated document, the MHP-QA Manager will request review of the document by at least one bilingual SCBH staff

member, who will notify the MHP-QA Manager of any recommended edits.

   i. Any edits will be made by Quality Assurance (QA) staff before the document is released for use by SCBH and/or MHP contracted provider.

D. With previously published SCBH documents, if an error in translation is identified; if content is deemed culturally insensitive for any reason; or if a document must be adapted to be accessible to persons with limited reading proficiency, the MHP-QA Manger will make necessary modifications/edits by adhering to the abovementioned review and approval process prior to re-release of the document.

E. When a revised document becomes available, QA staff will inform all applicable SCBH staff and/or MHP contracted providers of the change and request that any outdated documents be discarded and replaced by the revised version.

   i. QA staff will save the current document in a shared folder on the SCBH network for all staff to access and archive the outdated document.

   ii. QA staff will update the SCBH website with the revised document.

FORMS/BROCHURES:

1. *Guide to Medi-Cal Mental Health Services Handbook*
2. *Sonoma County Mental Health Plan Provider Directory*
3. *HIPAA Provider's Notice of County Privacy Practices*
4. *MHS 406-Client Rights and Grievance/Appeal Process and Form* with County addressed envelopes
5. *MHS 157-Your Right to Make Decisions About Medical Treatment-Advanced Directive* brochure (adult service providers only)
6. *Early & Periodic Screening, Diagnosis & Treatment Including Therapeutic Behavioral Services* brochure (for providers of youth - up to age 21 years)
7. *MHS 162-Free Language Assistance Services* (Taglines)
8. *Point to Your Language*
9. *MHS 402-Consumer Notification of Licensing Boards*
10. *MHS 400-Mental Health Patients' Rights* Poster (for Residential Treatment and other 24-hour treatment facilities)
11. *MHS 109-Request for Change of Service Provider*
12. *MHS 158-Non-Discrimination Notice*
13. *MHS 115*-Consent for Treatment

ATTACHMENTS:

1. Medi-Cal Informing Materials available online at: http://www.sonoma-county.org/health/publications/medi-calinforming.asp

Attachment G: Ethnic Services Summary Report, FY 2019-20 Performance Metrics

Ethnic Services Summary Report

FY 19-20 Performance Metrics

Introduction

This report was prepared as part of the annual system review of Sonoma County Department of Health Services, Behavioral Health Division (DHS-BHD) performance metrics with respect to client ethnicity and preferred language. The following tables and charts summarize Access to Services, Timeliness of Service Delivery, Distribution of Services, and Outcomes of Services. The reporting timeframe comprises Fiscal Year 2019-2020. Both Claimable and Non-Claimable services are included in this report. Age categories are defined as follows: Child/youth (ages 0-17); Adults (age 18+). Data for this report is taken from the ACD 24-hour call line, the Access Initial Request for Services Database, and the Electronic Health Record.

Access to Services

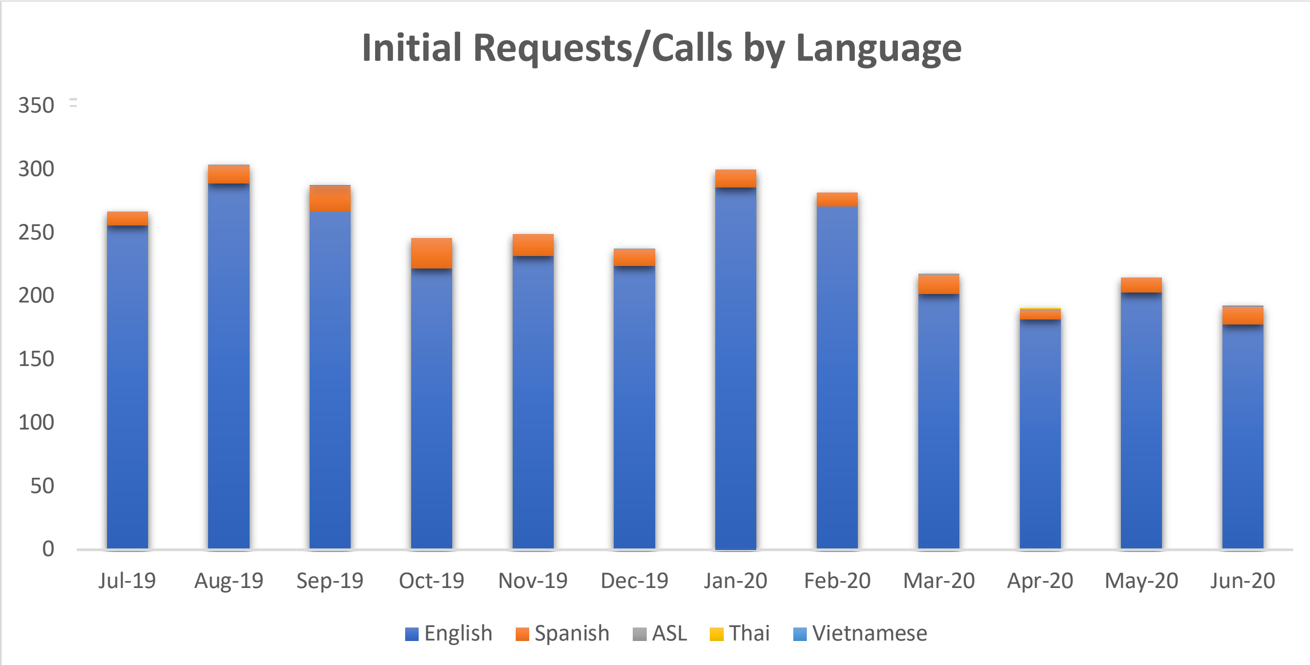
Access to services at DHS-BHD begins with a request for services to the Access Team. Requests are received by way of the 24/7 ACD line, faxed/emailed referrals, and walk-ins to the Access Clinic.

Call Log

The following data includes calls to the 24/7 ACD line and faxed/emailed referrals (not walk-in requests).

Caller Language

Month of Call	English	Spanish	ASL	Thai	Vietnamese	Total
July	256	11				**267**
August	289	14	1			**304**
September	267	20			1	**288**
October	222	24				**246**
November	232	17				**249**
December	224	13	1			**238**
January	286	14				**300**
February	271	11				**282**
March	202	15	1			**218**
April	182	7	1	1		**191**
May	203	12				**215**
June	178	14			1	**193**
Total	**2812**	**172**	**4**	**1**	**2**	**2991**

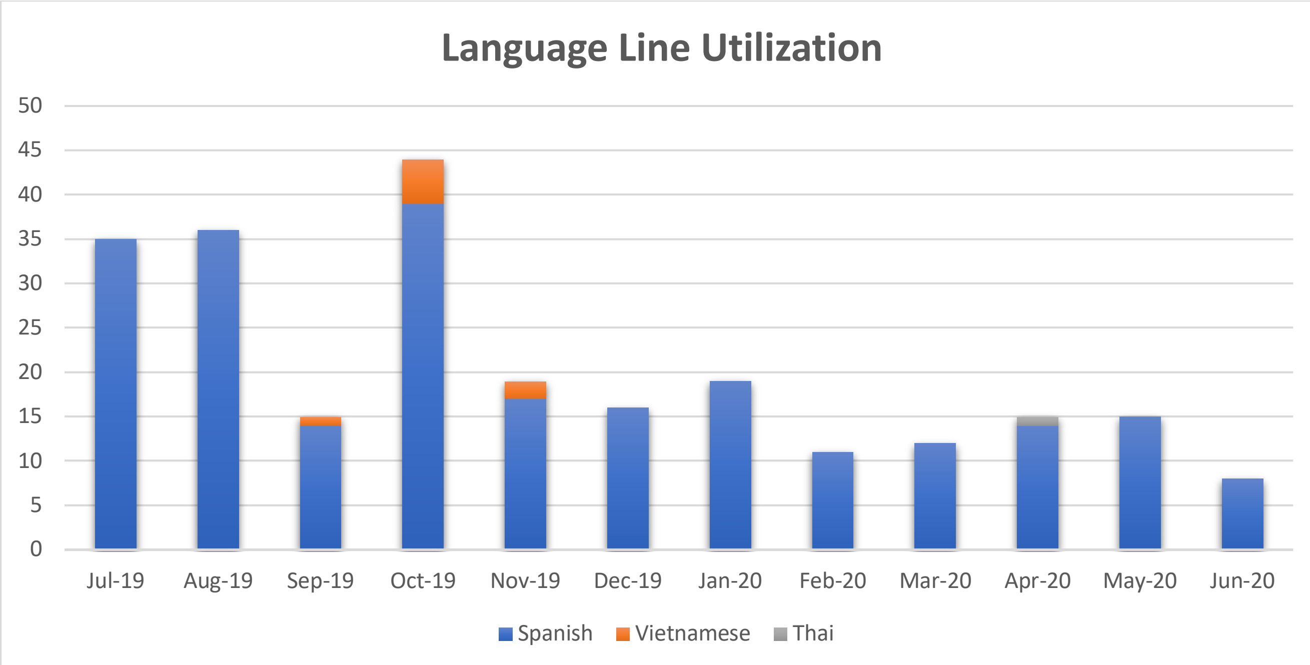


Language Line Utilization – Access

The Adult and Youth Access teams staff the 24/7 call line with bilingual staff. But in the event that a bilingual staff member is not available for call backs or screenings, the Language Line is available to provide telephonic interpretation services. Utilization of the Language Line for Access purposes is as follows:

Month of Call	Spanish	Vietnamese	Thai	Total
July	35			**35**
August	36			**36**
September	14	1		**15**
October	39	5		**44**
November	17	2		**19**
December	16			**16**
January	19			**19**
February	11			**11**
March	12			**12**
April	14		1	**15**
May	15			**15**
June	8			**8**
Total Utilization	**236**	**8**	**1**	**245**

Language Line utilization on the Access Teams trended downward when comparing the first half of the year to the second half. This is due to expanded bilingual capacity on both teams as well as a system workflow shift implemented partway through the year, in which the Youth Access Team began taking calls for service directly rather than filtering through the Adult Access Team first. The overall trend pattern is illustrated in the following chart.



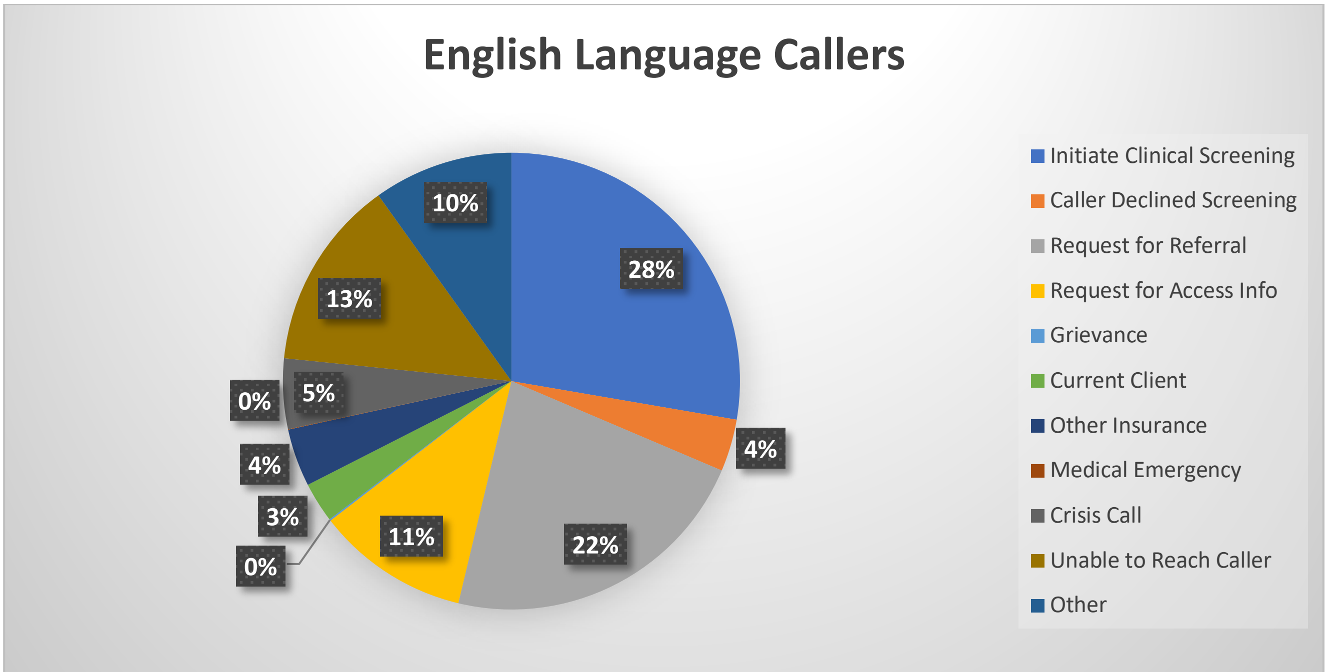
Call Log Disposition by Language

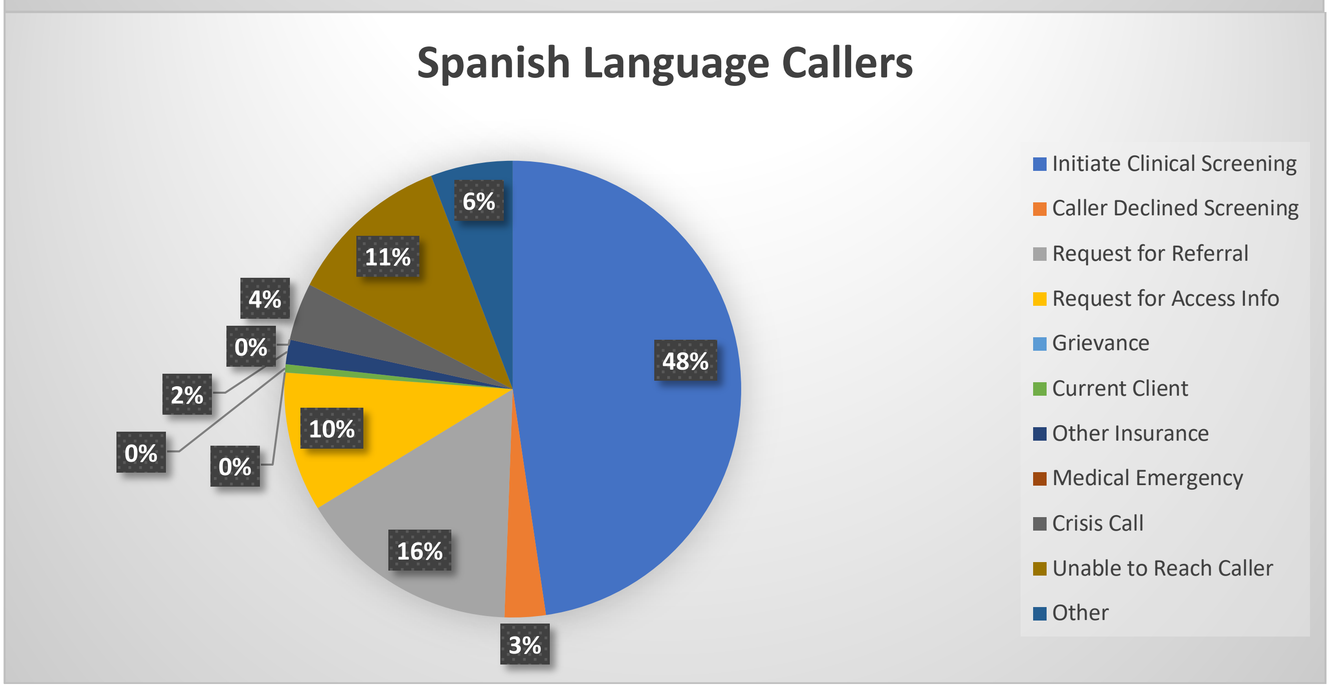
The Access Teams fielding the request call line receive several types of inquiries. Examples include:

- Requests for Specialty Mental Health Services
- Requests for information about mental health
- Requests for referral to a community resource
- Referral from a community provider
- Inquiries from concerned family members for their loved one
- Post-hospital referrals

The following tables and charts depict the call disposition by preferred language of the caller. At the point of initial call, ethnicity of the caller is unknown, so analysis of potential ethnic disparities in call disposition is not possible at this point in the access process.

Call Disposition	**English**	**Spanish**	**ASL**	**Thai**	**Vietnamese**	**Total**
Initiate Clinical Screening	779	82	2		1	**864**
Caller Declined Screening	104	5				**109**
Request for Referral	628	27		1		**656**
Request for Access Information	304	17				**321**
Grievance	3					**3**
Current Client	80	1				**81**
Other Insurance: Not Medi-Cal/Medi-Care	115	3				**118**
Medical Emergency: Transferred 911	1					**1**
Crisis Call: Transferred CSU	140	7				**147**
Unable to Reach Caller	380	20				**400**
Other	278	10	2		1	**291**
Total	**2812**	**172**	**4**	**1**	**2**	**2991**





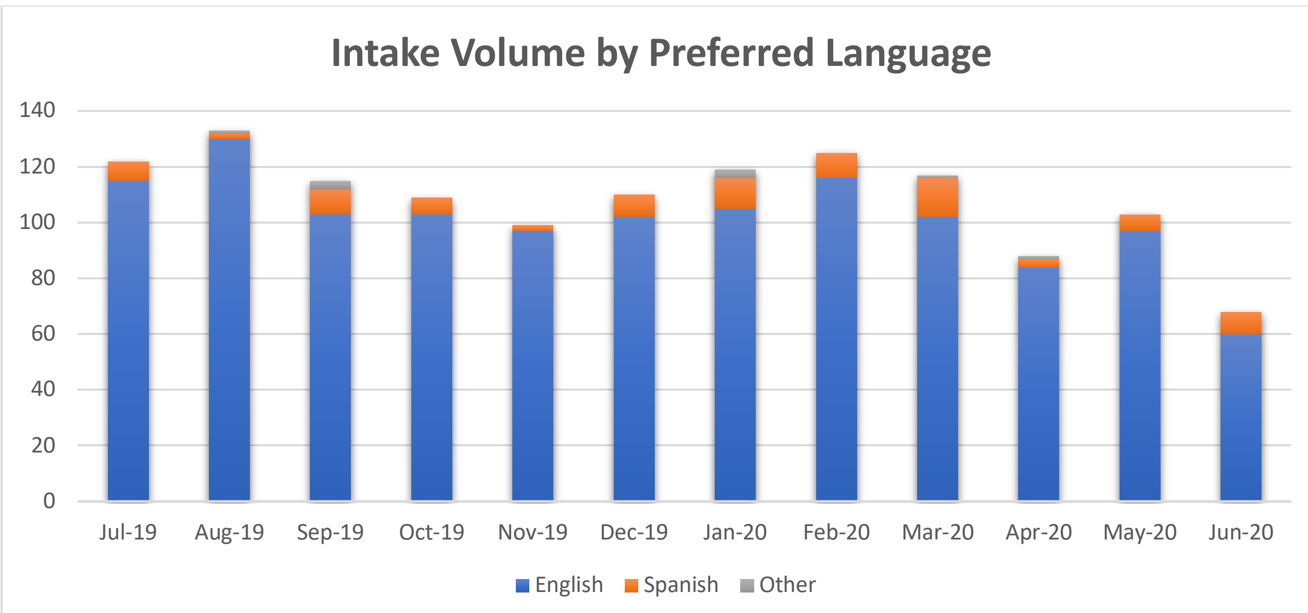
A significantly larger percentage of Spanish-speaking callers initiated a clinical screening versus English-speaking callers. Amongst English-speaking callers, there was a higher incidence of calls requesting referral rather than assessment. Similarly, there was a higher percentage of English-speaking clients that could not be reached for the return call.

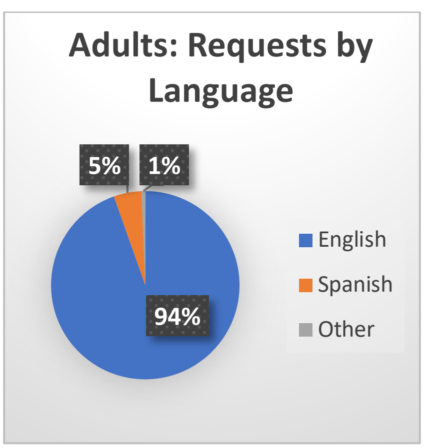
Clinical Screening/Intake Volume

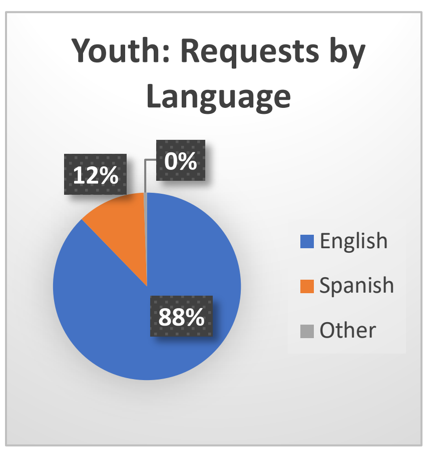
Overall, 28.89% of calls resulted in clinical intake. However, the walk-in percentages are much higher. The following charts include walk-in requests as well as calls and email/fax referrals.

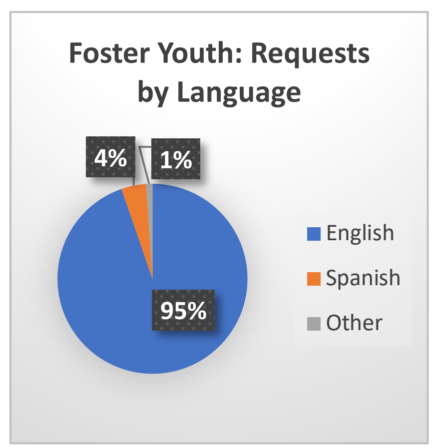
By Preferred Language

Month of Intake	English	Spanish	Other	Total
July	115	7		**122**
August	130	2	1	**133**
September	103	9	3	**115**
October	103	6		**109**
November	97	2		**99**
December	102	8		**110**
January	105	11	3	**119**
February	116	9		**125**
March	102	14	1	**117**
April	84	3	1	**88**
May	97	6		**103**
June	60	8		**68**
Total	**1214**	**85**	**9**	**1308**



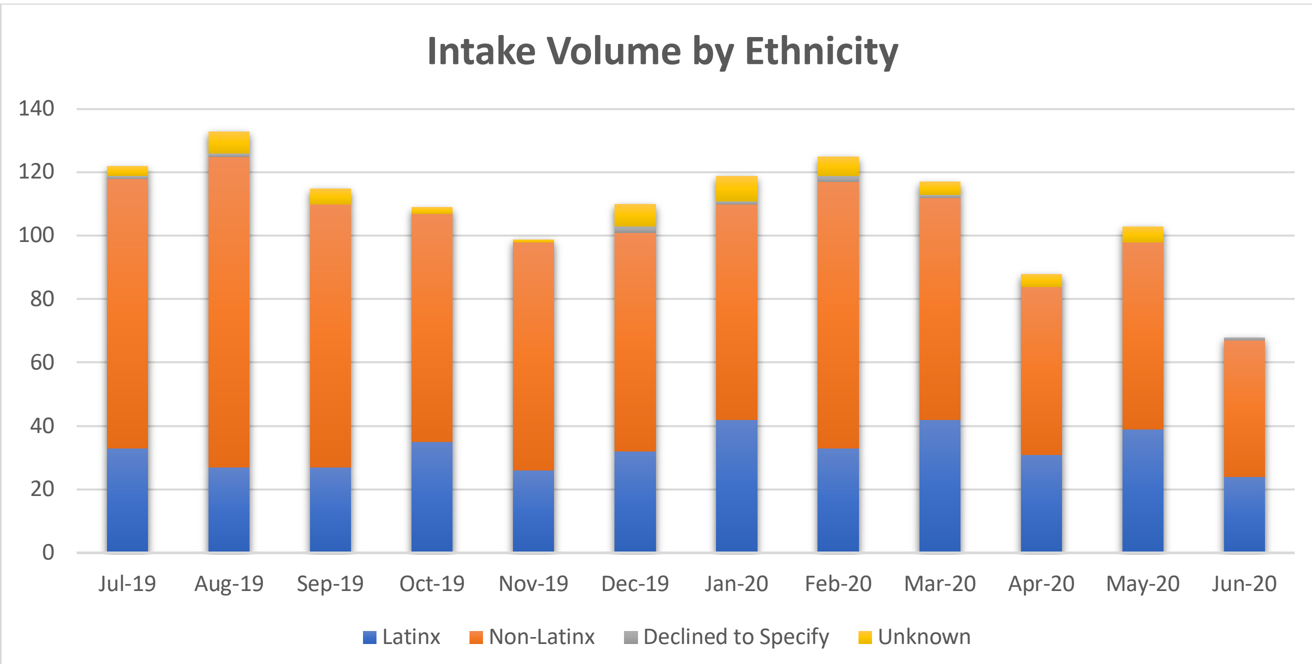


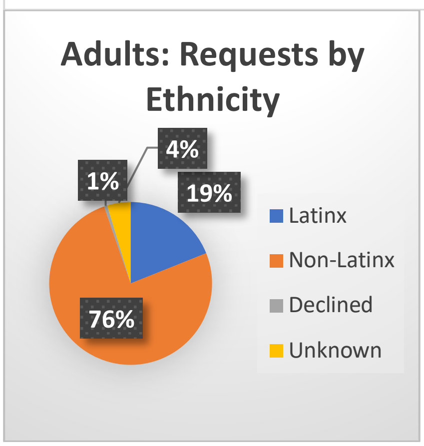


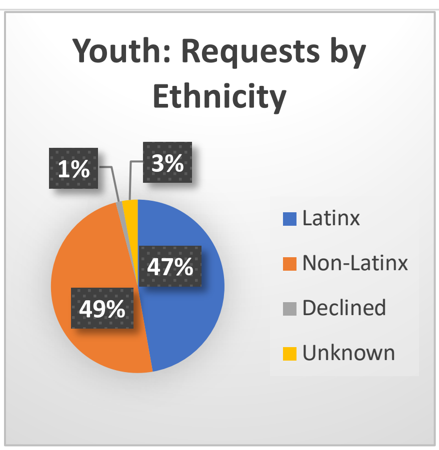


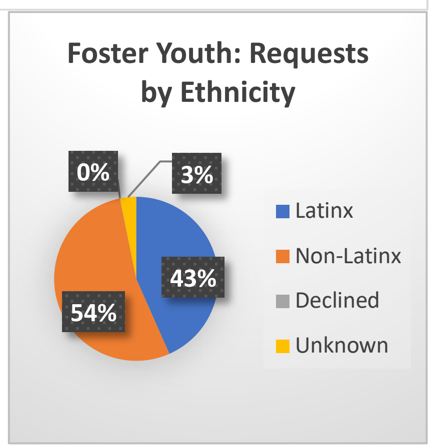
By Ethnicity

Month of Intake	Latinx	Non-Latinx	Declined to Specify	Unknown	Total
July	33	85	1	3	**122**
August	27	98	1	7	**133**
September	27	83		5	**115**
October	35	72		2	**109**
November	26	72		1	**99**
December	32	69	2	7	**110**
January	42	68	1	8	**119**
February	33	84	2	6	**125**
March	42	70	1	4	**117**
April	31	53		4	**88**
May	39	59		5	**103**
June	24	43	1		**68**
Total	**391**	**856**	**9**	**52**	**1308**









There is a significantly higher proportion of Spanish-speaking clinical intakes in the Youth System versus Adult system. Similarly, there is a much higher percentage of clients identifying as Latinx completing Youth Intakes versus Adult Intakes, by almost triple.

Clinical Screening/Intake Disposition

Of the 1308 Clinical Intakes completed in FY 19-20, 1032 (78.90%) resulted in an offered assessment appointment. Details by age group shown in the following table:

Intake Disposition Status	**Adults**	**Youth**	**Foster Youth**	**Total**
Offered Assessment Appointment	628	293	111	1032
Not Offered Appointment	148	50	78	276
Total	776	343	189	1308

The high percentage of non-offered appointments for foster youth stems from the practice of all foster youth at Valley of the Moon being screened for Specialty Mental Health Services, whether the family is requesting or not; whereas in the youth system, requests for service are made by the family or treating provider.

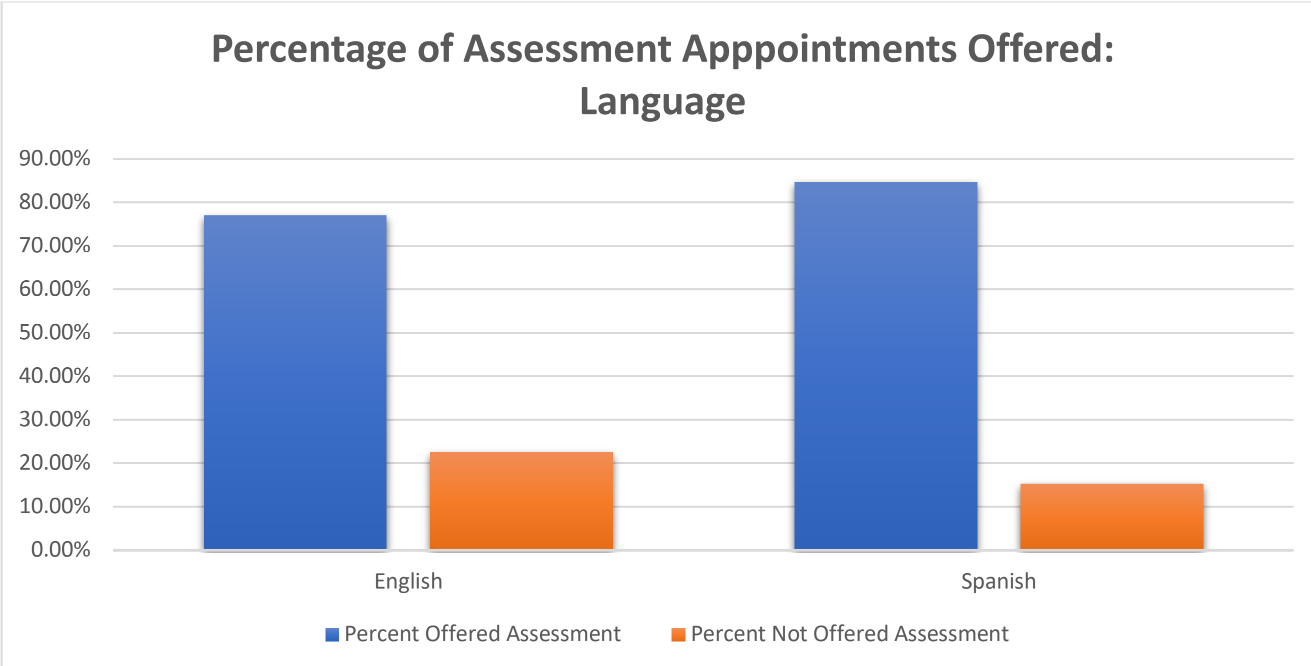
For the 276 requests that were not offered an appointment, the primary reasons for this were:

- Client declined services
- Client was ineligible for Specialty Mental Health Services
    - Did not meet medical necessity criteria
    - Ineligible for Medi-CAL
- Unable to establish contact with client after multiple attempts
    - Did not return calls
    - No working phone number

Not Assessed: Disposition	**Adults**	**Youth**	**Foster Youth**	**Total**
Client Already in Services	0	4	14	18
Client Declined Services	48	11	9	68
Hospitalized	2	2	0	4
Client Ineligible for SMHS	51	17	49	117
Client Moved Out-of-County	0	3	1	4
Client Referred Directly to WRAP	0	0	2	2
Client Re-Opened to Services	1	0	0	1
Unable to Establish Contact	46	13	2	61
Total	148	50	78	276

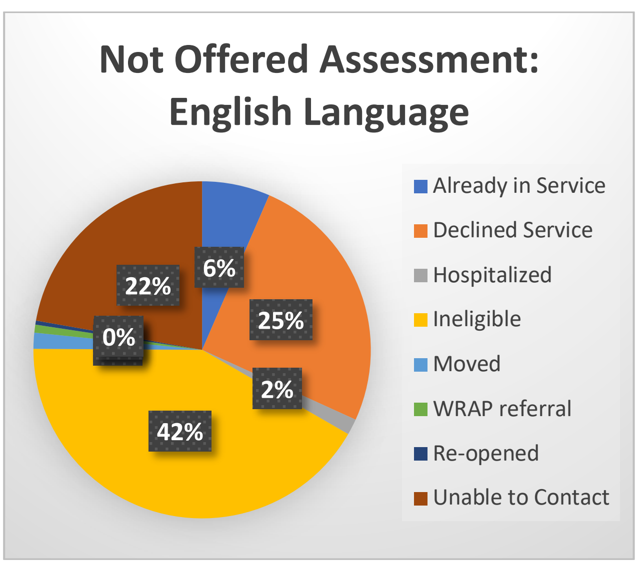
Clinical Screening/Intake Disposition by Preferred Language

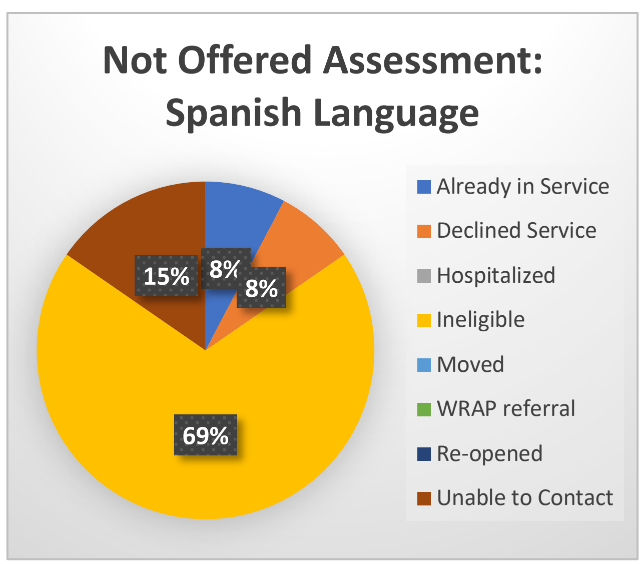
Intake Disposition Status	**English**	**Spanish**	**Other**	**Total**
Offered Assessment Appointment	935	72	7	**1032**
Not Offered Appointment	261	13	2	**276**
Total	**1214**	**85**	**9**	**1308**



Overall, a higher percentage of Spanish-speaking clients versus English-speaking clients are offered Assessment appointments through the Adult and Youth Access teams. For those not assessed, the reasons are as follows:

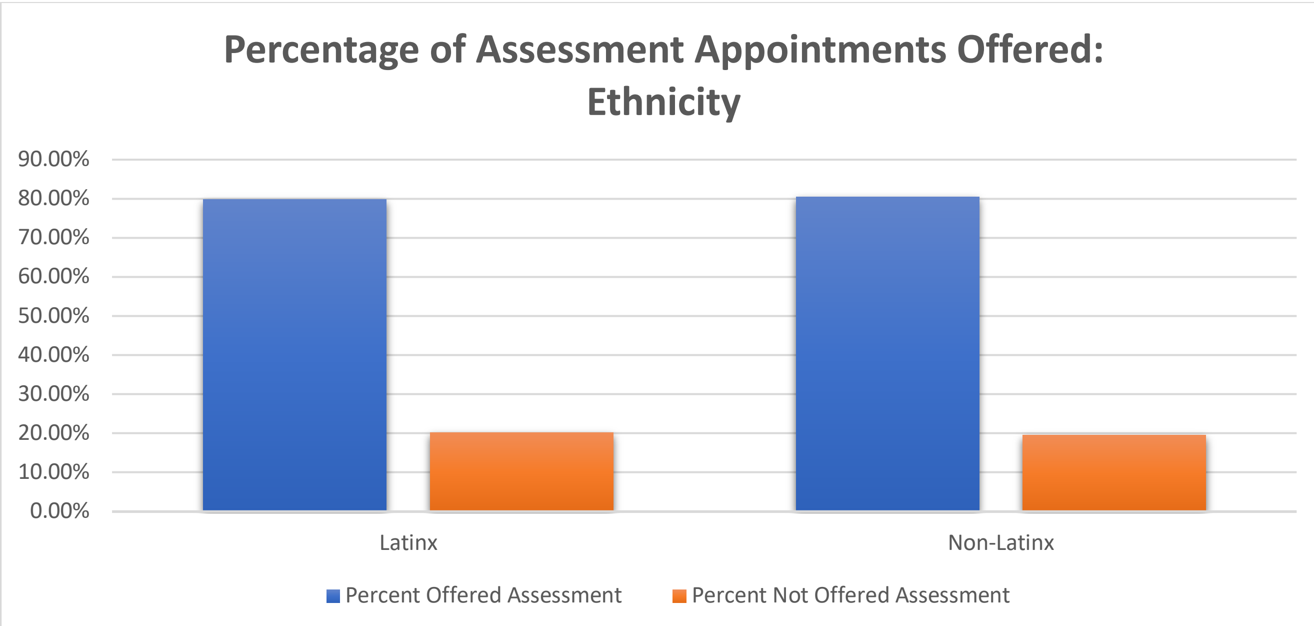
Not Assessed: Disposition	**English**	**Spanish**	**Other**	**Total**
Client Already in Services	17	1		**18**
Client Declined Services	66	1	1	**68**
Hospitalized	4			**4**
Client Ineligible for SMHS	109	9		**118**
Client Moved Out-of-County	4			**4**
Client Referred Directly to WRAP	2			**2**
Client Re-Opened to Services	1			**1**
Unable to Establish Contact	58	2	1	**61**
Total	**261**	**13**	**2**	**276**



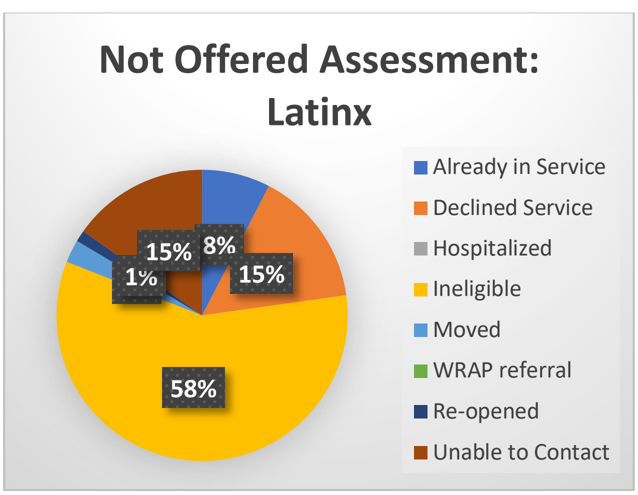


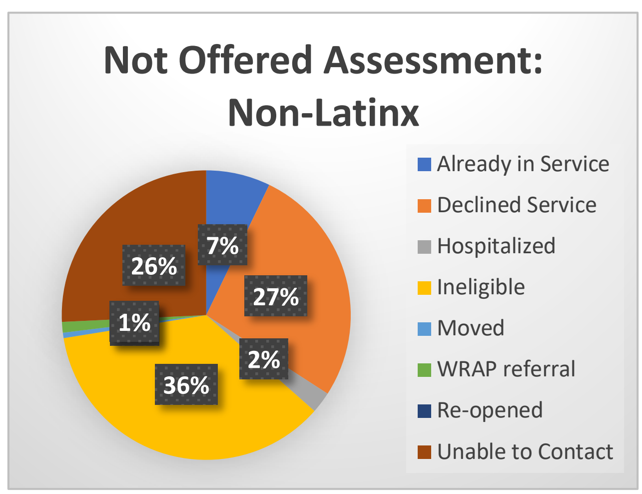
Clinical Screening/Intake Disposition by Ethnicity

Intake Disposition Status	Latinx	Non-Latinx	Unknown	Total
Offered Assessment Appointment	312	689	31	1032
Not Offered Appointment	79	167	30	276
Total	391	856	61	1308



Not Assessed: Disposition	Latinx	Non-Latinx	Other	Total
Client Already in Services	6	12		18
Client Declined Services	12	45	11	68
Hospitalized		4		4
Client Ineligible for SMHS	46	60	12	118
Client Moved Out-of-County	2	1	1	4
Client Referred Directly to WRAP		2		2
Client Re-Opened to Services	1			1
Unable to Establish Contact	12	43	6	61
Total	79	167	30	276





Of concern is the higher percentage of Spanish-speaking and Latinx clients deemed ineligible for services due to not meeting medical necessity, especially given that this determination is made prior to Assessment completion. Data analysis also reveals that Latinx and Spanish-speaking clients are much less likely to decline services or drop out due to non-contact. This data contradicts the commonly held stigma-based assumption that Latinx clients "don't want our services."

Timeliness

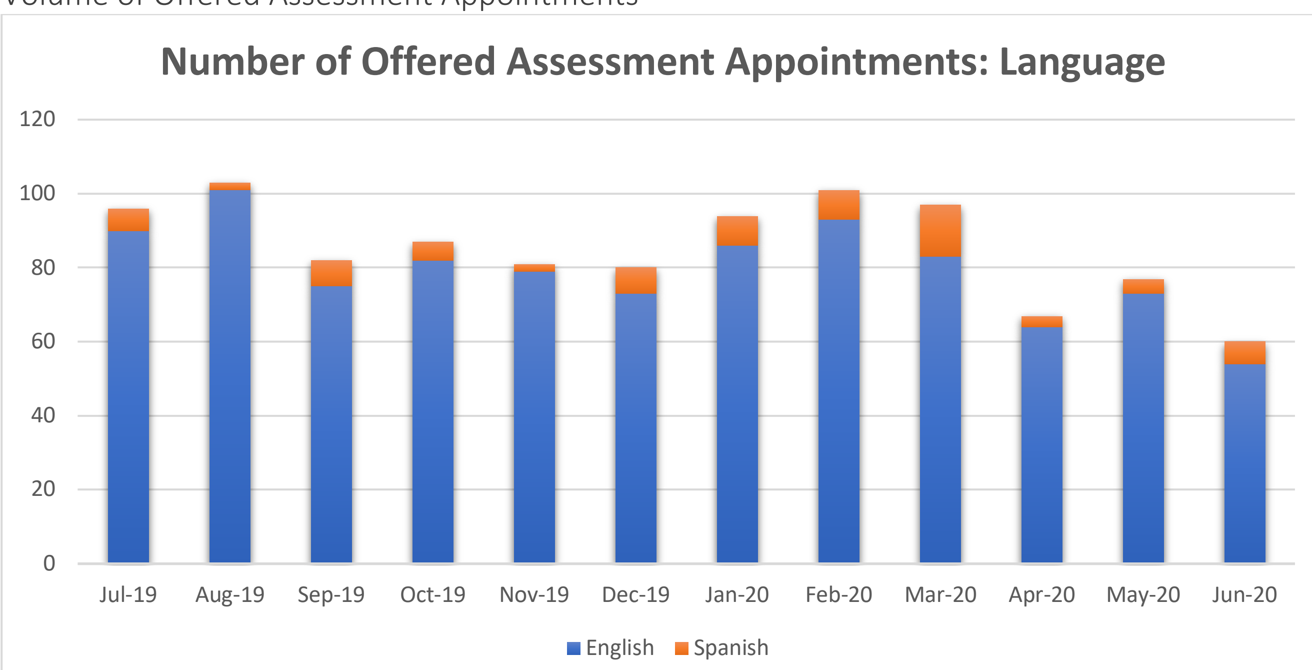
The California Department of Healthcare Services (DHCS) requires County Mental Health Plans to maintain a network of providers sufficient to meet the time and distances standards for services set forth in regulation. (See DHCS Information Notice 20-012). Per the regulations, when a client requests a non-urgent assessment for specialty mental health services, they are to be offered an appointment date that falls within 10 business days of the request. For ease of reference, timeliness standards are summarized as follows:

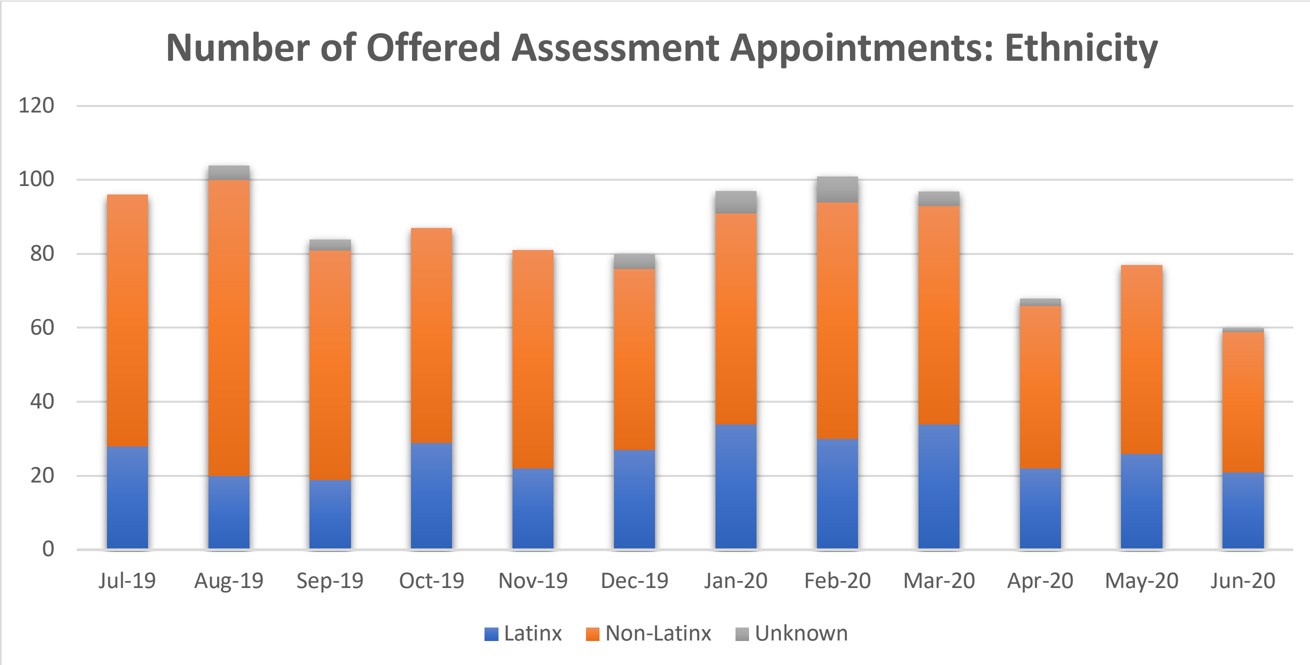
Appointment Type	Standard
Emergency Appointment	Within 24 hours of request
Urgent Care Appointment for services that do not require prior authorization	Within 48 hours of request
Urgent Care Appointment for services that require prior authorization	Within 96 hours of request
Non-Urgent Appointments with Specialist Physicians (i.e. Psychiatrists)	15 business days
Non-Urgent Appointments with non-physician mental health providers	10 business days

Timeliness to First Offered Assessment Appointment

The following charts depict the volume and timeliness metrics for offered Assessment appointments, analyzed by preferred language and ethnic identity.

Volume of Offered Assessment Appointments

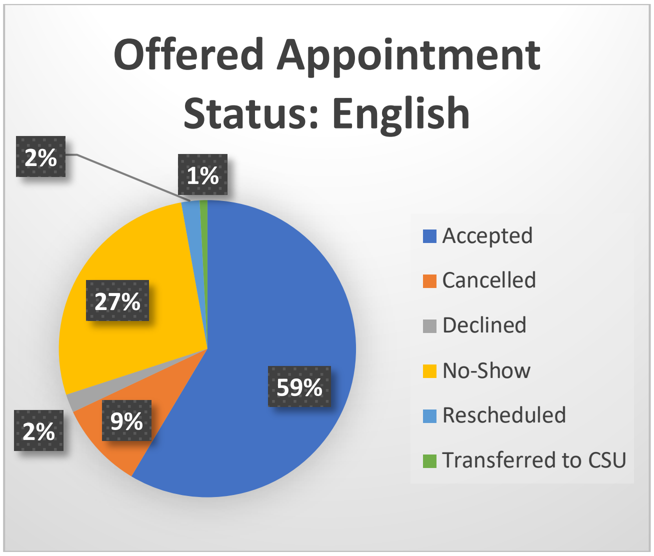


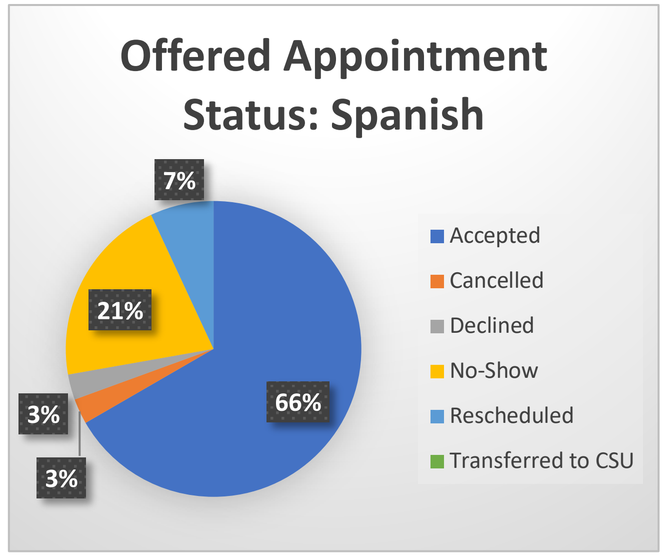


Of note is the increase in Spanish-speaking appointments in March at the onset of COVID. While both Latinx and Non-Latinx clients show a downward trend in offered appointments post-COVID, Non-Latinx offered appointments trended downward more sharply, whereas Latinx offered appointments dropped initially and then held steady.

Offered Appointment Status by Preferred Language

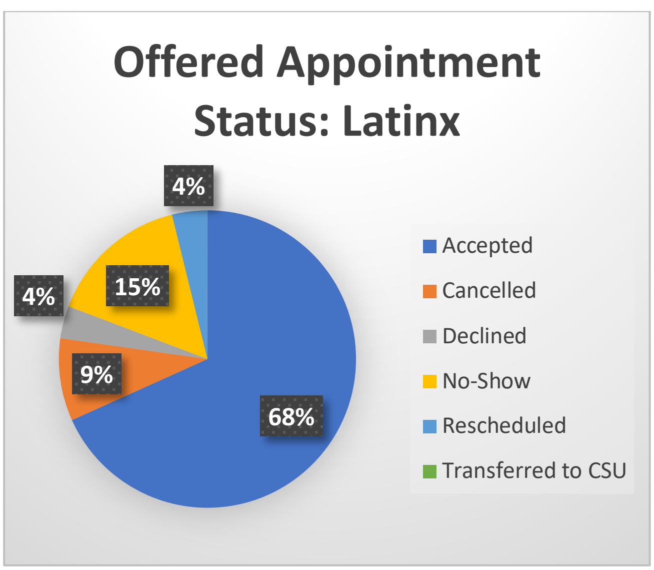
Appointment Status	English	Spanish	Other	Total
Accepted	558	48	5	611
Cancelled	90	2		92
Declined	19	2		21
No-Show	259	15	2	276
Rescheduled	19	5		24
Transferred to CSU	8			8
Total	953	72	7	1032

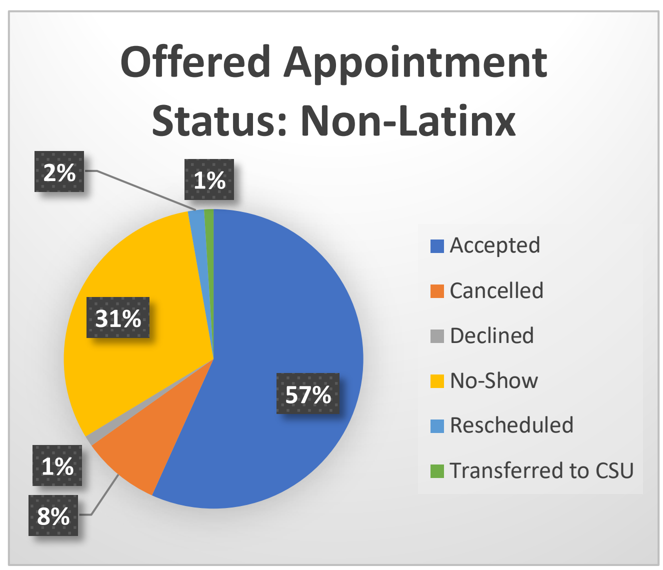




Offered Appointment Status by Ethnicity

Appointment Status	Latinx	Non-Latinx	Unknown	Total
Accepted	213	391	7	611
Cancelled	28	58	6	92
Declined	11	8	2	21
No-Show	48	213	15	276
Rescheduled	12	12		24
Transferred to CSU		7	1	8
Total	312	689	31	1032



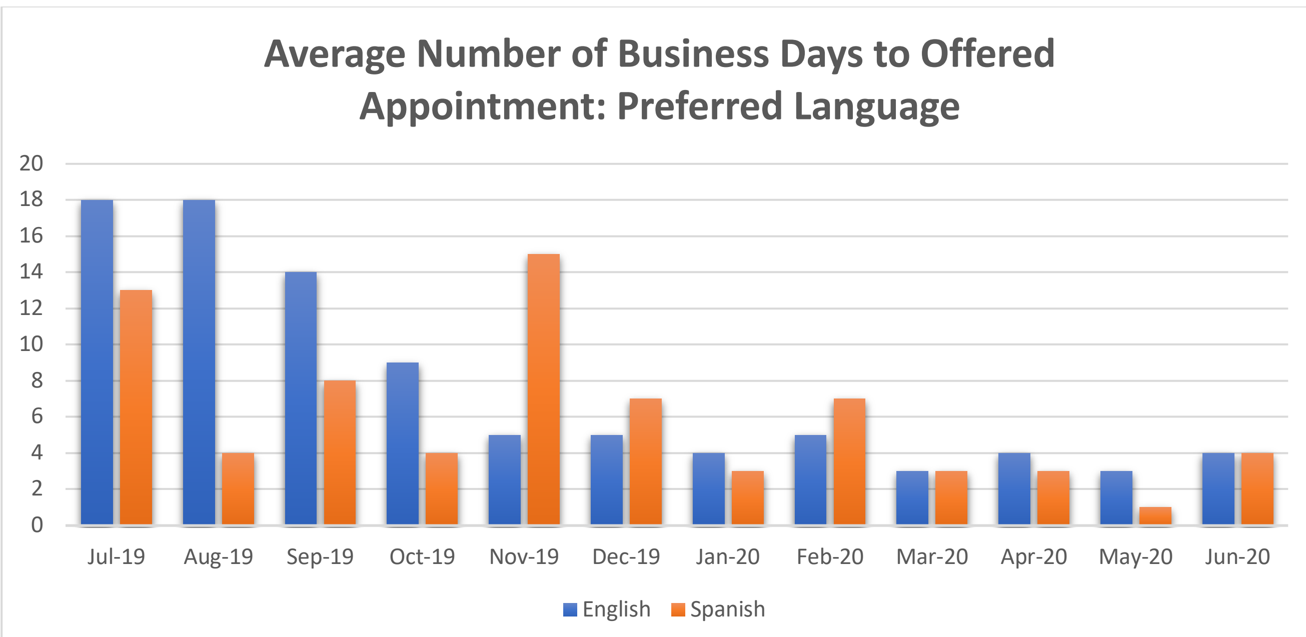


Of note is that Spanish-speaking and Latinx identified clients accepted the offered assessment appointment at a significantly higher rate. Additionally, Spanish-speaking clients had a lower no-show rate than English-speaking clients, and Latinx clients had a significantly lower no-show rate than non-Latinx clients (by half).

Average Business Days: Preferred Language

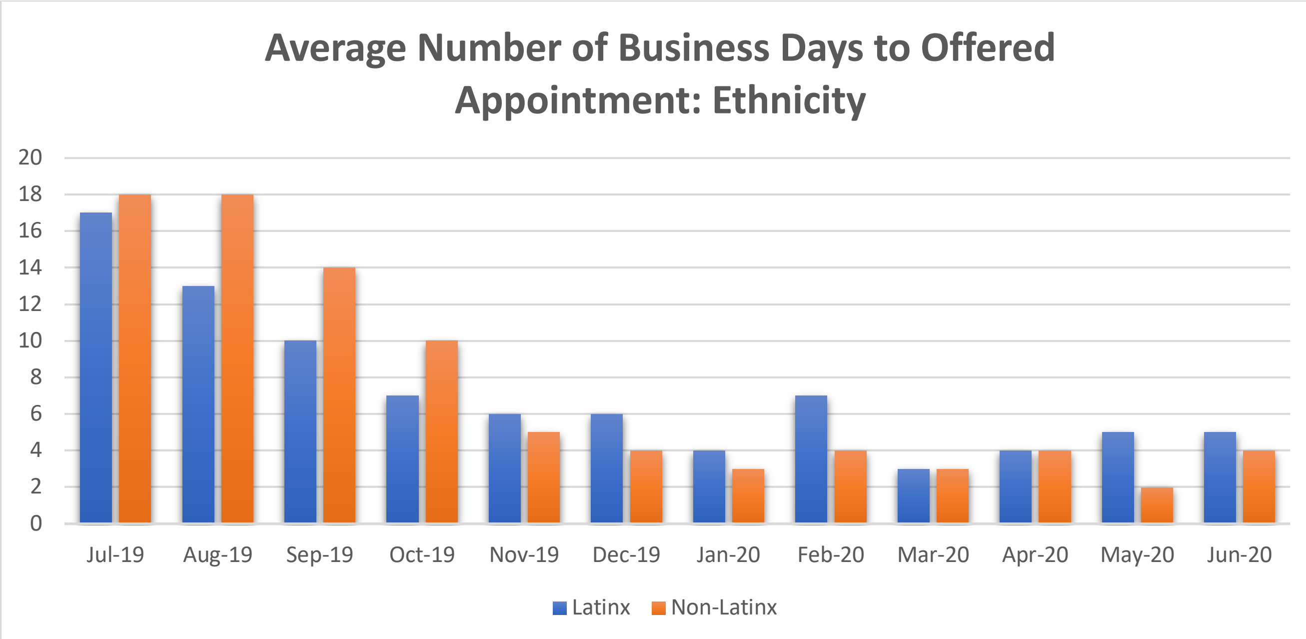
The target system goal is for average business days to offered assessment appointment to fall below 10 days. In an effort to improve timeliness metrics, the Adult Access team implemented a significant system change by converting to a walk-in clinic in October 2019. The following tables and charts describe the timeliness to offered appointment by preferred language and by ethnicity, both overall and trended over time.

Preferred Language	Adults	Youth	Foster Youth	Overall
English	8.79	6.74	6.34	7.98
Spanish	5.64	6.11	3.17	5.68
Other	2.33	3.00	5.50	3.43
Overall	8.62	6.63	6.15	7.79



Average Business Days: Ethnicity

Ethnicity	Adults	Youth	Foster Youth	Overall
Latinx	7.24	7.08	6.45	7.04
Non-Latinx	8.92	6.20	5.95	8.10
Declined to State	2.75	9.50	--	5.00
Unknown	10.95	4.60	4.00	9.40
Overall	8.62	6.63	6.15	7.79

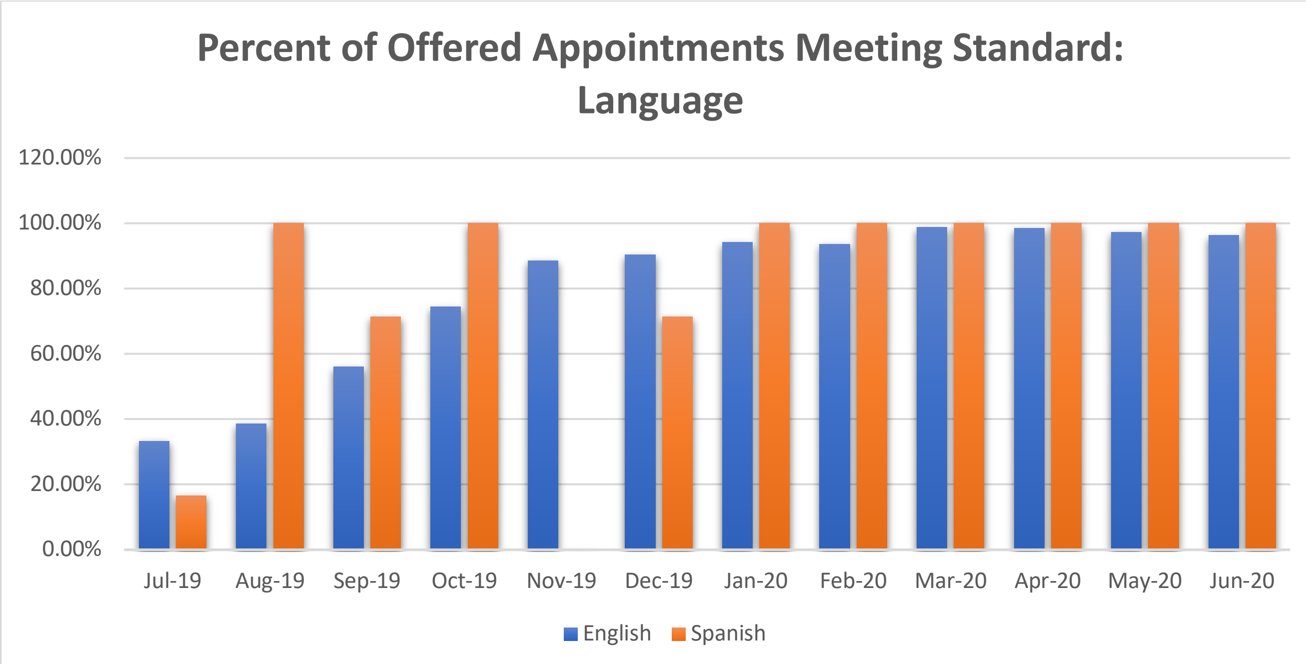


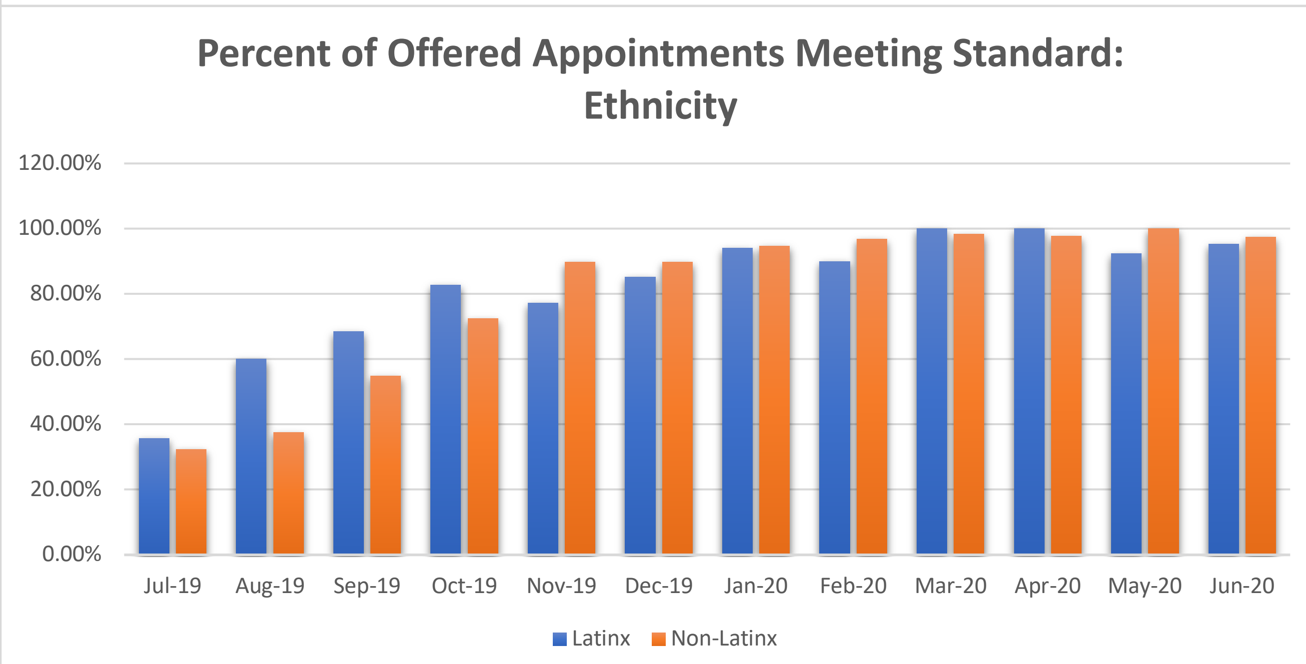
Overall timeliness metrics by language and ethnicity are excellent. Month-to-month analysis shows that the Access team changes implemented in October produced very positive results. These improvements took longer to materialize for Spanish-speaking clients than English-speaking clients, but both achieved the targeted goal by end of year.

Percent of Offered Appointments Meeting 10 Day Standard

The minimum threshold set by DHCS is 70% of offered appointments meeting the 10 Business Day standard. Overall, 78.78% of offered appointments met the standard. Analysis by preferred language and ethnicity are as follows:

- Preferred Language
  - English: 78.17%
  - Spanish: 84.72%
  - Other: 100%
- Ethnicity:
  - Latinx: 82.69%
  - Non-Latinx: 76.92%
  - Unknown: 80.65%





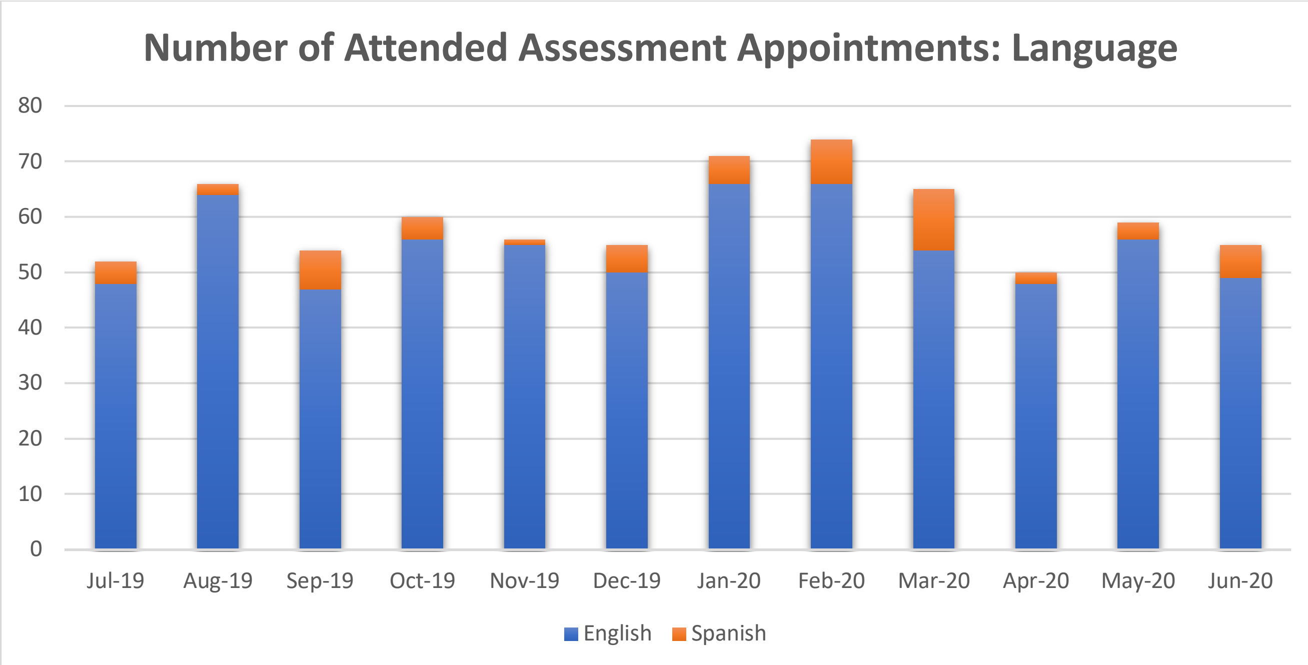
The percent of offered appointments meeting the 10-day standard increased significantly post-Access Team system change. Both English/Spanish and Latinx/Non-Latinx groups achieved 90% or higher consistently from January onward.

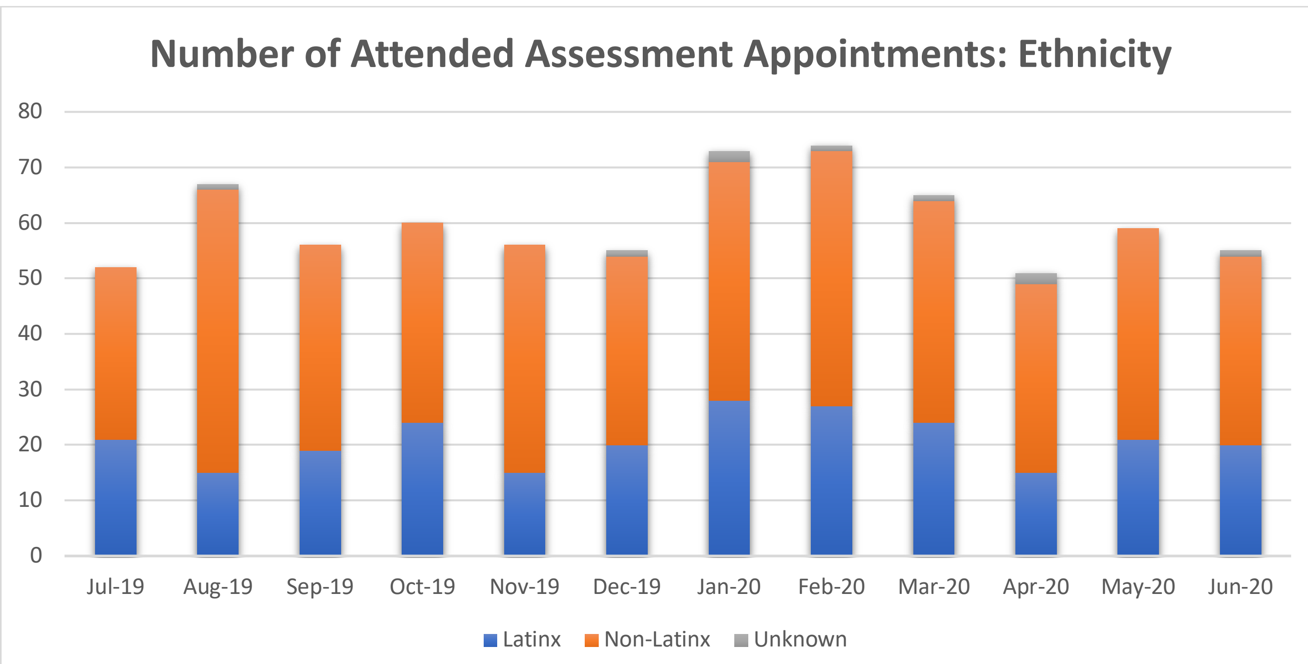
Timeliness to Attended Appointment

Timeliness to attended assessments does not fall under set standards, as clients have the latitude to change/decline appointments. DHS-BHD's goal is to stay within a 5-point range of 10 business days.

Volume of attended

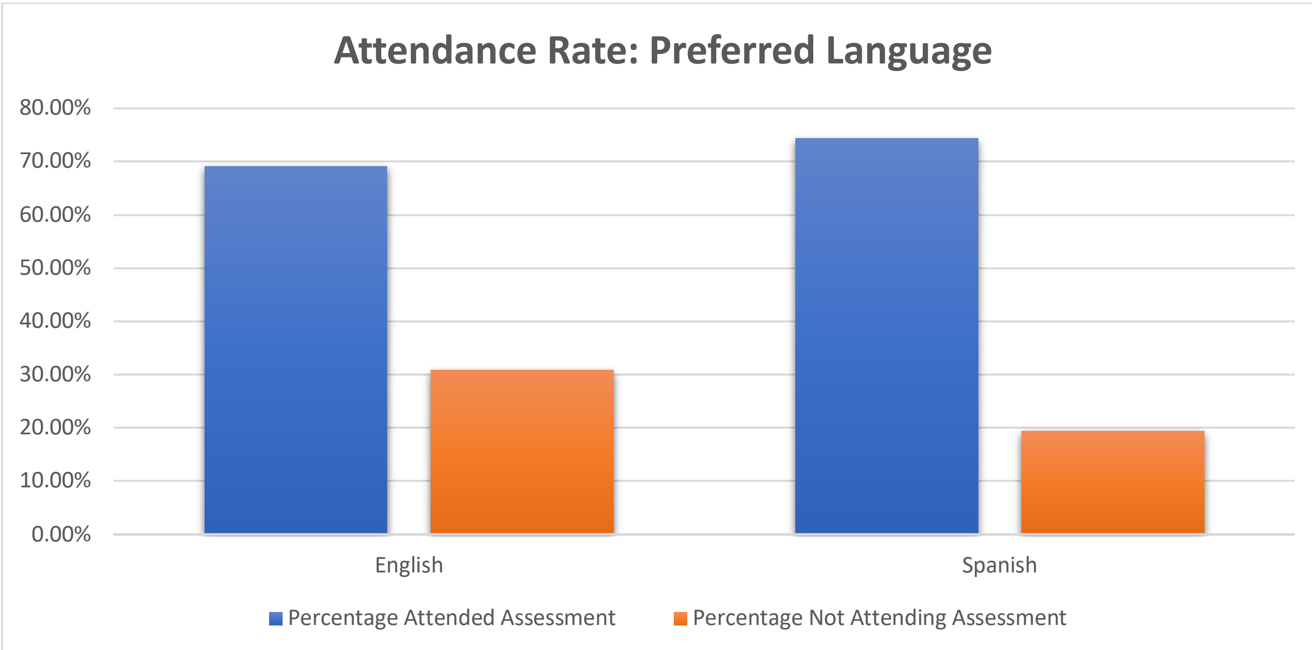
Of the 1032 offered assessment appointments, 723 (70%) resulted in attended assessment appointments. Of the attended appointments, 1 client was already in services, and 4 clients declined services during the assessment appointment.

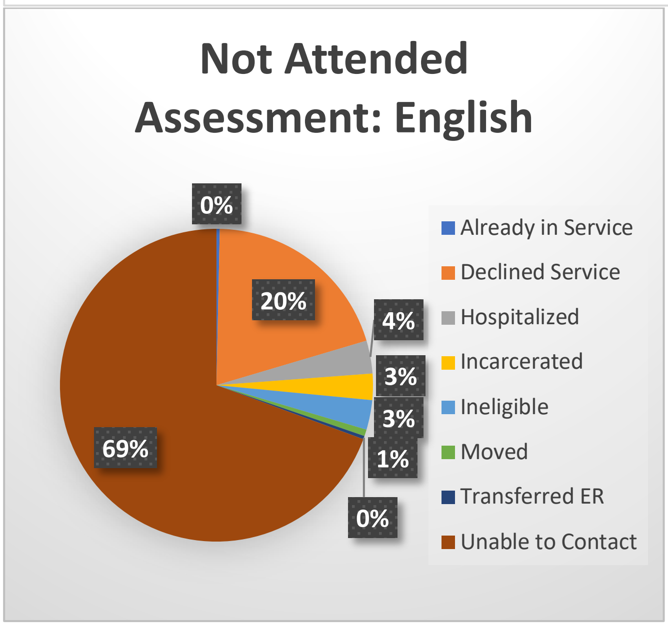


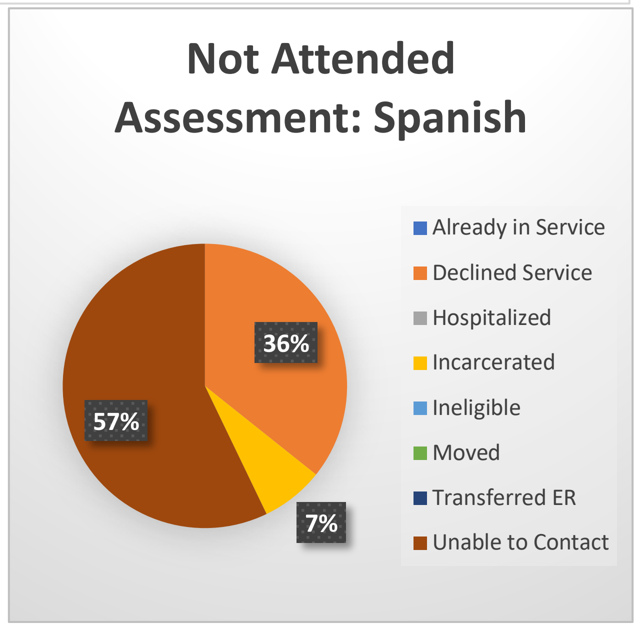


Attendance Rate by Preferred Language

Attendance Category	English	Spanish	Other	Total
Attended Assessment Appointment	654	58	6	**718**
Already in Services	2			**2**
Declined Services	63	5		**68**
Hospitalized	10		1	**11**
Incarcerated	8	1		**9**
Ineligible for SMHS	9			**9**
Moved Out-of-County	2			**2**
Transferred to ER	1			**1**
Unable to Establish Contact	203	8		**211**
Total	**953**	**72**	**7**	**1032**

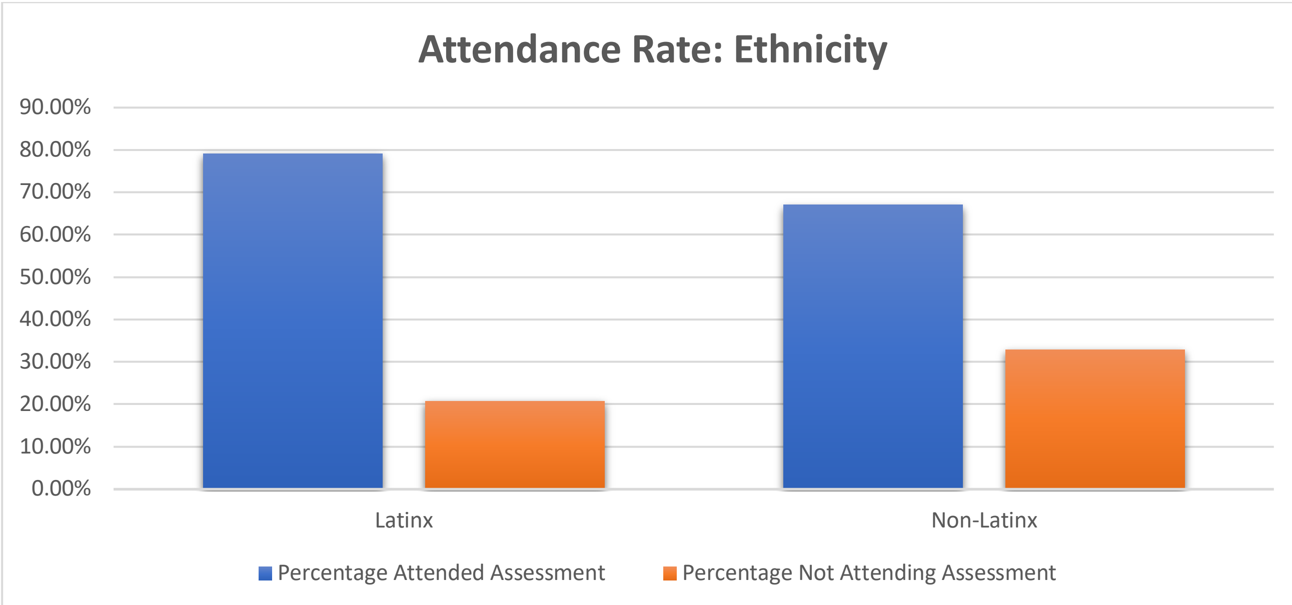


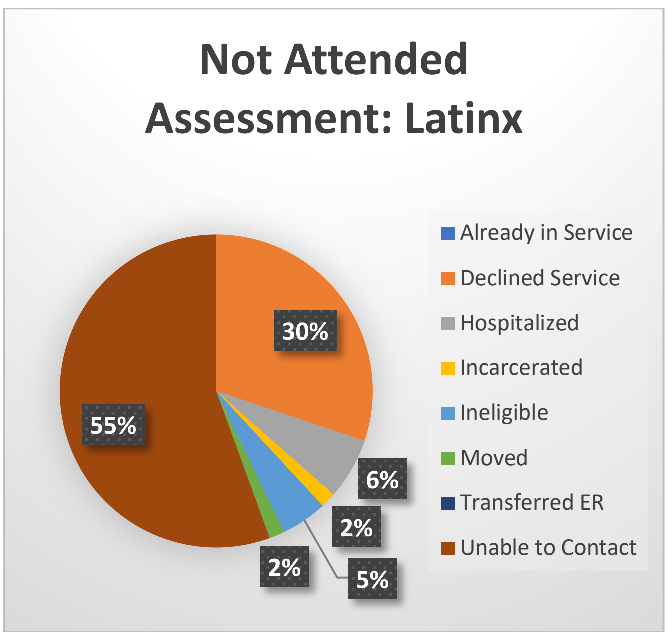


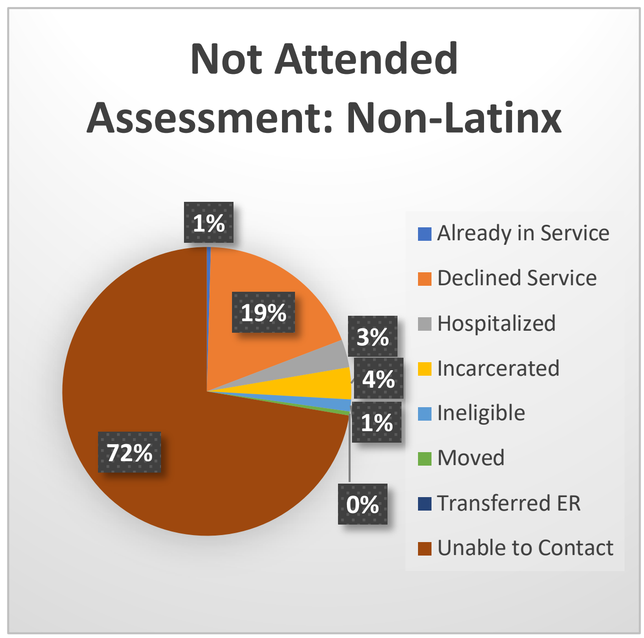


Attendance Rate by Ethnicity

Attendance Category	Latinx	Non-Latinx	Unknown	Total
Already in Services		2		**2**
Hospitalized	4	7		**11**
Ineligible	3	3	3	**9**
Transferred to ER			1	**1**
Total	**312**	**689**	**31**	**1032**







A higher percentage of Spanish-Speaking clients than English-Speaking clients attended assessments. Similarly, a higher percentage of Latinx clients than Non-Latinx clients attended assessments. Of those who did not attend, a lower percentage of Spanish-speaking clients dropped out due to non-contact, and a lower percentage of Latinx clients dropped out due to non-contact. Of note is that a higher percentage of Latinx clients were hospitalized before the Assessment appointment could be completed, perhaps indicating greater urgency of need.

No-Show Analysis

Language Category	No-Show Rate	Percent of No-Shows that Attended Later Appointment	Percent of No-Shows that Declined Later Appointment	Percent of No-Shows Unable to Contact
Spanish	20.83%	26.67%	13.33%	53.33%
Overall	**26.74%**	**17.39%**	**6.52%**	**72.10%**

Ethnic Category	No-Show Rate	Percent of No-Shows that Attended Later Appointment	Percent of No-Shows that Declined Later Appointment	Percent of No-Shows Unable to Contact
Non-Latinx	30.91%	17.84%	7.51%	71.36%
Overall	**26.74%**	**17.39%**	**6.52%**	**72.10%**

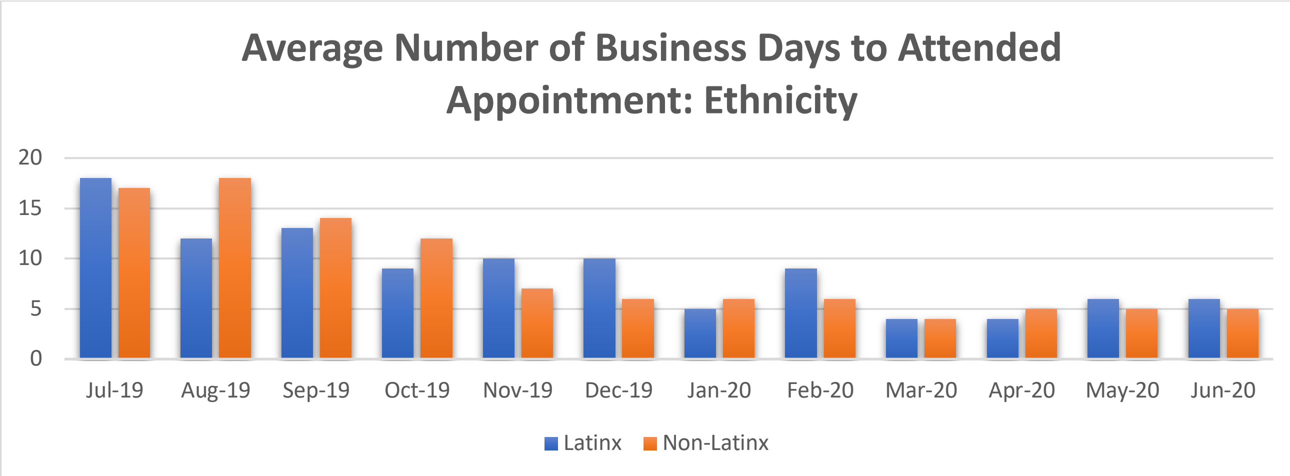
Spanish-speaking clients had a lower no-show rate than English-speaking clients. Of those that did no-show to their initial assessment appointment, Spanish-speaking clients were more likely to attend a rescheduled appointment and less likely to drop out due to non-contact than English-speaking clients. The no-show rate for Non-Latinx clients is double than of Latinx clients. Of those that did no-show, there were comparable numbers that attended a rescheduled appointment or that dropped out due to non-contact for both Latinx and Non-Latinx.

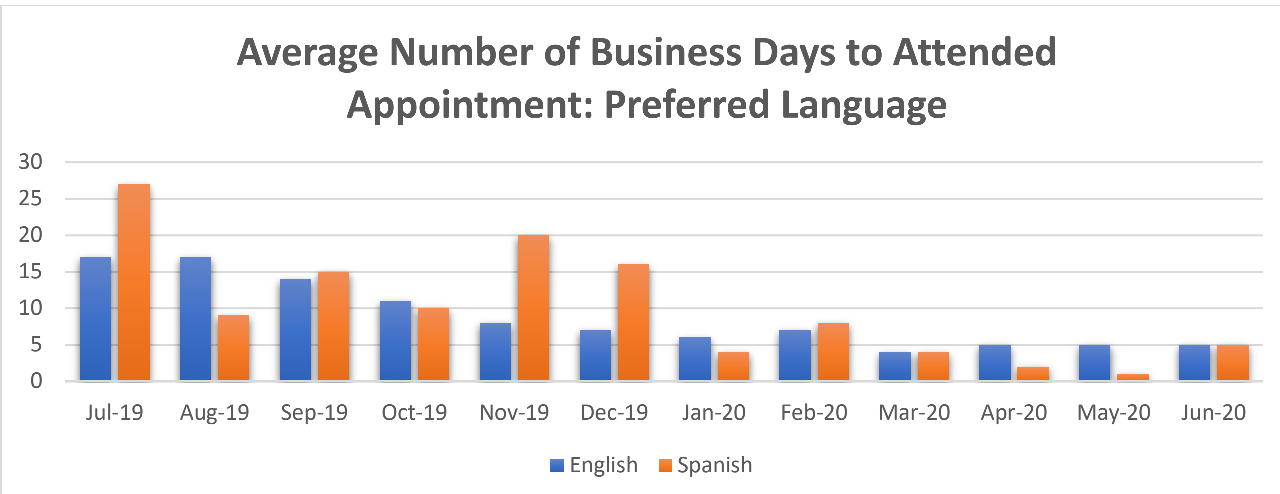
Average business days to attended Appointment: by Language and Ethnicity

While DHCS has not set a standard for this metric, the target goal is still 10 business days.

Spanish	8.06	10.64	3.17	9.16
Overall	8.23	9.69	8.38	8.76

Non-Latinx	8.60	9.52	8.85	8.87
Unknown	5.75	2.00	4.00	4.83





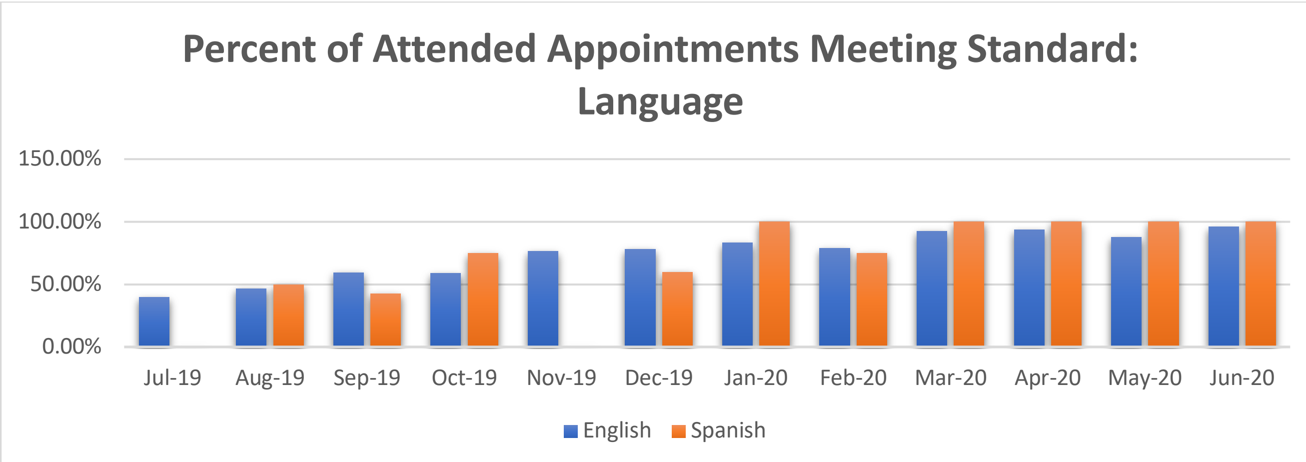
Overall attendance metrics are good. Structural improvements to the Access Team process were implemented in October 2019 when the Adult Access Clinic was transitioned to a Walk-In Clinic. Attendance timeliness improved considerably after these changes went into effect. The improvement in metrics took longer to manifest for Spanish-speaking clients than English-speaking clients, but increases in bilingual capacity in the second half of the year bring these metrics into an excellent range. Trends among Latinx versus Non-Latinx clients parallel each other, with performance improving significantly in the second half of the year. Of possible impact is the Kincade Fire, which took place in November. Evacuation orders affected several regions of the County during this time, which may have disproportionately impacted both Spanish-speaking clients and staff.

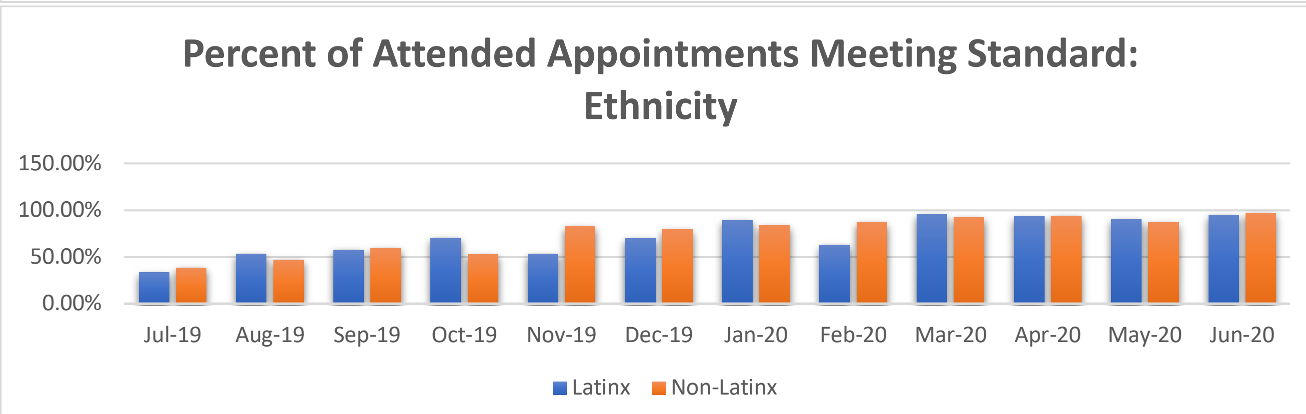
Percent of Attended Appointments Meeting 10 Day Standard

There is no minimum threshold set by DHCS for attended appointments meeting the 10 Business Day standard; however, DHS-BHD aims to meet the 70% threshold within a 5% range for attended appointments. Overall, 74.41% of attended appointments met the standard. Analysis by preferred language and ethnicity are as follows:

- Preferred Language
  - English: 74.20%
  - Spanish: 74.14%
  - Other: 100%

- Ethnicity:
  - Latinx: 73.09%
  - Non-Latinx: 75.05%
  - Unknown: 77.78%



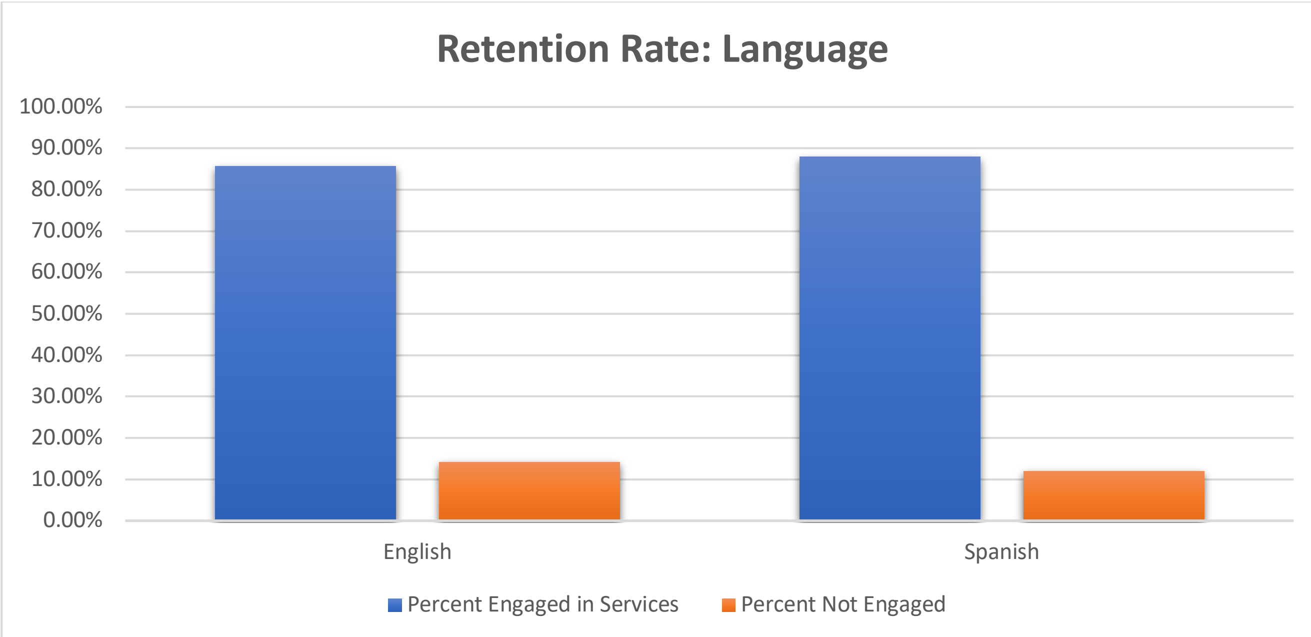


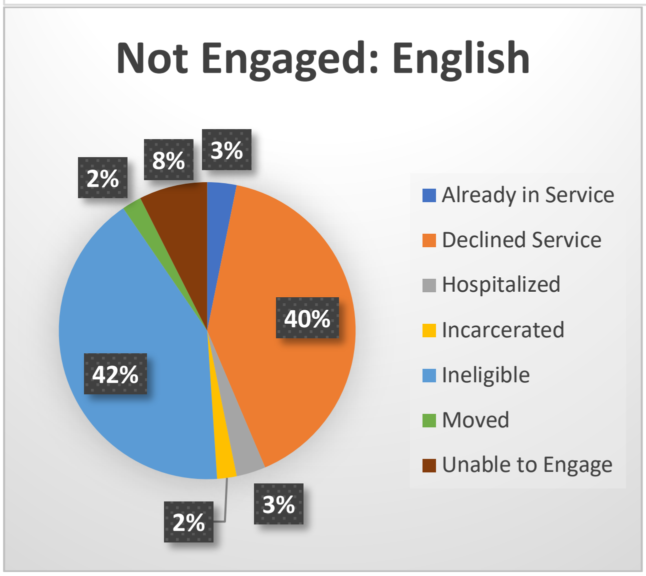
The percent of attended appointments meeting the 10-day standard increased significantly post-Access Team system change. Both English/Spanish and Latinx/Non-Latinx groups achieved 90% or higher consistently from March onward, despite COVID disruptions.

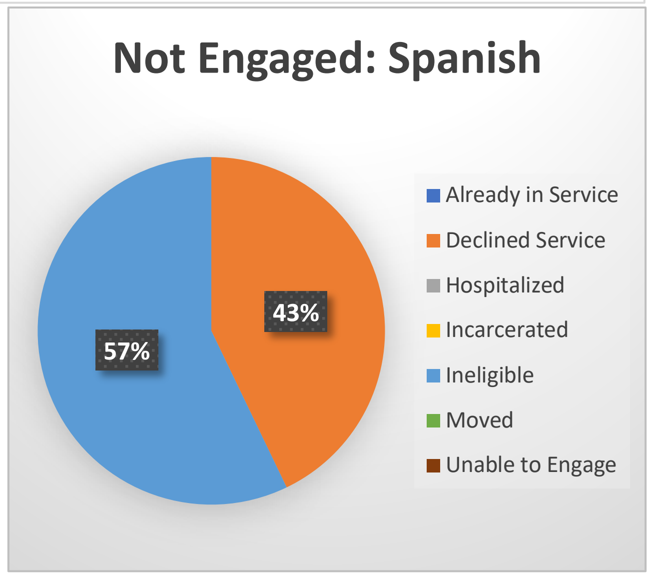
Retention Rate

Of the 723 Initial Assessments completed in FY 19-20, 621 clients (85.89%) engaged in services. The following charts explore retention rate by language and ethnicity.

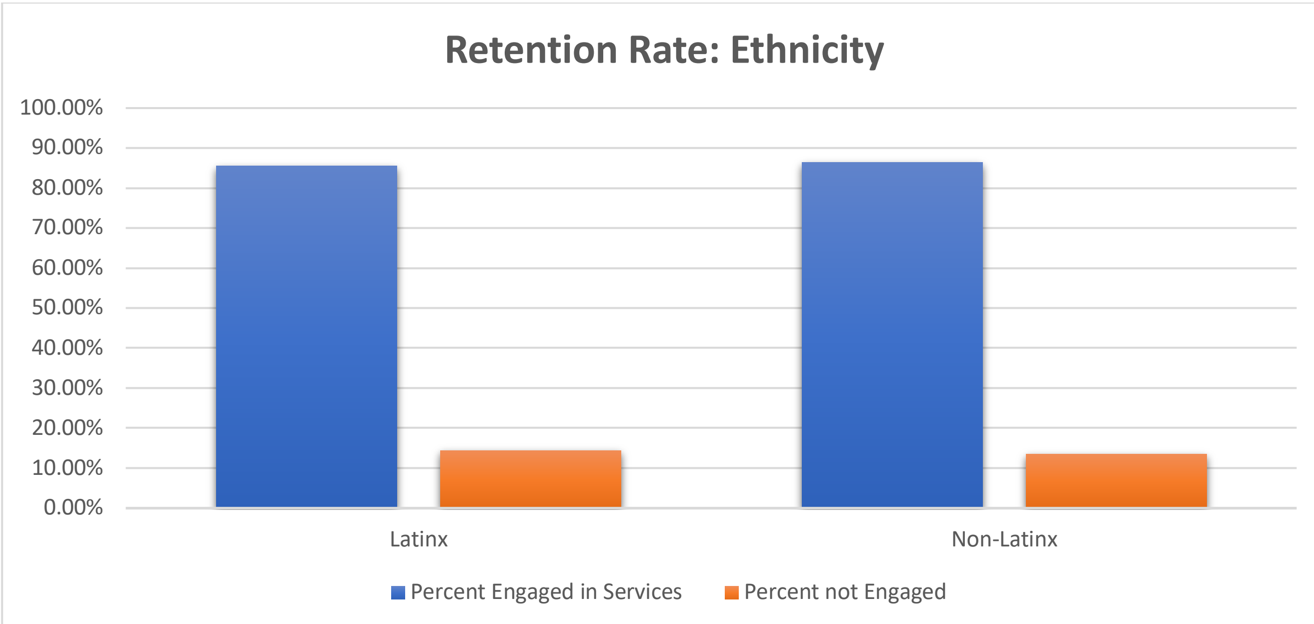
Post-Assessment Disposition	**English**	**Spanish**	**Other**	**Total**
Already in Services	3			**3**
Hospitalized	3			**3**
Ineligible for SMHS	39	4	1	**44**
Unable to Engage	7			**7**

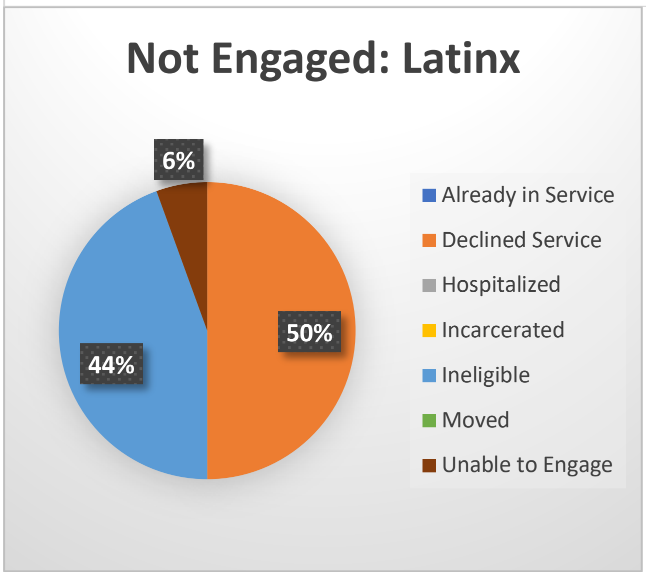


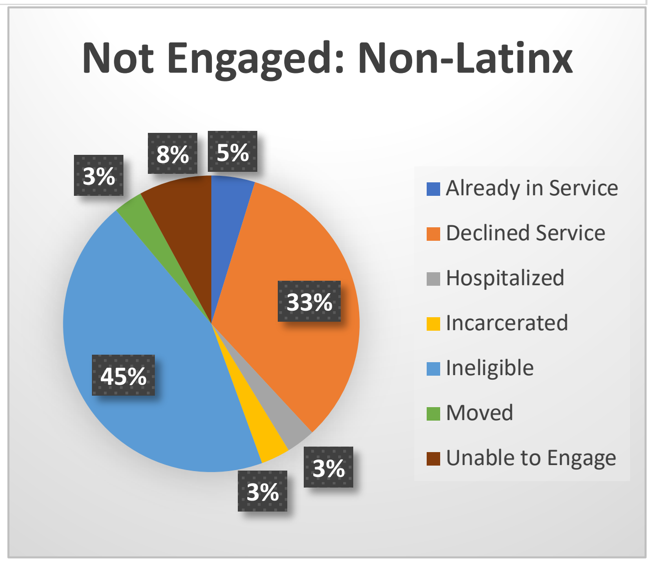




Post-Assessment Disposition	Latinx	Non-Latinx	Unknown	Total
Already in Services		3		**3**
Hospitalized		2	1	**3**
Ineligible for SMHS	16	28		**44**
Unable to Engage	2	5		**7**





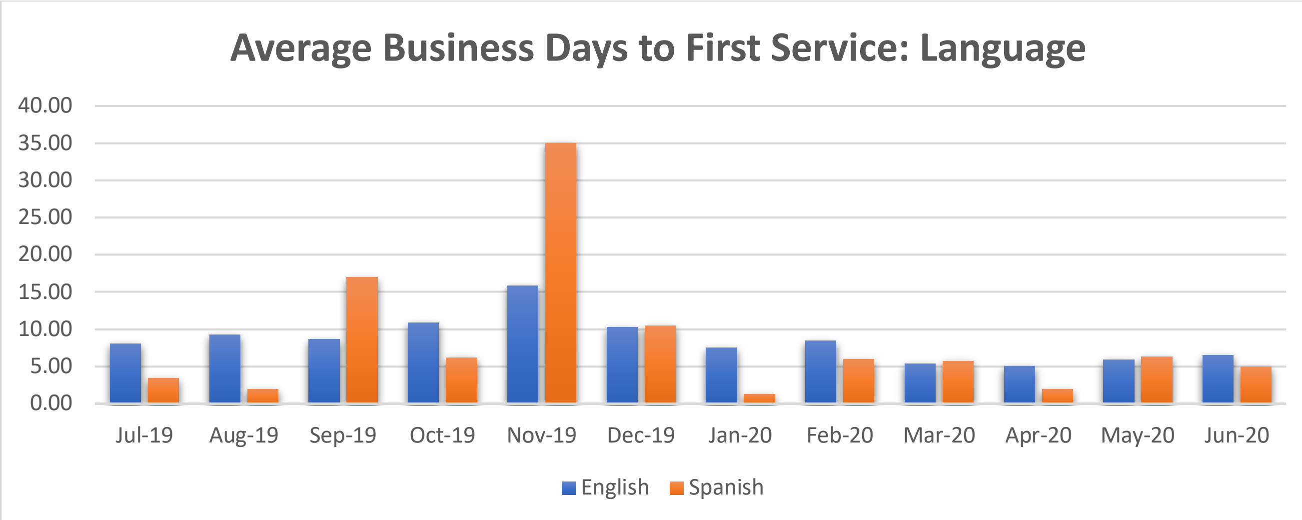


Retention rates are equivalent for both English-and Spanish-speaking clients, as well as for Latinx and Non-Latinx clients. Analysis of the reasons for non-retention reveals that Spanish-speaking clients are ruled ineligible for services at a higher percentage than English-speaking clients; however, rates of ineligibility are equivalent for Latinx and Non-Latinx clients. But, Latinx clients showed a much higher rate of declining services post-assessment than non-Latinx clients.

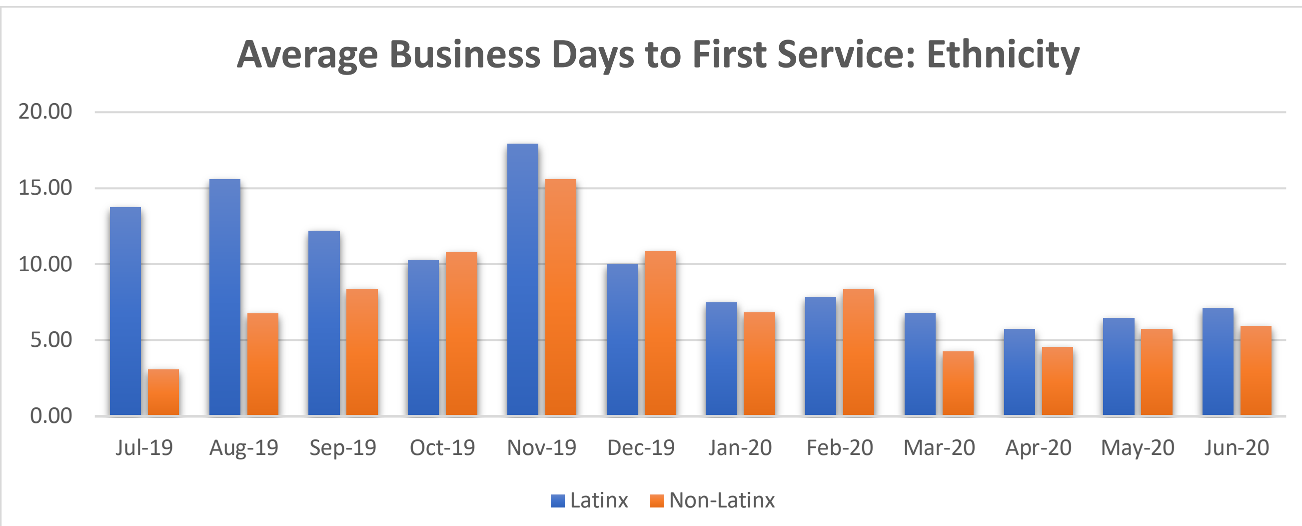
Timeliness to First Service

The DHCS standard set for timeliness to services is 15 business days for Psychiatry, and 10 Business days for Outpatient.

Spanish	4.91	8.85	5.00	7.55
Overall	5.89	12.50	6.63	8.37



Ethnicity	Adults	Youth	Foster Youth	Overall
Latinx	6.29	12.72	6.81	9.76
Non-Latinx	5.79	12.16	6.59	7.60
Declined to State	--	20.00	--	20.00
Unknown	6.00	10.00	2.00	6.00
Overall	5.89	12.50	6.63	8.37

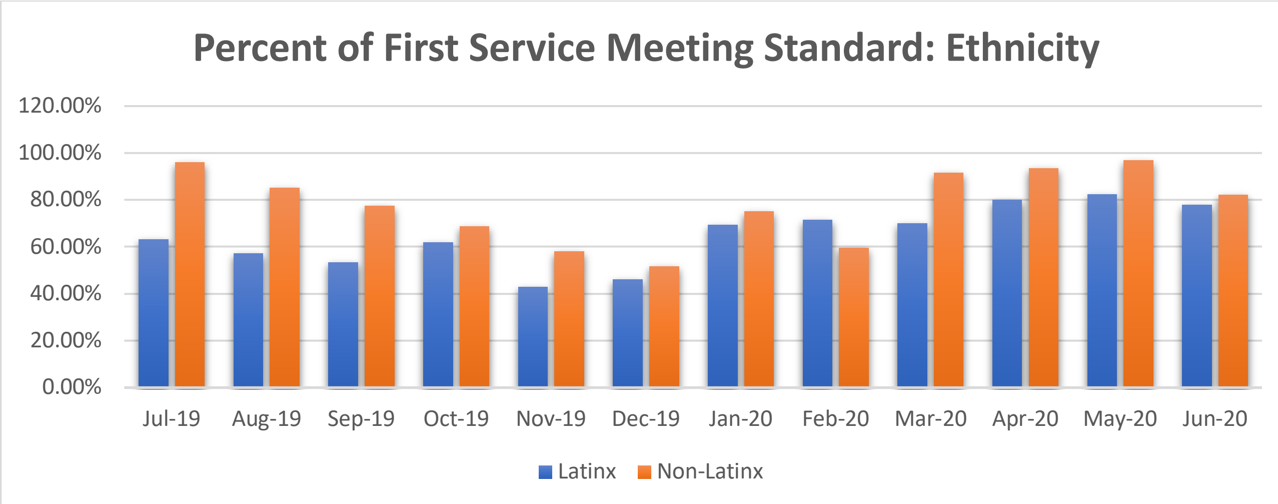


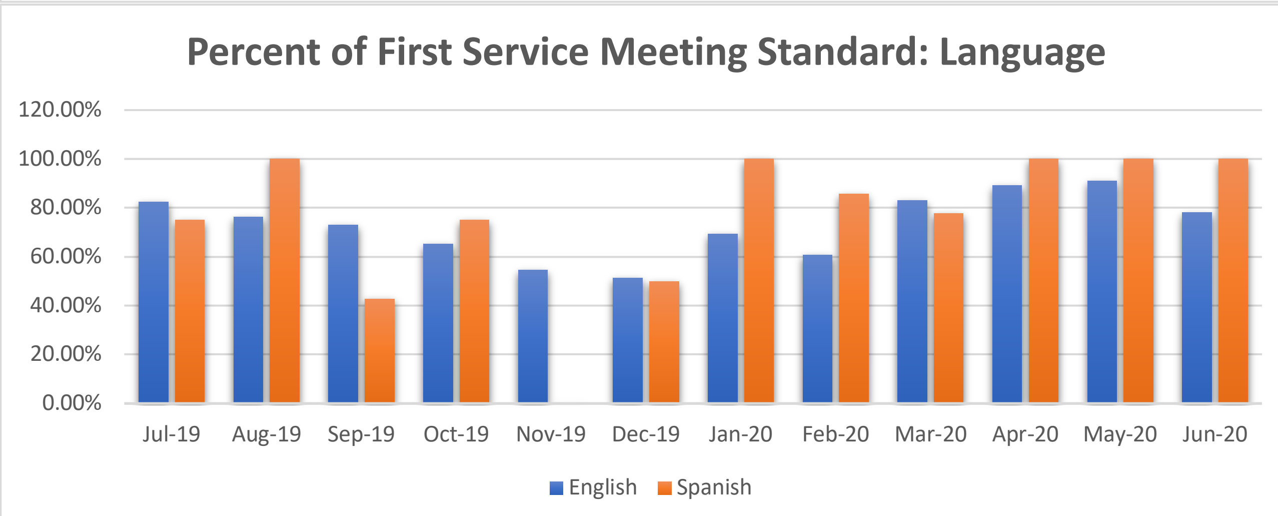
Of note is the significant spike in November due to Kincade Fire evacuations. All appointments were rescheduled. Also significant is the disparity in timeliness between Ethnicities in the first part of the year, equalizing in the second half.

Percent of First Service Meeting 10-Day Standard

There is no minimum threshold set by DHCS for first service appointments meeting the 10 Business Day standard; however, DHS-BHD aims to meet the 70% threshold applicable to other timeliness metrics. Overall, 73.27% of attended appointments met the standard. Analysis by preferred language and ethnicity are as follows:

- Preferred Language
  - English: 72.74%
  - Spanish: 76.47%
  - Other: 100%
- Ethnicity:
  - Latinx: 65.73%
  - Non-Latinx: 77.61%
  - Unknown: 75.00%

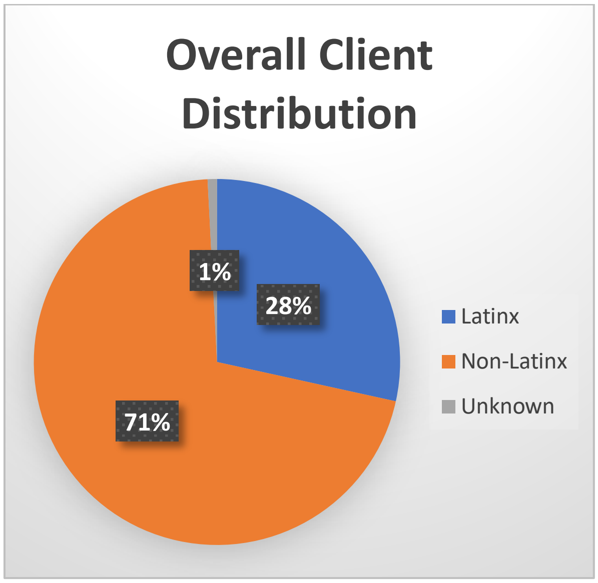

Percent of First Service Meeting Standard: Ethnicity
120.00%
100.00%
80.00%
60.00%
40.00%
20.00%
0.00%
Jul-19
Aug-19
Sep-19
Oct-19
Nov-19
Dec-19
Jan-20
Feb-20
Mar-20
Apr-20
May-20
Jun-20
Latinx
Non-Latinx

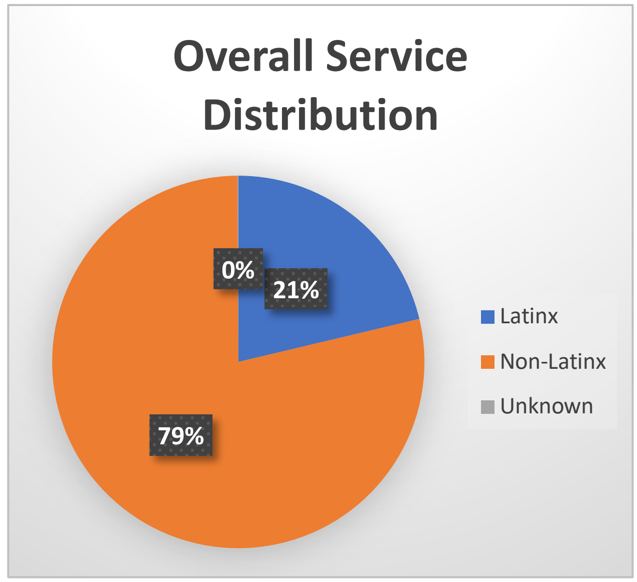

Percent of First Service Meeting Standard: Language
120.00%
100.00%
80.00%
60.00%
40.00%
20.00%
0.00%
Jul-19
Aug-19
Sep-19
Oct-19
Nov-19
Dec-19
Jan-20
Feb-20
Mar-20
Apr-20
May-20
Jun-20
English
Spanish

Performance on this metric dropped across all variables in Nov-Dec due to Kincade Fire evacuations causing rescheduling of appointments. Spanish-speaking first service encounters met the standard at a higher percentage than English-speaking. However, a disparity between ethnicities is evident in the first part of the year, improving substantially later.

Service Utilization

SCBH served 3543 unique clients in FY 19-20. 1008 unique clients identified as Latinx. 2506 unique clients identified as non-Latinx. 29 unique clients had unknown ethnic identity.

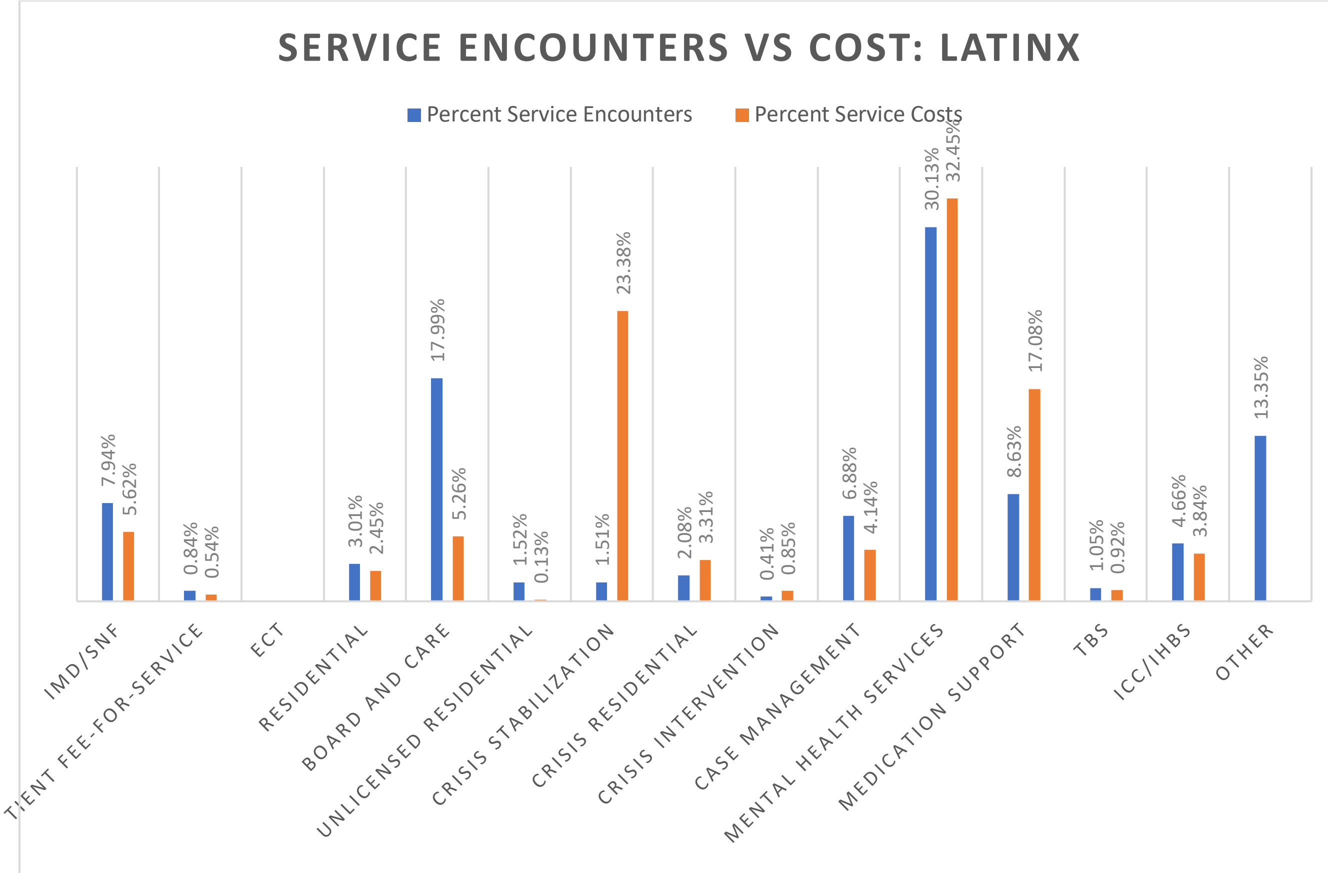


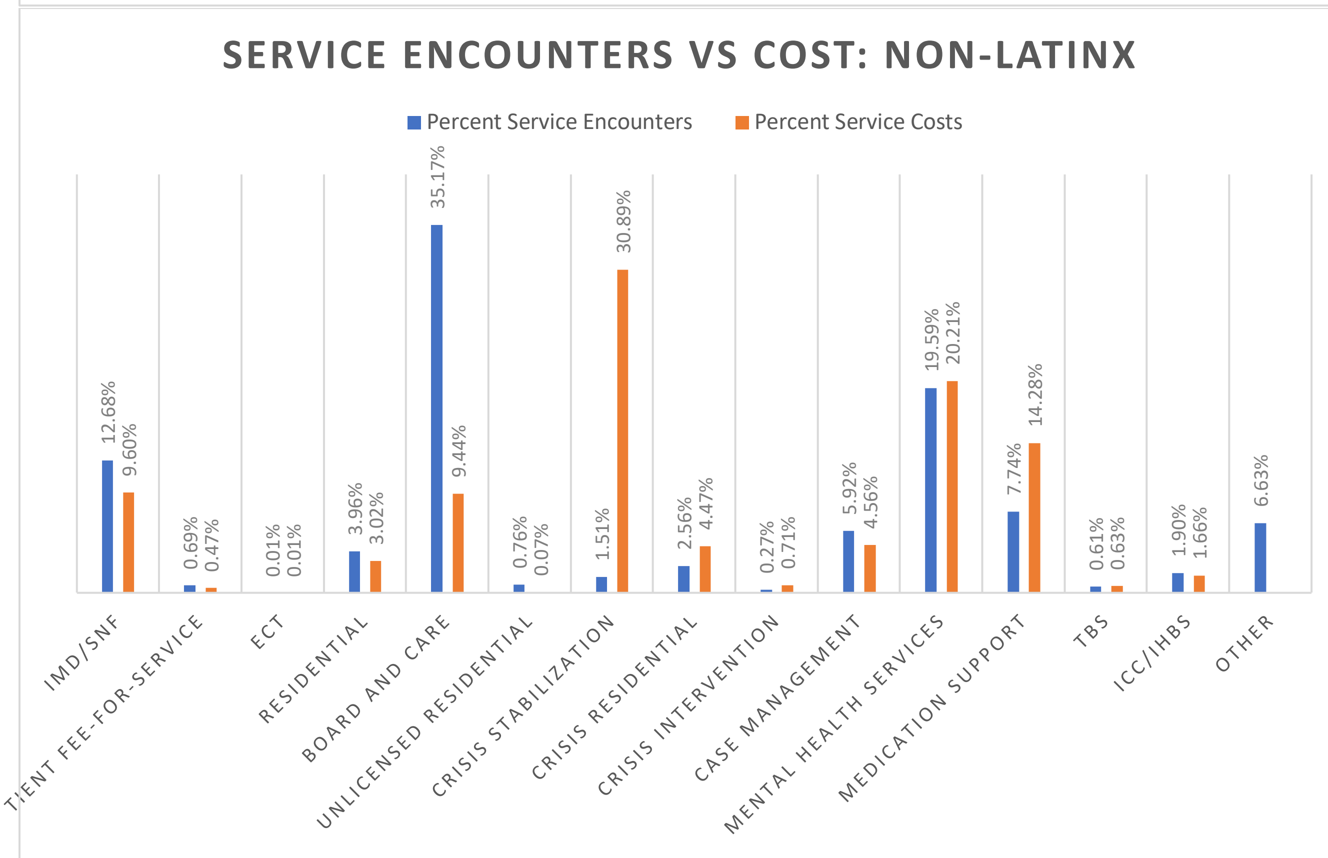


Of note is that while 28% of unique clients identified as Latinx, they only received 21% of the total services.

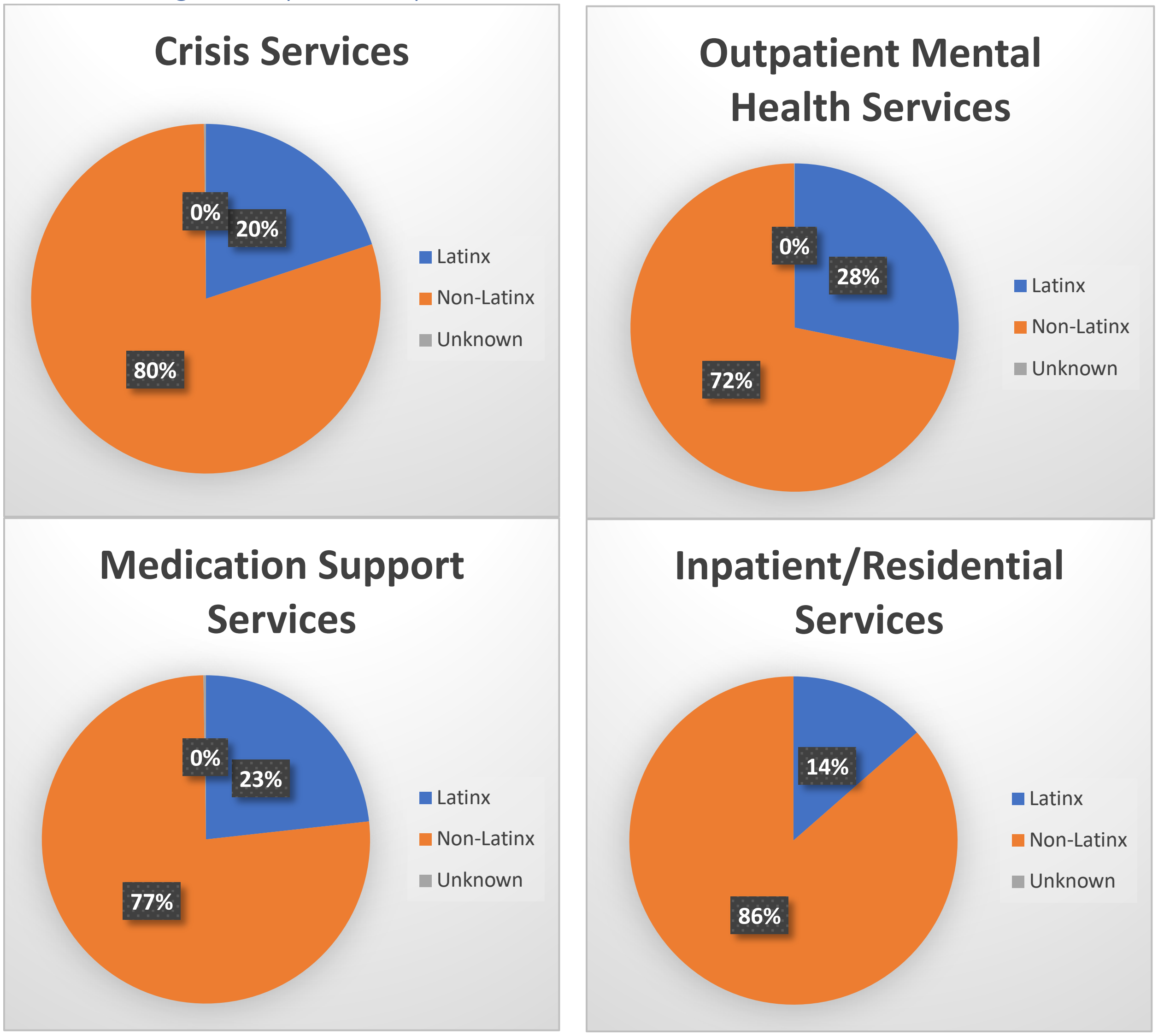
Service Counts vs Cost

Service Categories	Service Counts			Service Costs		
	Latinx	*Non-Latinx*	*Unknown*	*Latinx*	*Non-Latinx*	*Unknown*
IMD/SNF Services	4,148	24,475		662,755.12	3,896,685.98	
Inpatient Fee-for-Services	439	1,338	30	63,884.15	189,352.40	4,548.60
ECT		22	18		4,395.60	3,596.40
Residential Services	1,571	7,646		289,511.30	1,223,939.30	
Board and Care Services	9,396	67,863		620,650.91	3,831,234.35	
Unlicensed Residential	795	1,467		15,900.00	29,340.00	
Crisis Stabilization	791	2,906	19	2,757,583.22	12,537,568.51	42,384.02
Crisis Residential	1,085	4,935		390,226.00	1,813,944.00	
Crisis Intervention	213	521		100,819.37	286,498.07	
Case Management	3,596	11,420	7	488,686.73	1,848,948.61	462.56
Mental Health Services	15,742	37,801	37	3,827,023.95	8,201,850.08	13,992.24
Medication Support Service	4,508	14,942	23	2,014,615.90	5,796,695.41	7,736.20
Therapeutic Behavioral Services	549	1,173		108,918.55	255,940.34	
Katie A ICC/IHBS	2,433	3,670	14	453,188.13	672,235.59	1,437.27
Other (NPC, No-Show, etc.)	6,974	12,784	17			
Grand Total	52,240	192,963	165	11,793,763.33	40,588,628.24	74,157.29


SERVICE ENCOUNTERS VS COST: LATINX
Percent Service Encounters
Percent Service Costs
7.94%
5.62%
0.84%
0.54%
3.01%
2.45%
17.99%
5.26%
1.52%
0.13%
1.51%
23.38%
2.08%
3.31%
0.41%
0.85%
6.88%
4.14%
30.13%
32.45%
8.63%
17.08%
1.05%
0.92%
4.66%
3.84%
13.35%
IMD/SNF
T'IENT FEE-FOR-SERVICE
ECT
RESIDENTIAL
BOARD AND CARE
UNLICENSED RESIDENTIAL
CRISIS STABILIZATION
CRISIS RESIDENTIAL
CRISIS INTERVENTION
CASE MANAGEMENT
MENTAL HEALTH SERVICES
MEDICATION SUPPORT
TBS
ICC/IHBS
OTHER


SERVICE ENCOUNTERS VS COST: NON-LATINX
Percent Service Encounters
Percent Service Costs
12.68%
9.60%
0.69%
0.47%
0.01%
0.01%
3.96%
3.02%
35.17%
9.44%
0.76%
0.07%
1.51%
30.89%
2.56%
4.47%
0.27%
0.71%
5.92%
4.56%
19.59%
20.21%
7.74%
14.28%
0.61%
0.63%
1.90%
1.66%
6.63%
IMD/SNF
T'IENT FEE-FOR-SERVICE
ECT
RESIDENTIAL
BOARD AND CARE
UNLICENSED RESIDENTIAL
CRISIS STABILIZATION
CRISIS RESIDENTIAL
CRISIS INTERVENTION
CASE MANAGEMENT
MENTAL HEALTH SERVICES
MEDICATION SUPPORT
TBS
ICC/IHBS
OTHER

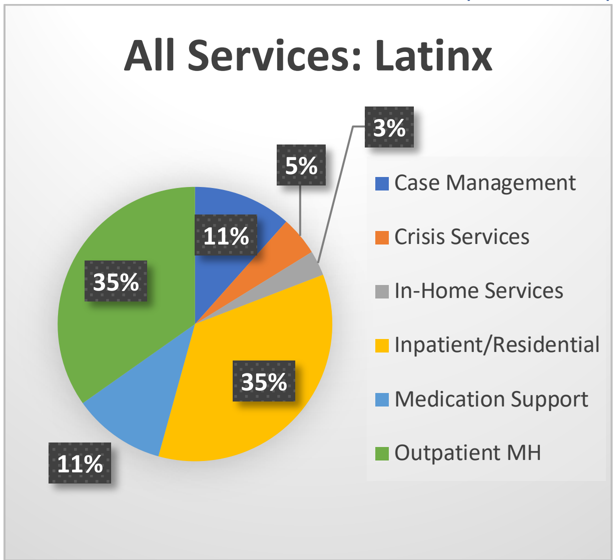
Service Categories by Ethnicity

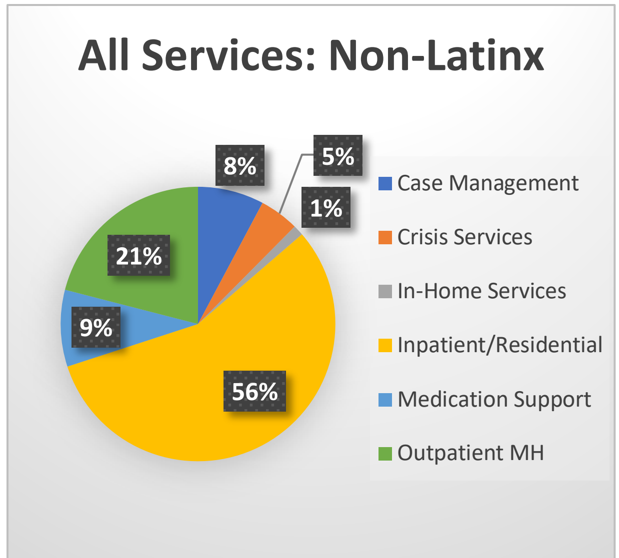


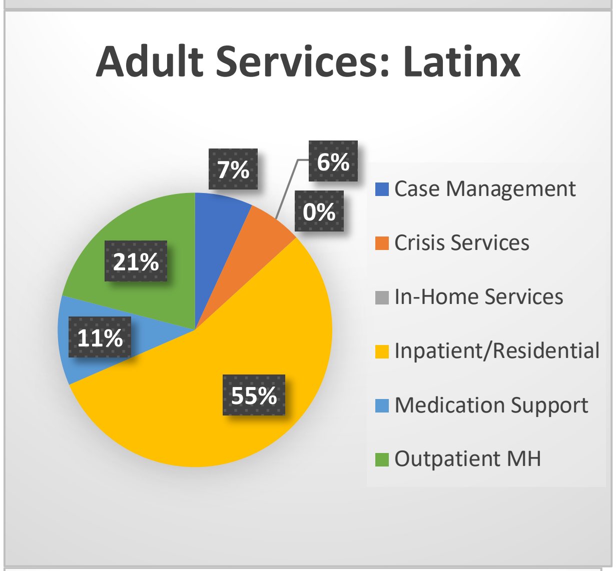
Latinx clients utilize Outpatient Mental Health and Med Support services at a higher rate than Non-Latinx clients. In contrast, non-Latinx clients utilize Board & Care and IMD/SNF level services at a much higher rate than Latinx clients.

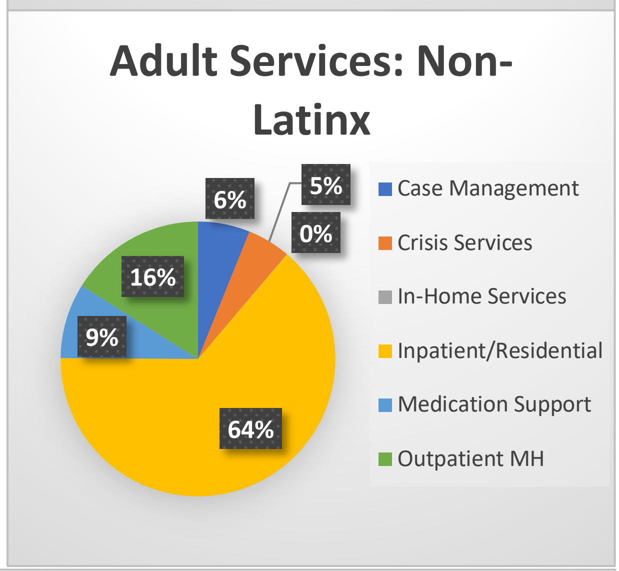
The following charts break-down the service distribution by age group. Of note is the higher percentage of Inpatient/Residential service utilization among non-Latinx clients and the correlating higher utilization of Outpatient Mental Health services among Latinx clients. This is particularly evident in the Adult system. The Youth system does not show this pattern.

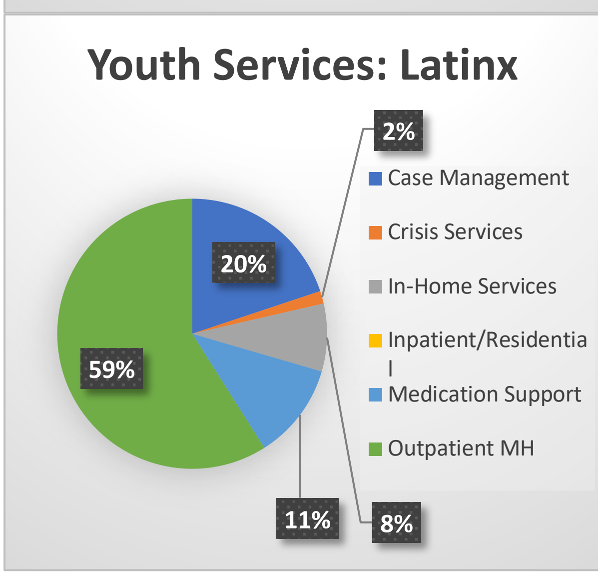
Portrait of Service Utilization by Ethnicity

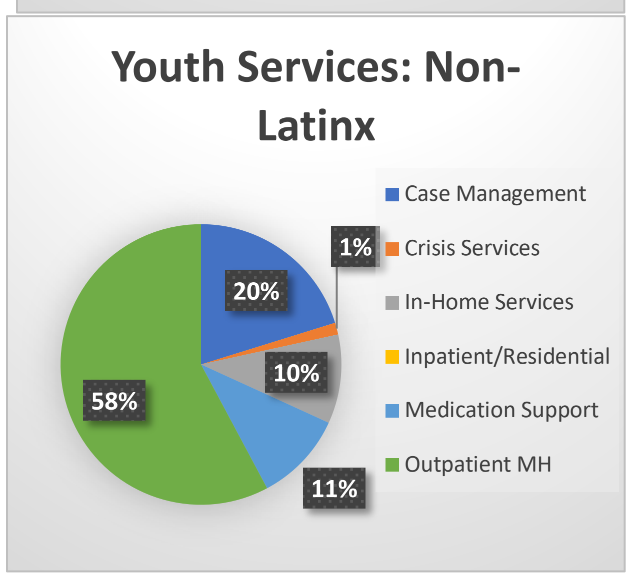




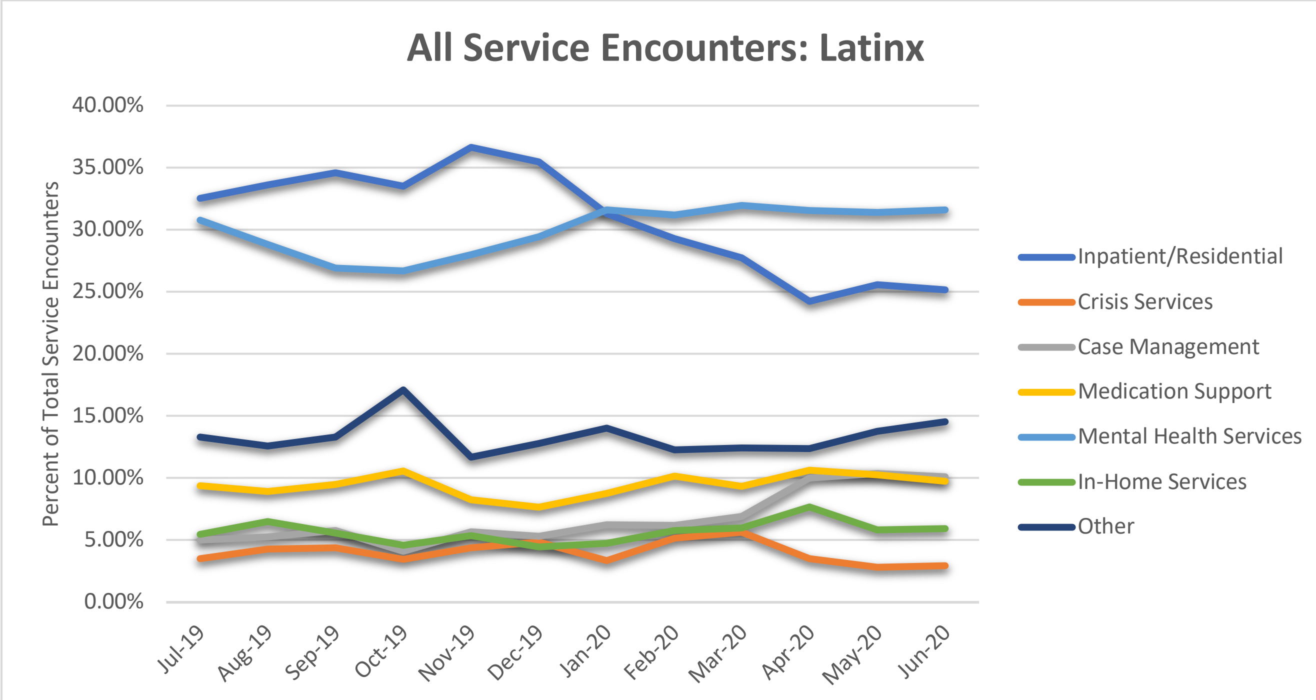


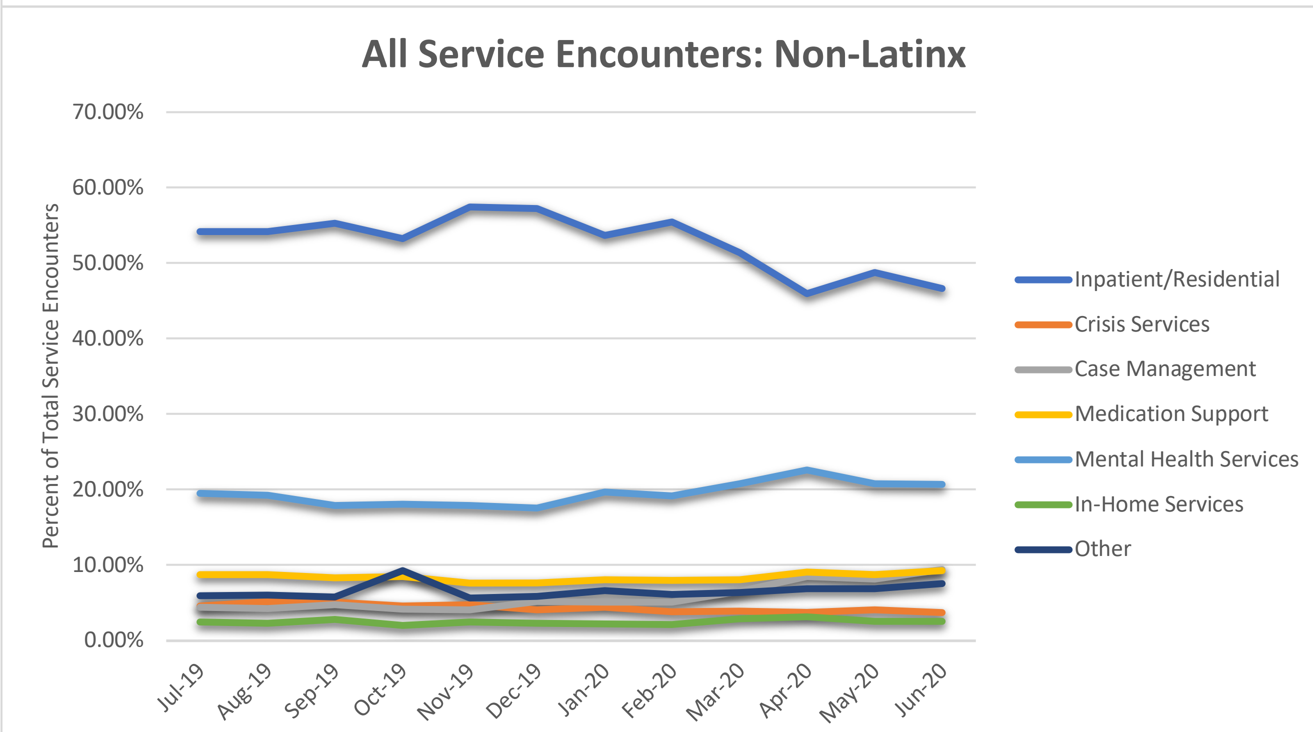




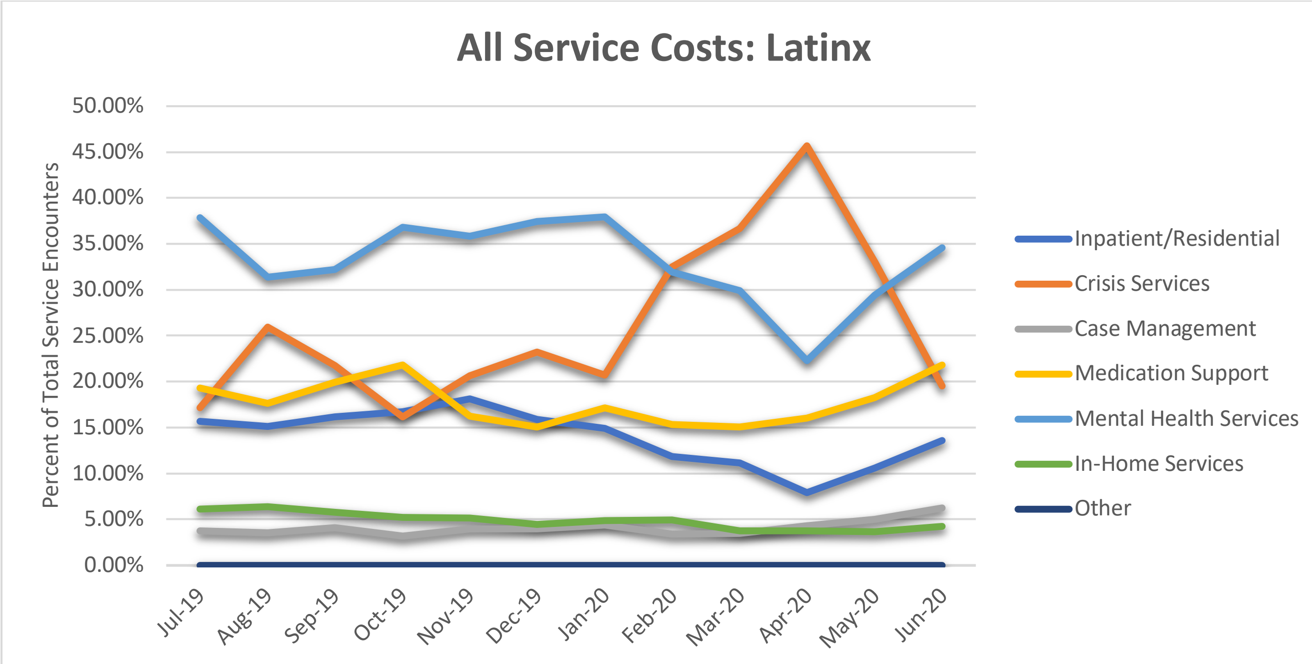


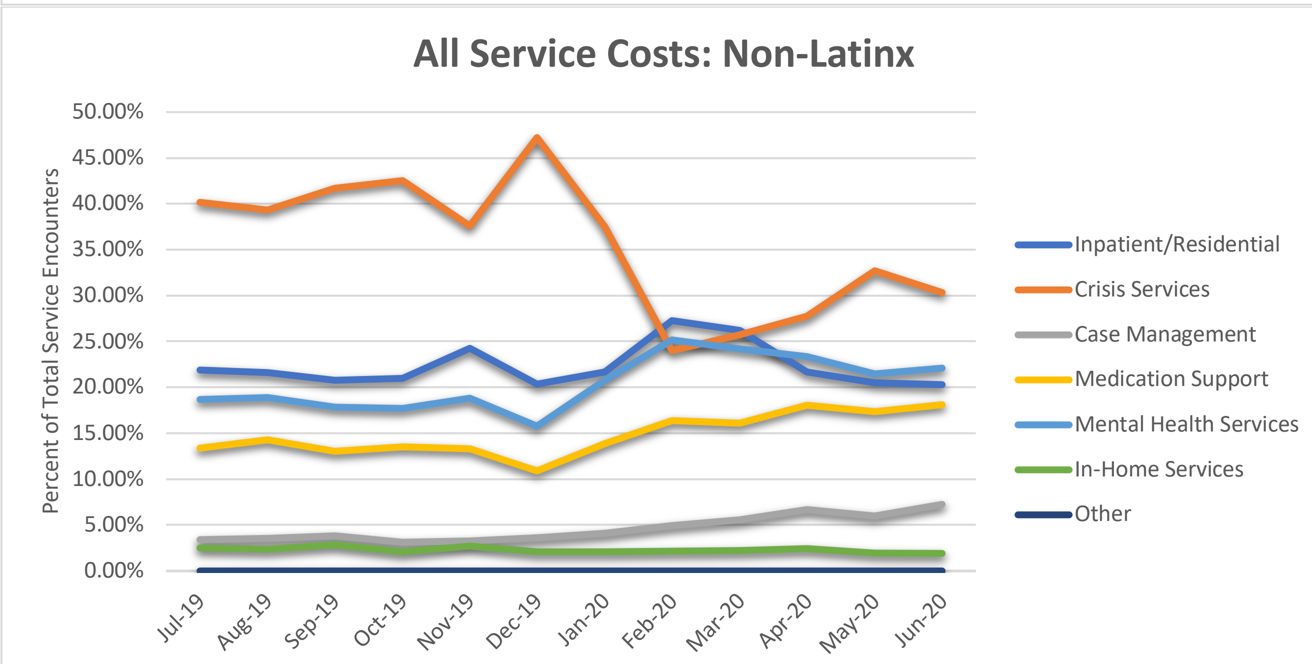
Service Trends





Latinx service trends show a drop in Inpatient/Residential utilization in the latter part of the year, corresponding to an increase in case-management utilization. Whereas, non-Latinx service trends hold relatively steady over time, with a slight reduction in Inpatient/Residential utilization post-COVID.

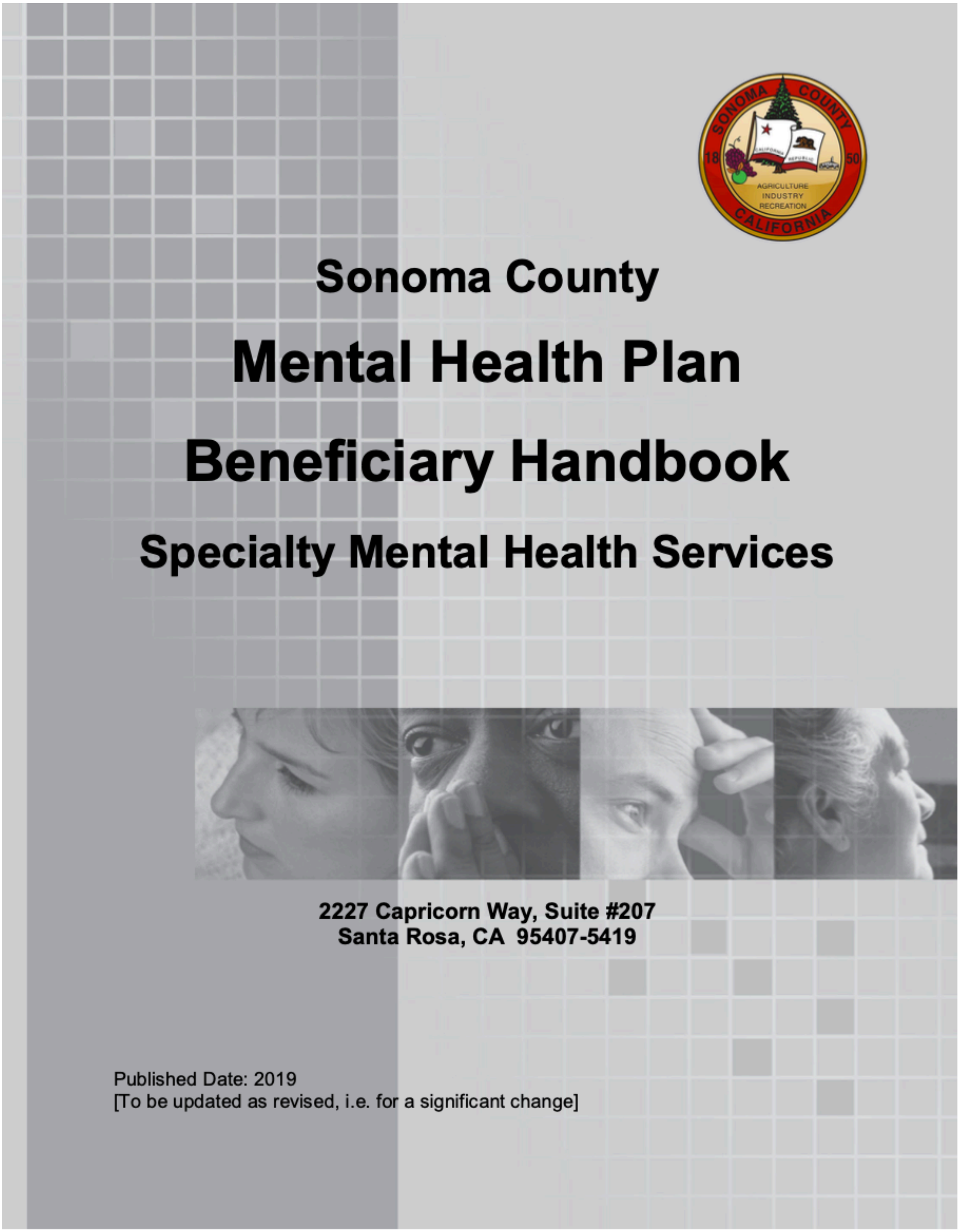




Of note is the spike in Crisis service costs in April for Latinx clients. This sharp increase corresponds with the initial onset of COVID shelter-in-place orders. As a corollary, Mental Health Services declines at the same rate. However, by June, both trends equalized to prior levels. In contrast, Non-Latinx Crisis service cost trends show a sharp decline during initial COVID response, with an associated increase in Mental Health Services that later equalizes.

XXX

Attachment H: Sonoma County Mental Health Plan Beneficiary Handbook (English)



Sonoma County

Mental Health Plan

Beneficiary Handbook

Specialty Mental Health Services

2227 Capricorn Way, Suite #207
Santa Rosa, CA 95407-5419

Published Date: 2019
[To be updated as revised, i.e. for a significant change]

TABLE OF CONTENTS

Medi-Cal Mental Health Services

OTHER LANGUAGES AND FORMATS 5

NONDISCRIMINATION NOTICE 5

GENERAL INFORMATION 8

INFORMATION ABOUT THE MEDI-CAL PROGRAM 10

HOW TO TELL IF YOU OR SOMEONE YOU KNOW NEEDS HELP 12

ACCESSING SPECIALTY MENTAL HEALTH SERVICES 14

MEDICAL NECESSITY CRITERIA 18

SELECTING A PROVIDER 19

SCOPE OF SERVICES 20

ADVERSE BENEFIT DETERMINATIONS BY YOUR MHP 24

THE PROBLEM RESOLUTION PROCESS: TO FILE A GRIEVANCE OR APPEAL ... 26

THE GRIEVANCE PROCESS 27

THE APPEAL PROCESS (STANDARD AND EXPEDITED) 28

THE STATE HEARING PROCESS 31

ADVANCE DIRECTIVE 33

BENEFICIARY RIGHTS AND RESPONSIBILITIES 34

Attachment I: Flyer for Public Notice of Language Access

Sonoma County Behavioral Health
FREE LANGUAGE ASSISTANCE SERVICES

If you have difficulty speaking English, or are Hearing Impaired, please ask for assistance from the receptionist. Interpreter services are available free of charge. Clients are entitled to receive information on treatment options and alternatives, presented in a language and format that is easily understood.

~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~

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Over **240** languages 24|7|365

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Point to your language

Amharic	አማርኛ	Hebrew	עברית	Portuguese	**Português**
Arabic	العربية	Hindi	हिन्दी	Punjabi	ਪੰਜਾਬੀ
Bosnian (Serbo Croatian)	**Bosanski**	Hmong	**Hmoob**	Romanian	**Română**
Burmese	မြန်မာစာ။	Italian	**italiano**	Russian	**Русский**
Cambodian	ខ្មែរ	Japanese	日本語	Somali	**Soomaali**
Cantonese	廣東話	Karen	ကညီ	Spanish	**Español**
Hatian Creole	**Kreyól Ayisyen**	Kirundi	**Ikirundi**	Swahili	**Kiswahili**
Farsi	فارسی	Korean	한국어	Tagalog	**Tagalog**
French	**Français**	Laotian	ພາສາລາວ	Thai	ภาษาไทย
French-Canadian	**français canadien**	Mandarin	國語	Tigrinya	ትግርኛ
German	**Deutsch**	Nepali	नेपाली	Urdu	اردو
Turkish	**Türkçe**	Polish	**Polski**	Vietnamese	**Tiếng Việt**

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Find us online: **ctslanguagelink**
Telephone: 1.800.208.2620

CTS languagelink®
We speak your customer's language

Sonoma County Behavioral Health Interpreter Services

How to Request Interpretation Services with CTS Language Link:

Step 1: **Call +1-800-535-7993**

Step 2: **Provide the Call Center Service Representative with:**

- Account Number: 19542 (SCBH- Jail MH)
- Language(s) Needed
- Your Name

Three-way telephone interpretation calls (county staff arranges the call):

Step 1: Press Conference button on Cisco Phone to put client on hold

Step 2: Place a call to CTS

Step 3: When CTS connects press Conference button again ; all 3 parties will be on the line

CTS can accommodate three-way telephone interpretation calls. Tell the call center agent the name and phone number of the third party, and they will arrange the call for you. The interpreter cannot facilitate this for you. You must ask the call center agent at the beginning of the call.

CTS offers 240+ languages and dialects, access 24 hours a day, 7 days a week, 365 days a year.

TIPS on How to Work with a Telephone Interpreter

- Always speak in first person, just as you would in normal conversation. For example, say, "Do you have a fever?" rather than "Ask her if she has a fever, please."
- Immediately introduce yourself to the limited-English proficient (LEP) client and explain your reason for calling.
- Telephone interpretation is "consecutive" interpretation. That means you will experience pauses when the interpreter repeats each statement in the respective language.
- After you speak one-two sentences or finish a thought, pause to give the interpreter enough time to interpret.
- Be prepared to explain some things in more detail for the telephone interpreter. Some terminology and concepts may not have an equivalent in the target language.
- Control the conversation. The telephone interpreter is only there to interpret. You are responsible for making sure the LEP client receives the same service as an English-speaking client.
- Ask the interpreter and the LEP client questions to ensure they understand what you want to communicate.
- Avoid asking the interpreter for his/her opinion about the situation being interpreted.

MHS 117 (10-16)

CTS Account Number Codes by SCBH PROGRAM

Account #	Account Name
19527	Sonoma Co Behavioral Health-Access
19528	Sonoma Co Behavioral Health-Administration
19529	Sonoma Co Behavioral Health-CAPE
19530	Sonoma Co Behavioral Health-CIP
19531	Sonoma Co Behavioral Health-CMHC
19532	Sonoma Co Behavioral Health-Crisis Stabilization Unit
19533	Sonoma Co Behavioral Health-Dependency Drug Court
19534	Sonoma Co Behavioral Health-Drug Court
19535	Sonoma Co Behavioral Health-DUI Court
19536	Sonoma Co Behavioral Health-FAAST
19537	Sonoma Co Behavioral Health-FACT
19538	Sonoma Co Behavioral Health-Foster Youth Team
19539	Sonoma Co Behavioral Health-Housing (ASP)
19540	Sonoma Co Behavioral Health-IHT
19541	Sonoma Co Behavioral Health-IRT
19542	Sonoma Co Behavioral Health-Jail MH
19543	Sonoma Co Behavioral Health-JV-220 Evals
19544	Sonoma Co Behavioral Health-MST
19545	Sonoma Co Behavioral Health-North Team
19546	Sonoma Co Behavioral Health-OAT
19547	Sonoma Co Behavioral Health-Patients Rights
19548	Sonoma Co Behavioral Health-PC1370
19549	Sonoma Co Behavioral Health-Sonoma Works
19550	Sonoma Co Behavioral Health-TASC
19551	Sonoma Co Behavioral Health-South Team
19552	Sonoma Co Behavioral Health-Transitional Age Youth
19553	Sonoma Co Behavioral Health-VOMCH Team
19554	Sonoma Co Behavioral Health-WET
19555	Sonoma Co Behavioral Health-AB109 - Out of Custody

Sonoma County Behavioral Health Interpreter Services

For American Sign Language (ASL) Interpretation
COMMUNIQUE INTERPRETING
330 College Avenue Santa Rosa, CA 95401 (707) 546-6869

ASL Interpreter Request Form
Fax To: (707) 546-1770

Date of interpreting needed:________________________ Start time:______am pm
End time: ______am pm

Appointment
Location/Address:____

Site phone #:__________________________ Contact person:____________________________

Type of appointment:____
(staff mtg., check up, interview...)

Deaf Person(s) Present at Appointment:____

Other Key Participants:____

Preferred Interpreters:____

Driving Directions: ____

____

Requester's Business:______________________ Phone #:______________________________

Requester's Name:________________________ Today's Date:___________________________

Billing address: ____

Payment Authorized by:____
(printed name and signature)
Fax #:________________________ Other relevant #s:____________________
PO #:________________________ Medical Record #:____________________
(if applicable)

Confirmation of interpreter will be faxed back to you as soon as the assignment is filled. If it is a particularly high demand time for interpreting, and we do not yet have an interpreter scheduled, we will call you two days before to let you know. If you would like more notification time, please let us know so we can honor that.

Interpreter Assigned: _________________________ Confirmation Date: __________________

MHS 118 (10-16)