



# County of Napa Mental Health

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CULTURAL COMPETENCY PLAN FY2019-2020

Health and Human Services Agency  
MENTAL HEALTH DIVISION, DECEMBER 2019 |

***Napa County Mental Health Plan  
Cultural Competence Plan***

**COVER SHEET**

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**CULTURAL COMPETENCE PLAN REQUIREMENTS CRITERIA CHECKLIST:**

- 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 ACTIVITIES**
- CRITERION 6: COUNTY'S COMMITMENT TO GROWING A MULTICULTURAL WORKFORCE: HIRING AND RETAINING CULTURALLY AND LINGUISTICALLY COMPETENT STAFF**
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- CRITERION 8: ADAPTATION OF SERVICES**

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CULTURAL COMPETENCE PLAN  
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**CRITERION 1**  
**COUNTY MENTAL HEALTH SYSTEM COMMITMENT**  
**TO CULTURAL COMPETENCE**

**Rationale:** An organizational and service provider assessment is necessary to determine the readiness of the service delivery system to meet the cultural and linguistic needs of the target population. Individuals from racial, ethnic, cultural, and linguistically diverse backgrounds frequently require different and individual Mental Health Service System responses

**I. County Mental Health System commitment to cultural competence**

Napa County Mental Health Plan (NCMHP) is committed to ensuring the provision of county- wide mental health services are delivered in ways which recognize, are sensitive to, and respectful of individual, cultural and linguistic differences as illustrated throughout this updated Cultural Competence Plan. Criterion 1 demonstrates NCMHP’s commitment to cultural competency by providing an overview of mission and philosophy statements, agency and NCMHP strategic plans and initiatives, policies and procedures, MHSA Prevention and Early Intervention (PEI) programs, Innovation Round 2 Projects, and other related documents.

**The county shall have the following available on site during the compliance review:**

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. Policy and Procedure Manuals;
5. Other Key Documents (additional documents to show system-wide commitment to cultural and linguistic competence).

A. **1. The Mission Statement** (See **Appendix 1** for NCMHP Mission, Vision, and Core Values) of the NCMHP: Our mission is to responsibly provide mental health services that promote individual strengths, inspire hope, and improve the quality of life for people within Napa County.

**2. Our Vision, Vivid Description, and Values** statements are as follows:

**Vision:** Napa County Mental Health Division leads the way in eliminating suffering associated with mental illness.

**Vivid Description:** We are dedicated to the provision of mental health services that meet the assessed needs of our community. We promote mental health services that are effective, community-oriented, culturally competent, and caring. We continue to educate and engage our community in the fight to eliminate the stigma of mental illness. We ensure optimal use of public resources to provide care that meets or exceeds established standards.

**Values:** *Respect.* Each individual has a contribution to make.

*Fairness:* Our actions and decisions are guided by the fair application of our performance standards and expectations in line with our mission.

*Accountability.* We encourage and value honesty and assume personal responsibility for our actions and decisions.

*Efficiency:* We make decisions that lead to desired outcomes.

*Teamwork:* We value working together in a way that supports and utilizes individuals' strengths.

*Integrity:* We prioritize ethical practices and act in the best interest of our clients, each other, the Mental Health Division and our community partners.

3. NCMHP is a Division within the Napa County Health and Human Services Agency (HHSA) and shares several functions with it, including human resource, quality management, and cultural competence activities. HHSA's vision statement is: HHSA is committed to the creation of an organizational culture that embraces diversity, works to identify and reduce barriers that impede access to services, and optimizes the delivery of services to all of the persons we serve. NCMHP has a proven record of commitment to cultural and linguistic competency by participating in the development and implementation of multiple strategies. NCMHP strategic plans include participation in Napa County Health and Human Service Agency's (HHSA) Diversity Vision and Plan (**Appendix 2**) and HHSA Cohort Participating in the Government Alliance on Race and Equity (GARE) and HHSA's Racial Equity Plan (**see Appendix 3**).

In January 2019, the Napa County Board of Supervisors approved the Napa County Strategic Plan 2019-2022, which identify five pillars with strategies and goals. The Health and Human Services Agency along with the Mental Health Division, are committed support the county's goals, which require providing ongoing trainings and education to staff and community members on culturally competent services. The NCMHP has also conducted an extensive Community Mental Health Needs Assessment Planning Process that has informed program development for cultural and ethnic unserved/underserved populations and HHSA's Racial and Cultural Equity Staff Development Training Program. This Community Mental Health Needs Plan is also aligned with the Napa County Strategic Plan with the Mental Health Division primarily focused on three strategic areas supporting the County Strategic Plan Pillar of "Healthy, Safe, and Welcoming Place to Live, Work, and Visit":

- Identify innovative ways to engage and treat individuals experiencing behavioral and mental health challenges who may not engage through existing methods of service delivery.
- Improve access to and engagement with County programs by engaging service recipients and non-recipients to identify how accessibility and use of services might improve.
- Enhance emergency preparedness functions from readiness to post-disaster.

4. The following list of policies and procedures (**Appendices 4, 5, 6, and 12**) reflect specific steps NCMHP has taken to ensure racial, ethnic and cultural diversity is respected and valued throughout our mental health system. These policies and procedures further demonstrate NCMHP readiness to deliver cultural and linguistic competent services and meet the needs of our targeted populations. NCMHP has made significant gains to integrate cultural competence standards throughout the mental health system, including:

- a) Cultural and Linguistic Competency Requirements for Mental Health Services Policy and HHSA Translation Review Guidelines (**Appendix 4**):

**POLICY STATEMENT:**

- i. It is the policy of the Napa County Mental Health Plan (MHP) to assure that culturally and

linguistically competent services are available to all of the individuals it serves, including those who do not meet the threshold language criteria. MHP staff shall be trained in the methods available to them for linking served individuals to culturally and linguistically appropriate services.

b) Medi-Cal Beneficiary Rights Policy (Appendix 5):

- i. Requires that all beneficiaries be treated with respect and due consideration for his or her dignity and privacy.
- ii. Requires that beneficiaries receive information on available treatment options and alternatives, presented in a manner appropriate to his or her condition and ability to understand.
- iii. Receive information in a manner and format that may be easily understood in accordance with Title 42, CFR, Section 438.10;

- c) Interpretation and Translation Assistance Requirements for Mental Health Services Policy and AT&T Language Line Instructions (Appendix 6):
  - i. Instructs staff to utilize the AT&T Language line when interpreter services are not readily available.

**5. NCMHP Mental Health Service Act (MHSA) Components**

**A. Prevention and Early Intervention Programs from FY 19-20 Annual Update to MHSA Three Year Plan (Appendix 7)**

1. American Canyon Student Assistance Program
2. LGBTQ Connection Program
3. Home Visitation Program
4. Kids Exposed to Domestic Violence Program
5. Native American PEI Program
6. Strengthening Families at Risk Program
7. Up Valley PEI Project Program
8. Court and Community Student Assistance Program
9. Healthy Minds, Healthy Aging Program

**B. Community Services and Support Plan from FY 19-20 Annual Update to MHSA Three Year Plan (Appendix 10)**

1. Children's FSP
2. TAY FSP
3. Adult FSP
4. Adult Treatment Team FSP
5. Older Adult FSP
6. Project Access
7. Mobile Outreach, Response and Engagement
8. Crisis Stabilization Services

**C. Innovation Round 2 Projects from FY 18-19 Annual Update to MHSA Three Year Plan (Appendix 8)**

1. Understanding Historical Trauma and Traditional Healing: A Training for Mental Health Providers Project
2. Work for Wellness Project
3. Adverse Childhood Experiences (ACEs) Project
4. Addressing the Mental Health Needs of the American Canyon Filipino Community Project

**D. Office of Statewide Health Planning and Development (OSHPD) 2018 Mental Health Service Act (MHSA) Workforce Education and Training (WET) Evaluation/Workforce Needs Assessment Survey (Appendix 9)**

**E. FY 18-19 Mental Health Services Act Workforce Education and Training Plan (Appendix 9)**

## **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.

NCMHP's Mental Health Services Act (MHSA) Community Services and Supports plan (Appendix 10) is attached and provides a description of practices and activities that demonstrate community outreach, engagement, and involvement with identified racial, ethnic, cultural, linguistic and other relevant small county cultural communities with mental health disparities. NCMHP's annual May is Mental Health Month campaigns, MHSA Contractors outreach and events, (Appendix 17) and Outreach Calendars and tracking reports (**Appendix 22**) are also evidence of our commitment ongoing outreach and engagement with identified racial, ethnic, cultural, linguistic, and other relevant small county cultural communities with mental health disparities.

**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.

NCMHP has established a Behavioral Health Cultural Competency Committee as a subcommittee of the Quality Improvement Committee (**Appendix 23**). NCMHP and Napa County Alcohol and Drug Services (NCADS) will collaborate as a joint committee in an effort to provide consistent culturally competent services to all consumers. It is common for NCMHP and NCADS to work with the same consumers that have co-occurring disorders. The first meeting was on June 2019 and will continue to meet every two months. The committee will provide guidance on cultural competence procedures and practices and aims to reduce mental health disparities based on race, ethnic cultural, linguistic, sexual orientation, gender difference and other dimensions of diversity.

Behavioral Health Cultural Competence Committee Representation: Invitations were sent out to a diverse community groups in Napa County. Representatives were self-selected the affiliation are as follows:

- Napa County Mental Health Department
- Disability Services and Legal Center
- Napa Emergency Women's Services
- COPE Family Resource Center
- Napa County Alcohol and Drug Services
- Buckelew
- NorCal Mental Health America
- ParentsCAN
- Community Advocate
- Puertas Abiertas Community Resource Center

NCMH uses several different committees that provide input to the division on a range of issues that affect unserved/underserved populations. For example, as part of Napa County's Mental Health Service Act (MHSA) Community Planning Process (CPP) that was initiated in 2005, the Mental Health Division developed the MHSA Stakeholder Advisory Committee (SAC) to help develop the Division's Community Services and Supports (CSS) Plan that was submitted to the Department of Mental Health (DMH) in 2006.

**Local Stakeholder Planning Process:** The Mental Health Services Act (MHSA) requires that county Mental Health departments submit MHSA Three Year Plans and Annual Updates to the MHSA Three Year Plan detailing expenditures of MHSA funds through a meaningful planning process that involves local

consumers and families as full partners from the inception of planning through implementation and evaluation of identified activities. The Mental Health Division also seeks input from stakeholders on various issues and decisions.

Stakeholder Advisory Committee (SAC) Representation: Historically, SAC representatives have come from the following sectors: Consumers, Families, Non-profit Coalition/Mental Health Service Providers, Law Enforcement, Schools, Health, Mental Health Board, and Alcohol and Drug.

The SAC continues to meet on a monthly basis to review MHSA component plans, updates, etc. and it is composed of representatives from the following sectors:

- Chief Probation Officer for Adult and Juvenile Probation representing Law Enforcement
- Representative from Napa Valley Unified School District representing K-12 Education
- Representative from Napa County Office of Education representing K-12 Education
- Members of the Behavioral Health Committee representing the Napa Valley Non-Profit Coalition
- Representative from the Napa County Commission on Aging representing Older Adults
- Representative from the Napa County Mental Health Board
- Representative from the Healthy Aging Population Initiative (HAPI) representing Older Adults
- Representative from Napa County Child Welfare Services representing Children/Youth
- Representative from Parent-Child Action Network (ParentsCAN) representing family members
- A representative from Ole Health representing Health providers
- A representative from Napa County Public Health Division representing Health providers
- Representative from Napa County's Alcohol and Drug Services Division representing Substance Abuse Services, Co-Occurring, Prevention and Youth
- LGBTQ Program Coordinator from a local non-profit organization representing the LGBTQ community
- Director of a local inter-tribal organization representing the Native American community
- Director, Clinical Director and Staff of the Mental Health Division

- Representative from Napa County Child Welfare Services representing Children/Youth
- Representative from Parent-Child Action Network (ParentsCAN) representing family members
- A representative from Ole Health representing Health providers
- A representative from Napa County Public Health Division representing Health providers
- Representative from Napa County's Alcohol and Drug Services Division representing Substance Abuse Services, Co-Occurring, Prevention and Youth
- LGBTQ Program Coordinator from a local non-profit organization representing the LGBTQ community
- Director of a local inter-tribal organization representing the Native American community
- Director, Clinical Director and Staff of the Mental Health Division

Mental Health Division Staff and SAC members are working to recruit additional committee members to fill several vacancies including Asian/Pacific Islander (API), Veterans, and Latino representatives.

The SAC participates in all stages of MHSA planning processes and provides input on other activities of the NCMHP. SAC members also work with the County to ensure that their constituencies receive the information necessary to be able to give input and participate in the planning process. Unserved/underserved populations that participate on the SAC include consumers, family members, Latinos, and LGBTQ individuals as well as representatives for Children/Youth, Adults, Older Adults/Seniors.

In addition to standing committees such as the Mental Health Board, Stakeholder Advisory Committee, Multi-Lingual Interagency Task Force, and Quality Improvement Committee (QIC), the NCMHP has also historically convened a number of specific stakeholder groups, focus groups. These groups have been involved in developing plans for the MHSA Community Services and Supports (CSS), Prevention and Early Intervention (PEI), CSS Housing, Workforce Education and Training (WET), Innovations Round 1 and Round 2 Projects, and the more recently the Community Mental Health Needs Planning Process. Collectively, these committees and MHSA planning efforts have involved participation from unserved/underserved groups including individuals with mental illness, family members, Asian/Pacific Islanders, Filipinos, Latinos, LGBTQ individuals, advocates for children 0-5, and transition- aged youth, Older Adults, Native Americans, and Veterans. Additionally, our planning efforts have identified and sought representatives from unserved/underserved geographical locations including rural unincorporated Napa County communities as well as the cities of St Helena, Calistoga, and American Canyon.

**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 NCMHP's various standing committees, MHSA, and other community planning processes have had varied success reaching unserved/underserved populations and efforts to include representatives of these populations are ongoing. Several methods have been used over the years to recruit participants including personal outreach from staff, representatives from community-based organizations, Mental Health Board members, Stakeholder Advisory Committee members as well as through phone calls, letters, email invitations, etc. Requests for participation have been posted around the county, sent by email as flyers have also been developed and distributed by various community contacts. Where individuals were not able to participate on a workgroup or committee, staff held focus groups or key informant interviews to gather input from unserved/underserved communities.

Findings from the NCMHP's Innovations planning processes are indicative of the challenges that the

NCMHP faces in developing an ongoing partnership with unserved/underserved populations. The perception by unserved/underserved representatives is that previous mental health/behavioral health planning processes have focused on short-term relationship building for funding collaborative that disband after the information is exchanged and funding has been allocated, often not to these same underserved/unserved populations. Examples that were offered included the Tobacco Master Settlement planning process, and the MHSA Community Services and Supports planning process to name a few. Though the practice is based on methods such as those described in the UC Davis guidelines, —Building Partnerships: Key Considerations when Engaging Underserved Communities under the MHSA<sup>1</sup>, the effect in Napa County has been a series of short-term and fragmented planning efforts that have solicited input for programs and, in the minds of these representatives, disappeared.

The underserved communities reported that providers did not understand the diversity within their community or the strengths offered and the challenges they encountered. Providers noted a need for increased cultural competency. These findings were reinforced by a review of the secondary data. At times, it is also difficult to get participation from consumers and their family members to remain active in the committees. The consumers and their family members are often faced with challenges that may prohibit them from being fully engaged like having difficulties following their own health plan to lacking transportation.

#### **Consumers reported that:**

- Across all of the unserved/underserved populations, the most common concern was that mental health providers are not informed about the unserved/under-served community.
- On average, over half of the unserved/underserved groups' comments were about the desire for providers to learn —to be more compassionate, know the struggle and know the stories of the population. Respondents also wanted providers to learn about their cultural point of view and the diversity within the underserved community. For example, participants shared the following statements:
  - *“The coming out process is different for everyone and affected by many factors (age, gender, culture, transgender, sexual orientation, HIV sero-status). Bisexuals get overlooked a lot.”*
  - *“Know about Native traditions (birth to death). For example, upon the death of a (Native) child, a parent asked to have the (child's) clothes. The coroner had already discarded them. The Coroner said that there are too many tribes, and (they) can't take care of them all.”*
  - *“Understand that not all veterans assimilate in the same way, for some veterans it's no easier to live here today than it was to be on active duty under extraordinary stress.”*
- When representatives from the underserved communities were asked what they would do to address the concerns, the comments included changing the relationships between mental health providers and the community, changing the type of mental health services and providing community education.

#### **Providers reported that:**

- The need to provide training and education for providers was reported by public mental health providers in the Workforce Education and Training community planning process.
- The current Federal Administration anti-immigrant political climate has produced fear, insecurity and lack of trust from the Latino community, the largest underserved population in the county. As a result of these fears and negative government community perception, NCMHP has collaborated with community organizations to provide mental health services in nontraditional locations. One way that MHSAs funds may be utilized to respond to this situation is by using reverted WET funds to provide trainings to staff, who are working directly with consumers and families negatively affected by the current political climate. Staff voiced the need for extra training prioritizing cultural competence and having difficult conversations about race and immigration in this political climate.
- As a desire and need to build relationships with underrepresented and historically underserved communities, MHD initiated and collaborated with community organizations to develop a process that would identify gaps in mental health services. Through this process, NCMHP invested MHSAs Innovation funds to develop projects and programs that addressed gaps of mental health services needed for the identified underserved groups.

The first round of the MHSAs Innovation planning process funded The Collaborative Project, developed in response to concerns from focus groups of underserved community stakeholders. These stakeholders felt that the Mental Health Division and its organizational partners did not consistently engage with these groups, except when there was a need for representation at community planning processes when new funding was received. These same communities felt that because of their small numbers and lack of visibility that their needs were consistently not funded and services were therefore inadequate and ineffective. In an effort to develop a more effective model of engaging with these populations, providers and consumers from these underserved populations worked on a number of strategies as part of a **Wellness and Prevention Framework**. The Framework was developed by Collaborative Project participants and based on comments received at the Stigma and Discrimination Reduction (SDR) Town Hall meeting, which took place in May 2014 and was attended by more than 260 community members and providers.

Through The Collaborative Project, the NCMHP developed a replicable model for improved collaboration with underserved populations and community-based organizations, which demonstrated to improve the relationships among underserved communities and providers of mental health services. This model relied on mutuality and long-term relationships to increase the perceived value placed on the collaborative process for improving the quality of services provided and for increasing access to services for underserved communities, including Latinos, LGBTQ, Native Americans and Veterans. By building the leadership of and connections between mental health professionals and consumers from these underserved groups, the intention is to create a sustainable collaborative structure and model that will have impact long into the future. The Systems Change Work Group also ensured projects are embedding culturally appropriate services into their projects.

- The following Innovations Round 2 Projects were submitted to the Mental Health Services Oversight and Accountability Commission (MHSOAC) in September of 2017 and approved. Outcome data is currently not available for these programs as they were initiated in April 2018. Innovations Round 2 Projects were submitted to the Mental Health Services Oversight and Accountability Commission (MHSOAC) in September of 2017 and approved. Funding was awarded for four new projects – Napa ACEs Innovation Project - \$438,869; Native American Historical Trauma and Traditional Healing Innovation Project - \$479,518; Understanding the Mental Health Needs of the American Canyon Filipino Community Project - \$461,016; and Work for Wellness Innovation Project - \$309,250. These Innovation Round 2 projects comprise the Mental Health Division Plans to Spend Reverted/Reallocated MHSAs Innovation Funds. (See **Appendix 8**)

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

- A. The Mental Health Division’s Ethnic Services Manager is Felix A. Bedolla, Project Manager, 2751 Napa Valley Corporate Drive, Napa, CA 94558. (707) 299-1759. Email is Felix.Bedolla@countyofnapa.org.

**IV. Identify budget resources targeted for culturally competent activities. The county shall include the following:**

- 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;
  2. Reduction of racial, ethnic, cultural, and linguistic mental health disparities;
  3. Budget amount allocated towards outreach to racial and ethnic county-identified target populations;
  4. Special budget for culturally appropriate mental health services; and
  5. If applicable, financial incentives for culturally and linguistically competent providers, non-traditional providers, and/or natural healers.

Below are highlights of resources dedicated to cultural competency activities

Description	Detail	Total
Language Competence	AT&T Language Line Language People Inc. Davin’s Interpreting Services, Inc. Total Expenditures	\$ 4,680.99 \$ 723.48 \$ 200.30 \$ 5,604.77
MHQuality Coordinator	The NCMHP’s Quality Improvement (QI) Coordinator dedicates time to cultural competency activities mentioned throughout this report. The QI Coordinator develops policies and procedures for cultural competency issues; oversees the implementation of quality improvement efforts throughout the system to increase the capacity of the system to provide culturally competent services, and works with the NCMHP’s MSHA Coordinator/Ethnic Services Manager to complete the NCMHP’s Cultural Competence Plan.  Quality Improvement Coordinator: .05 FTE	\$6,049.68
Description	Detail	Total

<p>Culturally Competent Internship Program</p>	<p>Workforce Education and Training – Internship Program that hires diverse ASW and MFT Interns to provide case management and therapy services.</p> <p>\$71,384 for Bilingual Internship Program Coordinator, which includes five stipends for interns at \$5,000 (includes taxes).</p>	<p>\$71,384</p>
<p>Bilingual stipends paid to bilingual staff for providing services primarily in Spanish, Napa County's only Threshold Language</p>		<p>\$53,404</p>
<p><b>Description</b></p>	<p><b>Detail</b></p>	<p><b>Total</b></p>

Description	Detail	Total
Other NCMHP Culturally Competent Staff	Add other bilingual staff from Access, Adult Therapy, Med Clinic, and any other appropriate MH Division programs, etc.	\$381,825.60
Culturally Sensitive Prevention and Early Intervention Programs for unserved/underserved populations	<p>The NCMHP's Prevention and Early Intervention programs are contracted to community based non-profit organizations and primarily focus on unserved and underserved populations and build the capacity of the community and the public mental health system to provide services to the target populations (Please see Appendix 7 for details on these PEI Programs).</p> <ol style="list-style-type: none"> <li>1. Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ) PEI Program</li> <li>2. Native American PEI Program</li> <li>3. Up Valley Mentoring Program PEI Program</li> <li>4. American Canyon Student Assistance Program (SAP) PEI Program</li> <li>5. Domestic Violence PEI Program</li> <li>6. Home Visitation PEI Program</li> <li>7. Strengthening Families PEI Program</li> <li>8. Older Adult PEI Program</li> <li>9. Court and Community Schools Student Assistance Program (SAP) PEI Program</li> </ol>	<p>\$ 43,500</p> <p>\$ 94,878</p> <p>\$ 76,150</p> <p>\$159,807</p> <p>\$ 109,400</p> <p>\$ 50,000</p> <p>\$ 98,000</p> <p>\$ 91,350</p> <p><u>\$ 81,600</u></p> <p>\$804685</p>

Description	Detail	Total
MHSA Community Services and Supports – Culturally Competent Program Budgets	<ol style="list-style-type: none"> <li>1. Children's Full Service Partnership (FSP)</li> <li>2. Transition Age Youth (TAY) FSP</li> <li>3. Adult FSP</li> <li>4. Adult Treatment Team FSP</li> <li>5. Older Adult FSP</li> <li>6. Project Access</li> <li>7. Crisis Stabilization Services Program</li> </ol>	\$ 559,060 \$ 465,577 \$ 706,674 \$ 301,067 \$ 368,651 \$ 814,740 \$ 238,422 \$3,454,191
MHSA Consultants	<p><b>ALLEN, SHEA &amp; ASSOCIATES: MHSA planning and Support</b> includes the following activities:</p> <ul style="list-style-type: none"> <li>- Provides support and assistance with MHSA planning with local stakeholder and community members for Community Mental Health Planning processes, Innovations program development and evaluation, support for Mental Health Month activities.</li> <li>- Facilitates meetings with Consumer Representatives and Family Representatives groups as needed.</li> <li>- Provides bilingual meeting materials as needed</li> <li>- Conducts meetings in both Spanish and English as needed. Compiles data, analyzes, and prepares written analysis relating to unmet mental health needs in Napa County and presents analyses to community stakeholders including the Behavioral Health Subcommittee of the Napa Valley Coalition of Nonprofit Agencies, the Napa County Mental Health Advisory Board, Mental Health Stakeholder Advisory Committee, etc.</li> <li>- Develops and maintains a revolving expense account in order to support stakeholder meetings expenses (such as stipends, childcare, supplemental meals, housing, transportation assistance, translation services), printing costs associated with stakeholder meetings, travel expenses (outside of local travel), Mental Health Month projects, and other expenses as specifically approved by county related to MHSA planning activities.</li> <li>- Assist with the development and implementation of a Community Participates in MHSA Trainings and/or conference calls as directed. Participation in other duties related to MHSA planning and implementation in Napa County, as needed.</li> </ul>	\$125,445.81

Description	Detail	Total
<p>Culturally Sensitive Innovation Projects for unserved/underserved populations</p>	<p>The NCMHP's Innovations Projects are contracted to community based non-profit organizations and also focus on unserved and underserved populations and are specifically intended to explore new strategies that will build the capacity of the public mental health system to improve services to these target populations (Please see Appendix 8 for details on these Innovations Projects).</p> <ol style="list-style-type: none"> <li>1. Understanding Historical Trauma and Traditional Healing: A Training for Mental Health Providers</li> <li>2. Work for Wellness</li> <li>3. Adverse Childhood Experiences (ACEs)</li> <li>4. Addressing the Mental Health Needs of the American Canyon Filipino Community</li> </ol>	<p>\$479,518</p> <p>\$309,250</p> <p>\$438,869</p> <p><u>\$461,016</u></p> <p>\$1,699,653</p>

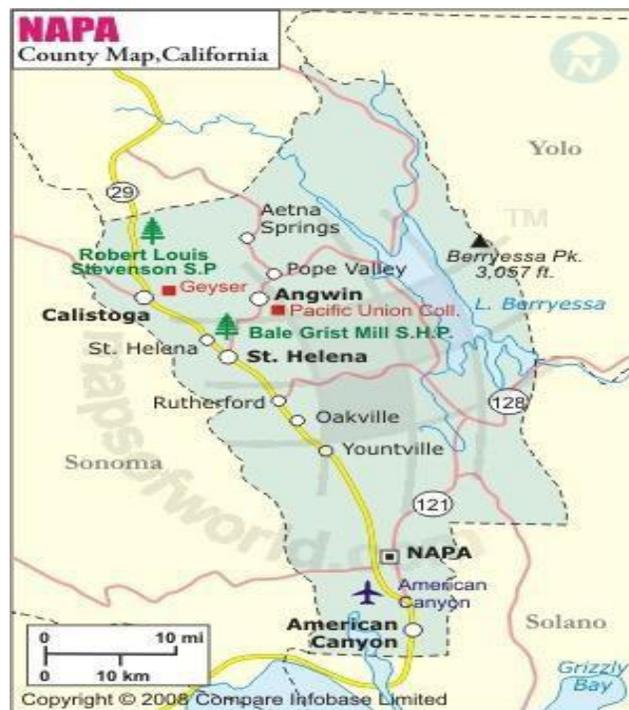
**CRITERION 2  
COUNTY MENTAL HEALTH SYSTEM  
UPDATED ASSESSMENT OF SERVICE NEEDS**

**Rationale:** A population assessment is necessary to identify the cultural and linguistic needs of the target population and is critical in designing, and planning for the provision of appropriate and effective mental health services.

**Note:** All counties may access 2007 200% of poverty data at the DMH website on the following page <https://www.dhcs.ca.gov/services/MH/Pages/SMI-MH.aspx> within the link titled —Severe Mental Illness (SMI) Prevalence Rates. Counties shall utilize the most current data offered by DMH. Only small counties, as defined by California Code of Regulations 3200.260, may request Medi-Cal utilization data from DMH by submitting the appropriate form to DMH, no later than five calendar months before plan submissions are due. To complete the Data Request Form, counties must contact the Office of Multicultural Services at 916-651-9524 to have a DMH staff person assist in the completion of the proper form. Eligible counties may be provided data within thirty calendar days from the data request deadline; however, all requests are first-come first-serve and provided according to DMH staff availability and resources.

Demographic information of Napa County residents, Medi-Cal beneficiaries, and consumers of mental health services in Napa County was analyzed and used to target strategies that reduce the disparities among underserved populations of mental health services in Napa County.

Figure 1



## I. Napa County General Population Data Profile

### Data Set: 2013-2017 American Community Survey 5-Year Estimates

**GENERAL POPULATION:** July 2018 Census statistics lists Napa County's total population at approximately 136,484<sup>1</sup>. The population is divided 50.1% female and 49.9% males. The median age for the general population is 40.8 years. 21.5% of the population is under 18 years and 17.4% is 65 years and older. It is anticipated that the population of older adults (65+) will continue to increase as the Baby Boomer generation ages.

**RACE:** For people reporting one race alone, 72.6% reported White; 2.1% Black or African American; .9% American Indian and Alaska Native; 7.9% Asian; .2% Native Hawaiian and Other Pacific Islander, and 3.8% reported that they were multiracial (two or more races). In addition, 33.7% of the people in Napa County reported that they were Hispanic/Latino, which can be of any race. White/non-Hispanic residents comprise 66.3% of the population.<sup>2</sup>

#### **NATIVITY AND LANGUAGE:**

Foreign born residents comprise 21.9% of Napa County's population with 78.1% reporting that they were born in the United States. Among people five years and older living in Napa County in 2017, 34.7% spoke a language other than English at home.<sup>3</sup>

**INCOME:** The median income of households in Napa County is \$79,637. Sixty-five % receive earnings and about 22.2% received retirement income other than Social Security. About 33% of the household received Social Security. The average income from Social Security was \$19,663. These income sources are not mutually exclusive; that is, some households received income from more than one source.<sup>4</sup>

**POVERTY AND PARTICIPATION IN GOVERNMENT PROGRAMS:** In 2017, 8.2% of the population in Napa was in poverty. In the past 12 months, 8% of related children under the 18 were below the poverty level. While, 7.8% of people 65 years old and over were below the poverty level. Out of the people below poverty.

**EDUCATION:** In 2017, 87.7% of people 25 years and over had at least graduated from high school, 9.9% did not graduate from high school, and 34.6% had a bachelor's degree or higher.<sup>4</sup>

**INDUSTRIES:** In 2017, for the employed population 16 years and older, the leading industries in Napa County were Educational services, and health care, and social assistance, 31.4%, and Manufacturing, 12.9%.

**OCCUPATIONS AND TYPE OF EMPLOYER:** Among the most common occupations were: Management, professional, and related occupations, 36.5%; Sales and office occupations, 21.5%; Service occupations, 21.2%; Production, transportation, and material moving occupations, 10.3%; and Construction, extraction, maintenance, and repair occupations, 10.7%.<sup>5</sup>

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<sup>1</sup> <https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=CF>

<sup>2</sup> <https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=CF>

<sup>3</sup> <https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=CF>

<sup>4</sup> <https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=CF>

<sup>5</sup> <https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=CF>

A. Table 1 shows the six cities in Napa County. Eighty one % of Napa County's population resides in these six cities, with the remaining 19% living in unincorporated areas.

**Table 1**

Napa County Land Area and Population - 2010 Census data, 2017 data not available by City	Square Miles	Population (2010)	%
Napa County Size	753.73	136,484	100.00%
American Canyon	4.8	19,454	14.25%
Napa	18.1	76,915	56.35%
Yountville	1.5	2,933	2.15%
St. Helena	5.03	5,814	4.26%
Calistoga	2.6	5,155	3.78%
Unincorporated, non CDP	723.02	20,718	17.25%
Angwin CDP		3,051	2.24%
Deer Park CDP		1,267	0.93%
Moskowite Corner CDP		211	0.15%
Oakville CDP		71	0.05%
Silverado Resort CDP		1,095	0.80%
Rutherford CDP		164	0.12%

**Table 2**

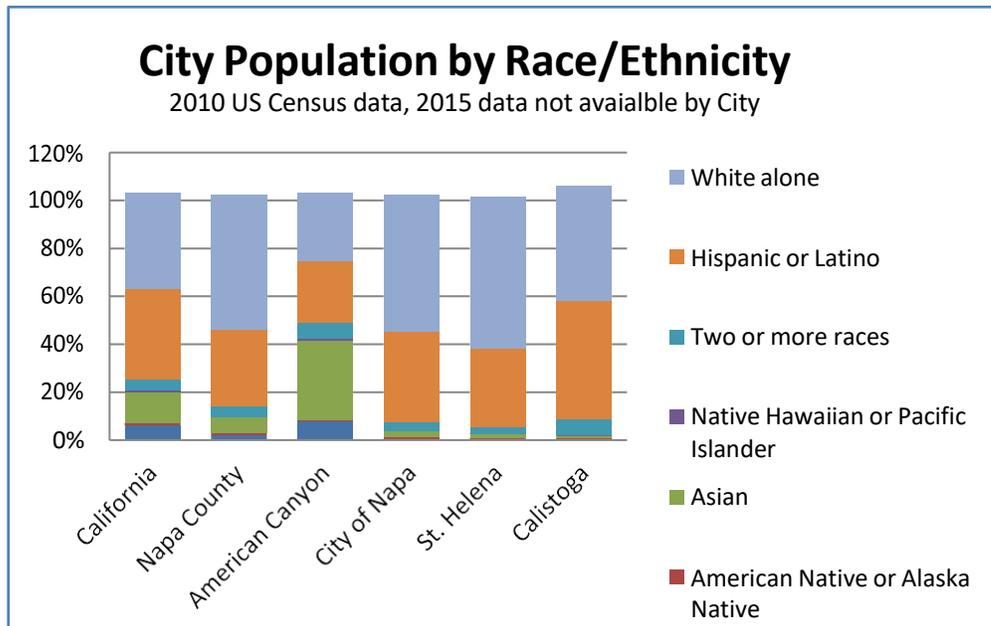


Table 2<sup>6</sup> shows population by city and race. American Canyon is the most diverse city in Napa County and Calistoga continues to have a large population of Hispanic/Latinos, making it the majority racial/ethnic group in the City of Calistoga.

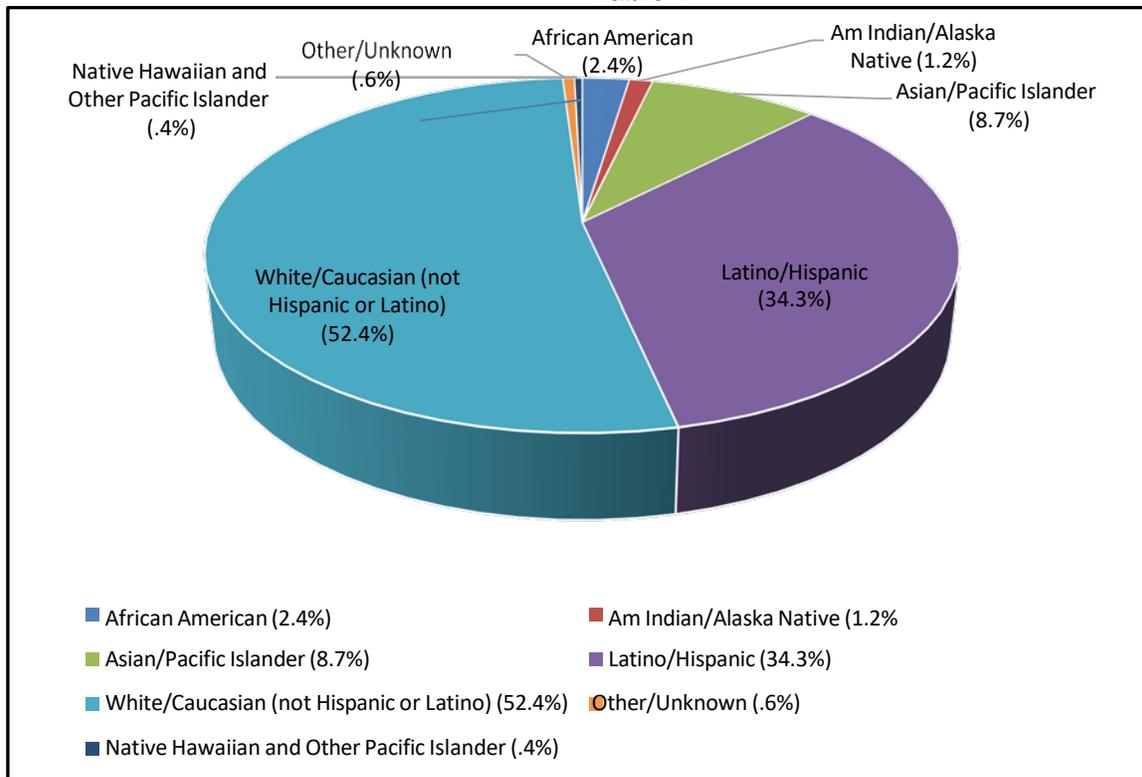
<sup>6</sup> <https://www.census.gov/quickfacts/table/RHI125215/06.0601640.0650258.0664140.0609892.06055>

Table 3<sup>7</sup> and 4 provide the racial distribution of the county's population:

**Table 3**

<b>Napa County Population by Race (1) and Hispanic or Latino: 2017 Census QuickFacts Population Estimates Incorporated Cities and Census Designated Places (CDP)</b> California Department of Finance Demographic Research Unit State Census Data Center	Population	%
African American	3,383	2.4%
Am Indian/Alaska Native	1,692	1.2%
Asian/Pacific Islander	12,265	8.7%
Latino/Hispanic	48,354	34.3%
White/Caucasian (not Hispanic or Latino)	73,870	52.4%
Other/Unknown	4,511	.6%
Native Hawaiian and Other Pacific Islander	564	.4%
<b>Total</b>	<b>144,639</b>	<b>100%</b>

**Table 4**



Napa County's Latino population increased by 2 % from 32.3% to 34.3% or 48,354 residents since the 2010 Census, while the non-Latino white population decreased 4 % from 56.4% to 52.4% or 73,870 according to 2010 U.S. Census data. Latinos accounted for the majority of the county's growth since 2000. Overall, the county has grown by 6% to 144,639 total residents in

<sup>7</sup> <https://www.census.gov/quickfacts/fact/table/napacountycalifornia/PST045217>

that time. Pacific, American Indian Alaska native, and African American populations make up approximately 12.7% of Napa County’s population. (Table 4)

**Table 5**

<b>LANGUAGE SPOKEN AT HOME</b>		
2013-2017 American Community Survey 5-Year Estimates Survey: American Community Survey		
<b>Population 5 years and over</b>	<b>133,501</b>	<b>133,501</b>
English only	87,123	65.3%
Spanish	36,173	27.1%
Other Indo-European languages	3,322	2.5%
Other languages	401	0.3%
Asian and Pacific Islander languages	6,482	4.9%

Table 5<sup>8</sup> shows information from the most recent American Community survey, approximately two thirds (65%) of the population in Napa County speaks “English only” at home. About 27% of the population speaks Spanish at home, which is the one official threshold language for Napa County. The remaining 7.74% speak other Indo-European, Asian Pacific, or other languages at home.

**II. Napa County Demographic Data and Medi-Cal Population Service Needs**

Inasmuch as no single set of data regarding population and demographic penetration rates can capture the full picture of county residents who can and do access mental health services, Napa County MHP tracks and examines data sets from several different perspectives. Among these are reports from EQRO, the DHCS POS system, actual served reports from our E.H.R. and projected census numbers. The following tables provide demographic data for Napa County’s Medi-Cal population, specifically SMHS recipients, and Medi-Cal beneficiaries served by NCMHP.

Additionally, (as noted in Criterion 2.II.B) Napa County provides analysis of the disparities between all Napa County Medi-Cal beneficiaries and Medi-Cal Beneficiaries served by the NCMHP. These data inform the overall planning of services in reducing disparities among un/under-served populations throughout Napa County Mental Health.

**Cultural & Ethnic Penetration Rates**

**Rationale:** Penetration rates establish information on the number of individuals who receive (utilize) mental health related services relative to the general population. These rates of utilization can be compared to state, regional, and national figures. They allow a rough analysis of patterns of utilization across various key demographics

**Methodology:** Information is extracted from state published data of individuals who are Medi-Cal eligible, who enroll in treatment within the Napa Mental Health Plan (MHP) delivery system, and

<sup>8</sup> <https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=CF>

who have at least one service divided by the total population (Medi-Cal eligible). This data can be evaluated in a number of ways (i.e., looking at Medicaid population eligibility, comparing against SMI/SED prevalence rates, cultural and ethnic populations, etc.).

**Data Source:** Prepared report from the California External Quality Review Organization (CAEQRO) “Medi-Cal Approved Claims Data for Napa County MHP”. Report data is based on Department of Health Care (DHCS) approved claims and Monthly Medi-Cal Eligibility File (MMEF) Data. Target is set based on Small County penetration rate data.

**Frequency of Review:** Annual

Age 0-5 Penetration Rate 2% (target increased from 1.20% to 2% on 06/19/2014)

Hispanic Penetration Rate 4% (target decreased from 5% to 4% on 01/17/2019)

## HOW ARE WE DOING?

Green highlight signifies that the MHP’s penetration rates are higher than Small County or Statewide rates. Red highlight signifies that the MHP’s penetration rates are lower than Small County or Statewide rates. Yellow highlight signifies that the MHP’s penetration rates are equal to those of Small County or Statewide rates.

**Table 6**

**Calendar Year 2016**

	<b>Avg # Eligible/Mo</b>	<b># Bene Served</b>	<b>Napa</b>	<b>Small Co.</b>	<b>Statewide</b>
<b>Age Group</b>					
0 to 5	4347	79	1.82%	1.46%	2.04%
6 to 17	9053	632	6.98%	6.77%	6.01%
18 to 59	15416	742	4.81%	5.15%	4.70%
60+	4474	158	3.53%	2.94%	2.75%
<b>Gender</b>					
Female	17637	728	4.13%	4.58%	4.07%
Male	15653	883	5.64%	5.07%	4.87%
<b>Race/Ethnicity</b>					
White	10190	740	7.26%	5.57%	6.01%
Hispanic	18927	613	3.24%	3.83%	3.38%
African American	592	33	5.57%	7.61%	7.76%
Asian/Pacific Islander	1892	37	1.96%	2.10%	2.25%
Native American	72	4	5.56%	4.89%	7.38%
Other	1619	184	11.37%	6.75%	6.23%
<b>Eligibility Categories</b>					
Disabled	2408	534	22.18%	15.92%	18.33%
Foster Care	149	67	44.97%	38.84%	46.26%
Other Child	7511	437	5.82%	4.74%	4.58%
Family Adult	4590	102	2.22%	3.13%	2.81%
Other Adult	2911	38	1.31%	1.39%	1.17%
<b>MHCHIP</b>	<b>6252</b>	<b>228</b>	<b>3.65%</b>	<b>3.32%</b>	<b>3.05%</b>
<b>ACA</b>	<b>8639</b>	<b>293</b>	<b>3.39%</b>	<b>4.06%</b>	<b>3.86%</b>

	<b>Avg # Eligible/Mo</b>	<b># Bene Served</b>	<b>Napa</b>	<b>Small Co.</b>	<b>Statewide</b>
<b>Service Categories</b>					
Inpatient Services	33290	95	0.29%	0.32%	0.38%
Residential Services	33290	106	0.32%	0.06%	0.06%
Crisis Stabilization	33290	47	0.14%	0.23%	0.44%
Day Treatment	33290	1	0.00%	0.00%	0.02%
Case Management	33290	477	1.43%	1.68%	1.59%
MH Services	33290	1247	3.75%	3.84%	3.55%
Medication Support	33290	661	1.99%	2.33%	2.16%
Crisis Intervention	33290	244	0.73%	0.88%	0.49%
TBS	33290	12	0.04%	0.03%	0.06%

In CY 2016 NCMHP surpassed small county penetration rates for age groups, 0-5, 6-17 and 60+. In terms of statewide penetration numbers, NCMHP surpassed all of the statewide penetration rates for all groups except for the age group 0-5. In CY 2016 NCMHP, served 728 females and 883 males. At the statewide level, NCMHP penetration rates were higher for both females and males. In terms of race and ethnicity, NCMHP White beneficiaries had the highest penetration rate at 7.26%. This rate exceeded both the small county and statewide penetration levels. For other groups such as Hispanic, African American, Asian/Pacific Islander, NCMHP had lower penetration rates compared to the penetration rates of small counties and statewide levels. The group with the highest penetration rate at 11.37% identified as "Other", thus it is difficult to determine the exact race or ethnicity.

Table 7: CY 2017

	Avg # Eligible/Mo	# Bene Served	Napa	Small Co.	Statewide
<b>Age Group</b>					
0 to 5	4110	71	1.73%	1.46%	2.07%
6 to 17	9026	591	6.55%	6.99%	6.31%
18 to 59	15304	734	4.80%	5.14%	4.71%
60+	4592	156	3.40%	3.04%	2.78%
<b>Gender</b>					
Female	14519	713	4.07%	4.61%	4.15%
Male	15513	839	5.41%	5.16%	4.96%
<b>Race/Ethnicity</b>					
White	9849	680	6.90%	5.43%	5.93%
Hispanic	19012	607	3.19%	4.01%	3.35%
African American	587	34	5.79%	7.20%	7.37%
Asian/Pacific Islander	1687	28	1.66%	1.69%	2.08%
Native American	71	3	4.23%	4.49%	6.38%
Other	1828	200	10.94%	7.24%	7.23%
<b>Eligibility Categories</b>					
Disabled	2396	498	20.78%	15.14%	17.85%
Foster Care	143	65	45.45%	39.64%	47.28%
Other Child	7271	412	5.67%	4.96%	4.76%
Family Adult	6226	92	1.48%	2.84%	2.13%
Other Adult	3078	40	1.30%	1.17%	0.91%
MHCHIP	5652	223	3.95%	4.27%	4.09%
ACA	8721	307	3.52%	4.09%	3.86%
<b>Service Categories</b>					
Inpatient Services	33032	102	0.31%	0.35%	0.42%
Residential Services	33032	112	0.34%	0.05%	0.07%
Crisis Stabilization	33032	187	0.57%	0.23%	0.48%
Day Treatment	33032	0	0.00%	0.00%	0.01%
Case Management	33032	452	1.37%	1.66%	1.60%
MH Services	33032	1191	3.61%	3.83%	3.63%
Medication Support	33032	648	1.96%	2.32%	2.17%
Crisis Intervention	33032	142	0.43%	1.01%	0.53%
TBS	33032	8	0.02%	0.03%	0.06%
<b>Katie A ICC/IHBS</b>	<b>33032</b>	<b>20</b>	<b>0.06%</b>	<b>0.11%</b>	<b>0.14%</b>

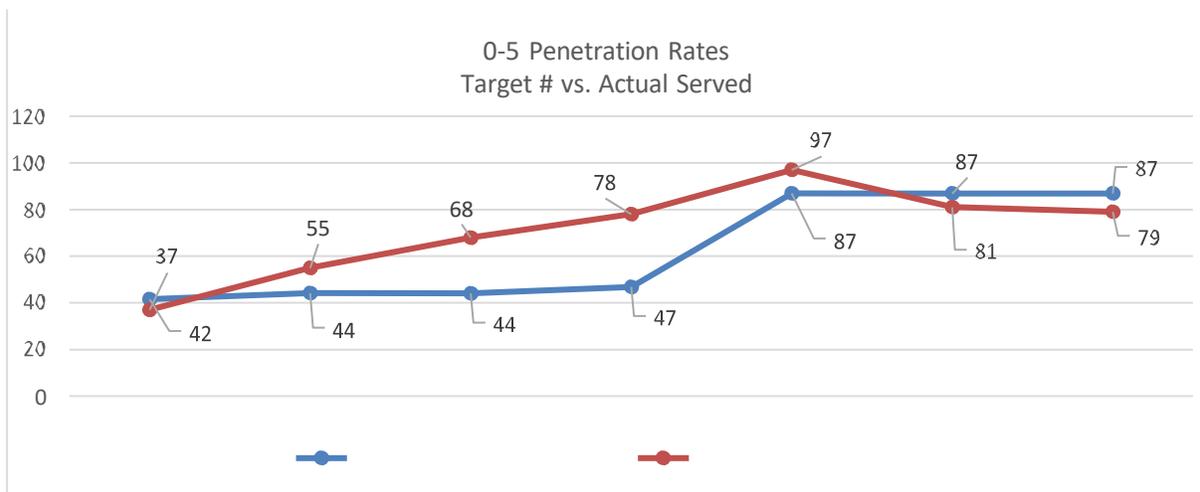
In calendar year 2017 NCMH surpassed the small county state services averages for the age groups of 0 to 5 and 60+. NCMH was below state average in beneficiaries age groups of 6 to 17 and 18 to 59. In the race/ethnicity category, NCMH surpassed serving Whites and the “Other” category at both the small county and state average. However, it did not reach the small county or statewide average of serving the Hispanic population, which accounts for over a third of Napa County’s population. In Eligibility Categories, NCMH surpassed small county average in beneficiary services for the Disabled, Foster Care, Other Child, and Other Adult. For the Services Categories, Residential Services and Crisis Stabilization the NCMH surpassed the small county and statewide

beneficiaries served. The Case Management, Medication Support and Crisis Intervention are categories that increase services.

**Table 8**  
**0-5 Penetration Rates**

YEA R	TARGET Penetration Rate %	NAPA Penetration Rate %	NAPA # Served/Year	Eligible/M o
2010	1.20%	1.07%	37	3469
2011	1.20%	1.52%	56	3685
2012	1.20%	1.85%	68	3671
2013	1.20%	2.00%	78	3906
2014	2.00%	2.23%	97	4348
2015	2.00%	1.86%	81	4344
2016	2.00%	1.82%	79	4347
2017	2.00%	1.73%	71	4110

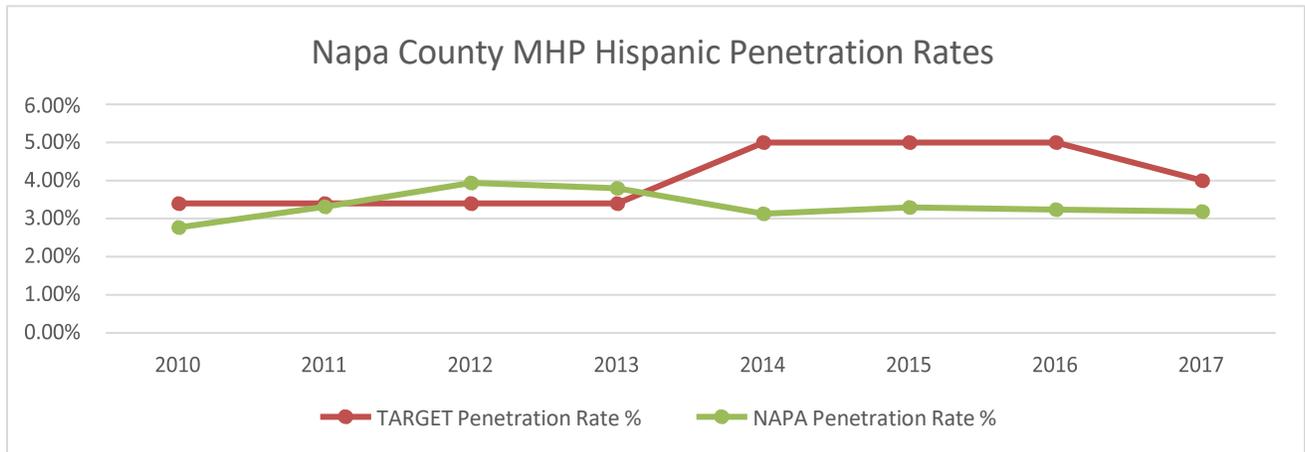
In 2014 target penetration rates increased from 1.20% to 2.0% Penetration rates for children gradually increase from 2010-2014 and decreased from 2015-2016. In 2015-2016, NCMHP did not meet the target penetration rate. From 2016 to 2017, the penetration rate dropped from 2% to 1.73%. The penetration rate has decreased since 2015.



**Table 9**

**Hispanic Penetration Rates**

YEAR	TARGET Penetration Rate %	NAPA Penetration Rate %	NAPA # Served/Year	Eligible/Mo
2010	3.40%	2.77%	266	9607
2011	3.40%	3.31%	347	10468
2012	3.40%	3.94%	419	10646
2013	3.40%	3.80%	449	11813
2014	5.00%	3.13%	445	14226
2015	5.00%	3.30%	491	14892
2016	5.00%	3.24%	613	18927
2017	4.00%	3.19%	607	19012



The largest underserved population in Napa County is the Latino/Hispanic population. Since 2010, the average eligible Medi-Cal beneficiaries and number of beneficiaries has gradually increase. However, NCMHP has not reached its targeted penetration rate from 2014-2017. NCMHP continues to explore different engagement and outreach strategies in order to reach its targeted goals.

**Demographic Penetration Rates**

**Rationale:** In order to better analyze overall service utilization and costs, the MHP reviews demographic penetration data for all individuals served and by specific pay sources.

**Methodology:** Number of individuals provided services during the review period broken down by gender, age, and ethnicity divided by the total number of residence in Napa County or by number of eligible individuals by pay source.

**Data Source:** Anasazi Unduplicated Client Services Report ALL and by Pay Source (All, Medi-Cal, CMSP), Medi-Cal Eligible Report from Self Sufficiency, 2010 Napa County Census Data

**Frequency of Review:** Quarterly

**Table 10**

**ALL Clients Served by the MHP by Quarter (last four quarters)**

	Napa Co Demo Profile Data	Apr-June 2018		July-Sept 2018		Oct-Dec 2018		Jan-Mar 2019	
		ALL	% ALL	ALL	% ALL	ALL	% ALL	ALL	% ALL
	<b>141005</b>	1546	1.10%	1432	1.02%	1407	1.00%	1461	1.04%
<b>ETHNICITY</b>									
NA, Unknown/Not Reported	<b>NA</b>	69		57		52		44	
Not Hispanic	<b>93659</b>	901	0.96%	864	0.92%	844	0.90%	877	0.94%
Hispanic	<b>47164</b>	576	1.22%	511	1.08%	511	1.08%	540	1.14%
<b>SEX</b>									
NA	<b>NA</b>	12		17		6		4	
Female	<b>70694</b>	616	0.87%	573	0.81%	548	0.78%	576	0.81%
Male	<b>70331</b>	918	1.31%	842	1.20%	853	1.21%	881	1.25%
<b>AGE</b>									
<b>0 to 4</b>	<b>7504</b>	21	0.28%	13	0.17%	12	0.16%	11	0.15%
<b>5 to 19</b>	<b>26397</b>	506	1.92%	425	1.61%	391	1.48%	425	1.61%
<b>20 to 59</b>	<b>73418</b>	858	1.17%	823	1.12%	830	1.13%	850	1.16%
<b>60 to 99</b>	<b>33686</b>	163	0.48%	176	0.52%	176	0.52%	180	0.53%

From April 2018 to March 2019, NCMHP served 141,005 Medi-Cal beneficiaries. Out of this total, 93,659 were not Hispanic, 47,164 identified as Hispanic, 70,694 were female, and 70,331 were males. In terms of age groups, the age group with the largest amount served was between the ages of 20-59 and 73,418 were served in this age range during this time. While the age group of 0 to 4 was the group with the lowest percentage served.

Table 12

Demographic	July-Sept 2017		Oct-Dec 2017		Jan-Mar 2018		Apr-June 2018	
	Medi-Cal	% Medi-Cal	Medi-Cal	% Medi-Cal	Medi-Cal	% Medi-Cal	Medi-Cal	% Medi-Cal

Medi-Cal Beneficiaries by the MHP by Quarter (last four quarters)

Avg # MC Eligible per Month (2017 ERQO data)	Apr-June 2018		Apr-June 2018		Oct-Dec 2018		Jan-Mar 2019		
	Medi-Cal	% Medi-Cal	Medi-Cal	% Medi-Cal	Medi-Cal	% Medi-Cal	Medi-Cal	% Medi-Cal	
	3303 2	1230	3.72%	1115	3.38%	1084	3.28%	1145	3.47%
<b>ETHNICITY</b>									
NA, Unknown/Not Reported	NA	44		30		29		32	
Not Hispanic	1402 2	703	5.01%	656	4.68%	638	4.55%	668	4.76%
Hispanic	1901 2	484	2.55%	429	2.26%	417	2.19%	445	2.34%
<b>SEX</b>									
NA	NA	4		4		4		2	
Female	1751 9	515	2.94%	466	2.66%	442	2.52%	468	2.67%
Male	1551 3	711	4.58%	645	4.16%	638	4.11%	675	4.35%
<b>AGE</b>									
0 to 5	4110	33	0.80%	31	0.75%	25	0.61%	23	0.56%
6 to 17	9026	421	4.66%	340	3.77%	324	3.59%	352	3.90%
18 to 59	1530 4	640	4.18%	602	3.93%	592	3.87%	629	4.11%
60 to 99	4592	142	3.09%	144	3.14%	145	3.16%	145	3.16%

Table 13

Trend Analysis Quarter before ACA to Last Four Quarters Medi-Cal Beneficiaries

	July-Sept 2014	Apr-Jun 2018	July-Sept 2018	Oct-Dec 2018	Jan-Mar 2019	% inc/dec
Medi-Cal	1199	1230	1115	1084	1145	-4.50%
<b>ETHNICITY</b>						

NA, Unknown/Not Reported	141	44	30	29	32	-77.30%
Not Hispanic	709	703	656	638	668	-5.78%
Hispanic	349	484	429	417	445	27.51%
<b>SEX</b>						
NA	5	4	4	4	2	-60.00%
Female	419	515	466	442	468	11.69%
Male	609	711	645	638	675	10.84%
<b>AGE</b>						
0 to 5	60	33	31	25	23	-61.67%
6 to 17	419	421	340	324	352	-15.99%
18 to 59	609	640	602	592	629	3.28%
60 to 99	118	142	144	145	145	22.88%

***\*% increase/decrease is the most current quarter compared to July-Sept 2014 quarter.***

***That was the last quarter before ACA came into effect.***

The trend analysis from the quarter before ACA to the quarter of January to March 2019 shows a decrease of 4.5% of Medi-Cal beneficiaries. There was a significant increase of Latino/Hispanic beneficiaries of 27.51% from the last quarter before the ACA. NCMHP also decreased services to the age group 0-5 by a significant 61.67%. A significant increase was shown in the age group of 60-99 by 22.88%. While both females and males show an increase, females increased by 11.69% and males by 10.48

**IV.**

**A. MHSA Community Services and Supports (CSS) Population Assessment:** Napa County Mental Health Services Act FY 19-209 Annual Update to MHSA Three-Year Plan for 17-18 to FY 19-20.

Napa County’s FSP programs include Children’s FSP, TAY FSP, Adult FSP, Adult Treatment Team FSP, Older Adult FSP, Project Access, Response, and Engagement, and the Crisis Stabilization Services Program. These services provide a variety of mental health services from outreach, wrap around services, mental illness services, housing placings to family support therapy and many more.

A total of 1,974 individuals of all ages were served and formally enrolled to CSS services from July 2017 to June 2018. Adults (ages 26-59) received the most outreach, while Older Adults received the least amount of outreach and services. The Crisis Stabilization Program provided services to the most consumers, totaling 1,275 individuals.

The table below shows the total number of individuals serves by age for the specific Community Services and Support Programs for July 2017 through June 2018.

**Table 14**

<b>Program by Age</b>	<b>Number Served 7/1/2017 to 6/30/2018</b>
<b>Full Services Partnership</b>	
0-15	83
16-25	28
26-59	77
60+	33
<b>System Navigators</b>	
0-15	3
16-25	10
26-59	83
60+	14
<b>Crisis Stabilization Services Program</b>	
0-15	165
16-25	269
26-59	748
60+	93
<b>Innovations Community Center</b>	
0-15	0
16-25	25
26-59	272
60+	71

NCMH System Navigators promote Mental Health services throughout Napa County in a variety of venues and community events. System Navigators have established relationships with community

partners that allow them to outreach and engage with individuals who may not feel comfortable seeking mental health services in the traditional government offices. The diverse events allow System Navigators to provide information about mental health services and in occasions provide on the spot direct services to individuals in crisis or who lack access to mental health services. In the past System Navigators have participated in a variety of events and locations. These events and locations include: health fairs, homeless shelters, adult school open house, Latina Women’s Conference, community hikes, Bi- National Health Fair, school fairs, community resource fairs, National Night Out, suicide prevention conferences, Latino markets and more.

**Table 15**

<b>System Navigators</b>	
<b>Year 2016</b>	<b>Number of contacts</b>
2 <sup>nd</sup> Quarter	825
3 <sup>rd</sup> Quarter	3,860
Total	4,685
<b>Year 2017</b>	<b>Number of contacts</b>
1 <sup>st</sup> Quarter	395
2 <sup>nd</sup> Quarter	2,620
Total	3,015
<b>Year 2018</b>	<b>Number of contacts</b>
1 <sup>st</sup> Quarter	260
2 <sup>nd</sup> Quarter	2,804
3 <sup>rd</sup> Quarter	4,925
4 <sup>th</sup> Quarter	60
Total	8,049
<b>Year 2019</b>	<b>Number of contacts</b>
1 <sup>st</sup> Quarter	680
2 <sup>nd</sup> Quarter	7,766
3 <sup>rd</sup> Quarter	2,100
Total	10,546

During the second and third quarter of 2016, System Navigators interacted with 4,685 community individuals. In 2017, between the first and second quarter System Navigators interacted with 3,015 individuals. Lastly, in 2018 System Navigators interacted with 8,049 individuals. So far in 2019, 10,546 individuals have been reached by the System Navigators. The numbers reflect the high importance of System Navigators to NCMH and the community of Napa.

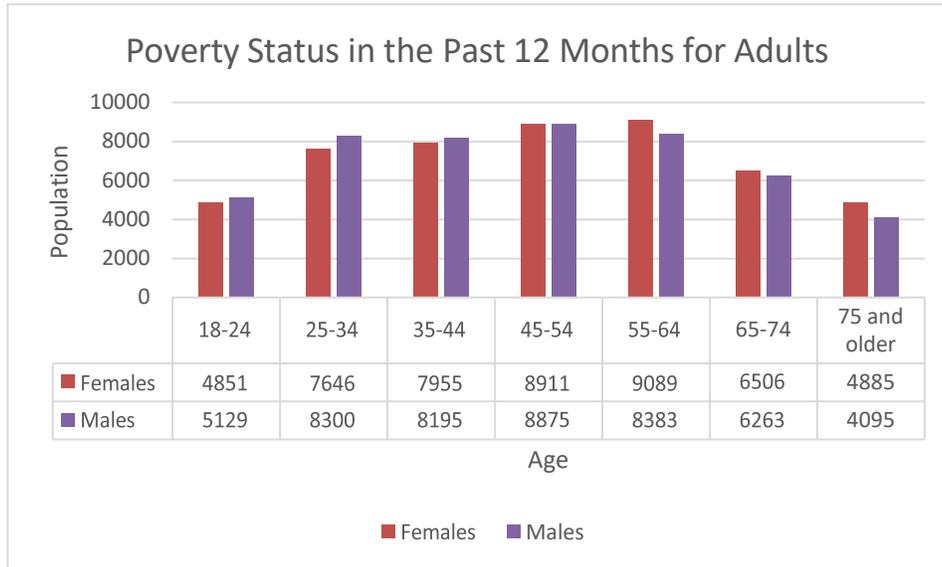
### Poverty

Geographic information system maps provided by the Metropolitan Transportation Commission indicate that there are concentrated areas of poverty in both the Calistoga and Napa communities. Consequently, we know that there are likely to be concentrations in those two areas of individuals who are impoverished, severely mentally ill, and unserved. Figure 2<sup>9</sup>, 8.2% of Napa County residents are below poverty level. In the last 12 months, 99,083 adults were under the poverty

<sup>9</sup> <http://www.dof.ca.gov/Forecasting/Demographics/Projections/>

level. The age range with the most adults in poverty were the ages between 45 to 54 years of age. For children, 27,047 were in poverty. The age range with the highest poverty level is between 5 years to 11 years with 10,427 children in

**Table: 16**



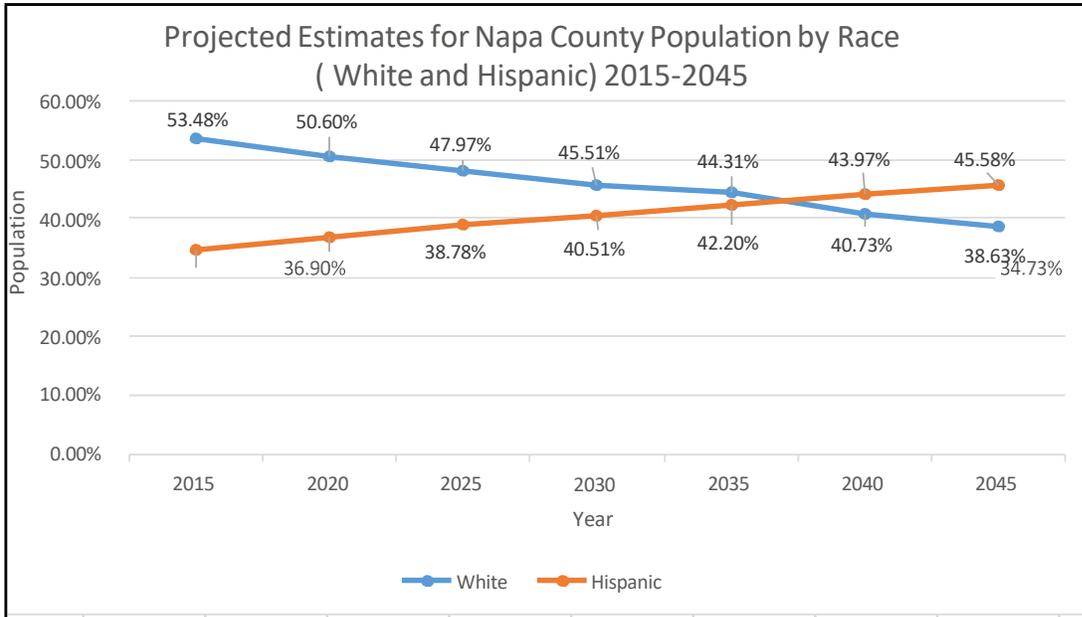
Based on the Census, 8.2% of Napa County residents are below poverty level. In the last 12 months a total of 99,083 adults were under the poverty level. The age range with the most adults in poverty were the ages between 45 to 54 years of age. For children, 27,047 were in poverty. The age range with the highest poverty level is between 5 years to 11 years with 10,427 children in poverty. <https://www.livestories.com/statistics/california/napa-county-poverty>

### Ethnicity and Population

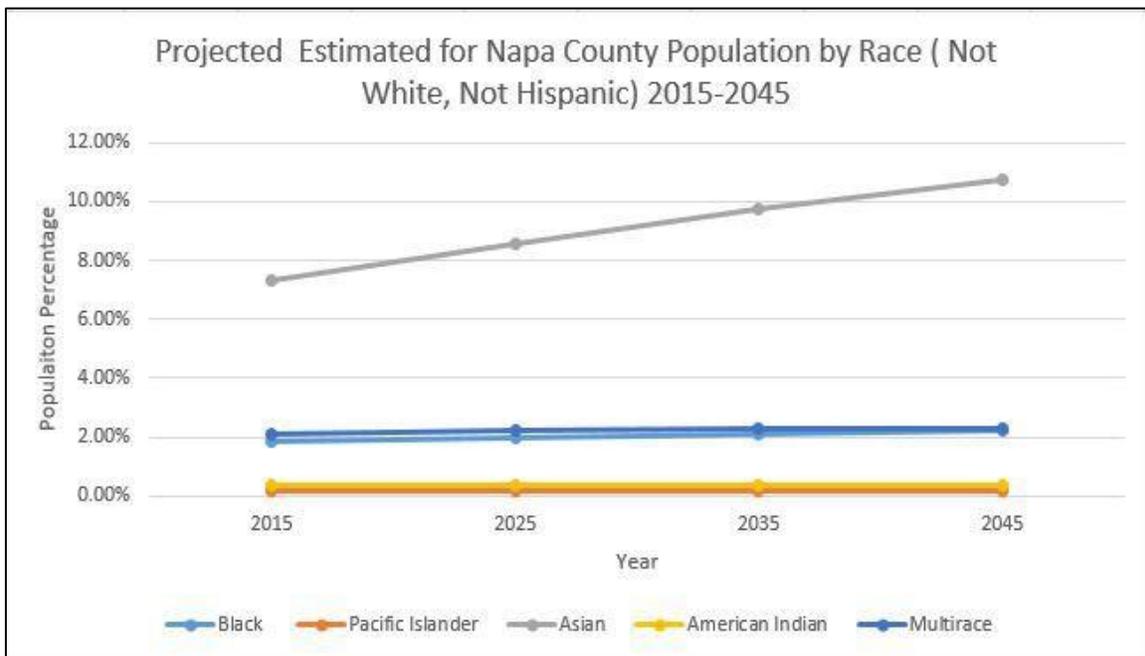
Table 17 and 18 show the projected population by race in Napa County. Latino and Asian populations are currently the fastest growing population in Napa County. It is projected that by 2037 the Latino population will surpass the Caucasian/Whites population while the Asian population will comprise about 8.5% of the total population by 2025.<sup>10</sup> Other racial categories such as Multiracial, Asian, American Indian and Black/African American also continue to grow at a slower rate through 2045. Pacific Islanders are the only race that is forecast to slightly decrease through 2015. With increasing population with diverse cultural needs, the CSS services may have to evolve along with the changing demographics.

<sup>10</sup> <http://www.dof.ca.gov/Forecasting/Demographics/Projections/>

**Table 17** Source: [California Department of Finance webpage](#)



**Table 18** Source: [California Department of Finance webpage](#)



**Table 19** - Source: [California Department of Finance webpage](#)

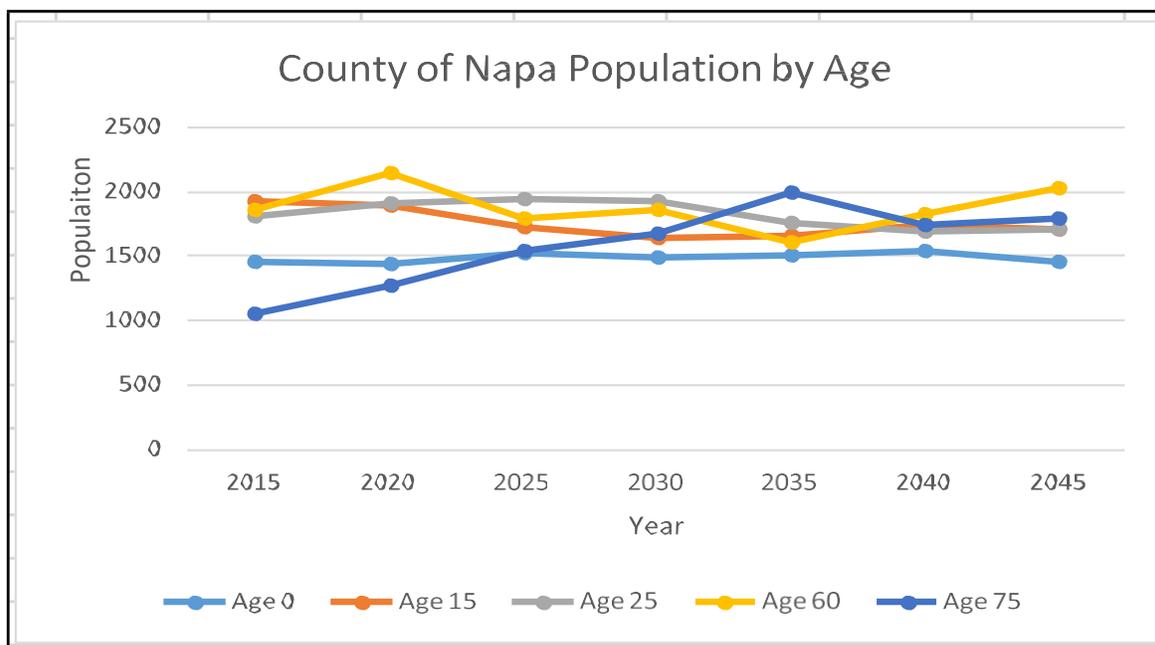


Figure 5 depicts the County of Napa’s population trends by age categories served by CSS program. As of 2015 to 2035, the population increasing at the fastest rate are individuals 75 years of age. From 2015 to 2035 it is projected that the age group of 60 will slowly decrease, but will begin to take an upward trend after 2035. The age groups of 0 and 15 remain at a steady from 2015 through 2045. The 25-year-old age group slightly increases, but begins to decrease in 2030. Based on these projections the CSS programs should continue focusing on the age group 25 as well as 60 and older.

**V. Prevention and Early Intervention (PEI) Plan: The process used to identify the PEI priority populations The county shall include the following in the CCPR Modification (2010):**

**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.**

The target populations in the NCMHP’s PEI Plan were developed through an extensive community planning process that involved community and provider surveys, town hall meetings in cities and towns throughout Napa County, focus groups, key informant interviews, and stakeholder meetings including a PEI Workgroup.

The PEI Workgroup spent time defining who is unserved and/or underserved by the current Prevention and Early Intervention services in Napa County. Latinos, seniors, and those who live outside the City of Napa had been identified in the CSS process using treatment data, and were the initial populations considered unserved and/or underserved by PEI services.

After completing the community and provider surveys and a review of existing services, the following groups were identified: Asian/Pacific Islander, Native American, Veterans, Lesbian/Gay/Bisexual/Transgender/Questioning (LGBTQ), and those living outside the City of Napa in geographically underserved areas. Though neither seniors nor Latinos were identified as particularly underserved by PEI services, they were included in the PEI Workgroup's definition of unserved/underserved as these groups have historically been underserved/unserved. Planning efforts also looked at groups who were over-represented in systems such as juvenile justice and non-traditional schools as a potential indicator that the group was under/unserved by prevention and early intervention services and was therefore being identified in systems once problems had progressed.

Based on the input from this process, the NCMHP's Stakeholder Advisory Committee (SAC) recommended specific priorities, which were further refined by staff into initial work plan concepts. These draft work plans were reviewed and approved by the Mental Health Director. Staff subsequently developed final work plans that were compiled into a Prevention and Early Intervention (PEI) Plan and submitted for public review and comment. Responses from the community were generally positive.

The PEI priority populations identified in Napa County are as follows: Latinos, Native Americans, Older Adults, LGBTQ individuals, Veterans and other communities (see **Appendix 7** for more detailed descriptions of current PEI programs). In order to serve the identified populations, the following PEI programs were implemented and continue to offer services to the community.

**Stigma and Discrimination Reduction Program: LGBTQ Connection Project**  
**Contractor: On the Move**

The LGBTQ Connection Project provides group and single agency training and technical assistance for local community providers on relevant LGBTQ issues facing youth to older adults. They do this by offering LGBTQ 101 training, Best Practices for LGBTQ TAY, and LGBTQ Older Adults training. Staff also offers training and technical assistance to local organizations looking to increase inclusivity and change organizational policies and protocols that may potentially be negatively impacting their ability to reach individuals in these communities. LGBTQ Connections is also a trusted hub for information and support in the community.

**Prevention Program: American Canyon Student Assistance Program**  
**Contractor: Napa Valley Unified School District (NVUSD)**

The American Canyon Student Assistance Program seeks to offer multi-tiered support for students in elementary through high school. Prevention Programs used include research-based PBIS (Positive Behavior Intervention & Support), BEST behavior school climate program as well as the Second Step youth development curriculum.

**Prevention Program: Home Visitation Program**  
**Contractor: Cope Family Center**

The Home Visitation program helps families develop skills to move toward self-sufficiency, and provide healthy homes for their children through access to prevention and primary care services. Cope uses the Healthy Families America (HFA), evidence-based program, and maintains accreditation by proving high model fidelity. This program is offered countywide. The goal of this program is to prevent child abuse.

**Prevention Program: Kids Exposed to Domestic Violence Program**

**Contractor: Napa Emergency Women's Services (NEWS)**

The KEDS Program helps children and families heal from their exposure to domestic violence and strives to prevent future domestic violence. KEDS Program Staff's goals is to help children heal from the trauma of Domestic Violence by offering a wide range of support services for children, offering support and empower their parents, increasing protective factors and creating community awareness of Childhood Exposure to Domestic Violence (CEDV).

**Prevention Program: Native American PEI Program**

**Contractor: Suscol Intertribal Council**

The Native American PEI project was developed with the goal of connecting Native American individuals with one another and with the Suscol Intertribal Council, a trusted resource in the community. Suscol staff and elder advisors hold many of the traditional medicinal practices that healed native people prior to western medicine. They feel that by educating the Native American community about their own background and heritage and traditional healing practices that this can help address some of the negative outcomes that are so prevalent in the community (alcoholism, suicide, incarceration, homelessness, prolonged suffering relating to historical trauma) and move towards recovery.

**Prevention Program: Strengthening Families At-Risk Program**

**Contractor: Cope Family Center, Sub-contractor: Mentis**

The Strengthening Families At-Risk Project addresses the prevention and early intervention needs of families at-risk of developing mental illness by offering parent/couple support groups and brief therapy for individuals who are identified as needing a higher level of services post support group. Support groups are offered in English/Spanish throughout the County. This program also offers emergency aid/assistance as needed.

**Prevention Program: Up Valley PEI Mentoring Project**

**Contractor: Up Valley Family Centers**

Challenging Latinos to Access Resources and Opportunities, known as CLARO, and Challenging Latinas through Awareness, Resources and Action, known as CLARA, are mentoring programs provided by the Up Valley Family Centers to help youth build positive identities in a process of self-exploration through the lens of culture. The program is for middle and high school aged youth. Although the focus is on serving Latinos and Latinas, these programs are offered to any student who is interested in increasing cultural awareness and in develop an appreciation for cultural diversity and inclusion.

**Prevention Program: Court and Community Schools PEI Project**

**Contractor: Napa County Office of Education**

The Court and Community Schools Student Assistance Program offers mental health services and counseling, as needed, along with a wide range of services including academic assistance in order to support students, reduce suspension rates, and increase school attendance. Students are referred to the community school for reasons of truancy, disciplinary issues or through expulsion. The majority of students are performing well below grade level; all come from a history of neglect, abuse, trauma, substance abuse, and/or diagnosed or undiagnosed mental health conditions.

**Prevention Program: Strengthening Families at Risk**

**Contractor: Cope Family Center and Mentis**

The Strengthening Families At-Risk Project addresses the prevention and early intervention needs of families at-risk of developing mental illness by offering parent/couple support groups and brief therapy for individuals who are identified as needing a higher level of services post support group. Support groups are offered by Mentis in English/Spanish throughout the County. Staff makes referrals to more intensive services as needed and modifies the curriculum when necessary to address specific group needs. The group is designed as a close

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

**Rationale:** “Striking disparities in mental health care are found for racial and ethnic populations. Racial and ethnic populations have less access to and availability of mental health services, these communities are less likely to receive needed mental health services, and when they get treatment they often receive poorer quality of mental health care. Although they have similar mental health needs as other populations they continue to experience significant disparities, if these disparities go unchecked they will continue to grow and their needs continue to be unmet...” (U.S. “Department of Health and Human Services, Surgeon General Report, 2001).

**Note:** The purpose of this section is to use this CCPR Modification (2010) as a logic model by continuing the analyses from Criterion 2 and to correlate the county’s defined disparities with targeted activities to address them.

Building on the information gathered in Criterion 2, Criterion 3 further examines who is accessing mental health services in Napa County. This section then highlights specific strategies to lessen disparities among underserved populations.

**The county shall include the following in the CCPR Modification (2010):**

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

**Medi-Cal Populations:**

- Latino/Hispanic
- African American
- Native American
- Other

**MHSA Components and Populations:**

**CSS Plan Target Populations**

- Children
- Older Adults
- Transition Age Youth
- Latinos
- Consumers

**PEI Plan Target Populations**

- PEI Target Populations Latinos
- LGBTQ
- Trauma exposed children
- Older Adults
- Native Americans Asian/Pacific Islanders

**WET Target Populations**

- Latinos and other unserved/underserved populations through Actions designed to improve cultural competency

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

The PEI Planning process for Napa County started in FY 2009-2010 and was finalized in FY 2010-2011. The process built on the success and information received from the Community Services and Supports Component planning and ensured that the feedback received was inclusive and representative of the community at large. Two main findings came from the original planning process. Data collected for the PEI planning process indicated that the entire community had an average of 39% of their PEI needs met, indicating that on average the community was NOT well-served. Unserved and underserved groups had as little as 17% of their needs met.

Napa County's approved PEI programs were designed to adhere to Department of Mental Health PEI Regulations. PEI programs also followed the Institute of Medicine and PEI framework described in the California Department of Mental Health's Information Notice 07-19 (Universal, Selected, and Indicated Populations) and Spectrum of Prevention model developed by designed to address the needs of historically unserved/underserved populations including Native Americans, Latinos, Veterans, Older Adults, the LGBTQ community and other geographically underserved areas.

The target populations in the division's PEI Plan were developed through an extensive community planning process that involved community and provider surveys, town hall meetings in cities and towns throughout Napa County, focus groups, key informant interviews, and stakeholder meetings including a PEI Workgroup, Stakeholder Advisory Committee (SAC) as well as further refinement of concept papers by staff based on priorities identified by the SAC. These recommendations were reviewed by the Mental Health Director. Once approved by the Director, the initial concepts were developed into final work plans that were compiled into a PEI Plan and submitted for public review and comment. Responses to the PEI plan from the community were generally positive.

**Spectrum of Prevention**



The planning process consisted of several stages, each designed to encourage stakeholders and community participation and input.

**Data Collection and Analysis**

- Collection of community and provider input through written and online surveys.
- Survey of service providers to determine current Prevention and Early Intervention services in Napa County.
- Review of existing data for each priority population to illustrate the scope of need for PEI services and supports.

**Synthesis of Data and Community Input**

- Workgroup members and representatives from unserved/underserved groups reviewed and synthesized data from community and provider surveys, current PEI services, and existing data source to develop ideas for potential PEI services and

supports.

- Input about services needed for each priority population from community members and providers through a series of community meetings.
- Additional input about services needed for each priority population from unserved/underserved communities through a series of focus groups.

**Review of Data, Plan Development and Submittal – County MHSa Staff (MHSa Project Manager and Staff Services Specialist)**

- Two workshops were organized by County MHSa Staff and consultants to review PEI guidelines, background information and community input and all community and provider recommendations with members of the Stakeholder Advisory Committee (SAC). The SAC recommended areas of focus for each of the priority populations.
- Work plans were developed by County MHSa staff based on recommendations from the County's MHSa Stakeholder Advisory Committee.
- County MHSa Staff presented the draft PEI Work plans for review to the Stakeholder Advisory Committee and the County's Mental Health Board.
- County MHSa Staff presented the Final PEI Proposal to the Stakeholder Advisory Committee and MH Board, prepared responses to written comment, and submitted the final plan to DMH and the MHSOAC.

**Participation of unserved/underserved populations in the PEI Planning Process**

**(See Figure 2)** - The PEI Workgroup spent time defining who is unserved and/or underserved by the current Prevention and Early Intervention services in Napa County. Latinos, seniors, and those who live outside the City of Napa had been identified in the CSS process using the treatment data, and were the initial populations considered unserved and/or underserved by PEI services.

After completing the community and provider surveys and a review of existing services, the following groups were identified: Asian/Pacific Islander, Native American, Veterans, Lesbian/Gay/Bisexual/Transgender/Questioning (LGBTQ), and those living outside the City of Napa. Though neither Older Adults nor Latinos were identified as particularly underserved by PEI services, they were included in the PEI Workgroup's definition of unserved/underserved as these groups have historically been underserved/unserved. Planning efforts also looked at groups who were over-represented in systems such as juvenile justice and non-traditional schools as a potential indicator that the group was under/unserved by prevention and early intervention services and was therefore being identified in systems once problems had progressed.

The PEI Workgroup relied on its representatives to reach out to groups who had at least one member of the workgroup representing their interests: seniors, Latinos, Asian/Pacific Islander, and those living outside the City of Napa. The representatives went back to their contacts and constituents as input and/or involvement was needed. The workgroup did not have representatives from the Native American, LGBTQ, and Veteran communities. The PEI Co-chairs and the MHSA Project Manager reached out to representatives in these communities and invited them to participate in the planning process.

This resulted in two ad-hoc workgroups: one for LGBTQ and one for Native Americans. Each of these workgroups reviewed the data the PEI Workgroup had collected and submitted two of the 27 provider ideas for PEI funding. All of the 27 provider ideas indicated the proposed PEI services and supports were designed to serve some or all of the unserved and underserved populations.

After the provider ideas were submitted, a series of community meetings were held throughout the County to ask the community which types of services should be available for the priority populations. Outreach for these meetings was done to all unserved/underserved groups through the PEI Workgroup and the ad-hoc committees.

Additional outreach was later initiated by the consultant to include veterans groups. When the community meetings were completed, eight focus groups, and interviews on veterans' and Native American needs were conducted to specifically talk with members of unserved and underserved communities. See Figure 2 on page 8 for details.

**Opportunities for individuals reflecting the diversity of the demographics of the County, including but not limited to, geographic location, age, gender, race/ethnicity and language to participate in the PEI Planning Process. (See Figure 2)** - The PEI planning group spent considerable time and effort to ensure the planning process was inclusive and accessible. Demographics were considered at each stakeholder involvement event/activity. (See a. above as well.)

**Geographic Location:** Online and paper surveys were distributed to residents and providers throughout the county. Community meetings were conducted in four locations: Calistoga, St Helena, Napa and American Canyon. Areas where community meeting attendance was low were targeted in the focus groups.

**Age:** Very young children, school-aged children and their families were well-represented on the workgroup and in the provider ideas. To reach Transition Aged Youth (TAY), a

PEI Co-chair worked with a local agency focused on TAY. This outreach helped the PEI Workgroup recruit TAY for the Napa community meeting. Adults were well-represented in the community and provider survey and through the PEI Workgroup and provider ideas. Additionally, many of the discussions about the services needed for children and youth involved parents. Seniors were represented on the workgroup, in the provider survey and in the provider ideas. Because they did not participate proportionally in the community survey or the community meetings, three of the eight focus groups were specifically focused on seniors.

**Gender:** In most of the outreach efforts, about 20-25% of the participants were male with 75-80% female. Nobody self-identified as transgender or other gender.

**Race/ethnicity:**

Workgroup members did specific outreach to the Latino and Asian American/Pacific Islander communities to encourage participation in each of the stakeholder process components. The MHSA Project Manager worked to involve the Native American community. A representative from the Native American community was also invited to and attended a PEI Conference with County staff and a consumer PEI Workgroup member.

**Language:** The surveys, community meetings and focus groups were all conducted in English and Spanish. Outreach to the Filipino Tagalog-speaking population was done through providers and community representatives who spoke Tagalog. Translation was made available, but it was not requested.

**Outreach to consumers with serious mental illness and/or serious emotional disturbance and their family members, to ensure the opportunity to participate.**

**(See Figure 2)** Outreach to consumers was done primarily through two local consumer-led agencies as well as through NCMHP case managers. Consumers and their family members participated on the PEI Workgroup and attended several PEI Conferences with County staff and PEI Workgroup members. Consumers submitted one of the 27 provider ideas and participated in several others. Consumers and family members were well-represented at the community meetings. To be sure consumers' voices were heard clearly, one of the eight focus groups was conducted with consumers exclusively. Consumers and family member representatives also participated as members of the Stakeholder Advisory Committee.

Table 20: Participation in the Community Planning Process									
% of Napa County Population		Community Survey	Provider Survey	PEI Workgroup	Ad-hoc Workgroups	Provider Ideas	Community Meetings	Focus Groups	
N=124,279 <sup>9</sup>		n=260	n=220	n=16	Yes/No	n=27	n=85	n=89	
	Asian/Pacific Islander	3%	3%	47%	6%	No	52%	4%	n/a
Race/ Ethnicity	Black/African American	1%	4%	n/a	n/a	No	n/a	0%	n/a
	Hispanic/Latino	24%	40%	67%	19%	No	81%	35%	24%
	Native American	1%	1%	45%	0%	Yes	48%	0%	24%
	White	70%	47%	n/a	n/a	No	n/a	33%	n/a
	More than one Race/Ethnicity	4%	3%	n/a	n/a	No	n/a	0%	n/a
	Other	0%	2%	n/a	n/a	No	n/a	0%	n/a

<sup>9</sup> Census 2000 Figures for Napa County. Accessed at [www.bayareacensus.ca.gov](http://www.bayareacensus.ca.gov) 4/27/09

**Table 21: Participation in the Community Planning Process**

		% of Napa County Population	Community Survey	Provider Survey	PEI Work Group	Ad-hoc Work Groups	Provider Ideas	Community Meetings	Focus Groups
	<b>N=124,279<sup>11</sup></b>		<b>n=260</b>	<b>n=220</b>	<b>n=16</b>	<b>Yes/No</b>	<b>n=27</b>	<b>n=85</b>	<b>n=89</b>
Age Groups	Young Children (0-5)	6% (<5)	n/a	37%	13%	No	48%	n/a	n/a
	Children (6-15)	18% (5-17)	1%	51%	13%	No	74%	n/a	n/a
	Transition Aged Youth (16-25)	61% (18-64)	27%	55%	6%	No	63%	25%	n/a
	Adults (26 to 59)		60%	42%	94%	No	26%	69%	55%
	Seniors (60 and over)	15% 65+	8%	39%	6%	No	22%	10%	45%
Gender	Male	50%	28%	n/a	25%	No	n/a	19%	n/a
	Female	50%	72%	n/a	75%	No	n/a	81%	n/a
Language	English	75%	78%	100%	100%	n/a	n/a	79%	76%
	Spanish	20%	35%	n/a	n/a	n/a	n/a	56%	24%
	Tagalog	n/a	2%	n/a	n/a	n/a	n/a	0%	0%

<sup>10</sup> Census 2000 Figure for Napa County. Accessed at [www.bayareacensus.ca.gov](http://www.bayareacensus.ca.gov) 4/27/09.

Medi-Cal Population

Criterion 2 detailed Napa County's unserved/underserved populations within the Medi-Cal population. Medi-Cal populations with disparities that were identified include: women, children ages 0-17, older adults, Hispanics/Latinos, Asian/Pacific Islanders, and Spanish speakers.

**Community Service and Supports: Full Service Partnership Population**

Napa County's Full Service Partnership populations for FY 17-18 are reflected in tables below.

**Table 22**

Napa County's Full Service Partnership Population by Age Demographics	NCMHP CSS FSP Population Served 7/1/2017 to 6/30/2018		
	CSS: 1,275	FSP: 221	873
<b>Total Population</b>			
<b>Age</b>			
0-15	165	83	248
16-25	269	28	297
26-59	748	77	151
60+	93	33	126

NCMH and services providers served 14,275 Crisis Stabilization Services Program consumers between 7/1/2017 to 6/30/2018. The age group with the largest number served is from 25-59. The table shows a breakdown of FSP population which is broken down by age. The breakdown of age are youth 0-15, TAY 16-25, adults 26-59 and older adults 60 plus. NCMH served 221 FSP consumers during 7/1/2017 to 6/30/2018.

**Table 23:**

**CSS by Ethnicity and Race**

Ethnicity	Children's FSP	TAY	Adult FSP	Older Adult	Adult Treatment	Outreach Engagement	Total
Not Hispanic	29	15	68	38	25	49	224
Mexican American/Chicano	31	9	9	2	5	3	59
Other Hispanic/Latino	8	3	6	2	2	7	28
Hispanic/Latino	26	1	2	1	1	11	42
Not Reported	1	0	6	9	2	1	19
<b>Race</b>							

Asian Indian	0	0	1	1	0	0	2
Black/African Am	3	1	7	1	1	1	14
Chinese	0	0	0	1	1	0	2
Guamanian	0	0	0	0	1	0	1
Filipino	2	2	1	0	0	1	6
Hawaiian Native	0	0	1	0	0	0	1
Japanese	0	0	0	0	0	1	1
Native American	0	2	3	0	0	3	8
Non White -Other	48	6	11	14	8	16	103
Vietnamese	0	0	1	0	1	0	2
White	33	14	1	50	23	40	161
Unknown	1	0	61	0	1	2	65
Other Asian	1	1	1	0	0	0	3
Other Pacific Islander	0	0	0	0	0	1	1
Other Race	4	0	2	0	0	0	6
Mixed Race	3	1	1	0	0	3	8

**II. Then list disparities in each of the populations (Medi-Cal, CSS, WET, and PEI).** Disparities in each of the populations are described in detail within the PEI Plans (**Appendix 7**), CSS (**Appendix 10**), Innovation Projects (**Appendix 8**) and WET Plans (**Appendix 9**), as well as the Medi-Cal population data contained in Criterion 2 of this document.

**III. Then list strategies for the Medi-Cal population as well as those strategies identified in the MHSa plans (CSS, WET, and PEI) for reducing those disparities described above.**

Specific strategies for reducing disparities include:

- Ongoing recruitment and hiring of bilingual staff to fill designated bilingual only positions
- Assignment of System navigators and other bilingual staff to Latino/Hispanic Outreach activities
- Translation of critical documents from English to Spanish
- Development of an English-Spanish Glossary of Mental Health Terms to improve the quality of translation and interpretation (**Appendix 24**)
- Creation of Full Service Partnership programs to provide “wrap-around” services to Latinos and other unserved/underserved populations that meet FSP requirements.
- Collaboration and contracts with multiple community-based organizations that are directly connected with the most vulnerable communities. Through these established relationships, NCMHP helps reduce disparities as it takes direct services closer to the clients. Some of the contracts and collaborations are with the following organizations:
  - Aldea Inc.
  - Buckelew
  - Exodus
  - Hospitals, group homes and other residential facilities
  - Mentis
  - Progress Foundation

NCMHP also participates and conducts outreach in non-traditional events as well as other established community events throughout the year. Two significant annual events are the Latino/Hispanic Bi-National Health Fair and the Latina Women's Conference. These two events allow the NCMHP to reach over 250 individuals who may be uninsured or may not be aware of the mental health services available to them. NCMHP's counseling staff provide on the spot mental health screenings and follow up with connecting consumers to adequate services based on their need and insurance status. These outreach efforts are intended to reach individuals who would normally not go into county or other doctor services. Other non-traditional outreach efforts include providing services in well-known non-profit organizations and community centers such as Puertas Abiertas, the Innovations Community Center, St Helena Family Center and Calistoga Family Center. Direct services, such as therapy and support groups, are offered in these locations, which are often less stigmatized and approachable than a government location. There are also year around outreach efforts that happen during other community fairs and events. Other locations are listed in the table below:

- Voices Community Center for TAY and LGBTQ community members
- South Napa Homeless Shelter
- Napa Valley Unified School District (NVUSD) Asian Pacific Islander Outreach
- Suscol Tribal Council's Annual Pow-wow
- American Canyon Parks and Recreation - Health Fair
- Synergy Gym
- St. John Baptist Catholic Church
- Oxbow Commons-Earth Day
- Target- National Night Out Event
- Calistoga Elementary School
- Napa County Sheriff's Department
- Meritage Health and Wellness Fair
- Aldea Suicide Prevention Conference
- Kaiser Permanente Bi-National Health Fair
- Napa Mexican Independence Day Celebration
- Mental Health Division and co-sponsored Mental Health Month Events (For examples of flyers from some of these events, please see **Appendix 17.**)

NCMHP also provides translation of commonly used and required documents into Spanish. Lastly, there are established programs to address the needs of unserved/underserved populations specifically through the MHSA components including CSS (**Appendix 10**), PEI (**Appendix 7**) and WET Plans (**Appendix 9**).

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

NCMHP's Utilization Review Committee sets penetration rate targets, and program contracts are monitored to ensure they meet required outcomes, but currently lacks sufficient resources to measure and monitor activities/strategies for reducing disparities. The Behavioral Health Cultural Competence Committee will propose and monitor Napa County Mental Health Division's and Alcohol and Drug Services Division's activities and strategies for reducing disparities in the identified groups.

**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).**

Lesson #1: Implementation of new programs takes a significant amount of time. Programs must be allowed adequate time for staffing and drafting/implementation of policies and procedures. Recruitment and hiring for bilingual/bicultural staff takes additional time. If programs are being implemented through contracts, a minimum of 6 months must be allotted for the County Request for Proposals and contracting processes.

Lesson #2: Even with the implementation of MHSA, NCMHP cannot address all mental health needs in our community. Despite our community's best effort to complete thoughtful and thorough planning processes, priorities must be ranked and not every need can be met. This becomes even more challenging during economic downturns and places stress on an already under-resourced mental health system.

Lesson #3: Implementation of new programs requires building relationships and successful partnering with other County Divisions and Departments, contractors, and community-based partners. It is important to develop collaborations that focus on the end goal of providing high quality services to the underserved communities.

Lesson #4: Whenever possible hold meetings and programs in locations and at times that accommodate participants. MHSA Stakeholder and community planning meetings were conducted in locations throughout the county to allow stakeholders with limited travel capacity to attend. Engaging consumers for planning and input is especially effective when meetings are brought to locations where they are already attending, such as Wellness and Recovery program sites. Many MHSA programs offer late afternoon/early evening and weekend hours to accommodate working family members, per their request. In addition, participants for planning meetings have requested a light dinner as they are often coming straight from work, which helps facilitate their participation. Programs are most successful when they include in their scope of work outreach and community collaboration and so our PEI Projects have been designed with collaboration and outreach as central strategies. Most of the PEI Projects are also offered in natural or community settings to enhance community participation.

Lesson #5: PEI and FSP programs have reported higher success rates in outcomes when their staff is trained in multiple evidence-based practices including Functional Family Therapy, Cognitive Behavioral Therapy-Psychosis (CBT-P), Motivational Interviewing (MI), Milestones of Recovery Scale (MORS), Cognitive Behavioral Therapy (CBT), Dialectical Behavioral Therapy (DBT) to name a few.

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

**Rationale: A culturally competent organization views responsive service delivery to a community as a collaborative process that is informed and influenced by community interests, expertise, and needs. Services that are designed and improved with attention to community needs and desires are more likely to be used by patients/consumers, thus leading to more acceptable, responsive, efficient, and effective care (CLAS, Final Report).**

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

**The county shall include the following in the CCPR Modification (2010):**

**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 NCMHP established the Behavioral Health Cultural Competence Committee, which is a subcommittee of the Quality Improvement Committee. For details, please see **Appendix 23**, which includes a Behavioral Health Cultural Competence Committee Charter, Organizational Chart, agendas and minutes. The committee is comprised of a diverse groups of community members, consumers and NCMH and ADS staff, who meet every two months. The role of this committee is to assure that Napa County Mental Health (NCMH) implements and provides culturally and linguistically competent services to reduce health disparities and meet the diverse needs of Napa County residents.

Napa County Health and Human Services Agency's Diversity and Inclusion Steering Committee (DISC), initially formed in 2006, is combining with the cohort members of the Government Alliance for Race Equity (GARE), which includes HHSA and other city and county agency staff, law enforcement, Napa Valley Unified School District, Napa Valley College and elected officials. HHSA is going into a fourth year of GARE learning, and has invited community-based organizations to join the cohort starting in January 2019. This new group will be a new committee, the Diversity, Equity & Inclusivity (DEI) Committee. DEI will continue to work on aspects of the older Diversity Strategic Plan as well as creating new recommendations. The GARE Cohorts created a Racial Equity Action Plan (**see Appendix 3**) that will be modified to integrate elements from HHSA's Diversity Initiative (**see Appendix 2**) for a combined DEI Action Plan. HHSA recently approved the new Race and Cultural Equity Policy and Procedure and was implemented in November of 2018 (**see Appendix 3**) and is currently being updated by the HHSA Diversity, Equity and Inclusion Committee.

The HHSA Diversity Initiative Strategic Plan is a multi-year plan that contains twenty-one recommendations, each containing implementation steps, staff resources, and estimated funding amounts. It is a roadmap to create an Agency culture that embraces and understands the rich diversity of our community. It will provide the design to implement structures, practices and policies to minimize barriers, and provide the best possible service to the Napa County community while meeting the expectations and legal requirements of the various stakeholders of this process. The recommendations are organized into five sections, which address the following areas from a Diversity perspective:

1. Organizational Development
2. Leadership Workforce Development
3. Standards and Training
4. Access to Quality Care
5. Diversity Program Infrastructure

Staff, agency partners and clients brought years of experience, passion and innovative thinking to create this plan. The research done to create the recommendations resulted in many heartfelt, compassionate comments as well as concerning facts, which helped identify where the implementation energy and resources should be placed. The recommendations have been sequenced over a four-year period to assure the implementation has the greatest impact, is manageable and sustainable. Although the recommendations have been developed with some flexibility, they complement one another and work in concert. Hence, to achieve the best possible results, the temptation to select two or three recommendations to implement first while waiting to see what else could be accomplished in following years should be avoided. These recommendations work together as a system of change – for example, accountability and education go hand-in-hand.

Recommended steps have been developed in a way to allow flexibility when it is determined that a step is not feasible due to budgetary or Departmental constraints or concerns without having to delay the entire recommendation. The cost associated with many of the recommendations is variable. The table below shows the flexibility possible in determining the range of fiscal resources needed for each recommendation over the course of the first four years.

**Table 24**

#	Activity	High Cost	Low Cost
R-1	Foster a safe and supportive working environment by building and strengthening relationships	> \$50,000	\$25,000
R-2	Establish a feedback process for instances of perceived intolerance	\$0	\$0
R-3	Provide a structure for increasing communication on diversity issues	\$0	\$0
R-4	Ensure Accountability for Diversity and Cultural Competency	\$0	\$0
R-5	Create an employee task force that focuses on bilingual workload issues	\$0	\$0
R-6	Develop transparent and equitable career and advancement opportunities that further diversify the HHSA workforce and meet the present and future needs of the Napa County community.	\$5,000	\$0
R-7	Recruit and retain adequate staffing to meet the needs of the community	>\$50,000	\$10,000
R-8	Create and implement a comprehensive, agency-wide training plan on diversity & cultural competency	>\$50,000	>\$50,000
R-9	Expand access and outreach opportunities to underserved populations	>50,000	\$5,000
R-10	Provide translation, forms and publications sensitive to dimensions and languages	\$25,000	\$5,000
R-11	Support Multi-level Client/Consumer Involvement	>\$50,000	\$5,000
R-12	Promote an inviting and functional atmosphere for all clients	>\$50,000	\$10,000
R-13	Improve County presence and services Up Valley and in American Canyon	>\$50,000	\$5,000
R-14	Diversity Program Infrastructure – Diversity Steering Committee	\$10,000	\$5,000
R-15	Diversity Program Infrastructure - QM Plan	\$0	\$0
R-16	Diversity Program Infrastructure – Diversity Officer	>\$300,000	>\$300,000

R-17	Perform periodic community and program assessments to identify needs and disparities in care to inform program planning for Napa County's diverse population	\$50,000	\$5,000
R-18	Improve County Collaboration with Napa County Unified School Districts and Napa County Office of Education	\$1,000	\$0
R-19	Improve relations with community-based organizations.	\$25,000	\$5,000
R-20	Improve coordination of client services between County HHSA and CBOs and other external agencies	\$1,000	\$0
<b>R-21</b>	Develop a central client registry of HHSA clientele.	>\$50,000	>\$50,000

**A. If so, briefly describe how the Cultural Competence Committee integrates with the county mental health system by participating in and reviewing MHSA planning process.**

The Behavioral Health Cultural Competence Committee will participate in and review the MHSA planning process by having a representative from this committee attend MHSA Stakeholder Advisory Committee meetings and report to the BHCC Committee and the Quality Improvement Committee.

**CRITERION 5  
COUNTY MENTAL HEALTH SYSTEM CULTURALLY  
COMPETENT TRAINING ACTIVITIES**

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

**I. The county system shall require all staff and shall invite stakeholders to receive annual cultural competence training. The county shall include the following in the CCPR Modification (2010):**

**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).**

**Steps the county will take to provide required cultural competence training to 100% of their staff**

**1. How cultural competence has been embedded into all trainings.**

Napa County formally began addressing racial inequity in 2007 with the development of its Diversity and Inclusion Strategic Plan and, since 2010, Napa County has greatly accelerated their racial equity agenda. The Health and Human Services Agency (HHSA) has served as the catalyst for advancing racial equity and created the Diversity and Inclusion Initiative to better serve an increasingly diverse population. Napa developed the initial business case for Diversity and Launching Diversity, as initiating its Inclusion Foundation Training in the summer of 2011.

Before partnering with the national Government Alliance for Racial Equity (GARE), HHSA took an outside in approach to affecting structural change in government by working closely with local nonprofits. HHSA partnered with community groups such as LGBTQ Connection, to develop services surrounding LGBTQ issues. In 2014, LGBTQ Best Practices was launched and now serves as a statewide model for service provisions. At the same time, the Collaborative Management Committee, born out of the Diversity and Inclusion Strategic Plan, began tackling the issues of health equity and Social Determinants of Health. The Diversity and Inclusion team worked with the collective impact initiative, Live Healthy Napa County, to address one of inequity's root causes, Race and Culture. In 2015, the Health and Human Services Agency launched a "Power, System, Culture" training to educate all of the divisions on the necessity of shifting Agency culture to normalize and operationalize conversations surrounding race.

Going from education to action, in 2015, the Diversity and Inclusion Steering Committee (DISC) collaborated with the Public Health Officer and proposed to Agency leadership implementation of the Bay Area Regional Health Inequities Initiative (BARHII) Agency Self-Assessment. This assessment was designed by a collaborative of local Public Health departments to help organizations establish a baseline for determining how well they were addressing the Social Determinants of Health based on information from employees, community partners, document and policy review to create a plan for addressing issues found as a result. HHSA became the first organization in the Bay Area to complete the BARHII assessment in its entirety and found notable discrepancies of life expectancy relative to income, which is largely driven by factors such as education, historic and current real estate practices, and race.

In an effort to continue the progress it had made in creating an organizational focus and transition towards an upstream prevention model of doing business that is inclusive, a small team of HHSA employees and one

member of the County Executive Office engaged in GARE's 2016-17 Learning Year.\

The initial HHSa GARE cohort created and began taking action on a Race and Cultural Action Plan it developed during the Learning Year. The plan encompasses the following areas:

- 1) Training and Infrastructure
- 2) Inclusive Engagement (Internal and External)
- 3) Workforce Equity
- 4) Healthy Outcomes (with a focus on food security initially)

GARE's training equipped HHSa with the tools to start setting goals and track measurable progress with the recognition that strategies must be targeted to close particular racial equity gaps. This work helped to change the internal culture and normalize conversations around systems and structures that are failing to adequately serve communities of color, LGBTQ individuals and other underserved/unserved populations.

Napa's HHSa training curriculum was developed out of the work of initial HHSa GARE cohort who attended the train-the-trainer sessions. Currently, training on race and culture are mandatory for the entire agency and started in November 2015. Half-day trainings are required within 90 days of hiring for all new employees including *Diversity Foundation Training* and *LGBTQ Best Practices*. Additionally employees participate in the *HHSa in the 21<sup>st</sup> Century* training series, which consists of three half-day trainings: Implicit Bias, Cultural Intelligence, and Emotional Intelligence and Teams. These trainings provide a basic foundation that equips each employee with the tools and understanding to work in a diverse environment.

HHSa sponsored a second GARE cohort for the 2017-2018 Learning Year that is comprised of HHSa staff from Divisions not previously represented, other County departments (Probation, Human Resources), Napa Valley College, Napa Valley Unified School District and key community based organizations such as On The Move and Up Valley Family Centers. HHSa recognized that it could not be successful in achieving the Agency and County Vision, Mission, or Goals without inclusive partnership within the organization and with our external community partners. Currently, the two GARE cohorts have begun working on the initial steps of each action plan goal. HHSa will also be sponsoring a third cohort for the 2018-19 Learning Year.

The cultural competence efforts mentioned above have produced a variety of cultural competence training implementations, these include:

- NCMHP participates in Racial and Cultural Equity Staff Development Program (Core Workshop Series), which consists of eight hours of training. The workshops focus on learning of Implicit Bias, Cultural Intelligence and Emotional Intelligence to support Racial and Cultural Equity. Other topics include Institutionalized and Systematic Racial Inequity. All NCMHP staff are required to attend these workshops.
- NCMHP staff are required to participate in overarching HHSa trainings, led by the Training and Organizational Development Unit in partnership with the Diversity and Inclusion Steering Committee. The *HHSa in the 21<sup>st</sup> Century* training consists of three workshops, each being two hours long. These workshops focus on, implicit bias, cultural intelligence and emotional intelligence and are meant to sustain organizational change.
- NCMHP participates in GARE (Appendix 3), a national network of government working to achieve racial equity and advances systematic opportunities for all. Since 2016, NCMHP has participated in helping develop a racial equity-training curriculum for staff. The GARE action plan consists of four different components, one of the component "Jurisdiction's employees understand, are committed to and have the infrastructure needed to advance racial equity." This component's goals include develop racial equity training curriculum and training tram, provide training on implicit bias, cultural intelligence, emotional intelligence, resiliency and more.

- The Multi-Lingual Taskforce reported and assessed data regarding the issues and concerns raised by bilingual and non-bilingual employees. The taskforce has developed and implemented recommendations to help overcome the barriers that affect timely and efficient delivery of culturally

and linguistically appropriate services to the population we serve. The taskforce has focused on translation and interpretation, training, bilingual certifications and inclusion. The taskforce has brought forward obstacles faced by bilingual staff members and has put forth specific recommendations that include a more culturally and linguistically holistic training approach:

- Multi-Lingual Task Force Recommendations: Offer ongoing training to all employees in the following areas –
  - Ongoing training to supervisors and manager on how to support bilingual employees (bilingual staff can give training recommendations even offer examples of vignettes that can be used in training)
  - Create a culturally relevant service standard (inclusive of cultural and socioeconomic status) to support and inclusive environment across HHSA
  - Discussion and training on diversity dimensions as an effective strategy in preparing people to offer place-based services and reduce any potential trauma employees may cause individuals or other employees should they not be prepared or willing to examine their biases.
  - Need for progressive discipline should training and supports not prove effective for employees (a separate process is in development by the Collaborative Management Ambassador group). Use Individual Development Plans as a tool to ensure training needs are met.
  
- In partnership with NCMHP, contractors and PEI providers also provide cultural competency trainings and workshops. Trainings include such workshops as Cultural Competency and Cooperation with Native American Communities, which focuses on training mental health providers on Native American history, healing practices and resiliency. A second example of contracted provider trainings includes the Suicide Prevention Conference hosted by Aldea. The conference assists those working in the medical profession to recognize the signs indicating that someone is at risk of suicide.

Below is a partial summary of trainings attended by Direct Services and Administration staff for more documentation please see **Appendices 20 and 25**.

**Table 25**  
**2019 HHSA Cultural Competency Trainings and Workshops**

Title	Duration	Description	Trainers
HHSA in the 21st Century: Emotional/Cultural Intelligence and Implicit Bias	4	<p><u>Cultural Intelligence:</u></p> <ul style="list-style-type: none"> <li>• Learn skills to quickly develop rapport and work effectively with people from any group.</li> <li>• Become aware of how individual backgrounds, biases and assumptions impact working with other people, and learn how to filter out those biases and assumptions.</li> <li>• Develop a more culturally intelligent mindset and increase cultural adaptability and resilience.</li> </ul> <p><u>Emotional Intelligence:</u></p> <ul style="list-style-type: none"> <li>• To learn the principles of EI and how to utilize this approach to better serve clients and interact with one another</li> <li>• Examine pre workshop test results to increase self awareness of EI</li> <li>• Identify EI examples that create barriers in the workplace</li> <li>• Become more proactive when working with clients from diverse backgrounds</li> </ul> <p><u>Implicit Bias:</u></p> <ul style="list-style-type: none"> <li>• Develop a keen awareness of how unconscious bias impacts professional relationships and service delivery.</li> <li>• Build skills at moving beyond the constraints of bias toward a more connected, inclusive professional response in working with clients.</li> </ul>	T&OD Staff with HHSA staff

HHSA LGBTQ Best Practices Workshop	4	This training assists agency staff wishing to implement research-based and community-defined practices effective in serving LGBTQ clients and families. The training explores vocabulary and linguistic considerations, provides essential information about sexual orientation, sexual identity, gender identity and expression and intersections of those issues with health and social services systems. Recommended practices for inclusion of LGBT Q clients are presented along with action steps and examples to help carry them out.	Contractor - On The Move
Let's Talk... A dialogue about race, racism, and culture	4	Racial and Cultural Equity CORE 1 - Let's Talk! A dialogue about race, racism and culture  HHSA has approached our equity work through a lens of power, culture and systems. As we continue to examine our systems through these lenses, we will need to be able to have open and honest conversations regarding race, racism and culture. The work of advancing equity depends on our ability to have these conversations in a way that moves us to action.	T&OD Staff with HHSA staff
Non-Violent Crisis Intervention for Alpha Responders, Managers & Supervisors	4	*This course is for Managers, Supervisors, and Alpha Responders only*  Please do not register unless you are a Manager, Supervisor or Alpha Responder  In this course, designed for Managers, Supervisors and Alpha Responders, employees will learn to how to  <ul style="list-style-type: none"> <li>· identify behavior that indicates an escalation toward aggressive and violent behavior</li> <li>· take appropriate measures to avoid, decelerate, and/or de-escalate situation</li> <li>· assess the level of risk associated with crisis behavior and make appropriate decisions related to the management of such risks</li> </ul> This course will also describe what to do before, during and after a workplace violence event. This training in 6 hours long.	T&OD Staff with HHSA staff
The System of Racial Inequity	4	Racial and Cultural Equity CORE 2 - The System of Racial Inequity  The System of Racial Inequity is a starting place for understanding structural racism. When different access becomes integral to institutions and systems, it becomes common practice, making it difficult to rectify. This workshop will provide a frame to support better understanding of the systems that perpetuate racial and cultural inequities and how they may show up in our own systems.	T&OD Staff with HHSA staff
Sexual Orientation and Gender Identity (SOGI) Training for HHSA	2	2 hour workshop, combining interactive presentation and practice, to help our employees understand and collect SO/GI information. This builds on what was covered in the LGBTQ Best Practices workshop already offered to all HHSA employees.	Contractor - On The Move

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

**The county shall include the following in the CCPR Modification (2010):**

**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.**

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

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

The NCMHP has sponsored Client Culture trainings in the past and has incorporated them into Annual Compliance Trainings (see **Appendix 25**). NCMHP is in the process of developing a training plan based on input from our WET Needs Assessment (see the following page), which will include Client Culture Trainings.

## Training Recommendations from WET Needs Assessment

### Training and Technical Assistance

- Develop a Train the Trainers Academy to increase local training capacity on the following topics:
  - o Facilitation Training
  - o Project Management
  - o Coaching/Mentoring
  - o Curriculum development
  - o Coordination of local/regional trainings
- Support for MH Division or Contractor Training Academy
  - o See training topic areas below
- Supervisor Academy
  - o Managing the job and staff to avoid burnout (yours and theirs)
  - o Time management for supervisors and line staff
  - o Clinical Supervision
  - o Fidelity to Best Practice Models
  - o Compassion Fatigue
  - o Stress Management and Self-Care

### Cultural Competence Training Topic Areas

- **Working with various populations**
  - o Older Adults
  - o Veterans
  - o Disabled
  - o Homeless
  - o LGBTQ
  - o Foster youth
  - o Criminal justice
  - o Latinos
  - o Asian/Filipinos
  - o Pacific Islanders
- **Suggestions for Training Modalities**
  - o One/two day lecture/workshop
  - o Panel discussions
  - o Mentoring/Shadowing
  - o On-line/E-Learning
  - o Cross-training w/other counties
- **Training Topics from Workforce Needs Assessment (in relative order of importance as indicated on WET Survey)**
  - **Core/Foundational Trainings (n=97)**
    1. Wellness, Recovery, and Resiliency
    2. Crisis Management and Safety
    3. Cultural Competency
    4. Service Excellence
    5. Consumers/Family Members as Providers and Colleagues (Dual Relationships)

**Clinical Skills Trainings (n=90)**

1. Assessment, Diagnosis and Level of Care
2. Co-Occurring Disorders
3. Clinical Documentation
4. Wellness and Recovery Action Plans
5. Basic Psychopharmacology
6. Cultural Competence in Assessment and Services
7. Psychosocial Rehabilitation
8. Clinical Supervision
9. Autism Spectrum Disorder

**Specific Intervention Trainings (Best/Evidence-Based Practices) n=89**

1. Motivational Interviewing
2. Cognitive Behavioral Therapy
3. Dialectical Behavior Therapy
4. Wraparound
5. Anger Management for children and adolescents
6. Play Therapy
7. Simple Best Practice Evaluation Tools
8. Gero-Psychology
9. Stigma/Discrimination Reduction

**Leadership/Management Trainings (n=85)**

1. Communication Skills
2. IT Management and Understanding
3. Organizational Awareness and Development
4. Team Management
5. Change Management
6. Staff Supervision
7. Project Management
8. Presentation Skills
9. Financial Skills/Budgets

**Other Training Suggestions**

1. How to deal with vicarious traumatization
2. How to work with resistant clients
3. Community Resources
4. How to involve parents and family members in client's recovery
5. Windmills Management Training (helps organizations hire people with disabilities)
6. How to improve communication/relationships with community providers

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

**Rationale:** The diversity of an organization's staff is necessary, but not a sufficient condition for providing culturally and linguistically appropriate health care services. Although hiring bilingual individuals from different cultures does not in itself ensure that the staff is culturally competent and sensitive, this practice is a critical component to the delivery of relevant and effective services for all clients. Staff diversity at all levels of an organization can play an important role in considering the needs of clients from various cultural and linguistic backgrounds in the decisions and structures of the organization. (CLAS, Final Report).

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

**The county shall include the following in the CCPR Modification (2010):**

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

NCMHP is currently working on developing a new WET Assessment. Most of the data in this section was retrieved from the last WET Assessment conducted in 2010, as most findings continue to be relevant to NCMHP. Please see **Appendix 9** for a summary of responses to a WET Survey requested by the Office of Statewide Health Planning and Development (OSHPD) Healthcare Workforce Development Division, which is developing the 2020-2025 Mental Health Services Act (MHSA) Workforce Education and Training (WET) Five-Year plan. The NCMHP's current WET Plan can also be found in **Appendix 9**.

**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.**

B. Comparison of data from the WET Plan assessment and general population, Medi-Cal population, and 200% of poverty data.

The following six charts show each of the six categories from the WET Plan charts and compare the percentage of FTEs in each category with the percent of that category in the general population, in the Medi-cal eligible population, and in the 200% Below Poverty Level (BPL) minus Medi-cal population.

**Table 26 - White/Caucasian statistics**

# County Staff, Direct Services	Total FTE	# FTEs of all White/Caucasian County Staff	% of FTEs by Classification and total	% White/Caucasian in the general population	% White/Caucasian 200%	% White/Caucasians Medical Eligible
Licensed	40.9	33.1	80.9			
Unlicensed	13.1	5.9	45.0			
Support	12	9.6	80.0			
Total	66	48.6	73.6%	56.39%	41.2%	35.3%

White/Caucasians make up approximately 74% of all staff members, but only 56% of the general population, 41% of those falling 200% or more below the BPL, (minus Medi-Cal population), and only 35% of Medi-cal Eligibles. Staff percentages do not appear to be influenced by the demographics of college graduates with social work degrees, (see Figure 51 from Integrated Post-Secondary Education system), although further research into graduation rates for related disciplines would be needed to develop a better understanding of the relative percentages of employees and graduates in the human services field.

**Table 27 - Latino/Hispanic Statistics**

# County Staff, Direct Service	Total FTE	# f FTEs: Hispanic County	% of FTEs by Classification and	% Hispanics in the general	% Hispanics 200%	% Hispanics Medi-cal
Licensed	40.9	3.1	7.6			
Unlicensed	13.1	7.2	54.9			
Support	12	1.2	10			
<b>Total</b>	<b>66</b>	<b>11.5</b>	<b>17.4%</b>	<b>32.25%</b>	<b>56.1%</b>	<b>54.2%</b>

Latino/Hispanics make up approximately twice the percentage of the general population as they do for all employees, although the difference appears to be primarily in licensed clinical and support staff. Unlicensed clinical staff percentages more closely mirror Hispanic percentages of the 200% BPL and Medi-cal eligible population, and far exceed Hispanic percentages of the general population.

**Table 28 - African American Statistics:**

# County Staff, Direct Service	Total FTE	# FTEs: African American County	% of FTEs by Classification and	% African American in the general population	% African American 200% BPL (minus Medi-Cal)	% African American Medi-
Licensed	40.9	1.7	4.2			
Unlicensed	13.1	0	0			
Support	12	0	0			
<b>Total</b>	<b>66</b>	<b>1.7</b>	<b>2.6%</b>	<b>1.8%</b>	<b>.46%</b>	<b>2.1%</b>

African American staff all fall into the —licensed category, and the percentages of staff exceeds the percentages found in the general population, 200% BPL, and the Medi-cal eligible populations.

**Table 29 - Asian/Pacific Islander Statistics:**

# County Staff, Direct Service	Total FTE	# FTEs: Asian/Pacific Islander County Staff	% of FTEs by Classification and total	% Asian/Pacific Islander in	% Asian/Pacific Islander 200% BPL (minus Medi-Cal)	% Asian/Pacific Islander
Licensed	40.9	1.6	3.9%			
Unlicensed	13.1	0	0%			
Support	12	1.2	10%			
<b>Total</b>	<b>66</b>	<b>2.8</b>	<b>4.2%</b>	<b>6.6%</b>	<b>2.4%</b>	<b>4.6%</b>

Asia/Pacific Islander staff percentages fall below of Asian/Pacific Islanders percentages of the general population, and exceed those of the 200% BPL and Medi-cal eligible populations.

**Table 30 - Native American Statistics:**

# County Staff, Direct	Total FTE	# Native American FTEs: County Staff	% of FTEs by Classification and	% Native American in the general	% Native American 200% BPL (minus Med— Cal population)	% Native American Medi-
Licensed	40.9	0	0%			
Unlicensed	13.1	0	0%			
Support	12	0	0%			
Total	66	0	0%	.40%	%6.7	.40%

The NCMHP does not have any Native American staff members.

**Table 31 - Multi-Race/Other Statistics**

# County Staff, Direct Services	Total FTE	# Multi-Race/Other FTEs: County Staff	% of FTEs by Classification and	% Multi-Race/Other in the general	% Multi-Race/Other 200% BPL (minus Med— Cal population)	% Multi-Race/Other Medical Eligible
Licensed	40.9	1.4	3.4%			
Unlicensed	13.1	0	0%			
Support	12	0	0%			
Total	66	1.4	2.1%	2.59%	0%	3.4%

The percentage of staff members identifying as —Multi-Racial/Other roughly match those in the general population, exceed those in the 200% BPL (minus the Medi-cal) population, but fall short of this populations percentage of Medi-cal Eligibles.

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

The NCMHP's WET component provided one-time, dedicated funding to address the education and training needs of the publicly funded mental health workforce that includes community based organizations and individual providers who, together with the Mental Health Division staff, collectively comprise Napa County's publicly funded mental health system workforce.

The local stakeholder approved WET Actions consisted of the following:

- Action 1 – Consumer Trainer/Work Experience Coordinator
- Action 2 – Staff Development/Training of Trainers
- Action 3 – E-Learning
- Action 4 – Spanish Language Training
- Action 5 – the Psychosocial Rehabilitation (PSR) Certification Program
- Action 6 – Mental Health Division Internship Program
- Action 7 – Stipends, Employment and Educational Incentives

Most of the NCMHP's WET Actions have already been completed. The remaining Actions consist of the Internship Program (Action 6) and the Stipends, Employment and Educational Incentives (Action 7). With such a small number of MSW graduates nationwide and facing competition from other Bay Area counties that can pay larger salaries for employees, the NCMHP has focused on a variety of strategies to "grow our own" staff from our community as well as interns including:

- Internship Program, Intern Stipends, which recruit between four to six MFT and MSW students, with a preference interns from a diverse ethnic and cultural background, who complete their clinical internships with NCMHP. Many interns have been hired over the years for permanent positions with NCMHP.
- Office of Statewide Health Planning and Development's (OSHPD) Mental Health Loan Assumption program
- Partnership with the Greater Bay Area Mental Health and Education Collaborative to host Mental Health School to Career Conferences for local high school students who may be interested in exploring careers in the Mental Health field.
- California Social Work Education Center (CalSWEC) Stipend
- Hiring for MHSA and other NCMHP positions
- Review of vacant positions to determine if they would be appropriate for bilingual preferred or bilingual only designation.

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

While the NCMHP has made extraordinary progress in hiring and retaining bilingual staff to provide culturally appropriate services to Latino/Hispanic residents as well as other unserved/underserved community members, there is still more work to be done for our staff to reflect the diversity of our community. For example, there is a rapidly growing Filipino community in our southernmost city of American Canyon. While Tagalog is not yet a Threshold Language, it is an emerging language.

E. Identify county technical assistance needs

The MHP could benefit from technical assistance related to improving recruitment and hiring practices to attract more bilingual applicants for positions as they become vacant

**CRITERION 7  
COUNTY MENTAL HEALTH SYSTEM LANGUAGE CAPACITY**

**Rationale:** Accurate and effective communication between clients, providers, staff, and administration is the most essential component of the mental health encounter. Bilingual providers and other staff who communicate directly with clients must demonstrate a command of both English and the threshold language that includes knowledge and facility with the terms and concepts relevant to the type of encounter (CLAS, Final Report). The DMH will provide threshold language data to each county

**I. Increase bilingual workforce capacity**

**The county shall include the following in the CCPR Modification (2010):**

**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.**

In an effort to address the language needs of our community, NCMHP makes every effort to hire bilingual staff proportionate to the Limited English Proficiency (LEP) community ratio. NCMHP informs its hiring process based on data from the Profile of Immigrants in Napa County, about a third of Napa County's population is considered LEP. In the last few years, NCMHP focused on hiring bilingual staff proportionate to this LEP ratio. About one third of NCMHP staff is bilingual and are able to provide culturally and linguistically competent services to the consumers.

In addition to the strategies listed previously in Criterion 6, the NCMHP's WET Programs included **Action #4: Spanish Language Training Program**, which was requested by staff, who expressed a desire to receive Spanish language training. The goal of the Spanish Language Training Program was not to help staff become fluent in Spanish. Rather it was intended to improve the ability of non-Spanish speaking staff (receptionists, mental health worker aides, case managers, psychiatrists, etc.), and providers to communicate more effectively with Spanish-speaking consumers and family members in order to improve the quality of services offered to this underserved/unserved population. NCMHP worked with Napa Valley Adult Education to develop a customized Spanish language training curriculum for the mental health workforce. The training had introductory levels for staff with no previous experience speaking Spanish so they could greet Spanish-speaking consumers in Spanish and make them feel welcome. The training also had an intermediate level for staff who had previous experience speaking Spanish or receiving Spanish language instruction.

The NCMHP is currently in the process of conducting an updated Workforce Education and Training (WET) Needs assessment, which we anticipate will be completed in 2020. The assessment will focus on determining culturally competency and linguistic training needs of the NCMHP workforce. One of the workforce assessment goals is to update the list of training gaps and needs that may be helpful for the mental health workforce in order to provide culturally and linguistically equitable and effective services that meets the needs of mental health consumers in our community.

**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.**

Currently, 29 NCMH staff members speak and have been tested/certified and are eligible to provide interpretation assistance.

<b>Position</b>	<b>JobTitle</b>	<b>Language</b>	<b>Level</b>
00000881	MENTAL HLTH COUNSELOR-LICENSED	Spanish	2
00001975	SUPV MENTAL HLTH CO II-LICENSE	Spanish	2
00002289	SUPV MENTAL HLTH CO II-LICENSE	Spanish	2
00000918	STAFF NURSE	Spanish	1
00002015	MENTAL HEALTH WORKER II	Spanish	2
00001977	MENTAL HEALTH WORKER II	Spanish	2
00001978	MENTAL HEALTH WORKER II	Spanish	2
00002502	MENTAL HLTH COUNSELOR-LICENSED	Spanish	2
00002055	MENTAL HLTH COUNSELOR-LICENSED	Spanish	2
00002021	MENTAL HLTH COUNSELOR-LICENSED	Spanish	2
00002542	MENTAL HLTH COUNSELOR-REGISTER	Spanish	2
00002435	MENTAL HLTH COUNSELOR-LICENSED	Spanish	2
00001287	MENTAL HLTH COUNSELOR-LICENSED	Spanish	2
00002402	MENTAL HLTH COUNSELOR-REGISTER	Spanish	2
00002071	MENTAL HEALTH WORKER II	Spanish	2
00000875	FORENSIC MENTAL HEALTH COUNSEL	Spanish	2
00002438	MENTAL HEALTH WORKER AIDE	Spanish	2
00001367	MENTAL HLTH COUNSELOR-LICENSED	Spanish	2
00001489	MENTAL HLTH COUNSELOR-REGISTER	Spanish	2
00002230	MENTAL HLTH COUNSELOR-REGISTER	Spanish	2
00002320	MENTAL HEALTH WORKER AIDE	Spanish	1
00001976	MENTAL HEALTH WORKER AIDE	Spanish	1
00000894	MENTAL HLTH COUNSELOR-REGISTER	Spanish	1
00000891	MENTAL HLTH COUNSELOR-REGISTER	Spanish	1
00000885	MENTAL HLTH COUNSELOR-LICENSED	Spanish	1

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

The NCMHP Contract for AT&T Language Line Interpreting Services is for \$5,604.77

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

**The county shall include the following in the CCPR Modification (2010):**

**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:**

NCMHP maintains a 24-hour phone line with statewide toll-free access that has linguistic capability, including TDD or California Relay Service, at all key points of access, and for all individuals. (See **Appendix 6** for the Interpretation and Translation Assistance Requirements for Mental Health Services Policy and AT&T Language Line Procedures.)

Policy:

“It is the policy of the Napa County Mental Health Plan (MHP) to provide culturally competent interpretation and translation assistance to individuals seeking or receiving mental health services, including those who do not meet the threshold language criteria, those who have limited English proficiency (LEP), or those who have other language or communication barriers (i.e., visual or hearing impaired), in a manner that affords equal access to these services. “

Procedure:

“The MHP shall maintain availability and access to language services 24 hours per day, seven days per week, depending on the business hours of the program, as to avoid delay in service to benefit LEP individuals.”

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.**

Because NCMHP does not have sufficient bilingual capacity to cover all in-person interpretation needs, we have made the decision to utilize the AT&T Language Line as the last resort when all other options have been explored. See **Appendix 6** for the Interpretation and Translation Assistance Requirements for Mental Health Services Policy and AT&T Language Line Procedures.)

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.**

**Appendix 6** provides the protocol for implementing language access through the county’s 24 hour phone line. After hours, a message in both English and Spanish advises the caller to leave contact information on the answering machine, or to dial 1 for psychiatric emergencies, where a live staff member will take the call and utilize the language line if necessary to facilitate communication.

**B. Evidence that clients are informed in writing in their primary language, of their rights to language assistance services.** Clients are informed about their rights to language assistance services in their primary language through posters in all key points of access that advise them to point to the text representing their primary language. The poster includes text in twenty languages. The AT&T language line is then utilized when a bilingual staff interpreter is not available. Additionally, the Guide to Medical Mental Health Services (**Appendix 19**) is provided to every served individual at the time of enrollment. The local section of this guide provides contact numbers within NCMHP for requesting information in various languages and formats, and is available in English, Spanish, large and regular fonts, and in CD (Sound) formats in both English and Spanish. The State section of the guide informs readers or listeners that services in the language of their choice or by an interpreter (if necessary) free of charge and lets individuals know that these interpreter services are available, as well as NCMHP’s commitment to providing them with written information about what is available to them in other languages or forms, depending upon the needs in their county.

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

The table below is a listing of 29 bilingual staff who are certified to provide interpreter and translation services to consumers who have LEP in NCMHP. All staff is certified in the Spanish language.

Description	ID	Position	Job Title	Level
HHSA - MENTAL HEALTH	11663	00000881	MENTAL HLTH COUNSELOR-LICENSED	2
HHSA - MENTAL HEALTH	11750	00001975	SUPV MENTAL HLTH CO II-LICENSE	2

HHSA - MENTAL HEALTH	12670	00002289	SUPV MENTAL HLTH CO II-LICENSE	2
HHSA - MENTAL HEALTH	12888	00000918	STAFF NURSE	1
HHSA - MENTAL HEALTH	13649	00002015	MENTAL HEALTH WORKER II	2
HHSA - MENTAL HEALTH	13731	00001977	MENTAL HEALTH WORKER II	2
HHSA - MENTAL HEALTH	14040	00002714	MEDICAL SECRETARY	2
HHSA - MENTAL HEALTH	14205	00002533	SECRETARY	1
HHSA - MENTAL HEALTH	14357	00001978	MENTAL HEALTH WORKER II	2
HHSA - MENTAL HEALTH	15039	00002502	MENTAL HLTH COUNSELOR-LICENSED	2
HHSA - MENTAL HEALTH	15050	00002055	MENTAL HLTH COUNSELOR-LICENSED	2
HHSA - MENTAL HEALTH	15158	00002021	MENTAL HLTH COUNSELOR-LICENSED	2
HHSA - MENTAL HEALTH	15907	00002542	MENTAL HLTH COUNSELOR-REGISTER	2
HHSA - MENTAL HEALTH	15990	00002435	MENTAL HLTH COUNSELOR-LICENSED	2
HHSA - MENTAL HEALTH	16172	00001287	MENTAL HLTH COUNSELOR-LICENSED	2
HHSA - MENTAL HEALTH	16805	00002402	MENTAL HLTH COUNSELOR-REGISTER	2
HHSA - MENTAL HEALTH	16912	00002071	MENTAL HEALTH WORKER II	2
HHSA - MENTAL HEALTH	17140	00000875	FORENSIC MENTAL HEALTH COUNSEL	2
HHSA - MENTAL HEALTH	17221	00002438	MENTAL HEALTH WORKER AIDE	2
HHSA - MENTAL HEALTH	17453	00001367	MENTAL HLTH COUNSELOR-LICENSED	2
HHSA - MENTAL HEALTH	17723	00002274	STAFF SERVICES ANALYST I	1
HHSA - MENTAL HEALTH	18136	00001489	MENTAL HLTH COUNSELOR-REGISTER	2
HHSA - MENTAL HEALTH	18380	00002230	MENTAL HLTH COUNSELOR-REGISTER	2
HHSA - MENTAL HEALTH	18558	00002234	STAFF SERVICES ANALYST II	2
HHSA - MENTAL HEALTH	18787	00002320	MENTAL HEALTH WORKER AIDE	1
HHSA - MENTAL HEALTH	18849	00001976	MENTAL HEALTH WORKER AIDE	1
HHSA - MENTAL HEALTH	18868	00000894	MENTAL HLTH COUNSELOR-REGISTER	1

HHSA - MENTAL HEALTH	18886	00000891	MENTAL HLTH COUNSELOR-REGISTER	1
HHSA - MENTAL HEALTH	19008	00000885	MENTAL HLTH COUNSELOR-LICENSED	1

The County's contract with AT&T accommodates persons with interpreter services when one of NCMHP's bilingual staff is unavailable. The figure below shows the 24/7 access line, face to face services and telephonic services utilization from September 2018 through November 2018. The services were used 70 times. Spanish services were the most needed with 49 interpretations. The second language most used was Portuguese with 6 interpretations. The third language most needed was Chinese with one interpretation. There were a total of 43 access line services, 12 face to face services and 15 telephonic services between this time period.

<b>Reporting Period</b>	<b>September 1,2018-November 31,2018</b>			
<b>Language</b>	<b>24/7 Access Line</b>	<b>F2F Services</b>	<b>Telephonic Services</b>	<b>Total</b>
Chinese	0	0	1	1
Portuguese	5	1	0	6
Spanish	38	11	14	63
<b>Total</b>	<b>43</b>	<b>12</b>	<b>15</b>	<b>70</b>

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

While it's difficult to ascertain the extent to which some mentally ill LEP individuals decide not to seek services because of the perception that LEP services are unavailable, it does appear as though NCMHP has successfully met the challenges inherent in providing those services to those individuals it identifies as LEP. There have been no identified instances of an individual being denied services due to a language barrier.

**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)**

The county is in need of document translation services.

**III. Provide bilingual staff and/or interpreters for the threshold languages at all points of contact. Note: The use of the language line is viewed as acceptable in the provision of services only when other options are unavailable. Counties should train their staff for the proper use of language lines but should seek other options such as training interpreters or training bilingual community members as interpreters.**

**Appendix 6** provides the policy and protocol for implementing language line access through the county's 24 hour phone line. After hours, a message in both English and Spanish advises the caller to leave contact information on the answering machine, or to dial 1 for psychiatric emergencies, where a live staff member will take the call and utilize the language line if necessary to facilitate communication.

**The county shall include the following in the CCPR Modification (2010):**

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

Interpreter service posters in 21 languages are posted in all lobbies. The attached policy (**Appendix 4**), Cultural and Linguistic Competency Requirements for Mental Health Services, provides the procedure by which NCMHP makes interpreter services available. Refer back to list of NCMHP's bilingual staff, provided in section above.

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

The Cultural and Linguistic Competency Requirements policy states that staff will document in a progress note any responses to offers of interpreter services and any steps taken to provide the services. Based on protocol, NCMHP staff develops wellness recovery actions plans that are client centered and that are written in a way that is culturally sensitive and linguistically acceptable by consumer. **Appendix 6** contains the Interpretive Services Disclosure form as documented evidence that interpreter services are offered and provided to clients. Response to the offer is contained evidenced by the provision of the service.

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

The list below displays certified bilingual staff who work between the hours of 8am and 5pm Monday through Friday.

Description	ID	Position	Job Title	Level
HHS - MENTAL HEALTH	11663	00000881	MENTAL HLTH COUNSELOR-LICENSED	2
HHS - MENTAL HEALTH	11750	00001975	SUPV MENTAL HLTH CO II-LICENSE	2
HHS - MENTAL HEALTH	12670	00002289	SUPV MENTAL HLTH CO II-LICENSE	2
HHS - MENTAL HEALTH	12888	00000918	STAFF NURSE	1
HHS - MENTAL HEALTH	13649	00002015	MENTAL HEALTH WORKER II	2
HHS - MENTAL HEALTH	13731	00001977	MENTAL HEALTH WORKER II	2
HHS - MENTAL HEALTH	14040	00002714	MEDICAL SECRETARY	2
HHS - MENTAL HEALTH	14205	00002533	SECRETARY	1
HHS - MENTAL HEALTH	14357	00001978	MENTAL HEALTH WORKER II	2
HHS - MENTAL HEALTH	15039	00002502	MENTAL HLTH COUNSELOR-LICENSED	2
HHS - MENTAL HEALTH	15050	00002055	MENTAL HLTH COUNSELOR-LICENSED	2
HHS - MENTAL HEALTH	15158	00002021	MENTAL HLTH COUNSELOR-LICENSED	2
HHS - MENTAL HEALTH	15907	00002542	MENTAL HLTH COUNSELOR-REGISTER	2
HHS - MENTAL HEALTH	15990	00002435	MENTAL HLTH COUNSELOR-LICENSED	2
HHS - MENTAL HEALTH	16172	00001287	MENTAL HLTH COUNSELOR-LICENSED	2
HHS - MENTAL HEALTH	16805	00002402	MENTAL HLTH COUNSELOR-REGISTER	2
HHS - MENTAL HEALTH	16912	00002071	MENTAL HEALTH WORKER II	2
HHS - MENTAL HEALTH	17140	00000875	FORENSIC MENTAL HEALTH COUNSEL	2
HHS - MENTAL HEALTH	17221	00002438	MENTAL HEALTH WORKER AIDE	2
HHS - MENTAL HEALTH	17453	00001367	MENTAL HLTH COUNSELOR-LICENSED	2
HHS - MENTAL HEALTH	17723	00002274	STAFF SERVICES ANALYST I	1
HHS - MENTAL HEALTH	18136	00001489	MENTAL HLTH COUNSELOR-REGISTER	2

HHS - MENTAL HEALTH	18380	00002230	MENTAL HLTH COUNSELOR-REGISTER	2
HHS - MENTAL HEALTH	18558	00002234	STAFF SERVICES ANALYST II	2
HHS - MENTAL HEALTH	18787	00002320	MENTAL HEALTH WORKER AIDE	1
HHS - MENTAL HEALTH	18849	00001976	MENTAL HEALTH WORKER AIDE	1
HHS - MENTAL HEALTH	18868	00000894	MENTAL HLTH COUNSELOR-REGISTER	1
HHS - MENTAL HEALTH	18886	00000891	MENTAL HLTH COUNSELOR-REGISTER	1
HHS - MENTAL HEALTH	19008	00000885	MENTAL HLTH COUNSELOR-LICENSED	1

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

**Appendices 12 and 13** describe the qualifications and testing process for assigning bilingual pay to county employees.

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

**The county shall include the following in the CCPR Modification (2010):**

**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.**

**Appendix 6** provides the policy for linking LEP clients to culturally and linguistically appropriate services. Cultural and Linguistic Competency Requirements for Mental Health Services

**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.**

Effective 8/1/2018 NCMHP implemented an updated Interpretation and Translation Assistance Requirement for Mental Health Services policy and procedure. The policy states:

“It is the policy of the Napa County Mental Health Plan (MHP) to provide culturally competent interpretation and translation assistance to individuals seeking or receiving mental health services, including those who do not meet the threshold language criteria, those who have limited English proficiency (LEP), or those who have other language or communication barriers (i.e., visual or hearing impaired), in a manner that affords equal access to these services. All individuals served by the MHP shall be informed, in a language they understand, that they have the right to language assistance services. The MHP shall ensure that interpreter services are available for all languages at key points of contact to assist beneficiaries with access to specialty mental health services. The MHP shall ensure that language assistance services are made available in a timely fashion, as is reasonably possible given the time of day and presenting circumstances, and are of no cost to the individual. Furthermore, the MHP shall comply with each of the Division responsibilities as outlined in the Napa County Health and Human Services (HHSA) policy *Translation and Interpretation #2001001-1007* and in Procedures, Section E of this policy.”

This policy is followed by procedures to follow and access the language line (**Appendix 6**).

**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**

See **Appendix 4** - Cultural and Linguistic Competency Requirements for Mental Health Services Policy provides the policy requiring staff comply with Title VI of the Civil Rights Act of 1964.

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

**The county shall have the following available for review during the compliance visit:**

**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.**

The Department of Health Care Services requires that all beneficiaries are informed about materials available in the threshold languages and on request any of state prevalence languages. NCMHP has translated all of the above documents, which would be available for review during a compliance visit, and would provide evidence of appropriately distributed and utilized translated materials.

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

Documented evidence in the clinical chart that clinical findings/reports are communicated in the clients' preferred language would be available for review during a compliance visit.

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

NCMHP has translated its current consumer satisfaction survey into Spanish (**Appendix 14**)

and has attached a summary report. (**Appendix 15**).

**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).**

NCMHP requires that two Bilingual Level 2, certified staff, provide translation and review all documents before publishing.

NCMHP's procedure for ensuring accuracy of translated materials in terms of both language and culture is provided in **Appendix 6**.

**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.**

NCMHP is actively searching for a suitable readability and suitability scale for Spanish reading grade level such as the Flesch-Kinkaid reading level scale used for documents written in English and would appreciate any Technical Assistance on available resources.

## CRITERION 8

### COUNTY MENTAL HEALTH SYSTEM ADAPTATION OF SERVICES

**Rationale:** Organizations should ensure that clients/consumers receive from all staff members, effective, understandable, and respectful care, provided in a manner compatible with their cultural health beliefs and practices and preferred language (CLAS Final Report).

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

**The county shall include the following in the CCPR Modification (2010):**

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

NCMHP's CSS Project Access includes a variety of programs and strategies that are focused on outreach and engagement to unserved/underserved community residents. Additionally, Project Access supports the Co-Occurring Disorders (COD) group, which is embedded in the HHSA's Alcohol and Drug Services Division, as well as the Innovations Community Center Adult Recovery and Resource Center. Some of ICC's successes include:

In 2018-19, ICC adopted a mental health recovery framework developed by the US Substance Abuse and Mental Health Services Administration to measure the impact of its peer support program on participants. Specifically, ICC has selected 5 participant-level indicators to measure the impact of its model:

- Increased sense of control and ability to bring about change in their lives
- Increased self-esteem and confidence
- Increased sense of hope and inspiration
- Increased social support and social functioning
- Increased engagement in self-care and wellness

Key findings from the 2018-19 feedback loop included:

- 71% say that Innovations has made an extreme or large positive difference in their lives
- 73% say that Innovations has met their needs extremely or very well.
- Clients who participated as interns and volunteers, in support groups, and in one-on-one coaching were most likely to report that Innovations made a large or extreme difference in their lives.
- Clients who participated in support groups and internships were most likely to report that Innovations met their needs very well or extremely well.

As a peer-led program, ICC actively works to engage its participants as peer staff, interns and volunteers. In 2018-19, ICC set a goal of involving 75 individuals as volunteers. Over the course of the year, 80 participants, or 19% of all participants, served as volunteer class facilitators, offered support during classes and special events and supported operations of the Center with housekeeping, donating a total of 1,216 hours of their personal time. In addition, 11 members served as program interns and 10

members participated as peer leaders in the Work for Wellness program.

The four (4) ICC participants hired as peer staff received numerous opportunities to grow their leadership and work skills through regular training and coaching. Peer staff completed 40 different training modules including topics such as Motivational Interviewing, substance abuse, group facilitation, CPR and First Aid, mandated reporting and other legal requirements, cultural competency, de-escalation, and mental health topics including diagnosis, psychosis, and QPR. Staff also participated in an ongoing coaching circle, adult reflection and clinical supervision.

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

### **The county shall include the following in the CCPR Modification (2010):**

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. Counties may develop a listing of available alternatives and options of cultural/linguistic services that shall be provided to clients upon request. The county may also include evidence that it is making efforts to include additional culture-specific community providers and services in the range of programs offered by the county.

The following lists are NCMHP and contracted community programs available that accommodate individual cultural and linguistic preferences through a variety of Mental Health Service Act program that are available across Napa County.

**Prevention and Early Intervention Projects (Appendix 7):**

- Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ) Connection Project
- American Canyon Student Assistance Program
- Home Visitation Program
- Kids Exposed to Domestic Violence
- Native American PEI Project
- Strengthening Families at Risk
- Up valley PEI Project
- Court and Community Student Assistance Program (SAP)
- Healthy Minds, Healthy Aging Program

**Community Services and Support Projects (Appendix 10):**

- Children’s FSP
- TAY FSP
- Adult FSP
- Adult Treatment Team FSP
- Project Access - System Navigator, Adult Recovery and Resource Center, Latino Outreach, etc.
- Crisis Stabilization Services

**Innovation Projects (Appendix 8):**

- Napa ACES Innovation Project
- Native American Historical Trauma and Traditional Healing Innovation Project
- Understanding the Mental Health Needs of the American Canyon Filipino Community Innovation Project
- Work for Wellness Innovation Project

**Appendix 16** also identifies providers who provide culturally and linguistically focused services. This information is provided to all individuals accessing Mental Health services at the time of their first intake.

The Medical Guide to Mental Health Services (**Appendix 19**), also handed to clients during the first intake, provides information on how to access a variety of diverse mental health services including doctors, therapists, clinics and hospitals.

**Community Collaborations:**

If individuals are unable or uncomfortable coming to our campus there is NCMH staff collocated throughout Napa County. These locations include:

- Napa Valley Unified School District
- Napa County Office of Education
- On the Move
- COPE
- Mentis

- Aldea Children and Family Services
- Progress Foundation
- Liliput
- Up Valley Family Center
- LGBTQ Connection

**A. 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.**

A mental health provider directory, including contracts, is provided to every client at the time of intake. (Appendix 16)

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

- a.) Evidence of community information and education plans or policies that enable Medi-Cal beneficiaries to access specialty mental health services; or**
- b.) Evidence of outreach for informing under-served populations of the availability of cultural and linguistic services and programs (e.g., number of community presentations and/or forums used to disseminate information about specialty mental health services, etc.)**

NCMHP provides outreach services to under-served populations in a variety of community venues and nontraditional locations (see Appendix 22).

**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;**
- 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); and**
- 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.)**

NCMHP is hosting a primary health care clinic on its Health and Human Services campus in collaboration with OLE Health, the primary health care clinic for the majority of Napa County's Medi-cal beneficiaries. NCMHP and OLE Health are located on the same campus. Consumers can access both mental health services, the clinic, self-sufficiency services and other health and human services on the same campus creating a one-stop shop.

NCMHP collaborates with a variety of community organizations, community resources centers, faith based organizations, school district and businesses to promote mental health services outreach to culturally and linguistically diverse population in non-threatening and less stigmatized locations. NCMHP has collaborated with the following community organizations and events:

- Puertas Abiertas Community Resource Center
- Innovations Community Center
- Voices Community Center for TAY and LGBTQ community members
- South Napa Homeless Shelter
- Napa Valley Unified School District (NVUSD) Asian Pacific Islander Outreach

- Suscol Tribal Council's Annual Pow-wow
- American Canyon Parks and Recreation - Health Fair
- Synergy Gym
- St. John Baptist Catholic Church
- Oxbow Commons-Earth Day
- Target- National Night Out Event
- Calistoga Elementary School
- Napa County Sheriff's Department
- Meritage Health and Wellness Fair
- Aldea Suicide Prevention Conference
- Kaiser Permanente Bi-National Health Fair
- Napa Mexican Independence Day Celebration
- Mental Health Division and co-sponsored Mental Health Month Events

(Forexamples of flyers from some of these events, please see **Appendix 17.**)

### III. Quality Assurance

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

**The county shall include the following in the CCPR Modification (2010):**

- 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. The county does not provide non Medi-cal clients with a formal grievance process nor does it track the ethnic backgrounds of its Medi-cal grievants. Pursuant to the development of these criteria by the Department of Mental Health's Office of Multicultural Services, the mental health division will be discussing the merits and risks of tracking the demographics of its grievants.**

NCMHP has an updated Quality Improvement Work Plan developed for 2018. The QI plan is introduced below and can be reviewed in detail in **Appendix 21**.

#### **Quality Improvement Work Plan - Introduction**

The Napa County Mental Health Quality Improvement (QI) Program is accountable to the Mental Health Director. It is designed to assure to all payers 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 may recover. In addition to attendance at the Quality Improvement Committee (QIC) and Utilization Steering Committee (URSC), beneficiaries, family members and stakeholders are encouraged to actively participate in the deliberations of the Mental Health Board, the outreach activities of the Napa County Mental Health Plan (NCMHP), Mental Health Service Act (MHSA) Stakeholder processes and in self-help education. All these efforts assist in the planning, design, and execution of the QI Program.

The QI Program coordinates performance monitoring activities throughout the organization, including but not limited to: beneficiary and system outcomes, utilization review and

management, credentialing, monitoring and resolution of beneficiary grievances, fair hearings and provider appeals, assessment of beneficiary and provider satisfaction, performance improvement projects, and clinical records reviews. The Napa County Health and Human Services Agency's Quality Management Division supports the program by providing additional auditing and processing of grievances.

The Quality Improvement Work Plan helps guide the NCMHP in managing: (i) conformity with federal and state requirements for quality improvement, and (ii) the behavioral health system's priorities for quality improvement and quality management. With this in mind, NCMHP developed its **2018 Quality Improvement Program and Work Plan** to meet California Department of Health Care Services (DHCS) requirements in Title 9, Section 1810.440. Contracts between the NCMHP and affiliated providers require: 1) cooperation with and participation in, the MHP's QI Program and 2) MHP access to relevant clinical records to the extent permitted by State and Federal laws.

The NCMHP QI Program and Work Plan is designed to:

- Implement quality improvement and assurance activities across NCMHP;
- Detail some of the mechanisms and key indicators addressing beneficiary outcomes, program development and system change;
- Support decision-making based on performance improvement measures and
- Promote continuous quality improvement in programs operating across the continuum of care