Behavioral Health Department

Alameda County Health

# CULTURAL COMPETENCE PLAN

BEHAVIORAL HEALTH & HEALTH EQUITY INITIATIVES

**December 2024 | Plan Update**

# Executive Summary

Alameda County Behavioral Health Care Services (ACBHD) is a department committed to system change, quality driven services, and addressing even the most complex system issues that might function as an unintentional barrier to the broader community. The department's Executive Leadership team has adopted a variety of strategies to promote this system change, including the ultimate development of a Health Equity Division charged with spearheading our system's internal and external processes in alignment with several fundamental principles. In December 2019, ACBHD developed a priority framework to foster strategic decision-making over the course of its organizational restructuring to ensure that departmental priorities are based upon critical areas of importance. These factors: *Alignment, Communication, & Organizational Structure* served as the initial framework for the transformational work. Specifically, Alignment with county, agency, and departmental mission, vision, values; improving Communication (internal/external stakeholders); and improving our Organizational Structure and service delivery continue to be relevant to how ACBH leadership approaches its work and every-day decision-making. For the current year, ACBHD data collection was impacted by delays related to SmartCare implementation. The sections impacted by SmartCare are highlighted.

The following Cultural Competence Plan includes many historical activities, and includes important pivots that have been made, new projects that have been launched, and the re-evaluation of several strategies that were adopted over several decades. To that end, we invite potential readers to evaluate this content critically and with an eye towards our eventual goal: a health equity driven workplace that promotes and provides equity-based services throughout the community. Our ultimate aims are to continually re-envision our practices, set into motion policies and procedures that strengthen our commitment to the provision of quality services; and to eliminate health disparities for all who seek or need services through our integrated system.

Thank you in advance for reviewing this most recent update. We look forward to continued progress and outcomes which can help to inform our decision-making and measure our success in the future

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# Alameda County Behavioral Health Department (ACBHD)

# Values

Alameda County Behavioral Health Department (ACBHD) serves both as the specialty behavioral health and substance use system within the Alameda County Health (ACH) Agency. Our vision, mission, and values (noted below), represent both our current operations and aspirational goals in relation to how we see ourselves as a public service organization.

## Vision

We envision a community where all individuals and their families can successfully realize their potential and pursue their dreams where stigma and discrimination against those with mental health and/or alcohol and drug issues are remnants of the past.

## Mission

To support and empower individuals experiencing mental health and substance use conditions along their path towards wellness, recovery, and resiliency.

## Values

Access, Consumer and Family empowerment, Best Practices, Health & Wellness, Culturally Responsive, & Socially Inclusive.

## Health Equity Division

The Office of Health Equity (OHE) was established in the fall of 2020 with the goal of providing a stronger foundation for the incorporation and promotion of Diversity, Equity, Belonging, and Inclusion practices throughout our system of care and supporting individuals, families, community-based organizations, stakeholders, and the workforce. The OHE is comprised of five units: the Office of Ethnic Services (OES), the Office of Family Empowerment (OFE), the Office of Peer Support Services (OPSS), Patients' Rights Advocacy (PRA), and, as of December 2022, the newly created Health Equity Policy and Systems Coordination (HEPSC) team. In October of 2021, the first OHE Officer/Director was hired and since that time a range of team building, training, Community-Based Organizations (CBOs) and workforce support, strategic planning, and DEBI promotion have been underway.

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# Introduction

Alameda County Behavioral Health Department (ACBHD) is fully committed to creating an anti-racist system that centers on diversity, equity, inclusion, and justice. This Cultural Competency Plan (CCP) assesses our current progress as it aligns with the National Culturally and Linguistically Appropriate Services (CLAS) Standards in Health and Health Care. These standards, found in the Appendix, provide guidance to improve health quality, advance equity, and reduce disparities to create a culturally respectful and responsive system. The CCP is a comprehensive plan that draws on our prior assessments and planning from the following:

- Mental Health Services Act (MHSA) Three-Year Plan FY 23–26
- 2024 Workforce Development, Education, and Training (WET) Needs Assessment
- Prevention and Early Intervention (PEI) Plan

The CCP complies with the State of California requirement and outlines strategies to advance cultural competency and health equity across the Department's seven systems of care:

- Acute and Crisis Services
- Adult and Older Adult Services
- Child and Youth Services
- Forensic Services
- Integrated Primary Care Services
- Psychiatry and Nursing Services
- Substance Use

The plan is developed by the Office of Ethnic Services (OES) through coordination with the Department's entire network, including its systems of care, contracted community-based organizations, and external vendors. The Health Equity Division (HED) is responsible for the CCP implementation and monitoring progress toward goals in the CCP's eight criteria:

I. Commitment to Cultural Competence
II. Updated Assessment of Service Needs
III. Strategies and Efforts for Reducing Racial, Ethnic, Cultural, and Linguistic Mental Health Disparities
IV. Client / Family Member / Community Committee: Integration of the Communities Within the County Mental Health System
V. Culturally Competent Training Activities
VI. The County's Commitment to Growing a Multicultural Workforce: Hiring and Retaining Culturally and Linguistically Competent Staff
VII. Language Capacity
VIII. Adaptation of Services

These criteria assist us in identifying disparities across our system and examining our efforts on the scale of cultural competency. We also identify where we need resources and methods to leverage our current efforts in actualizing cultural competence and humility. The CCP is updated annually to detail changes in demographics and our culturally responsive strategies. While our last plan was updated in December 2023,

this plan serves as a guide for the HED to advance cultural competency across ACBHD for the next three years. Our highlights across the CCP criteria are outlined in the table below.

| Criterion | Highlights | Responsible Parties |
|---|---|---|
| **Criterion I:** *Commitment to Cultural Competence* | ▪ Inclusive strategic planning process<br>▪ New Ethnic Services Administrator and expansion of OES team | **ACBHD network of staff and providers across all systems of care** |
| **Criterion II:** *Updated Assessment of Service Needs* | ▪ Transition to SmartCare<br>▪ Culturally specific recommendations from MHSA Community Program Planning Process listening sessions | **ACBHD network of staff, providers, and beneficiaries across all systems of care** |
| **Criterion III:** Strategies and Efforts for Reducing Racial, Ethnic, Cultural, and Linguistic Mental Health Disparities | ▪ Identified target populations from disparities across Medi-Cal data, Community Services Support (CSS) plan, WET Needs Assessment, and PEI Plan<br>▪ Identified strategies for four target populations | **HED** |
| **Criterion IV:** *Client/ Family Member/ Community Committee: Integration of the Communities Within the County Mental Health System* | ▪ Facilitated four culturally specific committees/coalitions<br>▪ Managed the Culturally Responsiveness Committee's involvement in the CCP drafting process | **OES** |
| **Criterion V:** *Culturally Competent Training Activities* | ▪ Trauma-Informed Systems | **OES/WET Training Unit** |
| **Criterion VI:** *The County's Commitment to Growing a Multicultural Workforce: Hiring and Retaining Culturally and* | ▪ Conducted WET Needs Assessment to identify linguistic and cultural competency workforce needs<br>▪ Comparing FY 23-24 to FY 22-23 staff demographics, we have retained nearly 80% of all newly hired culturally and linguistically competent staff | **WET Training Unit**<br>**ACBHD Systems of Care** |

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| *Linguistically Competent Staff* | | |
| **Criterion VII:**<br>*Language Capacity* | ▪ Facilitated Language, Interpretation, and Translation Workgroup comprised of 9 members<br>▪ Expanded access to translation services to community-based providers | **HED**<br><br>**OES** |
| **Criterion VIII:**<br>*Adaptation of Services* | ▪ Office of Peers Support Services (OPSS) and Office of Family Empowerment (OFE) hosted 9 community engagement meetings that included a total of 638 attendees<br>▪ In FY 23-24, ACBHD's clients completed the Consumer Perception Survey and majority (91.4%) reported satisfaction scores *comparable or higher than the statewide mean.* | **OPSS & OFE**<br><br>**Quality Assurance** |

# Criterion I
## *Commitment to Cultural Competency*

## I. ACBHD Commitment to Cultural Competence

At ACBHD, we believe that our commitment to recognize and value the racial, ethnic, and cultural diversity across Alameda County must be demonstrated both internally and externally. We reflect on this commitment internally through the following:

- Our vision for the clients we serve
- Our organizational strategic plan
- Department-wide activities, events, and programs

Our commitment to advancing cultural competency is explicitly demonstrated in our vision to foster a community that is inclusive and values the uniqueness of our beneficiaries.

- **Vision:** We envision a community where all individuals and their families can successfully realize their potential and pursue their dreams where stigma and discrimination against those with mental health and/or alcohol and drug issues are remnants of the past.
- **Values:** ACBHD's values reinforce our commitment to not only recognize the cultural, linguistic, and ethnic diversity of our community but also actively integrate cultural competency and humility into our services. By living the following values, we aim to create a system that supports and empowers all beneficiaries to achieve equitable health and wellness outcomes:
- **Access:** We value collaborative partnerships with peers & consumers, families, service providers, agencies, and communities, where every door is the right door for welcoming people with complex needs and assisting them along their journey toward wellness, resilience, and recovery.
- **Consumer and Family Empowerment:** We value, support, and encourage individuals and their families to exercise their authority to make decisions, choose from a range of available options, and develop their full capacity to think, speak, and act effectively in their own interest and on behalf of others they represent.
- **Best Practices:** We value clinical excellence through best practices, promising community-driven ideas, and effective outcomes, including prevention and early intervention strategies, to promote well-being and optimal quality of life. We value business excellence and responsible stewardship through revenue maximization and the wise and cost-effective use of public resources.
- **Health & Wellness:** We value the integration of psychological, emotional, spiritual and physical health care to promote the wellness and resilience of individuals recovering from the multi-dimensional effects of mental illness and substance use disorders.
- **Culturally Responsive:** We value the integration of psychological, emotional, spiritual, and physical health care to promote the wellness and resilience of individuals recovering from the multi-dimensional effects of mental illness and substance use disorders.

- **Socially Inclusive:** We value advocacy and education to eliminate stigma, discrimination, isolation, and misunderstanding of persons experiencing mental illness, trauma, and substance abuse disorders. We support social inclusion and the full participation of our clients, consumers, patients, and family members to achieve fuller lives in communities of their choice – where they can live, learn, love, work, play, and pray in safety, security, and acceptance.

ACBHD recently completed a community-centered strategic planning process integrating our values to achieve our vision for health equity. The Department engaged **28** organizations and agencies across Alameda County to develop an inclusive strategic plan. Leaders gathered feedback from key community members, groups, and organizations whose perspectives have been historically excluded from decision-making in the behavioral health system. The findings from these insights were analyzed into themes to develop seven strategic directions that will help us advance cultural competence among our service population:

- **Access:** Establish strategies co-designed with the community to advance equity, access, and cross-agency collaboration
- **Community Expertise:** Uplift community assets for policy/program development
- **Housing:** Collaborate with community partners to increase employment for people who are or are at risk of homelessness with serious mental illness and/or substance use disorders
- **Programs:** Evaluate and improve programs and services so they are whole-person focused, culturally relevant, and outcome-driven
- **Equitable Care:** Increase equitable care for communities facing the greatest inequities through outreach, recruitment, programs and opportunities for improvement persist especially for diverse Asian, Black, and LGBTQIA2S+ communities
- **Re-entry and Criminal Justice:** Increase collaboration and coordination between ACBHD and the Offices of the Public Defender, District Attorney, Probation, Sheriff, and the Collaborative Courts to ensure that Black men are considered for behavioral health treatment as an alternative to incarceration
- **Acceptable and Equitable Distribution of Funds for Mental Health and Substance Use Disorder Needs:** Ensure funding throughout the whole system that serves people with co-occurring conditions

Each strategic direction recommends how the Department can systemically leverage community members' lived expertise for more equitable and integrated behavioral health services. These recommendations also provide insight into how ACBHD can align its services, and support with the CLAS standards (see Appendix). Through some of the recommendations in the strategic areas of access, community expertise, programs and equitable care, we outline ways to advance cultural competency across the Department. By increasing culturally appropriate outreach and engagement, ACBHD both increases access and makes efforts to reduce racial, ethnic, cultural and linguistic mental health disparities. By integrating community expertise into service development and hiring members of priority populations or most impacted communities, ACBHD strengthens its infrastructure to inform client-driven programs and grow a multicultural workforce. The Department also expands the cultural, linguistic, ethnic and racial diversity of its workforce by hiring Community Health Workers and offering clinical training for providers. Improving the outreach, programming and staff's capacity to support diverse communities, with specific attention being paid to AANPHI (Asian American, Native Hawaiian and Pacific Islander), Black,

Latinx and LGBTQIA2S+ (Lesbian, Gay, Bisexual, Trans, Queer, Intersex, Asexual, Two- Spirit, Plus) communities, supports ACBHD's vision of all individuals and families realizing their potential without stigma or discrimination.

## A. Policies, procedures or practices to recognize and value the racial, ethnic, and cultural diversity within ACBHD

The HED facilitates department-wide culturally responsive activities and events to recognize and value the diversity across ACBHD. The activities and events in Table 1 outline ACBHD staff's commitment, efforts, and impact on elevating cultural, ethnic, and linguistic diversity.

*Table 1. Department-Wide Cultural Competence Events/Activities, 2024*

| Month | Title | Description |
|---|---|---|
| **January** | *ACBHD Honors Martin Luther King Jr.* | Memo acknowledging Martin Luther King (MLK) Day, highlighting the history of Martin Luther King Jr., and local MLK observances. |
| **February** | *ACBHD Honors Black History* | Memo acknowledging Black History Month and highlighting the national theme of African Americans and The Arts, stories of Black Joy, local Black History Month observances, and the Department's progress in:<br>○ Establishing an African American Wellness Hub<br>○ Raising awareness of mental health and wellbeing in the African American/ Black community<br>○ Strengthening the peer and family support networks to provide community care |
| **March** | *In Honor of Women's History Month* | Features of women who impact the way ACBHD provides services across Alameda County, including:<br>○ Dr. Karyn Tribble<br>○ Kinzi Richholt<br>○ Juliene Schrick<br>○ Rosa Warder<br>○ Mary Hogden<br>○ Shanequa McCrimmon<br>○ Stephanie Lewis<br>○ Karen Grimsich<br>○ Svetlana Lesova<br>○ Karen Capece |
| **April** | *The Total You Women's Health Forum* | Free event to highlight the health needs, challenges and opportunities for Black women presented by the Oakland branch of the National Association for the Advancement of Colored People with Dr. Karyn Tribble as a featured panelist |

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| **May** | *Recognizing Asian American, Native Hawaiian and Pacific Islander Heritage Month* | Memo acknowledging AANHPI Heritage Month and highlighting Alameda County and national resources to learn more about the AANHPI community |
| | *In Honor of the Asian American, Native Hawaiian and Pacific Islander Community* | Features celebrating ACBHD colleagues and community partners from the AANHPI community including:<br>○ Mona Afary<br>○ Christine Mukai<br>○ Cristina De Leon<br>○ Michael Castilla<br>○ Lai Phuong<br>○ Nwe Oo<br>○ Roxanne Wong |
| | *May is Mental Health Awareness Month* | Mental Health Moments YouTube video from Dr. Clyde Lewis, former Director of Substance Use Disorders, speaking to the mental health challenges faced by those with substance use disorders. |
| **June** | *Project Eden/Lambda Youth 27th Annual PRIDE Prom Event* | Support of the 27th Annual Project Eden/ Lambda Pride Prom held on June 15, 2024 |
| | *Profiles in PRIDE* | Reflections from Rafael Change and Robert Lopez, ACBHD team members and contracted provider-staff, on how being a part of the LGBTQIA+ community has shaped who they are |
| | *LGBTQIA+ PRIDE Month Observance* | Memo acknowledging LGBTQIA+ Pride Month and highlighting the chosen themes of "Reflect. Empower. Unite," "Medicine," and "Now," the historical origin of Pride Month in the Stonewall Riots, ACBHD's development of programs to engage the LGBTQIA+ community, potential emotions evoked by Pride Month, Alameda County Pride Month observances and additional resources to learn about the LGBTQIA+ community |
| | *Happy Juneteenth and What It Means* | Memo acknowledging Alameda County's recognition of Juneteenth and highlighting the history of Juneteenth and local Juneteenth observances and community resources |
| **September** | *Hispanic Heritage Month Observance* | Memo acknowledging Alameda County's recognition of Latino/Latinx heritage, highlighting the origin with activities and local events |

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| **October** | *Indigenous Peoples Day, Filipino American Heritage Month, LGBTQIA+ History Month* | Memo highlighting Alameda County's acknowledgment of the profound significance of Indigenous People Day by providing history and cultural celebrations in the community<br><br>Memo highlighting Alameda County's acknowledgment of the annual commemoration of Filipino American Heritage<br><br>Memo highlighting Alameda County's acknowledgment of the LGBTQIA+ history |
| **November** | *Native American Heritage Month & First-Generation Day* | Memo highlighting Alameda County's acknowledgment of Native American Heritage providing local events and resources to explore<br><br>Memo highlighting Alameda County's acknowledgment of National First-Generation Day and its importance by providing educational resources. |
| **December** | *International Day of Persons with Disabilities* | Memo highlighting Alameda County's acknowledgment of Persons with Disabilities and ACBHD's commitment to supporting identified needs |

## II. Recognition, Value, Inclusion of Racial, Ethnic, Cultural and Linguistic Diversity

We also ensure our commitment to cultural competency is evident in our engagement with external partners, including clients and community organizations. Through the following efforts, we aim to recognize and value our system's racial, ethnic, cultural and linguistic diversity:

- Department-wide policies, practices, and procedures
- Engagement of diverse clients and family members in system planning processes
- Strengthening the cultural competency of community- based providers

These strategies also further enable ACBHD to address emerging challenges in communities, especially those with mental health disparities. ACBHD addresses disparities that are impacted by local, regional, and state legislation. Recent changes at the state level have impacted our ability to reduce disparities within our client population and create a more inclusive system. The shifting legislative landscape in California is also significantly shaping the cultural competency needs of the ACBHD network by demanding a higher level of expertise and specialization from behavioral health providers. These changes have influenced how the HED supports the Department's commitment to value the county's racial, ethnic, cultural and linguistic diversity. CARE Courts allow for court-ordered treatment plans for individuals with severe untreated mental illnesses, necessitating specialized training for behavioral health workers to effectively engage in the legal processes and deliver integrated care.[1] Additionally, SB 43 expands the definition of "gravely disabled" to include severe substance use disorders and incorporates telehealth assessments for 5150

holds. These changes require providers to be adept in new legal frameworks, telehealth technologies, and the comprehensive management of co-occurring mental health and substance use disorders, highlighting the need for robust, evidence-based training programs.[2]

Moreover, the proposed changes under Proposition 1, which aim to redesign the Mental Health Services Act (MHSA), will require counties to redirect one-third of mental health dollars to housing interventions, potentially at the cost of broader behavioral health services.[3] Alameda County will lose more than one-third (35%) of MHSA funds now earmarked for behavioral health services and supports, and at least 51% of this allocation will be redirected towards early intervention for individuals under 25, which will impact our agency's ability to address disparities among our client population.[4] While the impact of Proposition 1's recent passing is still being determined, ACBHD leadership anticipates possible changes in prevention and early intervention services, particularly for communities of color.[4] Given that the majority of county mental health funding is allocated to community services and supports, we anticipate that the reallocation of funding to the state could result in the cancellation of CBO contracts, a reduction in county-level staff, and disruptions in prevention and early intervention programs and services.[4] Taken together, we anticipate an overall reduction in services, which may negatively impact our ability to provide the support needed to appropriately address the needs of our most vulnerable populations, including those from racially, ethically, and linguistically diverse groups.

## A. Practices and activities that demonstrate community outreach, engagement and involvement efforts with identified racial, ethnic, cultural and linguistic communities with mental health disparities to minimize the impact of legislative changes, we have implemented system-wide policies, procedures and practices to institutionalize our commitment to creating an inclusive behavioral health system.

We have also implemented policies, procedures, and practices to support the engagement and involvement of diverse communities, especially those with mental health disparities. These policies focus on improving authorization, protecting beneficiaries, reaching target populations with an array of services, and sustaining program integrity to promote an equitable continuum of care across Alameda County. Creating the infrastructure to provide an equitable continuum of care demonstrates our commitment to cultural competency. The HED supports the implementation and application of the following policies across ACBHD to ensure the provision of patient-centered, culturally affirming care:

- **200-2 Authorization of Specialty Mental Health Services** (01/18/ 24): Describes how Alameda County Mental Health Plan authorizes Specialty Mental Health Services
- **300-5-1 Interoperability and Patient Access P&P** (05/10/24): Describes how Alameda County Behavioral Health Plan will comply with the Centers for Medicare and Medicaid Services Interoperability and Patient Access Final Rule, which makes beneficiates the owners of their health information and gives them the right to transmit it to third-party applications
- **350-3-1 Privacy Security and Confidentiality Statement of Client Records and Information** (05/10/24): Updates the expectations and requirements regarding the access, use, disclosure, and protection of client records and confidentiality of all client

records created, received, maintained or transmitted by Alameda County Behavioral Health Plan to align with current ACBHD policies and language

- **401-2 Full-Service Partnership Implementation** (05/16/24): Updates to the ACBHD requirements for Full-Service Partnerships (FSPs) to comply with the Mental Health Services Act (MHSA) and local requirements for children's FSPs and align with the 2023 MHSA Performance Review
- **1703-1-1 Service verification for Medi-Cal Reimbursed Services** (5/16/24): Addresses the federal and state requirements that the Mental Health Plan implements and maintains, such as procedures designed to detect fraud, waste, or abuse that include provision to verify services reimbursed by Medi-Cal were received by beneficiaries

## B. Current relationship with, engagement with, and involvement of, racial, ethnic, cultural, and linguistically diverse clients, family members, advisory committees, local mental health boards and commissions, and community organizations in the mental health system's planning process for services

The Health Equity Division's Office of Ethnic Services (OES) is dedicated to integrating the perspectives and needs of diverse communities into the mental health system's planning process, ensuring that services are culturally competent and equitable, OES demonstrates the Department's commitment to culturally affirming outreach and engagement with diverse communities through culturally specific coalitions and committees. These coalitions and committees allow diverse clients and family members to support our system's planning processes and inform service provision. OES promotes a sense of community, wellness, belonging, and inclusiveness across ACBHD staff, community-based organizations, allies, and friends of the communities through the following coalitions and committees:

**Cultural Responsiveness Committee:** Works to embrace diversity, eliminate health disparities, and advance equity in Alameda County by providing:

- A space for collaboration and guidance for health equity initiatives
- A forum to discuss and respond to needs that impact the community
- A hub of information, training, and resources to advance equitable behavioral health care
- An environment to promote collective wellness, healing, and celebration

**Alameda County Pride Coalition:** Works to improve the well-being of the LGBTQIA+ community by achieving the following:

- Increase access to care, utilization of services, and positive outcomes using reliable and disaggregated data
- Improve access, communication, and coordination
- A space for collaboration and guidance for health equity initiatives
- A forum to discuss and respond to needs that impact the community

- A hub of information and resources to advance equitable behavioral health care

**Latinx/Latino Advisory Committee for Health and Wellness:** Works to improve the overall mental health of Latinx communities by achieving the following:

- Identify and address the mental health and substance abuse concerns within the Latinx communities, focusing on the unique challenges they face
- Work towards reducing inconsistencies in outcomes, especially in restrictive settings, by collaborating with relevant agencies and systems of care
- Develop and implement procedures and guidelines for the delivery of culturally responsive behavioral health services and treatment for the Latinx community
- Increase educational and training opportunities for Latinx community members, aiming to enhance awareness and understanding of mental health issues
- Expand outreach, engagement, and support to Latinx Alameda County residents
- Advocate for policies and systems change, conduct research, and evaluate data to inform decision-making processes related to behavioral health services
- Actively engage with the community through outreach initiatives, committee presence, and collaboration with community agencies
- Ensure representation from diverse backgrounds, including Afro-Latinx members, agencies, such as Family Paths, Axis Community Health, The Hively, and Alameda County Public Health Department, as well as subject matter experts in data analysis and substance abuse prevention
- Leverage diverse expertise and skillsets within the committee, including event coordination, data and evaluation, collective impact frameworks, marketing, youth programming, project management, and spiritual health
- Increase access to care, utilization of services, and positive outcomes using reliable and disaggregated data
- A space for collaboration and guidance for health equity initiatives
- A forum to discuss and respond to needs that impact the community
- A hub of information and resources to advance equitable behavioral health care

**Asian American, Native Hawaiian, and Pacific Islander Advisory (AANHPI) Committee for Health and Wellness:** Works to increase voices for advocacy, collaboration, intersectionality, and visibility of AANHPI holistic needs, especially for the most vulnerable, and improve system change by achieving the following:

- Increase outreach, engagement, and support to the AANHPI community
- Improve access and care for the AANHPI community in Alameda County

- Increase penetration rates for AANHPI communities, which represent a significant portion of Medi-Cal beneficiaries, by implementing strategies to remove any barriers to care
- Develop a plan to implement data disaggregation so that the county can address historically invisible smaller populations within the broader category of Asians and Pacific Islanders

**African American Steering Committee for Health and Wellness:** Works to create a behavioral health system where African Americans are equal partners with ACBHD by achieving the following:

- Identify the African American community's greatest concerns and challenges surrounding mental health and drug and alcohol abuse services
- Address inconsistency in outcomes despite serving African Americans at a disproportionately higher rate than other ethnic communities, and often in restrictive settings, such as hospitals and jails
- Manage funding secured to facilitate the introduction of the Tele-Therapist in Residency Response project that aims to train the workforce and volunteers within our systems of care on how best to work with African American clients
- Increase educational and training opportunities for African American community members
- Increase outreach, engagement, and support to the Black community
- Coordinate and host the annual African American Conference in collaboration with ACBHD
- Develop guidelines for delivering African American culturally responsive services and treatment
- Increase educational and training opportunities for African American community members
- Increase outreach, engagement, and support to the Black community
- Coordinate and host the annual African American Conference anticipated for the summer of 2025, in collaboration with ACBHD
- Coordinated and hosted the annual African American Family Day in the Park in 2023, in collaboration with ACBHD
- Develop and post on the Committee Website
- Provide Professional Development opportunities for Committee Members.
- Organize the annual African American Steering Committee for Health and Wellness member retreat to develop and revise a 5-year work plan
- Increase culturally responsive ACBHD-funded programs designed for African Americans

- Increase access to care, utilization of services, and positive outcomes using reliable and disaggregated data

## C. Skills development and strengthening of community organizations

To actualize our vision of an inclusive behavioral health system of care, we are building a network of culturally competent community-based providers. Community-based organizations deliver over 80% of clinical services to our client population. Through training to agency staff, peer and family members in our workforce, and licensed clinicians in our provider network, the Workforce Development, Education, and Training (WET) Unit and OES lead efforts to strengthen the capacity of providers to deliver evidence-based and culturally responsive services. Expert instructors lead trainings and cover a wide range of topics, including trauma-informed care, life skills, African American wellness, and community engagement. Through training and educational activities, ACBHD promotes an inclusive community with more cultural competency and tools and skills to advance health equity for all.

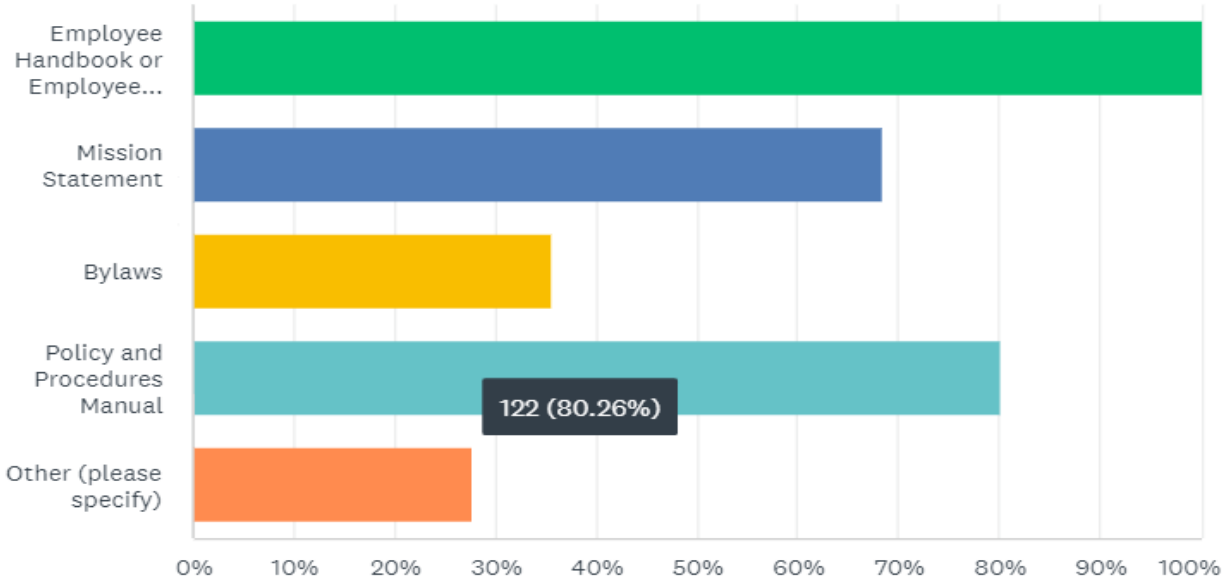
**Board of Supervisors' (BOS) Key Milestones about the African American Wellness Hub:**

- **August 2023**: The BOS approved funding allocations for capital improvements to support project completion through the 2027-2028 fiscal year.
- **September 2023**: After extensive community engagement, 1912 Martin Luther King Jr. Way was identified as the ideal site for the African American Wellness Hub. The bid submission marked a key moment in aligning community needs with a dedicated space.
- **May 2024:** The building at 1912 Martin Luther King Jr. Way was officially purchased, marking a significant step in securing a permanent site for the African American Wellness Hub. Coordination between GSA and ACBHD began to incorporate community input into the project planning process.
- **August 2024**: After a cost analysis, GSA considered remodeling/restoring/raising the existing structure at 1912 Martin Luther King Jr. Way.
- **September 2024**: The BOS approved the General Services Agency's (GSA) to design/build a capital campaign plan, initiating a procurement process to hire a Construction Management team for the design-build work, ensuring the project to move forward according to community expectations and safety standards.

The Board has approved ACBHD financial support for the Wellness Hub, including a $5 million initial project budget and additional program management resources to facilitate the design and construction process. These funds will cover project management, initial construction costs, and amendments to existing contracts to extend support through February 2028. The BOS has also authorized related budget adjustments to ensure proper fiscal oversight and successful project implementation.

OES also assesses the ability of systems of care (SOCs) to specialize in outreach, institutionalize culturally and linguistically appropriate policies, and integrate CLAS standards with its CLAS Standards Implementation Survey. In 2024, the survey had 129 respondents representing organizations across ACBHD. As seen in Figure 1, the majority of respondents (100) prioritized racial equity and demonstrated their commitment most through their organization's Mission Statements, employee handbooks, and agreements.

***Figure 1. Agency- Reported Commitment to Racial Equity***

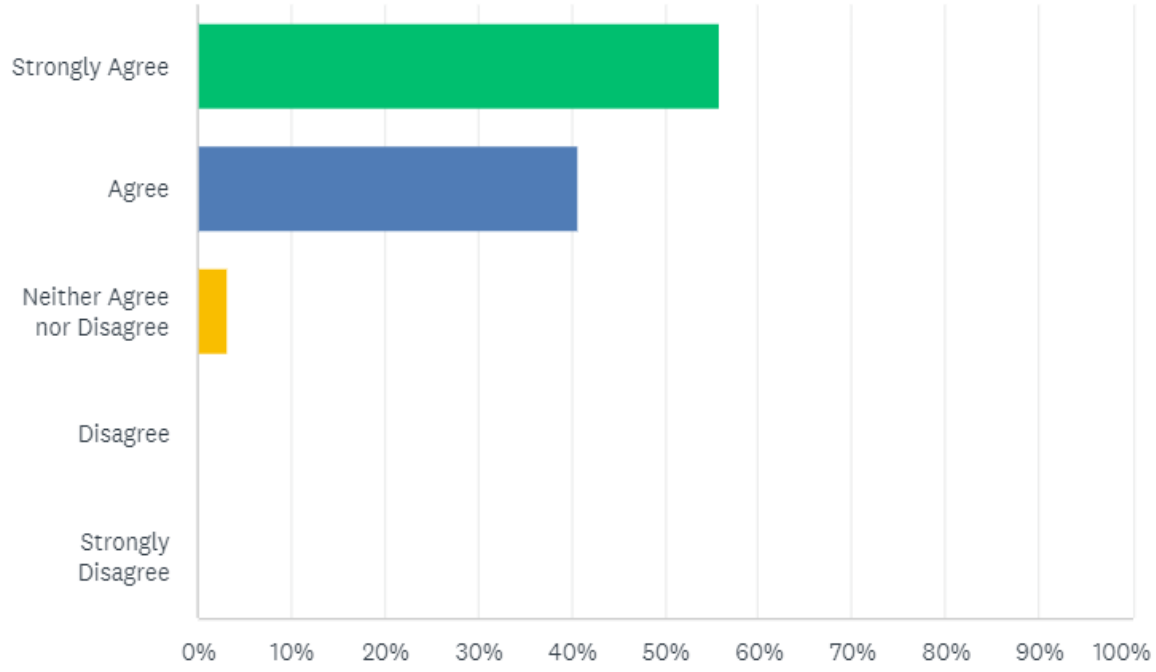



*Source: 2024 CLAS Standards Implementation Survey*

Majority of respondents **(55.92%)** also felt that their organization could meet beneficiaries' cultural needs, as seen in Figure 2, and **49.67%** felt the staff reflected cultural and linguistic needs.

Each SOC also led activities, outlined in Table 2, to develop and strengthen providers' skills to provide culturally responsive services and support.

*Figure 2. Agency- Reported Ability to Meet Beneficiaries' Cultural Needs*




*Source: 2024 CLAS Standards Implementation Survey Each SOC also led activities, outlined in Table 2, to develop and strengthen providers' skills to provide culturally responsive services and support.*

*Table 1. SOC-led Cultural Competency Activities and Events*

| System of Care | Event | Description |
|---|---|---|
| **Acute & Crisis Services** | Faces of the Future Inc. | Mental Health career exploration with a focus on Crisis Workshops |
| **Adult & Older Adult Services** | Resource Fair for the City of Oakland | One Care Fair Event from the City of Oakland Focused on Homeless Crisis |
| **Child & Youth Services** | Eating Disorders and Food Insecurity | Addressing the problem of eating disorder symptomology in those who lack economic access to safe and sufficient nutrition. |
| **Substance Use Disorders** | MHSA Community Intake Survey Outreach | To help Alameda County shape and impact Mental Health services and the Mental Health system |

## D. Lessons learned

The following section demonstrates our ongoing commitment to serving Alameda County's diverse communities through culturally responsive and linguistically appropriate mental health services, while actively engaging community stakeholders in our planning and implementation processes.

**1. Community Outreach and Engagement Practices**

**Targeted Outreach Programs**

- Maintain dedicated Cultural Responsiveness Teams that conduct targeted outreach in diverse communities, including:
  - African American/Black communities
  - Latino/Hispanic communities
  - Asian American and Pacific Islander (AAPI) communities
  - Native American communities
  - LGBTQ+ communities
  - Immigrant and refugee populations

**Culturally Specific Initiatives**

- Partnered with community-based organizations to host cultural celebration events and health fairs in partnership with community members
- Conduct activities in and around areas where mental health needs outpace available services
- Provide multilingual educational workshops on mental health awareness
- Organize community listening sessions in various locations, ensuring the needs of diverse communities are included in the development activities
- Implement cultural wellness practices in treatment approaches (e.g., Eastern Medicine)

**Language Access**

- Maintain a comprehensive language access program including:
- Availability of interpreters for threshold languages
- Telephone interpretation services available for County contracted providers
- Translation of vital documents and educational materials
- Bilingual/bicultural staff recruitment initiatives

**2. Stakeholder Engagement and Planning Process**

**Advisory Bodies**

- The Cultural Competency Advisory Board meets at set intervals and includes representatives from:
  - Diverse community organizations

- Faith-based organizations
- Family advocacy groups
- Peer support specialists
- Local mental health providers

**Collaborative Planning**

- Holds Stakeholder meetings and includes:
  - Local mental health boards
  - Cultural community leaders
  - Consumer and family member advocacy groups
  - Community-based organizations
- Integration of community feedback into:
  - Program development
  - Service delivery modifications
  - Policy updates
  - Resource allocation decisions

**Partnership Networks**

- Active partnerships with:
  - Ethnic community-based organizations
  - Cultural healing practitioners
  - Faith-based organizations
  - Grassroots advocacy groups
  - Local schools and educational institutions

**3. Community Organization Strengthening**

***Capacity Building***

- Provide technical assistance to community-based organizations in:
  - Cultural competency training
  - Administrative systems development
  - Quality improvement processes

***Resource Support***

- Facilitate access to:
  - Professional development opportunities
  - Networking events
  - Funding opportunities

- Technology Resources
- Best practice guidelines

***Collaborative Projects***

- Support joint initiatives between organizations serving similar populations
- Create platforms for knowledge sharing and best practice exchange

***Measurable Outcomes and Impact***

- Track engagement metrics including:
  - Number of community members reached through outreach efforts
  - Participation rates in programs and services
  - Language assistance utilization
  - Client satisfaction scores by demographic group

**Future Initiatives and Commitments**

- Expand cultural competency training programs
- Increase bilingual/bicultural workforce development
- Enhance data collection and outcome measurement
- Strengthening community partnership networks
- Explore the development of culturally specific treatment modalities

## E. Technical assistance needs

To further strengthen our ability to actualize our commitment to cultural competency, ACBHD would need support and will take the following actionable steps:

1. **Data Infrastructure Improvements**
   - Implement a centralized data collection system that tracks service outcomes by demographic groups (this is in progress with the implementation of SmartCare)
   - Create user-friendly dashboards for real-time monitoring (Office of Ethnic Services is working with our community partners to identify key data points)
   - Set up automated reporting for key cultural competency metrics (in development)
2. **Staff Development Priorities**
   - Continuing to provide cultural competency training sessions
   - Strengthen our internship pipeline and emphasize the recruitment from local universities for bilingual/bicultural staff
   - Establish regular supervision protocols that include cultural competency components
3. **Community Partnership Enhancement**

- Develop leadership structure and include community liaison officers for each major cultural/ethnic group
- Schedule regular meetings with community leaders and organizations to understand community needs
- Create a community feedback system (surveys, focus groups, suggestion boxes)
- Establish mini-grants program for community-based organizations

4. **Service Delivery Improvements**
   - Update intake forms to be more culturally responsive
   - Continuing to strengthen language access services through contracted interpreters
   - Create culturally specific treatment protocols
   - Implement regular service satisfaction surveys in multiple languages
5. **Policy Updates**
   - As appropriate, review and revise existing policies through an equity lens
   - Create clear procedures for language access
   - Establish quality assurance checkpoints
6. **Resource Management**
   - Allocate budget for cultural competency initiatives
   - Explore the development of resource-sharing agreements with similar organizations

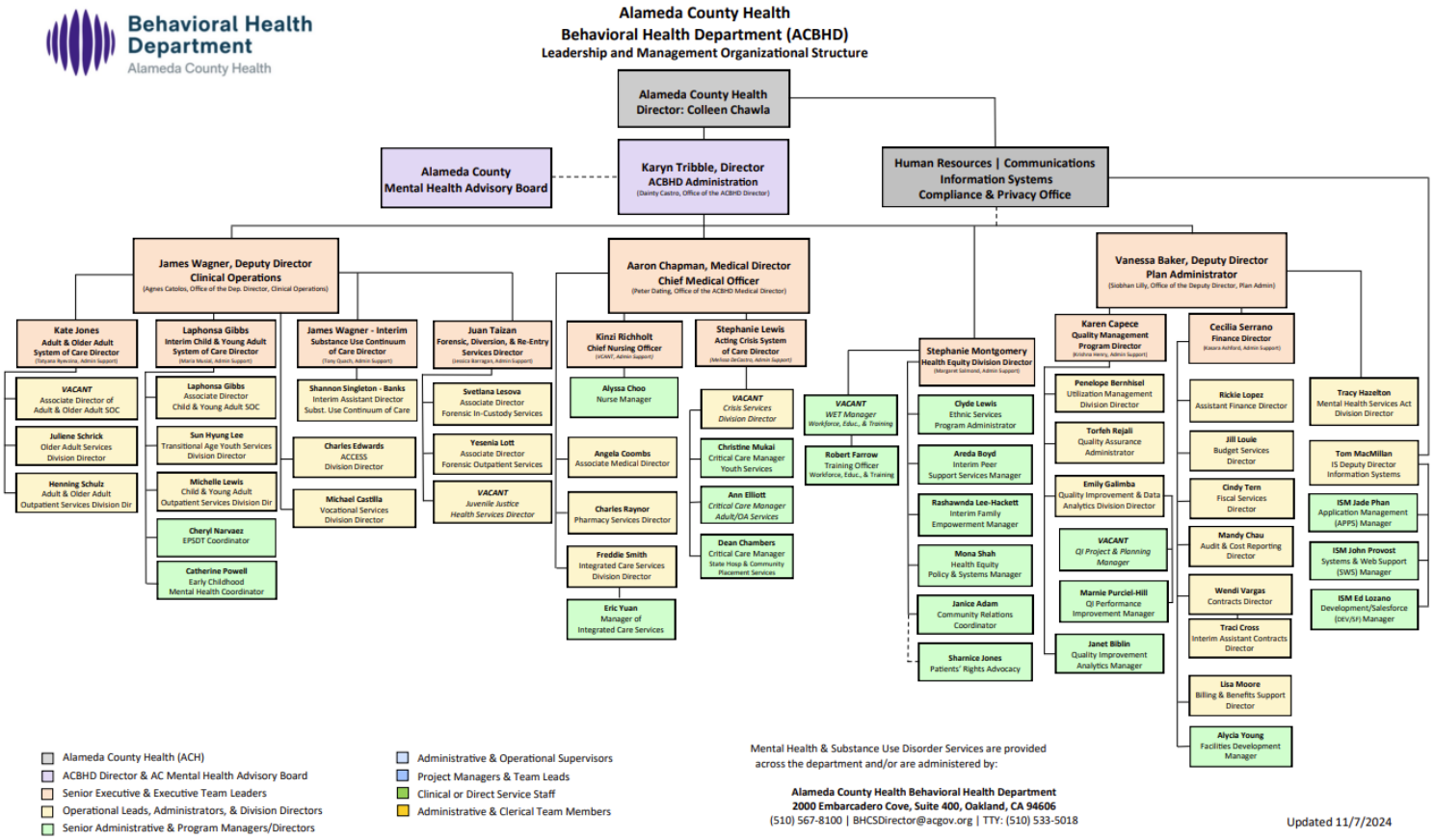
**Next Steps:**

1. From a technical assistance implementation team
2. Prioritize these initiatives based on current resources
3. Create a 12-month timeline with specific milestones
4. Begin with 2-3 high-impact, low-resource initiatives
5. Monitor progress monthly and adjust as needed

## III. Designated Cultural Competence/Ethnic Service Manager (CC/ESM) Reporting to and/or Direct Access to The Director

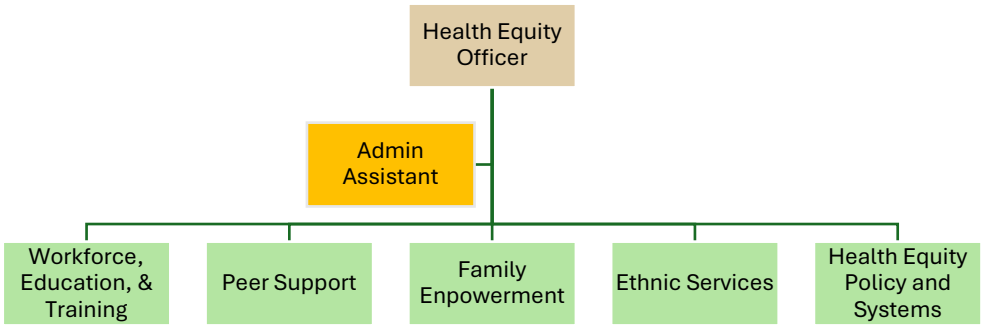
ACBHD executive leadership continues to address issues identified by CLAS and equity work through the Health Equity Division (HED). This team addresses how these issues are embedded across all our Systems of Care. The HED is an essential part of leading the integration of this work. As shown in the dashed boxes in Figure 3, the HED is within the Office of the Director and led by Stephanie Montgomery.

*Figure 1. ACBHD Leadership and Management Structure, November 2024*




The OES is within the HED, as seen in Figure 4. The Ethnic Services Administrator (ESA) is supervised by the HED Director and works in partnership with Dr. Karyn Tribble, ACBHD Director. By sharing this work across the system, we create the conditions needed to support a more inclusive and collaborative environment and increase access to culturally appropriate and high-quality care for all.

*Figure 2. Health Equity Division Organizational Chart*



## A. Evidence of a CC/ESM Responsible for Cultural Competence and Promoting the Development of Culturally Appropriate Mental Health Services

Over the past year, we have had changes in our staff capacity across the OES. Mona Shah served as interim OESA between May 2023 and August 2024. She transitioned to the Health Equity Policy and Systems Manager in February 2024. In June 2024, Rita Robinson began as a Program Specialist with OES. Before joining OES, Rita served as a Program Specialist for CALWORKS. A new OESA, Dr. Clyde Lewis Jr., was appointed in July 2024. Dr. Lewis brings a wealth of experience to the role including having previously served as Director of Substance Use Disorder, EPSDT Coordinator, and as a lecturer for several local universities including the University of California at Berkeley.

## B. Description of the Ethnic Services Administrator's Responsibilities

***Office of Ethnic Services Administrator***

**Alameda County Behavioral Health Department Position Overview**

The Office of Ethnic Services Administrator is the primary leader and advocates for culturally responsive behavioral health services within Alameda County Behavioral Health (ACBHD). This position is responsible for ensuring the development, implementation, and evaluation of culturally and linguistically appropriate services that meet the diverse needs of the county's racial, ethnic, and cultural communities.

***OES Administrator's Core Responsibilities***

**Strategic Leadership & Policy Development**

- Direct the strategic planning and implementation of cultural and linguistic competency initiatives
- Develop and oversee policies that promote equitable access to behavioral health services
- Ensure compliance with federal, state, and local cultural competency requirements
- Lead the Cultural Competency Committee and related advisory bodies
- Collaborate with executive leadership to integrate cultural competency into organizational strategy

**Program Development & Oversight**

- Oversee cultural competency training programs for staff and contractors
- Monitor and evaluate the effectiveness of ethnic services programs
- Develop and implement language access services
- Direct community outreach and engagement initiatives
- Supervise ethnic services staff and consultants

**Data Management & Reporting**

- Oversee collection and analysis of demographic and service utilization data
- Develop and track cultural competency metrics and outcomes
- Prepare required reports for state and federal agencies

- Monitor disparities in service access and outcomes
- Generate recommendations based on data analysis

**Community Engagement & Partnership**

- Build and maintain relationships with diverse community stakeholders
- Facilitate community input in program planning and evaluation
- Represent ACBHD at community meetings and events
- Develop partnerships with community-based organizations
- Respond to community concerns and feedback

**Workforce Development**

- Lead initiatives to recruit and retain diverse staff
- Develop and manage cultural competency training plan
- Oversee implementation of training programs
- Monitor staff cultural competency development
- Provide consultation to leadership on workforce diversity issues

**Budget & Resource Management**

- Manage the Office of Ethnic Services budget
- Allocate resources to support cultural competency initiatives
- Monitor contract compliance for cultural services
- Ensure efficient use of resources

***OES Administrator's Essential Functions***

**Direct Planning & Implementation**

- Lead strategic planning processes
- Develop implementation timelines
- Monitor progress and outcomes
- Adjust strategies based on evaluation
- Ensure alignment with organizational goals

**Supervise Ethnic Staff Services**

- Provide leadership and guidance
- Conduct performance evaluations
- Foster professional development
- Build team capacity

**Stakeholder Collaboration**

- Coordinate with internal departments
- Engage external stakeholders
- Facilitate cross-cultural communication
- Build consensus among diverse groups
- Maintain effective partnerships

**Quality Assurance**

- Monitor service quality
- Ensure cultural competency standards
- Review program effectiveness
- Implement improvement strategies
- Maintain compliance requirements

***OES Administrator's Key Competencies***

**Leadership**

- Strategic thinking
- Decision-making
- Change management
- Team building
- Vision setting

**Technical Knowledge**

- Cultural competency standards
- Behavioral health systems
- Program evaluation
- Policy development
- Data analysis

**Interpersonal Skills**

- Cross-cultural communication
- Relationship building
- Conflict resolution
- Public speaking
- Negotiation

**Administrative**

- Budget management
- Project planning
- Resource allocation
- Report writing
- Time management

## IV. Budget Resources Targeted for Culturally Competent Activities

Along with dedicated staff capacity, we have also demonstrated our commitment to cultural competency by allocating financial resources to programs and initiatives that drive toward our goals for cultural competency. Alameda County dedicated $747.8 million for behavioral health services reflecting Alameda County's commitment to cultural competency and health equity.

## A. Budget Dedicated to Cultural Competence Activities

The HED has also adopted a Results-Based Accountability (RBA) framework to strengthen our accountability to reduce disparities and advance health equity through culturally responsive activities. In reporting for the RBA evaluation, it was found that $5 million has been allocated across the Department to advance cultural competency.

## B. Funding Allocations, Including But Not Limited to:

**1. Interpreter and translation services**

We have allocated $1.2 million to providing interpretation and translation services with our contracted providers (i.e., Accent on Languages, AFAF, Cal Interpreters, Cayuse Civil Services LLC., Excel, HANNA, Interpreters Unlimited, and GLOBO).

**2. Outreach to racial and ethnic county-identified target populations**

Alameda County Behavioral Health Department (ACBHD) allocates $774,000 to outreach to local racial and ethnic-specific priority populations. These funds, administered by the Health Equity Division, are provided directly to community-led committees comprised of local leaders who reflect the respective groups. Additional funds are allocated to the Office of Ethnic Services to work with the leadership of these collective communities to identify unifying programs and supports to address needs that intersect the larger community.

**3. Culturally appropriate mental health services**

Alameda County Behavioral Health Department (ACBHD) dedicated $2 million to ensure our providers are equipped to provide culturally appropriate mental health services. This funding supports our training and community-identified services intended to address extant needs and is in addition to funds for direct services

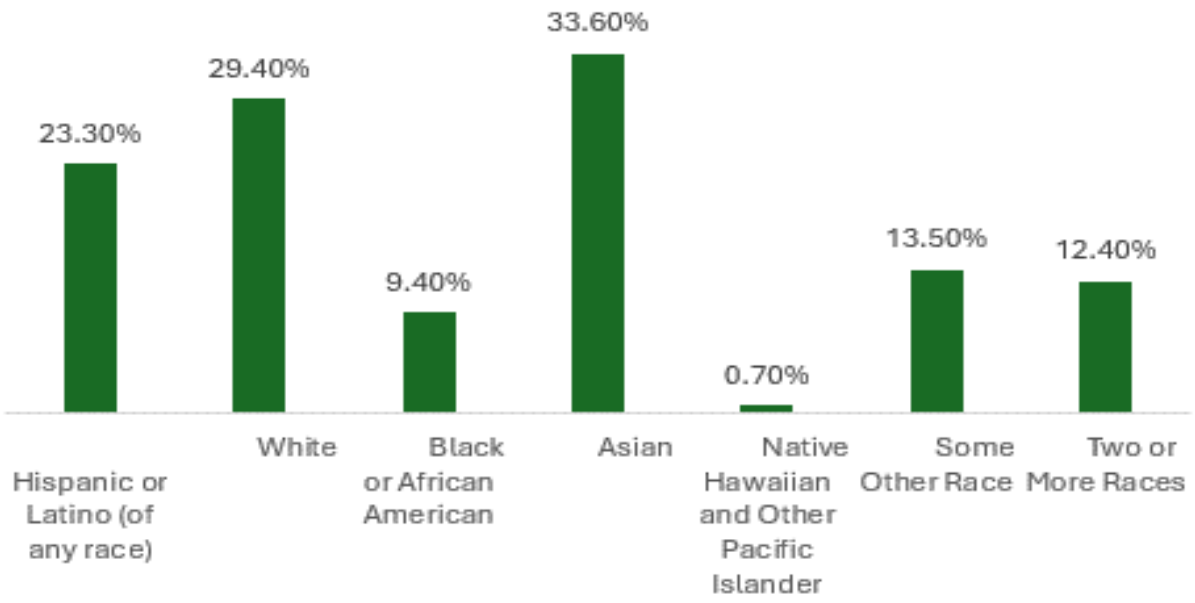
# Criterion II
## *Updated Assessment of Service Needs*

## I. General Population

Alameda County is California's 7th most populous county with an estimated population of 1,628,997 people.[5] By 2026, the population is projected to grow about 1% to 1,641,708. [6]

### A. Summary of The County's Population by Race, Ethnicity, Age and Gender

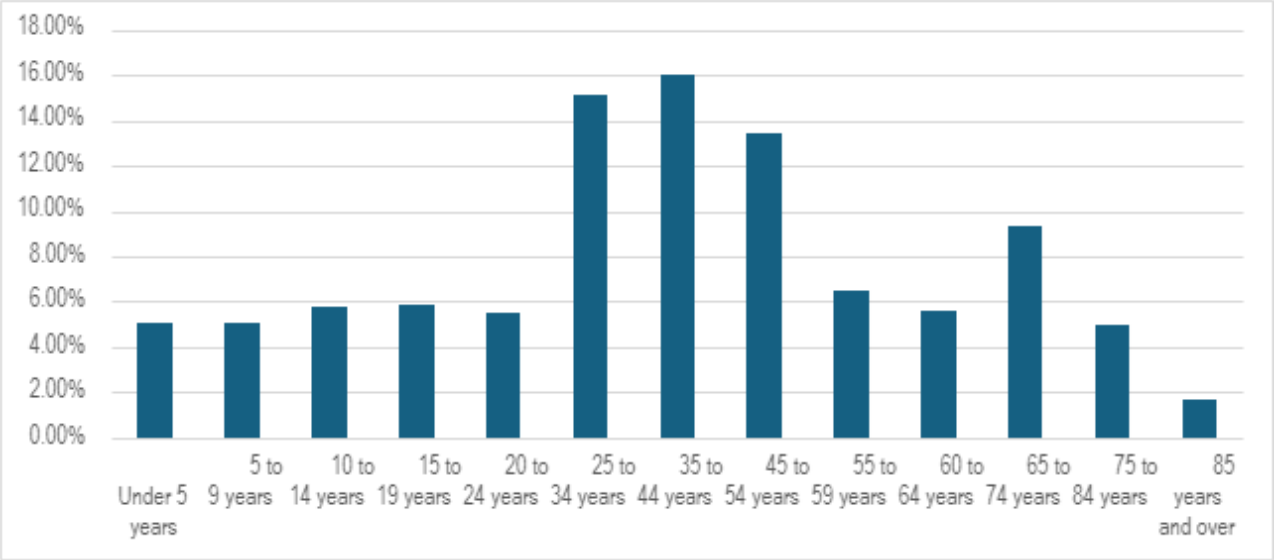
*Figure 5. Alameda County Race and Ethnicity Demographics, 2023*




*Source: U.S. Census Bureau, 2023 American Community Survey 1-Year Estimates, DP05*

The median age of Alameda County residents is 39.5. Alameda County's largest age group is 35-44-year-olds (16%), as seen in Figure 6.[9]

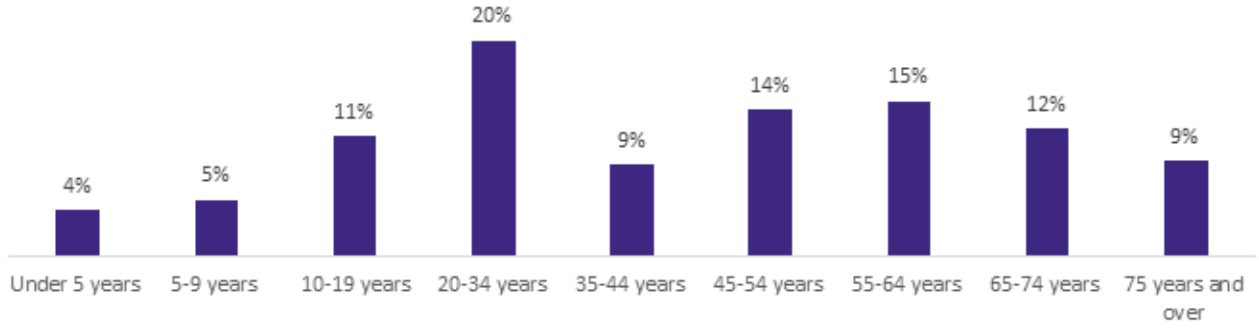
*Figure 6. Alameda County Age Demographics, 2023*




*Source: U.S. Census Bureau, 2023 American Community Survey 1-Year Estimates, DP05*

In 2026, the number of older Alameda County residents is expected to increase, as shown in Figure 7. The population of 35–44-year-olds is projected to have the largest decrease of 3%. The populations of 55–64-year-olds and 65–74-year-olds are both expected to increase by 3% in 2026.[10]

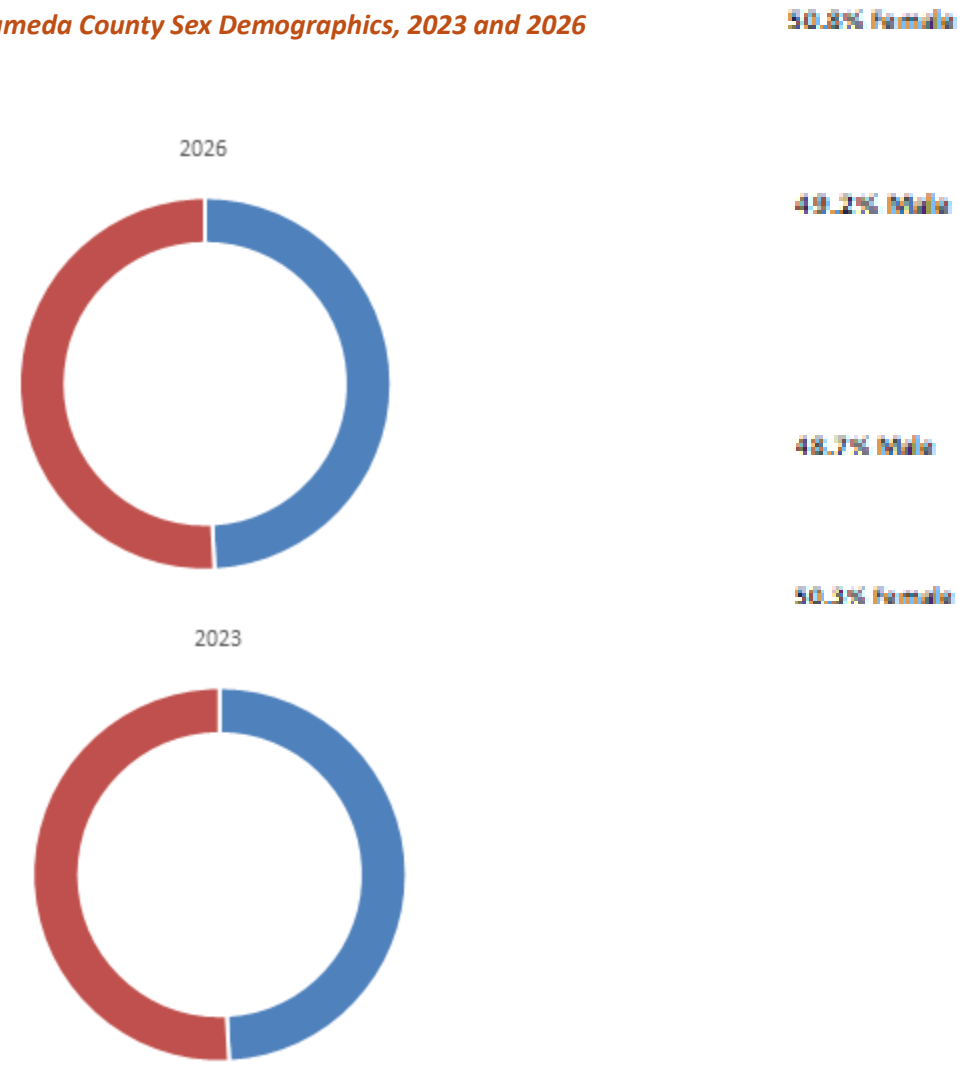
*Figure 7. Alameda County Projected Age Demographics, 2026*




*Source: State of California Department of Finance, County Population Projections (2020-2060), P-2B County Population by Age*

There is limited data on the gender demographics of Alameda County residents aside from sex. The population is evenly distributed among male and female residents and is not expected to change much in 2026, as seen in Figure 8. [11, 12]

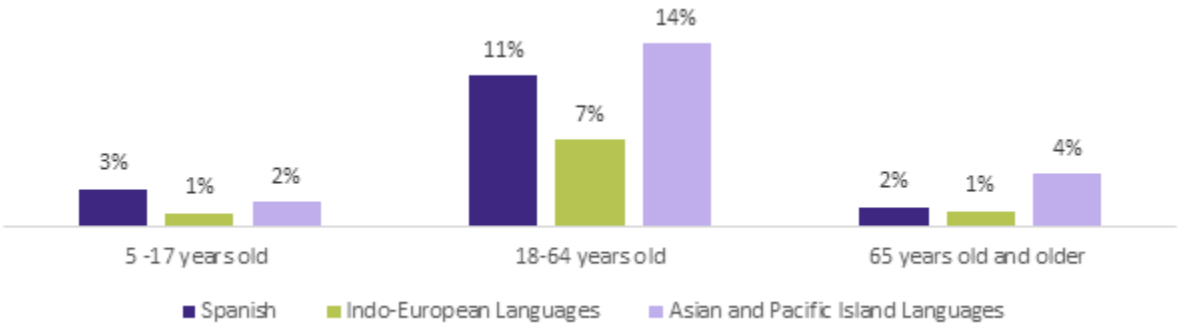
***Figure 8.*** ***Alameda County Sex Demographics, 2023 and 2026***




*Source: U.S. Census Bureau, 2022 American Community Survey 1-Year Estimates, DP05 & State of California Department of Finance, County Population Projections (2020-2060), P-2C County Population by Sex and Age Group*

Alameda County residents speak a variety of languages. Asian and Pacific Island languages are spoken the most among adults (20%) outside of English, shown in Figure 9. Spanish is spoken the most (3%) among youth in Alameda County followed by Asian and Pacific Island languages.

***Figure 9. Alameda County Languages Spoken at Home, 2023*** [13]




Source: U.S. Census Bureau, 2022 American Community Survey 1-Year Estimates, S1601

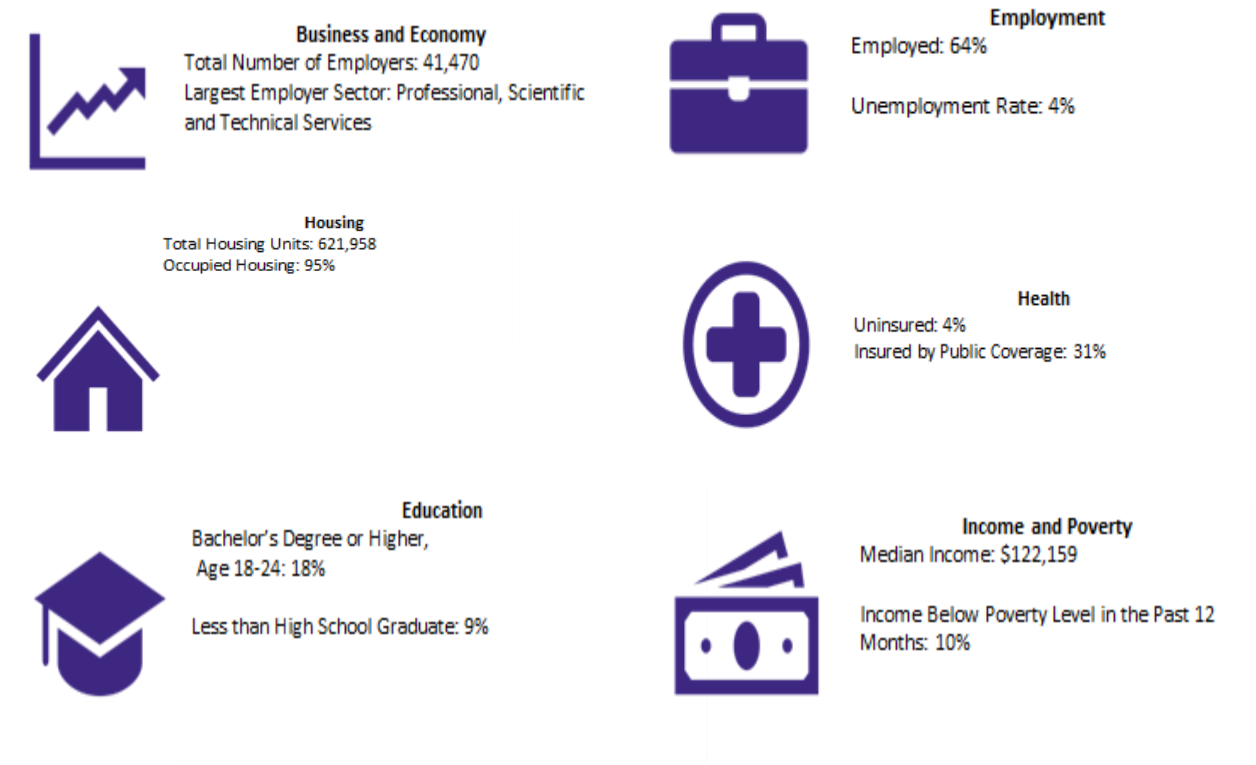
***Social Determinants of Health in Alameda County***

The mental well-being of Alameda County residents is impacted by their access to social and economic opportunities. Residents with more access to these opportunities are more likely to have protective factors to maintain their mental wellness through challenges. Those with limited or no access to social and economic resources have an increased risk for mental health conditions. ACBHD must consider the social and economic inequities impacting our community to effectively address behavioral health disparities.

On average, residents across Alameda County have a higher educational attainment than those across California. The proportion of 18–24-year-olds who obtain a bachelor's degree or higher in Alameda County (18%) is higher than the state average of 13%. This higher level of educational attainment is not equitable across all racial and ethnic groups. Alameda County residents, 18-24 years old, who identify as some other race that obtained a bachelor's degree or higher at the lowest percentage (18%).[14]

Higher educational attainment increases residents' chances of securing employment. As seen in Figure 10, over half (64%) of Alameda County residents are employed. Alameda County residents are also securing jobs with higher earning potential. The county's median income of $122,159 is higher than the state's median of $91,551 and adults report living below poverty (10%) less than their state counterparts (12%). [15, 16, 17] Economic mobility gives residents access to other resources, including housing and healthcare coverage. Alameda County residents are uninsured (4%) at a lower rate than their state counterparts (7%).[21]

*Figure 10. Social Determinants of Health Across Alameda County* [15,16,17,18,18 19,20]




Insurance increases the likelihood that Alameda County residents can access professional mental health resources. The resident to mental health provider ratio is lower in Alameda County (130:1) than in California (220:1) and the U.S. (320:1).[21] These resources are needed given that Alameda County adults report some mental health risk factors at a higher rate than those across the state and the nation. As seen in Figure 11, Alameda County adults report more poor mental health days (5.1) than adults across California (3.1) and the U.S. (3.3). Adults also report needing help with emotional/ mental health or alcohol/ drug problems (22%) more than their state counterparts (21%).[22]

*Figure 11. Mental Health Risk Factors for Alameda County* [22]

**Poor Mental Health Days**
Alameda County: 5.1
CA: 3.1
U.S. 3.3

**Excessive Drinking**
Alameda County: 16%
CA: 17%
U.S. 18%

**Family Life Impairment from Emotions During Past 12 Months, 18 and over**
Alameda County: 18%
CA: 21%

**Needed Help for Emotional/Mental Health or Alcohol/Drug Problem in Past 12 Months, 18 and over**
Alameda County: 22%
CA: 21%

**Serious Psychological Distress, 18 and over**
Alameda County: 11%
CA: 13%

**Work Impairment from Emotions, 18 and over**
Alameda County: 15%
CA: 17%

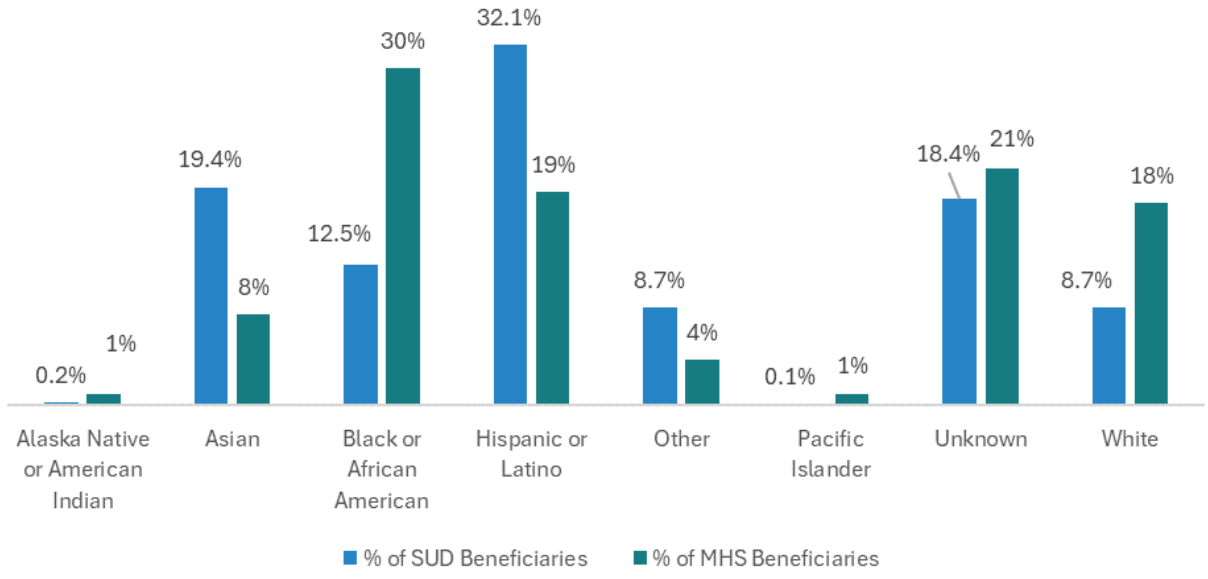
## II. Medi–Cal Population Service Needs

Alameda County Behavioral Health Department (ACBHD) provides services to Alameda County residents with a variety of health insurance coverage, including Medi-Cal, Medicare, and the uninsured. In FY 23-24, we provided mental health services (MHS) to 24,973 beneficiaries and 4,456 beneficiaries with substance use disorder (SUD) services across all health insurance coverage types. In FY 23-24, the majority (61%) of our MHS beneficiaries were Medi-Cal clients. About 24% of SUD beneficiaries were covered through Medi-Cal. This section describes the overall utilization and characteristics of our total client population.

### A. Client Utilization by Race, Ethnicity Language, Age Gender and Other Social/Cultural Groups as Available

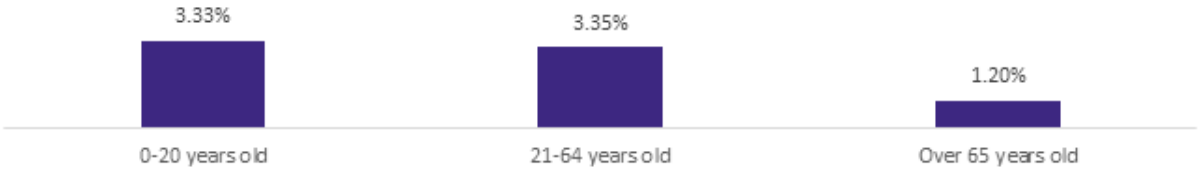
ACBHD beneficiaries represent the diverse racial and ethnic communities across Alameda County. As seen in Figure 12, the largest proportion of our MHS and SUD beneficiaries are Hispanic or Latino, (32.1% and 19% respectively). Disclaimer: Data for the following tables were impacted by delays related to a new database (SmartCare) being implemented.

*Figure 12. ACBHD MHS and SUD Beneficiaries and Alameda County Race and Ethnicity Demographics, FY 23-24*




*Source: U.S, Census Bureau, 2023 American Community Survey 1-Year Estimates, DP05 ; Yellowfin MHS Demographics- Ethnicity; Yellowfin SUD Demographics- Ethnicity* [22]

*Figure 13. Medi-Cal Penetration by Age Group, FY 23-24*




*Source: Yellowfin MHS Demographics- Age Group*

Majority of beneficiaries across all ages are served with Medi-Cal. The group with the largest proportion of Medi-Cal covered beneficiaries are 21-64 years old (72%), shown in Figure 15. Majority of Medi-Cal (73%) and non-Medi-Cal (65%)[27] beneficiaries identified their sex as male. The Medi-Cal penetration rate is 3.4% for male beneficiaries and 2.75% for female beneficiaries.

The primary language spoken among our MHS (81%), and SUD (94%) beneficiaries is English. Other than English, Spanish is the most spoken language among MHS (14%) and SUD (6%) beneficiaries, as shown in Table 3.

*Table 3. ACBHD MHS and SUD Beneficiaries Primary Language Spoken Other than English, FY 23-24*

| Language Spoken | Mental Health Services | Substance Use Disorders |
|---|---|---|
| Arabic | 38 | 1 |
| Chinese | 270 | 1 |
| Farsi | 108 | 2 |
| Other | 224 | 4 |
| Spanish | 2,292 | 195 |
| Vietnamese | 109 | 1 |
| Tagalog | 26 | 1 |

*Source: Yellowfin MHS Demographics- Primary Language; Yellowfin SUD Demographics- Language* [23]

We collect data on beneficiaries' sexual orientation and gender identity and expression (SOGIE) to provide more inclusive services and support. Our beneficiaries have a broad range of gender identities as seen in Table 4.

*Table 4. ACBHD MHS and SUD Beneficiaries by Gender Identity, FY 23-24*

| Gender Identity | Mental Health Services | Substance Use Disorders |
|---|---|---|
| Female | 7,845 | 1,258 |
| Female to Male | 70 | 4 |
| Intersex | 23 | 2 |
| Male | 11,091 | 2,597 |
| Male to Female | 48 | 9 |
| Multiple Gender Identities | 38 | 3 |
| Non-Conforming | 90 | 10 |
| Queer | 38 | 3 |

*Source: Yellowfin MHS Demographics- Gender Identity; Yellowfin SUD Demographics-Gender Identity* [24]

Beneficiaries also have a wide range of preferred pronouns, as shown in Table 5.

*Table 5. ACBHD MHS and SUD Beneficiaries' Preferred Pronouns, FY 23-24*

| Preferred Pronouns | Mental Health Services | Substance Use Disorders |
|---|---|---|
| He/Him | 8,182 | 2,382 |
| Other | 70 | 6 |
| She/Her | 5,064 | 1,098 |
| They/Them | 78 | 16 |

*Source: Yellowfin MHS Demographics- Pronouns; Yellowfin SUD Demographics- Pronoun* [25]

Majority of MHS (53%) and SUD (75%) beneficiaries with sexual orientation data were heterosexual, as shown in Table 6.

*Table 6. ACBHD MHS & SUD Beneficiaries' Sexual Orientation, FY 23-24*

| Preferred Pronouns | Mental Health Services | Substance Use Disorders |
|---|---|---|
| Heterosexual | 7,592 | 3,394 |
| Gay | 1,041 | 69 |
| Bisexual | 253 | 95 |
| Lesbian | 111 | 32 |
| Other | 101 | 20 |
| Questioning | 56 | 1 |
| Multiple Sexual Orientations | 53 | 14 |
| Queer | 39 | 15 |

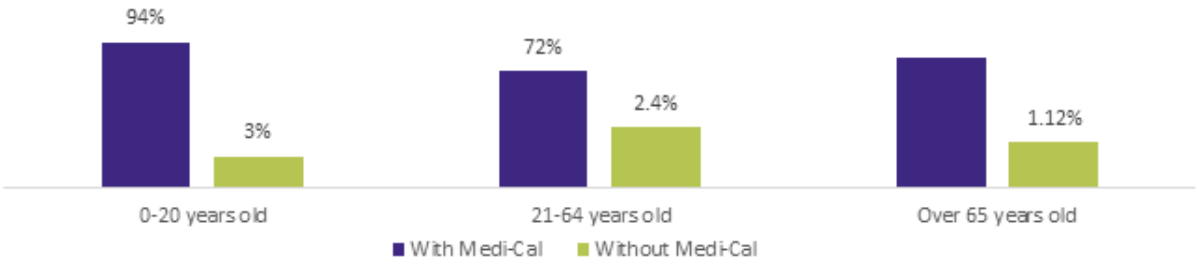
*Source : Yellowfin MHS Demographics- Sexual Orientation: Yellowfin SUD Demographics- Sexual Orientation* [26]

Alameda County Behavioral Health (ACBHD) collects data on beneficiaries' disability status to ensure a more inclusive continuum of care for all Alameda County residents. Majority of MHS (72%) and SUD (76%) beneficiaries did not report having a disability. ACBHD aims to ensure our services and facilities can serve those MHS (8%) and SUD (11%) beneficiaries who are living with a disability.

## B. Summary of Medi-Cal population by race, ethnicity, language, age, gender and other social/cultural groups as available

In FY 23-24 we served a total of 581,104 Medi-Cal MHS patients with an overall penetration rate of 3.06%. This section describes their characteristics and how they differ from the overall beneficiary population. Majority (81%) of Medi-Cal patients were served in outpatient settings. Over half (56%) of Medi-Cal beneficiaries are adults, age 21-64. The age group with the smallest representation (5%) and lowest penetration rate (1.2%) among Medi-Cal beneficiaries are those over 65 years old. We have the highest Medi-Cal penetration rate among beneficiaries 21-64 years old. as seen in Figure 15.

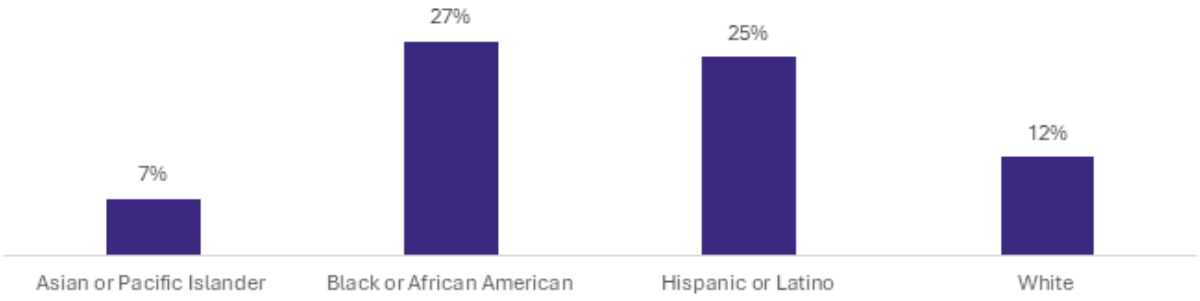
***Figure 15. Beneficiaries Served with and without Medi-Cal by Age Group, FY 23-24***




*Source: Yellowfin MHS Medi-Cal Penetration by Age Group*

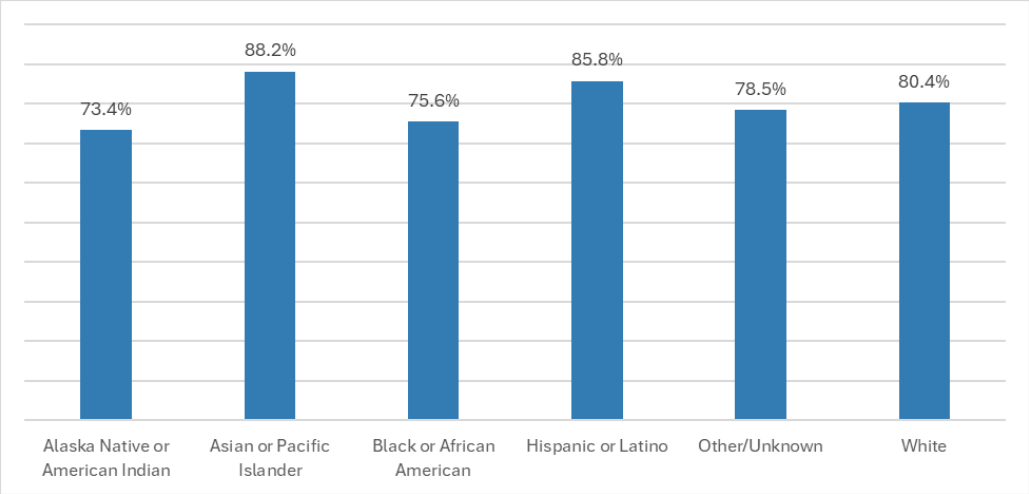
ACBHD Medi-Cal beneficiaries represent a variety of racial and ethnic groups. As shown in Figure 16, the two largest racial and ethnic groups in our Medi-Cal population are Asian or Pacific Islander (88%) and White (80%).

***Figure 16. Medi-Cal Beneficiaries Ethnic and Racial Demographics, FY 23-24***



The highest Medi-Cal penetration rates are among Asian or Pacific Islander (88.2%) and beneficiaries, Hispanic or Latino (85.8%) as seen in Figure 17.

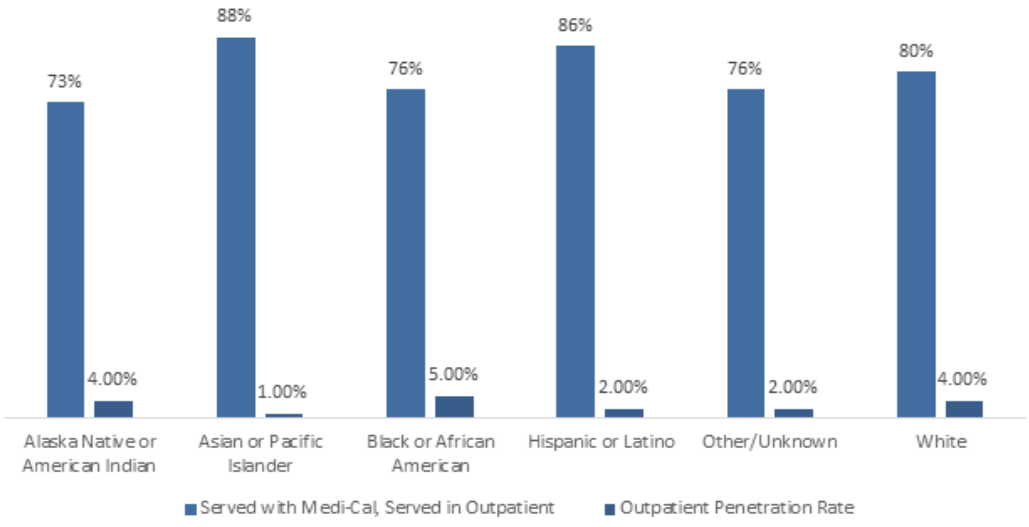
***Figure 17. Racial and Ethnic Medi-Cal Penetration Rates, FY 23-24***




*Source: Yellowfin MHS Medi-Cal Penetration by Ethnicity [29]*

When comparing Medi-Cal and non-Medi-Cal services, majority of beneficiaries across all racial and ethnic groups are served with Medi-Cal. The group with the largest proportion of Medi-Cal served beneficiaries is Hispanic or Latino (86%), as shown in Figure 18.

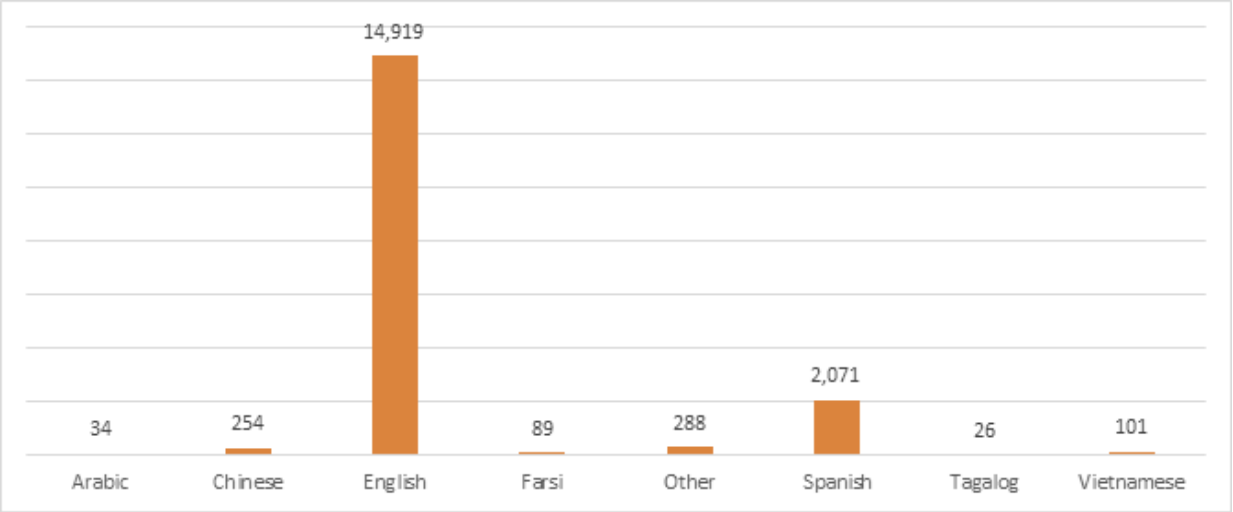
***Figure 18. Beneficiaries Served with and without Medi-Cal by Race and Ethnicity, FY -23-24***




*Source: Yellowfin MHS Medi-Cal Penetration by Ethnicity [30]*

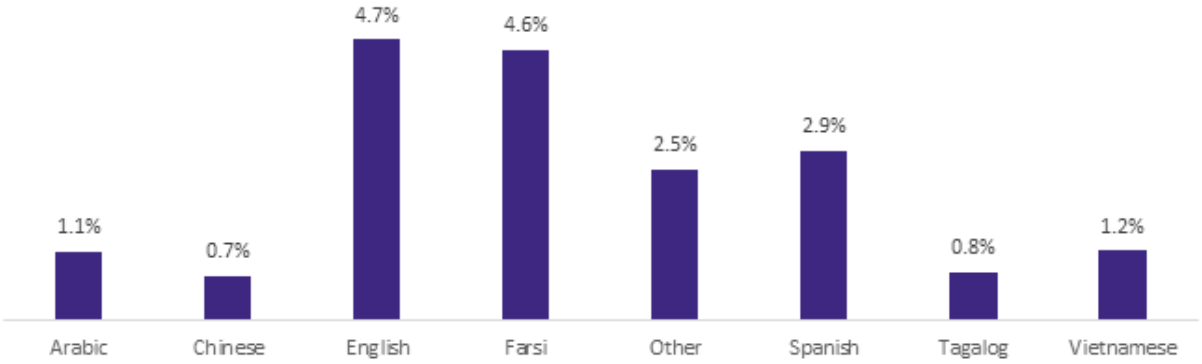
As seen in Figure 19, the most commonly spoken language other than English (14,919) among Medi-Cal beneficiaries was Spanish (2,071).

*Figure 19. Commonly Spoken Languages other than English among Medi-Cal Beneficiaries*




The highest Medi-Cal penetration rates are among those who speak English (4.7%) and Farsi (4.6%), as seen in Figure 20.

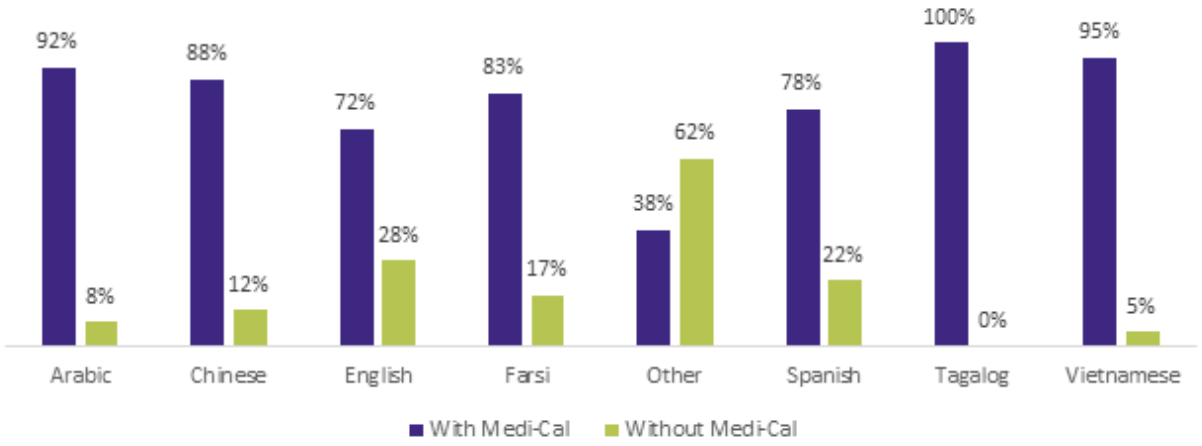
*Figure 20. The proportion of Beneficiaries with and without Medi-Cal by Language Spoken, FY 23-24*




*Source: Yellowfin MHS Medi-Cal Penetration by Language*

The largest proportion of Medi-Cal covered beneficiaries were among those who speak Tagalog (100%), Vietnamese (95%) and Arabic (92%), shown in Figure 21.

***Figure 21. The Largest Portion of Medi-Cal covered Beneficiaries among those who speak Tagalog***




## C. Analysis of Client Utilization Disparities

When comparing population and utilization data, there are evident disparities in the usage of our services across racial and ethnic groups. Although Asian communities make up the highest proportion of Alameda County residents, they have some of the lowest utilization of the county's mental health and substance use services. Black or African American residents who make up 10% of the population have the highest utilization of mental health and substance use services across all racial and ethnic groups. There are also disparities in services provided across different age groups. Residents ages 20-34 represent the largest portion of Alameda County's population but younger adults under 30 have some of the lowest utilization of our services.

Gender identity data for Alameda County residents is limited and not representative of the spectrum of gender identities. We are intentionally making systemic changes to improve SOGIE data. Previously, SOGIE data was collected in assessments and registration in our client management system. This process led to only 48% of SOGIE data being collected for beneficiaries served. ACBHD implemented measures to capture SOGIE data in all systems of care. Future reports will include information for this population.

To move towards our goal of more comprehensive data, our Data Governance Committee established a sub-committee focused on improving SOGIE data collection. This subcommittee shared recommendations to ensure comprehensive SOGIE data collection with our transition to SmartCare. We will use this guidance to address the unknown SOGIE data due to gaps in staff skills in discussing and collecting SOGIE data. Disclaimer: While this committee was scheduled and did meet, there were delays in data collection due largely to the issues with the implementation of the ACBHD data collection system (SmartCare).

## D. Analysis of Medi-Cal Disparities

There are service disparities across the Medi-Cal population. With an aging population across Alameda County, Alameda County Behavioral Health Department (ACBHD) must increase our penetration rate among older adults. While among our general beneficiary population, we mostly serve older adults, the trend is different among our Medi-Cal population. The highest Medi-Cal penetration is among young adults and youth, ages 20 and under. There are also disparities across the Medi-Cal population among racial, ethnic, and linguistic groups. Penetration rates for Black or African American beneficiaries are over four times higher than the rate for Asian beneficiaries. Asian beneficiaries have the lowest Medi-Cal penetration rates. The need for linguistically appropriate outreach is demonstrated by Asian and Pacific Island languages, including Chinese, Vietnamese, and Tagalog, representing the lowest proportions of languages spoken other than English.

# III. 200% of Poverty (Minus Medi-Cal) Population and Service Needs

In 2020, statewide county-level data was provided on beneficiaries living at 200% poverty. However, ACBHD does not collect data on household income so beneficiaries' data cannot be disaggregated by income or poverty level.

# IV. MHSA Community Services and Supports (CSS) Population Assessment and Services Needs

The following information represents our assessment of the MHSA Community Services and Supports (CSS) population needs and services from our CSS plan. Compared to neighboring Bay Area counties, Alameda, experienced the highest increase in population from 2017 to 2019, with over 4,500 people, and the third-highest percent of foreign-born residents (33%). At home, Alameda County residents speak a variety of languages. Among the neighboring Bay Area Counties, Alameda has the second-highest percent of residents who speak non-English languages at home. Due to this diversity of languages, Alameda County has seven threshold languages:

- English
- Spanish
- Vietnamese
- Arabic
- Tagalog
- Other
- Chinese: Traditional and Simplified (If Written)
- Chinese: Cantonese and Mandarin (If Spoken)

Threshold languages are those where at least 3,000 residents or 5% of the Medi-Cal beneficiary population, whichever is lower, identify that language as their primary one. While Farsi, Korean, and Khmer are no longer threshold languages, Alameda County is committed to providing materials in these languages because of how close they are to becoming a threshold language. Mental health providers must comply

with cultural competence and linguistic requirements set out by the state for these languages, including oral interpretation services and translation of general program literature used to assist beneficiaries.

Compared to other Bay Area counties, Alameda County residents have the lowest median household and per capita income, as seen in Table 7. While the median rent is the lowest among the Bay Area Counties, Alameda County has the higher rental rate compared to Contra Costa, Marin, and Santa Clara counties, meaning a higher percentage of residents do not own a home.

***Table 7. Poverty Indicators for Bay Area Counties***

| Indicator | Alameda | Contra Costa | Marin | San Francisco | Santa Clara |
|---|---|---|---|---|---|
| **Median household income, 2017-2021** | $112,017 | $110,455 | $131,008 | $126,187 | $140,258 |
| **Income, past 12 months, 2017-2021** | $53,815 | $53,656 | $78,995 | $77,267 | $65,052 |
| **Median gross rent, 2017-2021** | $2,043 | $2,061 | $2,307 | $2,130 | $2,530 |
| **Rental occupied, 2017-2021** | 46% | 33% | 36% | 62% | 44% |
| **Households whose rent is 30% or more of their income** | 49% | 54% | 52% | 37% | 45% |
| **Poverty percent, all ages** | 9% | 8% | 7% | 10% | 7% |
| **Poverty percent under 18** | 9% | 10% | 7% | 10% | 7% |
| **Households with SNAP/Food stamps, percent** | 7% | 7% | 4% | 7% | 4% |

About 49% of renters spend 30% or more of their income on their rent, experiencing a financial burden by these rent payments. Alameda County also has the second highest percent of people in poverty for all ages; it is the third highest of the 5 Bay Area counties for people under 18 years old living in poverty. Alameda County is tied with San Francisco with respect to the percent of households that receive Supplemental Nutrition Assistance Program (SNAP) to help purchase food and beverages.

Every two years, the Alameda County Continuum of Care (ACCC) conducts comprehensive counts of the homeless population in Alameda County for the Point-in-Time Count. Due to the COVID-19 pandemic, the 2021 count was postponed to 2022. This most recent count recorded 9,746 people experiencing homelessness, which is a 21% increase from the last count in 2019. Seventy-three percent (7,134) were unsheltered, meaning they lived in tents, parks, vehicles, vacant buildings, underpasses, and so forth. The other 27% were sheltered or living in a county shelter during the count. The top three reported causes of homelessness were (1) family or friends could not let them stay or argument with family/friend/roommate (27%); (2) eviction/foreclosure/rent increase (25%); and (3) job loss (22%).

Additionally, 7% of survey respondents cited issues related to the COVID-19 pandemic as at least one contributing factor with respect to their primary cause for homelessness, with 16% reporting that it was the primary factor.

Alameda County has the second lowest life expectancy, at 82.8 years compared to the neighboring counties. Alameda and San Francisco Counties have much higher rates of violent crime than the other neighboring counties. Alameda County has the lowest percent of those without health insurance under the age of 65 (5.0%). However, rates are similar across all neighboring Bay Area Counties. The percent of those under 65 that are disabled, defined as limited or restricted to fully participate in activities at school, home, work, or in their community, is 5% in Alameda County, as seen in Table 8.

***Table 8. Poverty Indicators for Bay Area Counties***

| Indicator | Alameda | Contra Costa | Marin | San Francisco | Santa Clara |
|---|---|---|---|---|---|
| **Life expectancy, years** | 82.8 | 82.2 | 85.2 | 83.7 | 84.7 |
| **Violent crime rate, per 100,000 people** | 629 | 336 | 178 | 760 | 264 |
| **Persons without health insurance, under 65 years** | 4.9% | 5.4% | 4.2% | 4.9% | 5.0% |
| **With disability, under 65 years, 2014-2018** | 5.7% | 7.5% | 5.1% | 5.7% | 4.7% |

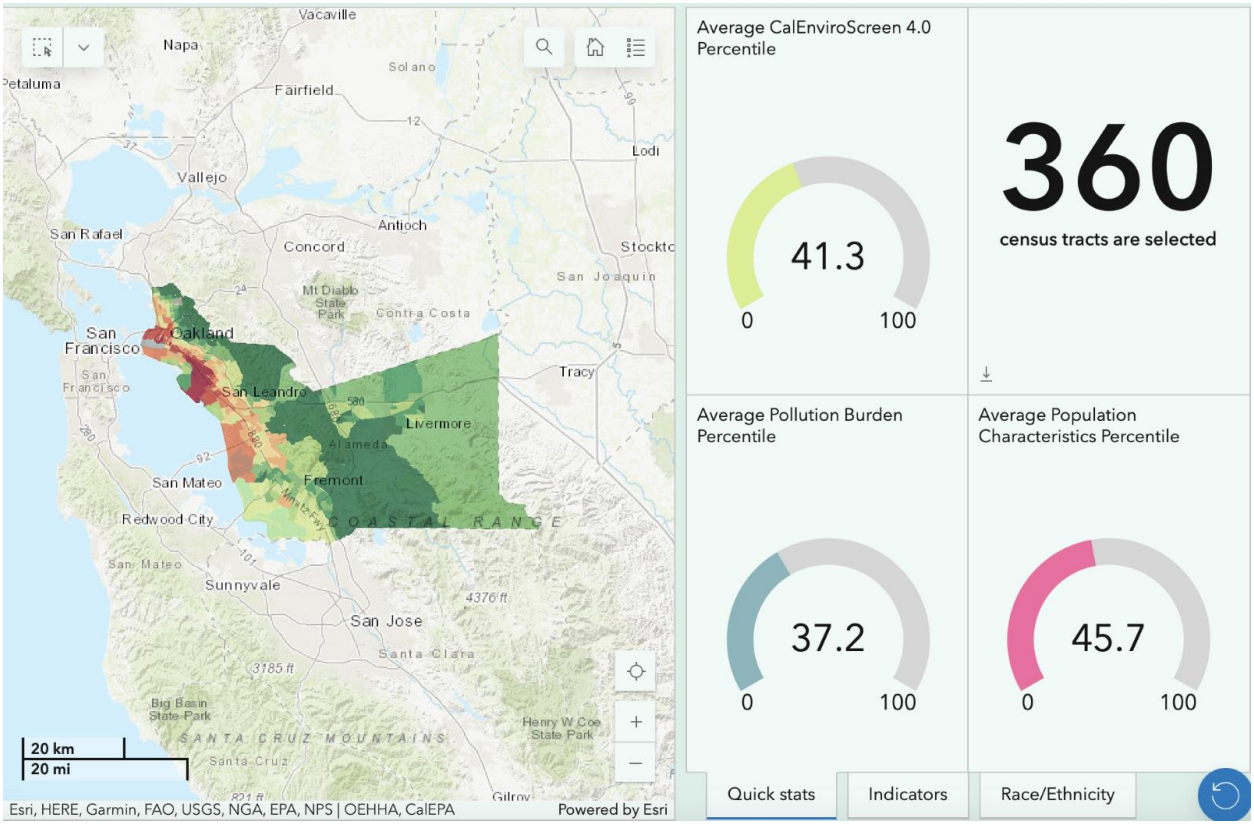
*Source: University of Wisconsin Population Health Institute, County Health Rankings & Roadmaps (2023) and US Census Bureau, QuickFacts, Population Estimates, July 1, 2022 (V2022)*

Alameda County has the second lowest age-adjusted death rates due to drugs (15 per 100,000), which is lower than the Healthy People 2030 goal. The county's age- adjusted suicide rate is 9.0 per 100,000, which is also lower than Health People 2030 goal.

California's Office of Environmental Health Hazard Assessment has created the CalEnviroScreen 4.0 model to assess pollution burden and population characteristics that increase vulnerability to pollution among census tracts throughout the state. The pollution burden is measured through the averages of environmental exposures and effects. Population characteristics are measured through the average of sensitive populations and socioeconomic factors components. The total score is calculated by combining the pollution burden and population characteristics. Below in Figure 22 is a map of the 2023 CalEnviroScreen results for Alameda County. The areas with lower burden and vulnerability to pollution

are green and the neighborhoods with the highest are red. Areas of Oakland, San Leandro, and Hayward have the highest burden of pollution and vulnerability to pollution.

***Figure 21. Alameda County Burden of Pollution and Vulnerability to Pollution Scores***




*Source : California Office of Environmental Health Hazard Assessment, CalEnviroScreen 4.0 Dashboard, (2023)*

Using pooled yearly California Health Interview Survey (CHIS) data from 2018 through 2021, an analysis of 5 Bay Area counites (Alameda, Contra Costa, Marin, Santa Clara, and San Francisco) revealed that San Francisco (15.4%) has the highest percentage of their population reported to have "likely had psychological distress during the last year," while Marin has the lowest (11.5%). Alameda County has the third highest percentage of moderate or severe "social life impairment" during the past year (20.4%); 13.4% of the Alameda survey respondents reported seriously thinking about suicide. Additionally, 22.1% of Alameda County respondents responded that they "needed help for emotional/mental health problems or use of alcohol/drugs," a percentage also held by both Marin and Santa Clara County. About 20% of Alameda County respondents saw any form of healthcare practitioner for emotional/mental health or drug/alcohol issues in the past year.

When compared to the previous plan analysis, which used pooled data for the years between 2015 through 2022, the current mental health indicators reveal a worsening trend with respect to respondents' mental health status. A comparison between Tables 9 and 10 shows all 5 counties reported increases in psychological distress; moderate or severe social impairment; serious thoughts of suicide; and needing help for emotional/ mental health or substance abuse disorders. Furthermore, this comparison reveals a marked drop in the percentage of respondents receiving care for mental health or substance use disorders

from a healthcare practitioner. While a causal analysis of these trends is beyond the scope of this plan, we note that such movement corresponds to the impact wrought upon the population at large by the COVID 19 epidemic that began in 2020.

*Table 9. Mental Health Indicators for Adults in Bay Area Counties (2018-2021)*

| Indicator | Alameda | Contra Costa | Marin | San Francisco | Santa Clara |
|---|---|---|---|---|---|
| **Likely has had serious psychological distress in the past year** | 14.4% | 14.5% | 11.6% | 15.9% | 14.1% |
| **Moderate or severe social life impairment in the past year** | 47.3% | 42.4% | 58.4% | 45.2% | 50.7% |
| **Ever thought about committing suicide** | 14.7% | 13.8% | 14.5% | 15.1% | 14.6% |
| **Needed help for emotional/mental health problems or use of alcohol drug** | 24.0% | 23.6% | 22.9% | 31.7% | 22.5% |
| **Saw any healthcare provider for emotional-mental and/or alcohol-drug issues in past year** | 64.5% | 59.9% | 64.0% | 57.0% | 51.0% |

*Source: 2023 California Health Interview Survey and County Health Rankings (Pooled)*

*Table 10. Mental Health Indicators for Adults in Bay Area Counties (2023)*

| Indicator | Alameda | Contra Costa | Marin | San Francisco | Santa Clara |
|---|---|---|---|---|---|
| **Likely has had serious psychological distress in the past year** | 17.1 | 10.7% | 12.8% | 17.8% | 16.3% |
| **Moderate or severe social life impairment in the past year** | 12.0% | 7.4% | 6.4% | 10.1% | 12.6% |
| **Ever thought about committing suicide** | 19.2% | 16.3% | 18.0% | 23.3% | 16.4% |
| **Needed help for emotional/mental health problems or use of alcohol drug** | 9.1% | 6.4% | 11.6% | 14.0% | 7.4% |
| **Saw any healthcare provider for emotional-mental and/or alcohol- drug issues in past year** | 57.6% | 61.1% | 56.9% | 68.2% | 58.7% |

Source: 2015,2016, 2017, 2018 California Health Interview Survey and County Health Rankings (Pooled)

The CHIS data also reveals trends in behavioral health indicators with respect to race and ethnicity in Alameda County, seen in Tables 11 and 12.

*Table 11. Mental Health Indicators for Adults in Bay Area Counties by Race (2023)*

| Indicator | Asian | Black or African American | White | Other Race | Two or More Races |
|---|---|---|---|---|---|
| **Likely has had serious psychological distress in the past year** | 41.9% | 15.8% | 21.8% | Not Statistically Available | 31.6% |
| **Moderate or severe social life impairment in the past year** | 17.3% | Not Statistically Available | 45.6% | Not Statistically Available | Not Statistically Available |

| | | | | | |
|---|---|---|---|---|---|
| **Ever thought about committing suicide** | 11.9% | 30.0% | 24.7% | Not Statistically Available | 33.8% |
| **Needed help for emotional/mental health problems or use of alcohol drug** | 12.8% | 27.0% | 27.6% | Not Statistically Available | 36.6% |
| **Saw any healthcare provider for emotional-mental and/or alcohol-drug issues in past year** | 11.3% | 21.5% | 25.3% | Not Statistically Available | 23.2% |

*Source: 2023 California Health Interview Survey*
*Source: 2018,2019, 2020, 2021 California Health Interview Survey and County Health Rankings (Pooled)*

***Table 12.** Mental Health Indicators for Adults in Bay Area Counties by Ethnicity (2015-2018)*

| Indicator | Hispanic/Latino | Not Hispanic/Latino |
|---|---|---|
| **Likely has had serious psychological distress in the past year** | 10.6% | 13.7% |
| **Moderate or severe social life impairment in the past year** | 15.4% | 21.7% |
| **Ever thought about committing suicide** | 17.2% | 15.0% |
| **Needed help for emotional/mental health problems or use of alcohol drug** | 14.4% | 24.3% |
| **Saw any healthcare provider for emotional-mental and/or alcohol-drug issues in past year** | 17.8% | 20.8% |

*Source: 2015,2016, 2017, 2018 California Health Interview Survey and County Health Rankings (Pooled)*

To live into our value of culturally responsiveness, we used community-driven strategies to assess population and service needs for our MHSA CSS plan. From October 10,2023- January 16, 2023, we conducted our Community Program Planning Process (CPPP) with 36 listening sessions for 396 participants. As outlined in Table 13, the listening session participants represented key communities identified using Alameda County's profile data. The CPPP Planning Committee (CPPP-PC), comprised of 21 members representing service providers, social services, education, law enforcement and peer and family members, did the outreach and facilitation of the listening sessions.

***Table 13. CPPP Listening Session Descriptions***

| Listening Session | Description |
|---|---|
| ***Mental Health Services Act Community Education & Input Meeting*** | Education and Information sharing about MHSA, Stakeholder Engagement and Information Gathering |
| ***ACBH Pride Coalition Meeting*** | This listening session, attended by 13 participants, aimed to get strategies, solutions, and feedback that would help the MHSA Division gather data for the FY 24/25 Update Plan that goes to the BOS and then the State. |
| ***Alameda/ Contra Costa Medical Association*** | This session, held on 1/4/2024 shared their top concerns for community needs, such as Community Violence and Trauma, Behavioral Health Workforce, and Access, Coordination and Navigation to Services. |
| ***African American Family Outreach Project*** | This session was held on 10/2/23 and was attended by 15 participants. Participants identified streamlining service access with a centralized system, consistent crisis response, and comprehensive aftercare plans. |
| ***First 5 Fatherhood Summit*** | This session was held on 12/4/23. The MHSA team spoke with leaders of the Fatherhood Summit with First 5 Alameda County to address the needs of fathers in the mental health landscape. |
| ***AHS TAY Group*** | This session was held on 11/29/23 and was attended by 4 participants. Participants identified solutions such as media projects to reduce stigma/discrimination regarding mental health services and stories and information on how effective or helpful mental health services can be. |
| ***Axis Community*** | Held on 11/09/23 this listening session focused on addressing the crisis in the behavioral health workforce, creating integrated systems to address substance abuse, minimizing gaps in crisis intervention services, and creating service-enriched housing programs. |
| ***Casa Ubuntu English Listening Session*** | Held on 10/24/23 with 5 participants this session presented information regarding community needs based on collected data over prior years. |

| | |
|---|---|
| ***Casa U Spanish Speaking*** | This event was held on 10/24/ 2023 with 5 participants, this session presented information in Spanish regarding the needs of the community that were based on collected data over prior years. |
| ***City of Fremont Human Services team*** | This event was held on 11/8/2023 and was a listening session featuring 4 participants who worked with youth, young adult, adult, and older adult services for the City of Fremont (Provider). |
| ***City of Livermore, Community Development Department*** | This event held on 11/17/2023 focused on the need for services and support to be physically located in the Tri-Valley Area. Having services in the Tri-Valley area would allow for relationship development and knowledge of residents and neighborhoods, which helps increase access, coordination, and navigation of services. |
| ***City Oakland Human Services Department*** | This event held on 11/13/2023 focused on the needs and challenges focusing on diverse demographic groups. Community Violence and Trauma are a top priority to address escalating domestic violence and homeless violence threats. |
| ***Community Planning & Processing Committee*** | This event held on 10/27/2023 and included 12 participants and identified community needs and solutions. |
| ***City of San Leandro*** | This event held on 11/16/2023 focused on the need for crisis intervention services and ways of identifying opportunities for continued collaboration. |
| ***Family Education and Resource Centers (FERC)*** | This event held on 11/03/2023 and included 13 participants discussed pressing community needs and offered insights. Participants voiced concerns about the cycle of violence, theft, and gun violence in East Oakland, highlighting the need for changes in police priorities, aesthetics improvement, and the creation of safe spaces for youth. |
| ***Family Education Resource Center Spanish Listening*** | This event held on 12/18/2023 focused on the mental health challenges and solutions to addressing the mental health needs of the Spanish speaking population. The group highlighted the barriers to language accessibility, the stigma around receiving mental health services, and the lack of accessible information. |
| ***First 5 Help Me Grow*** | This event held on 12/1/2023 focused on ways to address clients' top needs: Access, Coordination, and Navigation to Services, Behavioral Health Workforce, Community Violence and Trauma, and the Housing Continuum. |
| ***Jay Mahler Recovery Center*** | This event held on 12/07/2023 and included 10 participants and focused on the top needs of the group, which were the Housing Continuum, Substance Use, and the Needs of the Re-entry Community. The group expressed the need for more housing for the unhoused and detailed how housing is a barrier to mental health. |

| | |
|---|---|
| ***La Familia*** | This event held on 12/6/2023 reviewed the complexities of structuring mental health services in Alameda County. The discussion highlighted the essential need for increased access, efficient coordination, and successful navigation of the services available to mental health clients in Alameda County. |
| ***LGBTQ Center*** | This event held on 12/7/2023 focused on understanding/ addressing the need for more programs to address social isolation in the elderly population. |
| ***Mental Health Association for Chinese Communities*** | This event held on 1/4/2024 and included 12 participants and focused on top mental health needs, which included access/coordination/navigation of services, workforce and children/youth/young adult needs. |
| ***Pacific Center*** | This event held on 11/20/2023 and focused on clients' top needs: Access, Coordination and Navigation to Services, Behavioral Health Workforce, Child/Youth/Young Adult Needs, and the Crisis Continuum. |
| ***Peers Transitional Age Youth Group*** | This event held on 12/6/2024 and included 7 community members highlighted their top concerns as: Access, Coordination and Navigation to Services, Housing Continuum, Child/Youth/Young Adult Needs and Substance Use. They addressed that there needs to be cultural destigmatization around mental health services and incentivization for youth to want to come forward to access mental health services. |
| ***Peers Org. Comm. Change (POCC) MHSA Planning Meeting*** | This event held on 11/21/2023 included 30 participants and focused on identified areas of need. |
| ***Supportive Housing Community Land Alliance (SHCLA)*** | This event held on 11/29/2023 presented the top needs of the clients which were: Housing Continuum, Behavioral Health Workforce, Crisis Continuum, Access, Coordination and Navigation to Services, and Substance Abuse |
| ***Swords to Plowshares (STP)*** | This event held on 11/02/2023 and included 17 participants and identified Veterans' Need, which were more Advocacy centers like Swords to Plowshares, emphasize more mental health training, addressing impacts of hospital closures, and call for ongoing support. |
| ***African Communities Program Manager*** | This event held on 12/8/2023 highlighted their top needs as Access, Coordination and Navigation to Services, Community Violence and Trauma, Child/Youth/Young Adult Needs, and Adult/Older Adult Needs. |
| ***Veterans Collaborative Courts*** | This event held on 10/24/2023 and 10/27/2023 included 6 participants and focused on the need for more local facilities and improved transportation options to these facilities. |

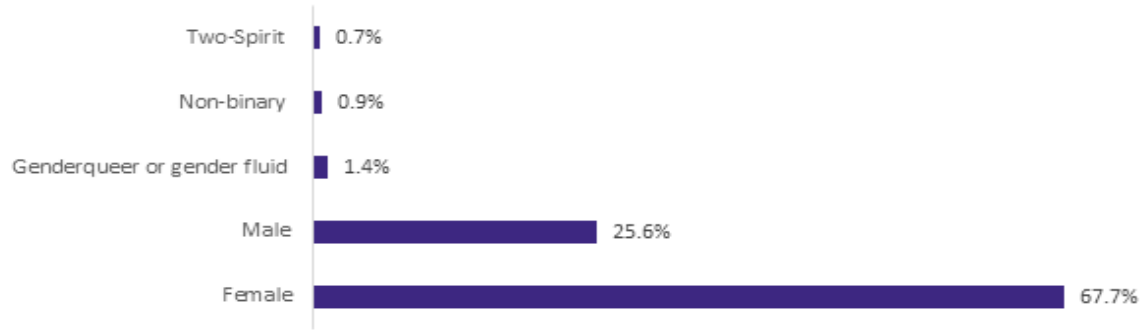
| | |
|---|---|
| ***Families Advocating for the Seriously Mentally Ill (FASMI)*** | This event held on 1/12/2024 and included 7 participants focused on overall concern and frustration with the lack of coordination of care for those living with a serious mental illness. |
| ***Ashland Cherryland Food and Basic Needs Coordination Committee*** | This event held on 1/9/2024 and 2/13/2024 included 45 participants who identified Access/Coordination/Navigation, Housing and Child/Youth Needs as top areas of needs. |

The CPPP-PC also engaged with mental health affiliate groups and adapted outreach activities to reduce community members' barriers, such as lack of technology access and inadequate transportation, to participate in the CPPP. One key adaption the CPPP-PC implemented was re-launching the community input website. The new version of the website had 16,457 pageviews and 4,058 new users. The CPPP-PC also developed community podcasts and forums and administered an online survey to gather insights and feedback from the broader community. The 21-question survey was available in English, Chinese, and Spanish, which are three of Alameda County's threshold languages. A total of 581 surveys were completed with 99% completed in English. Survey respondents ranged from 16 years old to over 60 with majority (60%) being 26-59 years old, as seen in Figure 23.

***Figure 22. Survey Respondents by Age, n=576***


*Source: MHSA Three-Year Plan for FY 23/26* [31]

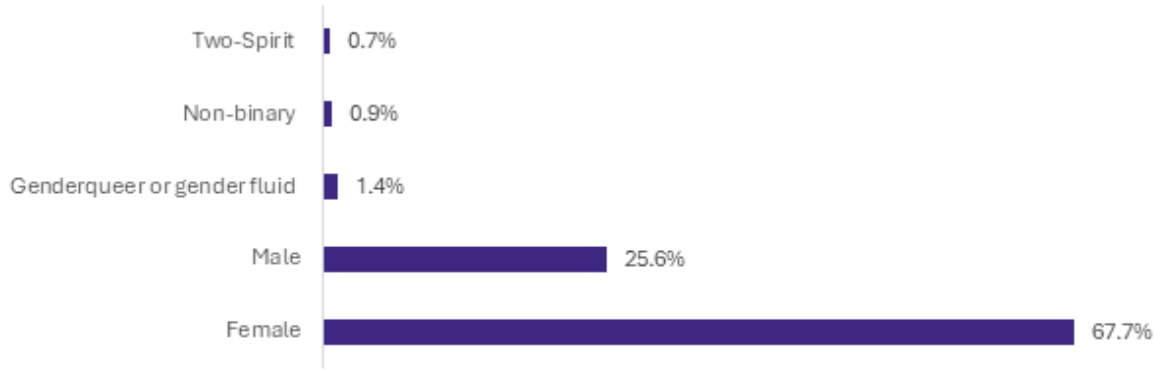
***Figure 23. Survey Respondents by Gender Identity, n= 558***




*Source: MHSA Three-Year Plan for FY 23/26* [32]

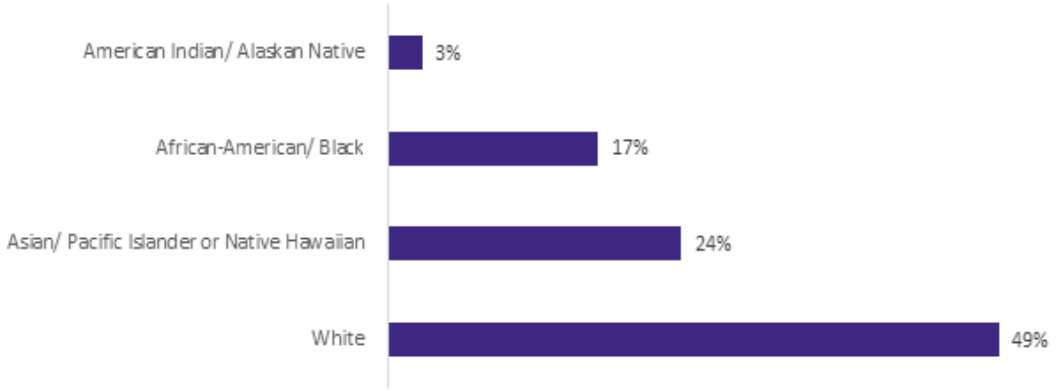
As shown in Figure 24, majority of survey respondents identified as female (68%).

***Figure 24. Survey Respondents by Race, n=552***

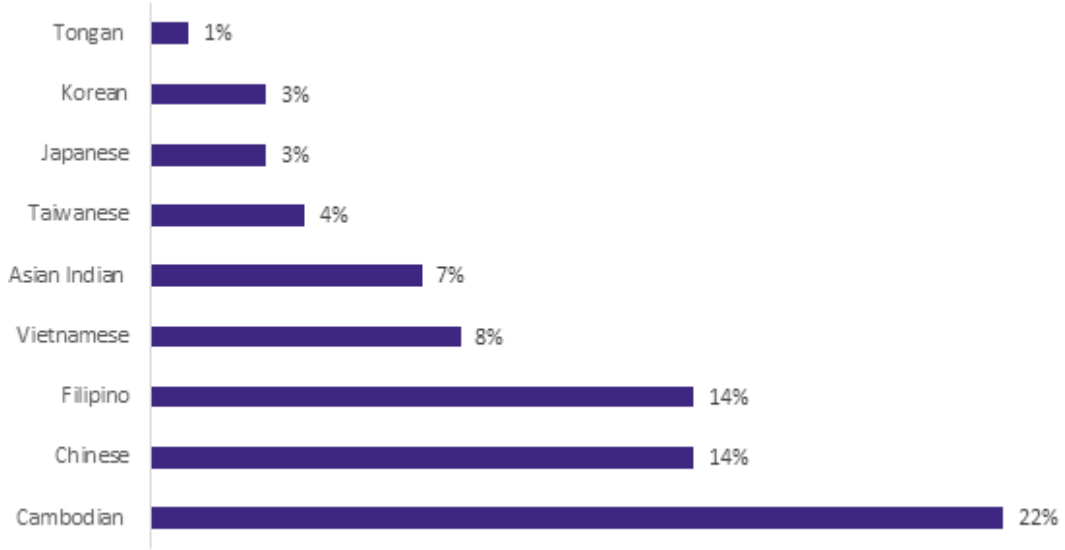



*Source: MHSA Three-Year Plan for FY 23/26* [33]

Almost half of respondents identified as White (49%), as shown in Figure 25, and 13.4% identified as Hispanic/Latino. (See below)




Of the respondents who identified as Asian or Pacific Islander, the highest identified nationalities were Cambodian (22%), Chinese (14%) and Filipino (14%), shown in Figure 26. (See below)




## B. Analysis of Disparities

From the MHSA CSS population assessment, there is one particularly noticeable gap between general population and mental health survey data for those identifying as Asian. In the CHIS data, this racial group embodies a substantially lower percentage of the survey respondent data for any given mental health indicator. For example, those identifying as Asian report suicidal thoughts or serious psychological impairments at much lower levels (10.1% and 10.7%, respectively) when examined against the Census general population percentage of 32.1%. Similar trends exist among White populations. For example, 22.6% of White CHIS respondents indicate moderate or severe social impairment but represent 28.1% of the Census data. On the other hand, 27.0% of CHIS respondents that identify as

being Black or African American reported needing help with emotional/mental health or substance abuse issues while representing only 9.5% of the Census data. Similarly, people that self-identify as being of two or more races, while representing 5.3% of the Census population, represent 36.0% of the CHIS respondents that report needing help with emotional/mental health or substance use issues.

Across each CPPP listening session, community-specific priorities to address behavioral health disparities were identified, as outlined in Table 14.

***Table 14. CPPP Listening Session Priorities***

| Listening Session | Priorities |
|---|---|
| ***Board of Supervisors' District 4 (Oakland) —Listening Sessions*** | The stakeholder group was identified as Oakland residents. Participants identified homeless/unhoused veterans and school-age youth as the most underserved populations within their community. It was also shared that increased isolation, fentanyl use, and issues with rate hikes for online therapy were pressing concerns. Participants suggested that MHSA provide CFTN funds to update John George and provide more outreach at local libraries as well as mental health first-aid training. |
| ***Peers Envisioning and Engaging in Recovery Services (PEERS) WRAP® — Listening Session*** | Participants identified the African American, Latinx, LGBTQIA+, TAY, and Asian populations as groups that should be targeted for programming. Participants suggested that MHSA address the needs of vulnerable groups with more peer support services, co-located services where populations congregate, and centralized resource hubs. The session included 10 Hispanic/Latinx (Mexican, Puerto Rican, Salvadorian, and Peruvian) participants. |
| ***Asian-Pacific Islander Reentry and Systems Impacted Individuals —Listening Session*** | Participants identified the African American, Latinx, and substance user subgroups as the most underserved within their community. Reported concerns include a lack of culturally appropriate linguistic services, stigma in communities, and the need for outreach to support Asian mental health. Participants suggested that MHSA address the reentry process by using elderly API members and interpreters to provide services and technical support for APIs and to encourage those with lived experience to lead decision-making processes. The session included nine API (Vietnamese, Tongan, Chinese, Cambodian, Filipino) and Hispanic participants. |
| ***Behavioral Health Collaborative of Alameda County — Listening Sessions I and II*** | MHSA facilitated two listening sessions with behavioral health providers who identified homelessness, a need for service integration, and safety nets for children as pressing mental health needs. Participants reported many barriers for their agencies, such as the shift to CalAIM, which may impact their ability to travel to meet clients. The stakeholders suggested more pop-up services in mental health desert communities, as well as embedding services where community members meet, such as churches and liquor stores. |

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| ***Pacific Islander Wellness Initiative (RAMS, Inc.) — Listening Session*** | Participants reported the following barriers: PTSD/grief, family relations and stigma, anxiety, and telehealth. Participants identified at-risk groups, such as undocumented communities, low-income individuals, the elderly, Micronesians, Palauans, Native Hawaiians, and Polynesians. Additional recommendations were made concerning the use of Western medicine, which may not be appropriate; the need to reduce funding to organizations that do not provide adequate services; and more funding around transportation. The session included six Pacific Islanders (Samoan, Tongan) who are 18–59 years old. |
| ***MHSA Stakeholder Group — Listening Session*** | The MHSA Stakeholder Group identified supportive housing and the need for sub-acute beds as the most pressing mental health issues. Participants noted many barriers, such as communication silos, workforce pay issues, and a need for more peer support specialists. |
| ***Transitional Age Youth (TAY) —Listening Session*** | MHSA cohosted a community-input meeting with college-age youth. The top mental health issues for this age group included parental consent for treatment, self-identity, basic needs, and anxiety. Stakeholders identified underserved groups as veterans, LGTBQIA+ individuals, Black students, immigrants/refugees, and people with cognitive disabilities. Participants identified solutions, such as using personality tests to identify appropriate resources for youth, increasing university mental health resources, wellness centers, and one-stop shops for counseling young adults. The session included 10 African American, Asian, Latinx, and Vietnamese youth who are 18–24 years old. |
| ***Afghan Coalition —Listening Session*** | Participants identified a variety of barriers, such as trauma, transportation, language barriers, school bullying, fear of harm, outreach, financial burdens, and the need to address basic services first. Participants recommend establishing more Muslim schools / empowerment-focused educational centers, launching anti-stigma campaigns, establishing a basic needs distribution center, establishing elderly centers, and diversifying mental health teams with Pashto-speaking providers. |
| ***Mental Health Association of Alameda County (MHAAC) African American Family Support Group—Listening Session*** | MHSA cohosted a community- input meeting with African American family members who identified high-needs groups as poor communities, children and teens, and the unhoused. Specific recommendations for families included more mental health counselors in schools, culturally competent screenings, addressing HIPAA issues and revisiting waiver policies, and using African American models in psychiatry. |
| ***MHAAC—Family Education Resource Center (FERC) — Listening Session*** | Specific recommendations for families included increasing supports in schools and IEPs, more 504s, implementing NAMI Ending the Silence programs in high schools, and adding a line item to the MHSA budget to support AB2002. |
| ***Alameda-Contra Costa Medical Association (ACCMA) — Listening Session*** | MHSA facilitated a listening session for a multicounty provider collaborative. ACCMA providers brought up a variety of barriers, such as the workforce shortage of mental health professions, appointment availability, narrow access to services, communication issues between providers, and a need for care coordination and support. The group recommended intervention, such as creating spaces adjacent to the emergency department for patients with psychiatric emergencies that are more clinically appropriate than keeping them in the ED. |

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| ***Veterans, Active Duty, and Reservists —Listening Session*** | MHSA cohosted an active military/veteran listening session with Swords to Plowshares. Participants identified post-traumatic stress disorder (PTSD), anxiety, anger, and housing as major mental health challenges. Participants suggested using MHSA dollars to help provide mental health education in schools to destigmatize attitudes and encourage mental health groups/therapy that meet in person to promote social connections. |

Feedback across all listening sessions elevated the following culturally relevant priorities:

- Address mental health workforce needs using non-traditional pathways
- Support the reentry community with diversion services
- Provide more services for the African American community across the lifespan
- Provide supports and activities for the LGBTQ community, particularly the transgender community of color and sex workers
- Increasing language capacity

Survey respondents and focus group participants identified age group specific priorities to advance cultural competency. For children 5 and under, community members expressed the need for culturally responsive programming to address family stress and conflicts and provide screening and assessments. Most survey respondents identified family conflict/stress (52%) and screening/assessment (46%) as absolutely essential. These areas were also identified as priorities for youth 6-12, especially those impacted by community violence and trauma. Majority of survey respondents identified family conflict/stress (56%) and community violence and trauma (55%) as absolutely essential concerns for youth 6-12. Community input also highlighted the disparities in access to mental health resources among middle and high school aged youth. Survey respondents noted the higher need for mental health support for this age group due to increased mental illness and risky behaviors. For transitional age youth (TAY), ages 18-24, survey respondents prioritized the need for resources to address substance use/abuse (65%) and employment, and job/vocational training (65%). Community members noted the need for programs such as collaborative courts to address substance use and abuse and prevent future involvement with the traditional criminal justice system. One essential priority identified by survey respondents for adults and older adults is community violence and trauma (53%). Specifically, respondents emphasized the need for survivor support services, such as PTSD counseling.

The three most unserved or underserved populations identified by survey respondents were those who were severely mentally ill (61%), people experiencing homelessness (61%), and African American/Black residents (58%). ACBHD is exploring including these populations within our priority groups as they have been identified as underserved or unserved in the CSS plan data.

In noting gaps in the behavioral health system, respondents mentioned concerns around language capacity and the system's limited ability to support people who do not speak English. For programs serving those with severe mental illness, community members mentioned a need for more family input for treatment and a better understanding of the Health Insurance Portability and Accountability Act. Community input highlighted the need for more centralized resources for people experiencing homelessness and increased the quality and cultural responsiveness of services for the African American/Black community.

# V. Prevention and Early Intervention (PEI) to Identify Priority Populations

## A. PEI priority population(s)

Alameda County Behavioral Health Department has assessed our Prevention and Early Intervention (PEI) population. The priority populations outlined in our PEI plan include the following:

- **Trauma-exposed children:** Address the early origins of mental health needs with childhood trauma prevention and early intervention
- **Individuals experiencing early psychosis and mood disorder:** Provide mood disorder and suicide prevention programming across the lifespan
- **Children/youth at risk of school failure:** Partnering with college mental health systems for youth outreach and engagement strategies to target secondary school and transition-age youth
- **Culturally and linguistically diverse communities:** Provide culturally competent and linguistically appropriate prevention and early intervention
- **Older adults:** Strategies targeting the mental health needs of older community members
- **Individuals experiencing onset of mental health disorders, including anxiety, depression, and psychosis:** Programming for early identification of mental health symptoms and disorders

## B. Process and rationale in selecting their PEI priority populations(s) (e.g., assessment tools or method utilized).

Internal and external stakeholders recommended that ACBHD develop a task force of Prevention and Early Intervention (PEI) experts, leaders, clients/consumers, family, and community members to develop targeted strategic and programmatic recommendations for the populations identified below. Involved participants reviewed data, prioritized issues, and recommended the expansion of interventions designed to address the needs of youth in the community and include evidence-based crisis prevention efforts such as training of youth, parents, and school staff on identifying signs of mental health or substance use related issues, reducing stigma and supporting youth behavioral health acknowledge of available resources.

# Criterion III

## *Strategies and Efforts for Reducing Racial, Ethnic, Cultural, and Linguistic Mental Health Disparities*

We are intentional in our efforts to reduce mental health disparities and create a more equitable and inclusive behavioral health system.

### I. Identified unserved/underserved target populations with disparities

Through our analysis of data for the Alameda County community and our MHS and SUD beneficiaries, we have identified the unserved and underserved priority populations in Table

*Table 15. Unserved and Underserved Target Populations*

| Population Assessed | Target Populations |
|---|---|
| **Community Services Support (CSS)/ Full-Service Partnership** | • Transition Age Youth<br>• Older adults, individuals with forensic background, zero income and who have active substance use disorder in addition to co-occurring mental health conditions. |
| **Prevention and Early Intervention (PEI)** | • Trauma-exposed children<br>• Individuals experiencing early psychosis and mood disorder<br>• Children/youth at risk of school failure<br>• Culturally and linguistically diverse communities |

**Selection Process for Prevention and Early Intervention (PEI) Priority Populations**

**I. Stakeholder Engagement Process**

A. Key Stakeholders Involved/Invited

B. Data Collection Methods

**II. Selection Criteria and Disparities Analysis**

A. Key Stakeholders Involved/Invited

- Access Disparities
- Outcome Disparities
- Cultural Barriers

B. Priority Population Selection Criteria

**III. Selected Priority Populations**

A. Primary Focus Groups:

- Limited English Proficiency
  - Demonstrated Significant access barriers
  - High unmet prevention needs

        - Limited culturally appropriate services
    - Transitional Age Youth (TAY) 16-25 years old
        - High Risk for onset of mental health conditions
        - Lower engagement in preventative services
        - Cultural barriers to help-seeking
    - Rural Communities
        - Limited-service access
        - Transportation barriers
        - Resource limitations
    - Ethnic Minority Families
        - Cultural stigma Concerns
        - Language access needs
        - Traditional

## IV. Stakeholder Input Integration

A. Input Mechanisms
    - Structured feedback sessions
    - Written recommendations
    - Community forums
    - Advisory board meetings
    - Provider consultations

B. Impact on Selection
    - Modified population definitions based on community input
    - Expanded selection criteria
    - Adjusted priority rankings
    - Enhanced understanding of cultural factors
    - Identified additional service needs

## V. Ongoing Review Process

A. Annual Review Components
    - Updated disparities data
    - Population demographic changes
    - Service utilization trends
    - Emerging community needs
    - Resource allocation analysis

B. Adjustment Procedures
    - Progress reviews
    - Stakeholder feedback integration
    - Data-driven modifications
    - Resource reallocation as needed
    - Strategy refinement based on outcomes

This selection process remains dynamic, with regular reviews and adjustments based on emerging data and community input to ensure continued alignment with population needs and systemic disparities reduction goals.

## II. Identified disparities within target populations

### A. Disparities from the Medi-Cal, CSS, WET and PEI Priority/Targeted Populations

To create a continuum of care available for all Alameda County residents, we will reduce the population-specific disparities identified in Table 17.

## III. Strategies/objectives/actions/timelines

### A. Strategies identified for each targeted area in the following sections:

- Medi-Cal population
- MHSA/CSS population
- PEI Priority population(s)

| | |
|---|---|
| **AREA 1:** | Enhance Behavioral Health Access and Engagement for Asian American Native Hawaiian and Pacific Islander (AANHPI) Communities |
| **OBJECTIVE:** | Enhance health equity for AANHPI communities, through increasing access and utilization of behavioral health services and improved health outcomes for Alameda County residents who have emerging to persistent, severe mental health conditions.<br>▪ Create an AANHPI Advisory Committee in February 2024 to strategize increase of utilization through outreach and engagement, identifying and addressing barriers to service provision, and development or support of relevant and appropriate service provision to/within communities. |
| **INDICATOR & BASELINE:** | ▪ Number of people/organizations participating in the AANHPI Advisory Group<br>▪ Number of AANHPI related community engagement events<br>*Baseline data pending |
| **ACTION STEPS:** | ▪ Implement recurring AANHPI-focused community engagement events and activities.<br>▪ Provide AANHPI focused Behavioral Health related trainings for providers, ACBH staff and advisory committee members. |
| **MONITORING METHOD/ TIMEFRAME:** | ▪ Recruitment and engagement of AANHPI providers/partners- September to December 2023<br>▪ AANHPI Advisory Committee- February 2024<br>▪ Community Engagement Activities- May to June 2024 |
| **RESPONSIBLE PARTNERS:** | Health Equity Division, Office of the Medical Director, and all Systems of Care (SUD, Children and Youth, Adult, Forensics) |

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| **AREA 2:** | Enhance Behavioral Health Access and Engagement for Asian American Native Hawaiian and Pacific Islander (AANHPI) Communities In South County and Older Adult AANHPI Population |
| **OBJECTIVE:** | Increase ACBH services to the older adult AANHPI population by enhancing our existing partnership with the City of Fremont<br>▪ Increase services to older adult AANHPI clients by providing services in community settings.<br>▪ Establish a presence in the two (2) Age Well Centers and in the two (2) Senior Housing Complexes whose residents are primarily AANHPI.<br>▪ Improve penetration rates within Alameda County for individuals in the older adult AANHPI communities, with a focus on those residing in South Alameda County (Fremont, Newark, Union City).<br>▪ Develop a curriculum that is culturally appropriate and responsive to AANHPI needs. |
| **INDICATOR & BASELINE:** | ▪ Number of AANHPI older adults served by the Older Adult program<br>▪ Number and percentage of field-based services provided by the Older Adult program<br>▪ Number of group outreach sessions provided by the Older Adult program<br>*Baseline data pending |
| **ACTION STEPS:** | ▪ Expand the contract with the City of Fremont Older Adult Program<br>▪ Hire 2-4 additional bilingual full-time clinicians to provide Specialty Mental Health services<br>▪ Establish an ongoing presence at the City of Fremont Age Well Centers<br>▪ Establish an ongoing presence at three Senior Housing Complexes<br>▪ Facilitate stakeholder meetings to explore additional community locations, such as ethnic faith-based facilities |
| **MONITORING METHOD/ TIMEFRAME:** | Contract expansion to be completed by beginning of FY 23/24<br>ACBH and the City of Fremont will hold monthly meetings to assess deliverables, successes and challenges. A survey will also be developed and used to gather client centered data. Service data from SmartCare will be used to establish both baseline and post contract augmentation metrics. |
| **RESPONSIBLE PARTNERS:** | Adult and Older Adult System of Care – Older Adult Division |

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|---|---|
| **AREA 3:** | Enhance Behavioral Health Access and Engagement for AANHPI Communities within Primary Care Settings/ Integration of Primary Care and Behavioral Health Care Services |
| **OBJECTIVE:** | Enhance health equity for the AANHPI communities, through increasing access and utilization of behavioral health services within a primary care setting: Bay Area Community Hospital (BACH), and improve health outcomes for Alameda County residents who have emerging to persistent, severe mental health conditions<br>▪ Increase the percent of adult AANHPI BACH patients referred to behavioral health services at BACH by 20%<br>▪ Increase the percent of adult AANHPI BACH patients receiving at least one behavioral health service at BACH by 15%<br>▪ Reach at least 300 AANHPI adult residents in AANHPI -focused health outreach activities<br>▪ Create an API Patient Advisory Board at BACH |
| **INDICATOR & BASELINE:** | ▪ Number and percent adult AANHPI BACH patients referred to behavioral health services at BACH<br>▪ Number and percent of adult AANHPI BACH patients receiving at least one behavioral health service at BACH<br>▪ Number of adult AANHPI residents participating in AANHPI -focused outreach health activities<br>▪ Number of people participating in the AANHPI Patient Advisory Board at BACH<br>*Baseline data pending |
| **ACTION STEPS:** | ▪ Implement recurring AANHPI -focused community health outreach events<br>▪ Build AANHPI behavioral health capacity at BACH to serve AANHPI residents<br>▪ Form AANHPI Patient Advisory at BACH |
| **MONITORING METHOD/ TIMEFRAME:** | Outreach Activities to begin in October 2023<br>AANHPI Advisory Board by February 2024<br>Data from SharePoint, OCHN Epic |
| **RESPONSIBLE PARTNERS:** | Office of the Medical Director, Health Equity Office, BACH |

# IV. Additional strategies/objectives/actions/timeline and lessons learned

## A. New Strategies

1. Success and Lessons Learned from the Development of Strategies, Objectives, Actions and Timelines to Reduce Disparities within target populations of Medi-Cal, CSS, WET and PEI

Alameda County Behavioral Health Department has identified several key successful approaches in developing and implementing disparities reduction strategies across Medi-Cal, CSS, WET, and PEI programs:

**Community Engagement Success Factors:**

- Early and consistent involvement of the Community Review Committee proved essential in strategy development
- Integration of cultural brokers in planning processes enhanced community trust and participation
- Regular feedback loops with service recipients helped refine objectives and timelines
- Multilingual community forums increased diverse participation in planning

**Data-Driven Strategy Development:**

- Comprehensive baseline assessments informed realistic goal-setting
- Integration of both quantitative and qualitative data strengthened strategy development
- Regular review of demographic data helped identify emerging needs
- Population-specific metrics improved the targeting of interventions

**Key Lessons Learned:**

**1. Timeline Considerations**

- Initial timelines often need to be extended
- Implementation pace varies by population
- Cultural adaptation requires additional time
- Community engagement timelines need flexibility

**2. Strategic Adjustments**

- Increased focus on virtual service delivery
- Enhanced language access services
- Strengthened community partnerships
- Modified outreach strategies based on population needs

**3. Resource Allocation**

- Reallocation of resources based on emerging needs
- Investment in technology infrastructure
- Enhanced staff training resources
- Increased translation and interpretation services

**4. Future Focus Areas:**

- Continued refinement of data collection methods
- Enhanced integration of services across programs
- Expanded use of technology solutions
- Strengthened community partnerships

**5. Sustainability Measures:**

- Development of long-term funding strategies
- Building sustainable community partnerships
- Creating permanent feedback mechanisms
- Establishing ongoing evaluation processes

These findings continue to inform our approach to reducing disparities and improving service delivery across all programs and populations served.

# V. Planning and monitoring of identified strategies/objectives/actions/timelines to reduce mental health disparities

## A. Strategies/objectives/actions/timelines and status of implementation efforts

ACBHD implementation of disparities reduction strategies have yielded several critical insights that have shaped our approach:

**1. Timeline Flexibility**

- Community engagement activities needed extended timeframes for meaningful participation
- Service adaptation and staff training required additional time for proper integration
- Population-specific considerations often necessitated timeline modifications

**2. Resource Allocation Lessons**

- Language access services required greater investment than initially projected
- Technology infrastructure needs emerged as critical for service delivery
- Staff training resources needed expansion to address cultural competency gaps
- Community outreach efforts required additional resource allocation

**3. Engagement Strategy Refinements**

- Virtual service delivery options improved accessibility for certain populations
- Cultural broker partnerships proved essential for community trust-building
- Family-centered approaches showed greater effectiveness than individual-focused strategies
- Peer support integration enhanced program acceptance and outcomes

Strategic adjustments made, based on these lessons, we implemented the following adjustments

**Program Delivery Modifications:**

- Enhanced language access protocols across all service points
- Expanded cultural competency requirements for staff
- Implemented flexible service delivery options
- Strengthened community partnership approaches

**Timeline Revisions:**

- Extended implementation phases for cultural adaptation
- Added preparation time for community engagement
- Adjusted staff training schedules to ensure thorough completion
- Modified evaluation timelines to allow for meaningful data collection

Population-Specific Milestones and Notable achievements across different populations include:

**Cultural/Ethnic Minority Groups**

- Increased culturally specific service options
- Improved satisfaction rates among diverse populations
- Enhanced cultural competency across service delivery
- Established new community advisory partnerships

**Youth and Family Services**

- Enhanced school-based program effectiveness
- Improved youth engagement metrics
- Strengthened family-centered care approaches

**Rural Communities**

- Implemented telehealth options
- Improved access to specialized services

**Next Steps and Ongoing Adjustments**

**Moving forward, ACBHD will:**

- Continuing to refine data collection methods
- Expanding successful pilot programs
- Strengthening community feedback mechanisms
- Developing sustainable funding strategies

These lessons and adjustments continue to inform our approach to reducing disparities while ensuring culturally responsive and effective service delivery across all populations served.

## B. Mechanisms to measure and monitor the effect of identified strategies, objectives, actions and timelines on the reduction or elimination of disparities

Alameda County Behavioral Health Department has continued to develop system-wide policies, practices, and procedural guidelines, including a guide on culture, community, and other considerations to ensure more complete data collection of racial and ethnic demographics. The systemwide transition to SmartCare is one practice that aims to improve the collection of baselines and tracking data. The changes to regulatory billing requirements caused by CalAIM were the primary driver for the transition from our legacy system, INSYST, to SmartCare. This new platform will capture the racial, ethnic, cultural, and linguistic diversity of our beneficiaries more efficiently. SmartCare will support providers to be both compliant with ever-changing regulatory requirements and more informed of community needs to better serve beneficiaries. The transition to SmartCare provides stronger, more secure, and coordinated client engagement tools to support more responsive care and service delivery. Our Information Systems team is informing the customization of the platform for the Department's needs and providing technical assistance throughout the transition to SmartCare. This support, including office hours for troubleshooting, will

increase providers' comfort level with the new platform and ensure a streamlined integration of data into their client support.

The HED has also supported efforts for comprehensive demographic data collection in the SmartCare transition, including the collection of SOGIE data and a health equity dashboard. These efforts strengthen our ability to assess our progress in reducing behavioral health disparities across our community.

Alameda County Behavioral Health Department has implemented a multi-faceted approach to monitoring health disparities while adhering to CLAS standards. Our comprehensive monitoring system includes standardized data collection across all service points, quarterly demographic analyses, and a systematic review of patient outcomes stratified by cultural and linguistic factors.

**Current Implementation Strategies**

The Department employs three primary mechanisms to monitor disparities:

**1. Integrated Data Collection System**

- Standardized collection of patient demographic data including race, ethnicity, language preference, and social determinants of health
- Patient satisfaction surveys in multiple languages
- Electronic health record-based disparities dashboard

**2. Quality Monitoring Framework**

- Analysis of clinical outcomes stratified by demographic groups
- Quarterly assessment of service utilization patterns
- Regular evaluation of interpreter services accessibility
- Systematic review of patient grievances and feedback

**3. Community Engagement Process**

- Regularly scheduled community needs assessments
- Regular focus groups with diverse community members
- Partnership with cultural brokers and community health workers
- Ongoing dialogue with community advisory boards

**Measurement Mechanisms and Baseline Data**

Current baseline metrics include:

- Language access: Increased access to Language Interpretation services for our contracted providers
- Cultural competency training
- Patient satisfaction
- Health outcomes

**Successful Strategies**

Several initiatives have shown success:

- Implementation of real-time language access tracking has improved response times
- Cultural competency training program has increased staff confidence in cross-cultural communications
- Community health worker program has improved patient engagement and follow-up rates
- Integrated EHR alerts for language preferences have reduced interpretation delays

**Lessons Learned**

Key insights from our monitoring efforts include:

- Data collection must be streamlined to minimize staff burden while maximizing useful information
- Regular feedback loops with front-line staff are essential for identifying barriers and solutions
- Community input must be incorporated early and often in the monitoring process
- Flexibility in measurement approaches is necessary to capture emerging disparities and trends

**Future Directions**

Based on our findings, Alameda County Behavioral Health will focus on:

- Expanding our disparities dashboard to include additional social determinants of health
- Developing more robust patient experience measures for diverse populations
- Strengthening our community engagement processes
- Implementing automated disparities alerts and tracking systems

Alameda County Behavioral Health Department remains committed to continuous quality improvement with existing disparities in monitoring processes. Our team is focused on actionable data collection and meaningful community engagement. Our evolving approach ensures we can adapt to changing community needs while maintaining consistent progress toward health equity goals.

## C. Technical Assistance Needs

Alameda County Behavioral Health Department has identified several key areas where technical assistance and external expertise would enhance our capacity to reduce behavioral health disparities among priority populations. These needs have emerged through our ongoing monitoring processes and stakeholder feedback.

**Priority Technical Assistance Needs**

**1. Data Analytics Enhancement**

- Technical expertise in integrating social determinants of health data with behavioral health metrics
- Consultation on best practices for measuring behavioral health equity in real-time

**2. Cultural Competency Development**

- Technical support in developing culturally specific outcome measures
- Assistance in creating and validating culturally appropriate assessment tools

**3. Community Engagement Optimization**

- Expertise in developing sustainable community-based participatory research models
- Guidance on establishing effective behavioral health peer support programs
- Consultation on engaging hard-to-reach populations in behavioral health services

**Implementation Support Needed**

The Department requires specific guidance in the following areas:

- Creation of standardized processes for measuring cultural competency impact
- Implementation of evidence-based practices for reducing stigma in diverse communities
- Enhancement of language access services specific to behavioral health contexts

**Timeline Considerations**

Technical assistance is particularly needed to:

- Accelerate the implementation of identified strategies while maintaining quality
- Develop realistic timelines for cultural adaptation of services
- Create meaningful milestones for measuring progress in disparities reduction
- Establish sustainable long-term monitoring processes

**Resource Development Needs**

Support is required for:

- Creating culturally appropriate educational materials for diverse populations
- Developing multilingual behavioral health screening tools
- Building capacity for cultural competency training
- Establishing metrics for evaluating community engagement effectiveness

The Department seeks partnerships with organizations and experts to provide ongoing consultation and support in these areas while aligning with CLAS standards and evidence-based practices in behavioral health equity.

# Criterion IV

***Client/Family Member/Community Committee: Integration of the Communities Within the County Mental Health System***

## I. Cultural Competence Committee (CCC) that addresses cultural issues and participation that is reflective of the community Alameda County Behavioral Health Department has developed to institutionalize our value of social inclusiveness by collaborating with multidisciplinary teams to facilitate culturally competent committees and coalitions; reflective of ABHD's diversity, specifically the Cultural Responsiveness Committee (CRC).

The CCC provides ongoing support for ACBHD in compliance with the State of California, Health and Human Services Agency, and The Department of Health Care Services. The CCC elevates the voice and activates the power of consumers, family members, and staff across the Department. Committee members lift the cultural, racial, and linguistic mental health and substance misuse needs of Medi-Cal beneficiaries and others throughout Alameda County. The CCC collaborates with OES to ensure policies, procedures, and practices demonstrate the following:

- Participants are included in the overall planning and implementation of services at the county level
- Reports are provided to the Quality Assurance and/or Quality Improvement Program
- An annual report of CRC activities is completed as required in the CCP
- Training programs are implemented to improve the cultural competence skills of staff, management, and contracted providers
- Participants are a diverse group of dedicated individuals who reflect the racial, ethnic, cultural, and linguistic diversity of Alameda County

CCC members meet every third Tuesday, bi-monthly for one and a half hours to share insights and provide feedback to support our mission to be client-driven. In its early stages, the CRC was leveraged to support culturally specific groups and plan events. Since planning these events and navigating the changing COVID landscape, the CRC is reimagining its role in supporting ACBHD to advance cultural competency. In this revisioning stage, the CRC is considering its potential role in the following:

- The sharing of CLAS-related knowledge and facilitation of CLAS training
- The growth of the African American Steering Committee for Health and Wellness and its African American Wellness Hub facility
- Change management support for the transition from the Mental Health Services Act to the Behavioral Health Services Act, including community dialogue to discuss and process the impending changes
- Support of new community-specific committees and coalitions, including the AANHPI Advisory Committee for Health and Wellness

- Providing incentives for provider engagement in culturally competent initiatives, such as the CRC
- Raising the awareness of the CRC across ACBHD and the broader community

The members of the CRC represent diverse perspectives and experiences. Several members are asylees or escaping countries impacted by genocide or wars. To ensure members of the CRC are reflective of Alameda County, we instituted the following guidelines.

**I. Membership Composition and Diversity**

**A. Committee Structure**

- The Community Review Committee shall consist of Community members, ACBHD staff, and Contracted Providers
- Membership must maintain representation across the following categories:
- Community members with lived experience
- Healthcare providers or clinical professionals
- Social service organizations
- Cultural/ethnic community organizations
- Public health representatives
- Behavioral health specialists
- Youth advocates (ages 18-24)
- Family members of service recipients

**B. Diversity Requirements**

- Committee composition shall reflect the demographic diversity of the service area
- No single racial/ethnic group shall comprise more than 40% of the membership
- Bilingual Representation
- Geographic representation must include both urban and rural areas
- Various socioeconomic backgrounds must be represented

**II. Member Selection Process**

**A. Nomination Procedures**

Nominations (if needed) may be submitted by:

- Current CRC members
- Partner organizations
- Community members
- Department staff

Nominations must include:

- Detailed background information
- Statement of interest
- Two references
- Demographic information for diversity tracking

### B. Selection Criteria

- Demonstrated commitment to health equity
- History of community involvement
- Unique perspective or expertise
- Ability to attend regular meetings
- Willingness to participate in required training

## III. New Member Onboarding

### A. Required Orientation

- Overview of CRC mission and objectives
- Review of bylaws and procedures
- Cultural competency training
- Confidentiality requirements
- Conflict of interest policies

### B. Mentorship Program

- New members paired with experienced members
- Three-month mentorship period
- Regular check-ins and support

## IV. Meeting Requirements and Participation

### A. Meeting Schedule

- Monthly full committee meetings
- Quarterly strategic planning sessions
- Subcommittee meetings as needed
- Minimum 75% attendance required

### B. Decision-Making Process

- Quorum requires 2/3 of current membership
- Decisions made by consensus when possible
- Formal votes require a simple majority
- Members must recuse themselves from votes presenting conflicts of interest

## VI. Review and Amendment Procedures

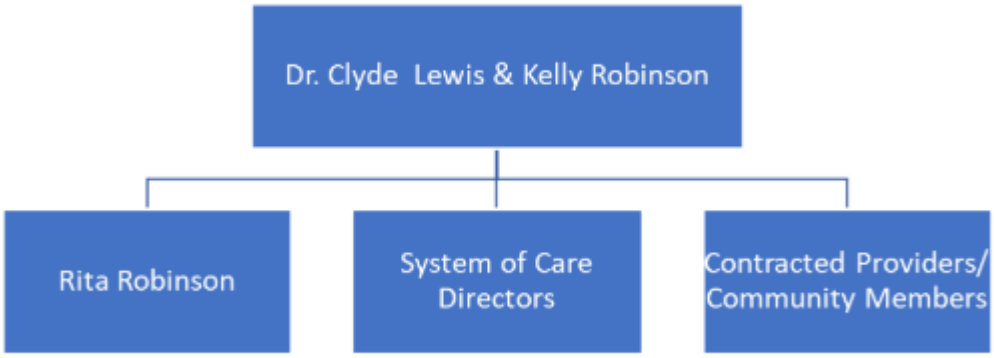
### A. Bylaw Review

- Annual review of bylaws
- Amendments require 2/3 majority vote
- Changes must be approved by Department leadership

**B. Documentation**

- All changes must be documented with rationale
- Updated bylaws distributed to all members
- Training provided on significant changes

These bylaws shall be reviewed annually and updated as needed to ensure continued effectiveness in maintaining diverse representation and meaningful community engagement.




The CRC is co-led by Clyde Lewis, Office of Ethnic Services Administrator, and Kelly Robinson, Prevention & Early Intervention Coordinator. Kelly has been facilitating the CRC since 2020 and led the committee's early support of events and activities to provide space for building community and collective grieving of traumatic events including, COVID and broadcasted police murders of Black men. Clyde took over the role as co-lead in August 2024 when Mona transitioned from her interim ESA tenure

## II. Cultural Competence Committee (CCC)

The CRC has been an active body in advancing cultural competency across our department. The CRC's efforts are reinforced by OES's investment in other culturally specific coalitions and committees. OES intentionally collaborates with those communities most impacted by systemic racism and other oppressions to support our system to move toward the following visions for justice, equity, diversity, and inclusion:

**Alameda County Cultural Responsiveness Committee Vision:** To serve as a guiding body that works to embrace diversity, eliminate health disparities, and advance equity in Alameda County

**Alameda County Pride Coalition Vision:** To decrease stigma among members of the LGBTQIA2S+ community accessing mental health services by providing culturally appropriate care

**Latinx/Latino Advisory Committee for Health and Wellness Vision:** To improve the overall mental health of Latinx communities and improve access, communication, and coordination by breaking the taboo regarding mental health services

**Asian American, Native Hawaiian, and Pacific Islander (AANHPI) Advisory Committee for Health and Wellness Vision:** To develop and improve outreach and engagement that honors AANHPI diverse cultures and languages and destigmatizes behavioral health services to increase access to care, utilization of services, and positive outcomes using reliable and disaggregated data

**African American Steering Committee for Health and Wellness Vision:** To have a behavioral health system where African Americans are equal partners with behavioral health services and are included in the decision-making processes to create, design, develop, and implement policies, procedures, and services for the African American community

The CRC regularly provides insights and guidance for the Department's PEI Site Visits and CCP.

We have expanded the impact of the CRC combining its influence with other committees providing invaluable insights from the peer and family perspective. One committee that has streamlined its efforts is the Family Member and Consumer Quality Improvement Committee Workgroup. This workgroup is comprised of stakeholders who provide feedback on the quality improvement work plan, policies, and procedures. This workgroup has combined with the Peer Family Member Support Committee to create a stronger, more unified voice for peers and families. The Peer Family Member Support Committee is actively engaged in reviewing the Quality Improvement Plan and joins the Quality Improvement Committee meetings once a month to share feedback.

The CRC meets with community stakeholders to identify extant and emerging behavioral health challenges and barriers to service. These meetings allow community stakeholders to inform CRC members, who compile received responses and report back

Community Review Committee Service Planning and Implementation Role

***I. Strategic Planning Involvement***

**A. Needs Assessment**

- CRC conducts reviews of community needs and service gaps
- Provides cultural and linguistic expertise in service design
- Ensures diverse community perspectives are incorporated
- Review demographic data to identify emerging needs
- Validate assessment findings through community feedback

**B. Program Development**

- Participates in initial service design phases
- Review the cultural appropriateness of proposed services
- Provides input on accessibility considerations
- Recommends modifications based on community feedback
- Ensures alignment with CLAS standards

***II. Implementation Oversight***

**A. Service Delivery Monitoring**

- Review implementation progress through monthly reports
- Identifies barriers to service access
- Monitors cultural and linguistic appropriateness
- Evaluate community engagement effectiveness
- Provides real-time feedback on service modifications

**B. Quality Assurance**

- Review service utilization data
- Monitors satisfaction rates across diverse populations
- Evaluate effectiveness of language access services
- Assesses cultural competency in service delivery
- Recommends quality improvement measures

***III. Community Engagement***

**A. Feedback Collection**

- Facilitates community forums and focus groups
- Gathers input through cultural brokers
- Conducts surveys in multiple languages
- Maintains ongoing dialogue with community members
- Documents community concerns and suggestions

**B. Communication Channels**

- Serves as liaison between community and department
- Provides regular updates to community stakeholders
- Facilitates bi-directional information flow
- Ensures transparency in planning processes
- Maintains community trust through consistent engagement

***IV. Continuous Improvement Role***

**A. Performance Monitoring**

- Reviews outcome data by population group
- Identifies disparities in service delivery
- Recommends targeted improvements
- Tracks progress on equity goals
- Evaluate the effectiveness of interventions

**B. Program Adaptation**

- Suggests modifications based on community feedback
- Recommends cultural adaptations as needed
- Identifies emerging community needs

- Proposes innovative service solutions

This involvement ensures community voice and cultural considerations remain central to service planning and implementation while maintaining accountability to diverse populations served.

***V. Recommendation Development Process***

**A. Initial Documentation**

- CRC recommendations emerge through meetings and reviews
- Recommendations are formally documented using standardized templates
- Supporting data and community input must be included
- Specific disparities impact and population benefits are clearly outlined

**B. Internal Review Process**

- Draft recommendations undergo initial review by CRC subcommittees
- Full committee review and discussion at monthly meetings
- Refinement based on member feedback and additional data
- Final approval requires a majority vote from CRC members

**VI. Communication Pathway**

**A. Formal Submission Protocol**

- Recommendations packaged into quarterly executive briefings
- Urgent matters may be submitted through an expedited process
- All submissions include
  - Executive summary
  - Detailed recommendation
  - Supporting data and rationale
  - Implementation considerations
  - Resource implications
  - Timeline suggestions

**B. Presentation Structure**

- Quarterly in-person presentations to executive leadership
- Led by CRC Chair and designated committee members
- Includes representation from affected populations
- Interactive discussion and Q&A session

Participation in and review of MHSA planning processes

The CPPP Planning Committee (CPPP-PC) is comprised of 21 members who represent service providers, social services, education, law enforcement, and peer and family members and is responsible for the facilitation of the MHSA CPPP listening sessions. The CPPP-PC also engaged with mental health affiliate groups and adapted outreach activities to increase community participation in the CPPP. The CPPP-PC also developed community podcasts and forums and administered an online survey to gather insights and feedback from the broader community.

To ensure the MHSA process was inclusive, we engaged the CRC and other culturally specific committees in the MHSA stakeholder process. The CRC and Alameda County Pride Coalition participated in the MHSA listening sessions.

The Community Review Committee (CRC) and affiliated coalitions provide integral oversight and input in the MHSA plan review through structured engagement processes. The CRC conducts quarterly reviews of the plan, focusing on equity measures and cultural/linguistic appropriateness of services. Recommendations are formally submitted to executive leadership through standardized documentation and in-person presentations.

Partner committees, including cultural coalitions and consumer advisory boards, contribute through:

- Forums to assess plan alignment with community needs
- Written feedback on implementation progress
- Reviews of demographic data and outcomes
- Input on cultural adaptations and modifications

The CRC maintains oversight by monitoring implementation progress, evaluating service delivery effectiveness, and ensuring continuous quality improvement through regular data review and community feedback collection. This collaborative approach ensures diverse perspectives inform plan development and implementation while maintaining accountability to the populations served.

The Community Review Committee (CRC) collaborates with service recipients and community coalitions to evaluate client-developed programs through a structured review process. The CRC conducts quarterly assessments of these programs, examining cultural appropriateness, accessibility, and alignment with community needs.

Key involvement includes:

- Program reviews with client/peer advisory groups
- Evaluation of program outcomes and cultural relevance
- Assessment of language accessibility and cultural adaptations
- Recommendations for program modifications based on community feedback

Partner coalitions and lived experience committees provide additional oversight by conducting participant surveys, facilitating focus groups, and offering direct feedback on program effectiveness. This collaborative approach ensures client-developed programs remain responsive to community needs while maintaining fidelity to peer-driven principles.

**CRC provides the following:**

- A space for collaboration and guidance for the Health Equity Initiatives
- A forum to discuss and respond to needs and events that impact the community
- A hub of information and resources to advance equitable behavioral health care

**The goals and objectives of the CRC are:**

1. To increase external stakeholder involvement in policy development
2. To expand reach into underserved communities
3. Increase awareness of community needs

Over the past year, OES has facilitated other culturally specific coalitions and committees to achieve the accomplishments outlined in Table 18 to address behavioral health disparities. OES hired a permanent administrator to oversee the implementation of identified goals. This implementation will include the voices of community members and will develop plans to address their identified needs.

*Table 18. Culturally Specific Coalition and Committee Accomplishments*

| Coalition/Committee | Highlights/Accomplishments |
|---|---|
| **Alameda County Pride Coalition** | PRIDE Panel<br>Participated in the PRIDE Parade & Tabling |
| **Latinx/Latino Advisory Committee for Health and Wellness** | Ongoing meetings with County contracted providers serving the Latino/Latinx community<br>Accomplishment/ Highlight #2 |
| **Asian American Native Hawaiian and Pacific Islander (AANHPI) Advisory Committee for Health and Wellness** | AANHPI Committee was established in February 2024<br>ACBHD Office of the Medical Director – Eastern Medicine Meets Western Practices |
| **African American Steering Committee for Health and Wellness** | Outreached to the Black community through meetings, webinars, and town hall meetings. During FY 23-24, the Committee conducted 12 webinars and 8 Town Hall meetings<br>Supported the purchasing of African American Wellness Hub Facility |

The Community Review Committee (CRC) oversees multiple departmental programs and services to ensure cultural and linguistic appropriateness and equitable access.
Key programs under CRC review include:

- Medi-Cal behavioral health services and access
- Community Services and Supports (CSS) programs
- Prevention and Early Intervention (PEI) initiatives
- Workforce Education and Training (WET) development
- Innovation projects and pilot programs
- Language access services and interpreter programs
- Cultural competency training initiatives
- Peer support and advocacy programs
- School-based mental health services
- Crisis intervention and response systems
- Outreach and engagement activities

The CRC conducts quarterly reviews of these programs, examining utilization data, demographic trends, and outcome measures while providing recommendations for service improvements and cultural adaptations. Their oversight ensures programs maintain alignment with CLAS standards and effectively address community needs.

**Cultural Competency Plan (CCP) Overarching Goals and CRC Implementation Role**

*CCP Core Goals*

1. Equitable Access
    - Eliminate barriers to behavioral health services
    - Ensure linguistically appropriate services across all programs
    - Expand culturally responsive care delivery
    - Improve service accessibility in underserved communities

2. Workforce Development
    - Increase diversity in the behavioral health workforce
    - Enhance cultural competency training
    - Develop career pipelines for underrepresented groups
    - Strengthen retention of diverse staff

3. Community Engagement
    - Build sustainable community partnerships
    - Strengthen culturally specific outreach
    - Enhance community-based service delivery
    - Improve community trust and participation

4. Quality Improvement
    - Reduce behavioral health disparities
    - Monitor culturally specific outcomes
    - Implement evidence-based practices
    - Ensure continuous service enhancements

**CRC Implementation Role**

*The CRC actively supports these goals through:*

- Regular review of implementation progress
- Recommendations for cultural adaptations
- Oversight of community engagement efforts
- Monitoring of disparities reduction initiatives
- Evaluation of workforce development progress
- Assessment of language access effectiveness
- Review of outcome data by population group
- Guidance on cultural competency standards

This collaborative approach ensures CCP goals align with community needs while maintaining accountability for implementation outcomes.

**Human resource report**

The Community Review Committee (CRC) actively reviews the human resource report through a structured evaluation process focusing on workforce diversity and cultural competency goals.

*Key Areas of CRC Review:*

- Workforce demographic composition and trends
- Staff recruitment and retention patterns
- Language capacity across service positions
- Cultural competency training completion rates
- Career development program outcomes
- Position vacancy rates in critical service areas
- Staff distribution across programs and communities

*The CRC provides quarterly recommendations for:*

- Enhancing recruitment strategies for diverse candidates
- Strengthening retention initiatives
- Improving cultural competency training
- Expanding language capacity
- Developing career advancement opportunities
- Addressing identified staffing gaps
- Supporting workforce development goals

Their involvement ensures human resource practices align with CLAS standards and effectively support the department's commitment to culturally responsive service delivery.

**Organizational assessment**

The Community Review Committee (CRC) conducts comprehensive organizational assessments focusing on cultural competency and service equity across all departmental operations.

*Key Assessment Areas:*

- Cultural competency integration in policies and procedures
- Language access service availability and effectiveness
- Staff diversity and cultural representation
- Service accessibility for diverse populations
- Community engagement effectiveness
- Training program outcomes
- Implementation of CLAS standards
- Documentation practices and language accessibility
- Facility cultural appropriateness
- Communication strategies and materials

*Assessment Methods:*

- Quarterly data review and analysis
- Site visits and program observations
- Staff and client satisfaction surveys
- Cultural competency evaluations
- Service utilization pattern review
- Community feedback collection
- Policy and procedure audits

The CRC provides formal recommendations based on assessment findings to strengthen organizational cultural competency and reduce service disparities. Their evaluations inform strategic planning and quality improvement initiatives while ensuring accountability for equitable service delivery.

The Community Review Committee (CRC) oversees and directs cultural competency training plans across the department, ensuring alignment with CLAS standards and community needs.

*Key Training Plan Review Areas:*

- Cultural competency curriculum content and delivery
- Language access training requirements
- New employee orientation components
- Ongoing staff development programs
- Specialized population-specific training
- Trauma-informed care approaches
- Training effectiveness measures
- Community engagement strategies
- Peer support training programs

*CRC's Training Plan Involvement:*

- Quarterly review of training completion rates
- Assessment of training effectiveness metrics
- Recommendations for curriculum updates
- Evaluation of trainer qualifications
- Review of training materials for cultural appropriateness
- Monitoring of staff competency assessments
- Input on emerging training needs
- Oversight of training schedule and accessibility

The CRC ensures training plans remain responsive to workforce needs and effectively support culturally competent service delivery through regular review and recommendations for enhancement.

# Criterion V

## *Culturally Competent Training Activities*

ACBHD supports our workforce to be culturally competent and to actualize its vision of an inclusive behavioral health system of care through a wide range of trainings. Through trainings to agency staff and licensed clinicians, the WET Unit and OES lead efforts to strengthen the capacity of providers to deliver clinical services that meet the diverse needs of served communities.

**Annual Cultural Competence Training**

The annual CLAS training ensures all Department staff, subcontractors, and affiliated personnel are aligned on our collective goal of advancing cultural competency. Per the executed contract:

All direct service staff and managers who are providing or supporting services through this Agreement shall complete at least four CLAS trainings annually. At least two of the CLAS trainings shall be offered through ACBH and shall be attended by at least two staff from Contractor's organization, one of which shall be a manager.

**Three Year Training Plan for Required Cultural Competence Training:**

We recognize the importance of training providers across the continuum of care on our shared vision and strategy for providing culturally responsive and appropriate services.

**Projected Number of Unduplicated Staff Who Need the Required Cultural Competence Training:**

Over the next three years, we require no less than two (2) staff from each contracted provider to complete the required cultural competency training annually. Per the executed contract:

Applicable for programs operating under a Master (versus Services As Needed) Contract – All direct service staff and managers who are providing or supporting services through this Agreement shall complete at least four CLAS trainings annually. At least two of the CLAS trainings shall be offered through ACBH and shall be attended by at least two staff from Contractor's organization, one of which shall be a manager. Contractor shall submit the following information by July 10th of the following fiscal year to the ACBH Office of Ethnic Services: a. An electronic survey that demonstrates Contractor's implementation of CLAS Standards; b. A list of CLAS trainings attended by staff and managers who are providing or supporting services through this Agreement; and c. A summary or copy of a plan to further implement CLAS Standards throughout the organization.

**Steps to Provide Required Cultural Competence Training to 100% of Staff Over Three-Year Period**

To ensure that all staff completes the required Cultural Competence Training, ACBHD requires compliance for all internal staff. Each contracted provider is required to abide by contractual obligations. Completion of required cultural competency training is reviewed annually by ACBHD staff. Per the executed contract:

Provider, Program and Staff Information Contractor shall submit any needed updates to provider, program and staff information, as well as attestation of accuracy of information on file by the 15th of each month as requested by ACBH to complete required publications, submissions and monitoring including but not limited to Provider Directory and Network Adequacy Reporting. Contractor's submission shall include but not be limited to Contractor's cultural and linguistic capabilities in service delivery and documentation of staff completion of cultural competence training and shall be in accordance with the format specified by ACBH and the California Department of Health Care Services (DHCS).

**How Cultural Competence is Embedded into All Trainings**

We strive to integrate cultural competency throughout all training beyond the required annual CLAS training. Our trainings focus on helping providers understand the culturally specific needs of beneficiaries and equip them with the advanced skills to address these needs. ACBHD uses a multi-prong approach to ensure that our staff and CBO providers are equipped to deliver culturally and linguistically appropriate services by offering training led by:

- Workforce Development, Education and Training Unit
- Office of Ethnic Services
- Contracted Training Providers (OnTrack, Health and Human Resource Education Center (HHREC) and African American Technical Assistance and Training Program (AATA)
- A comprehensive list and description of the training offered are detailed in subsequent sections.
- Annual Cultural Competence Trainings

**Training, Staff, and Stakeholder Attendance by Function:**

- Administration/ Management
- Direct Services, Counties
- Direct Service Contractors
- Support Services
- Community Members/ General Public
- Community Event
- Interpreters; and  Mental Health Board and Commissions
- Community-based Organizations/Agency Board of Directors

As seen in Table 20, we have trained staff ranging from executive leadership to community-based providers. ACBHD contracts with expert instructors from ONTRACK, HHREC, and AATA to offer a wide range of trainings that strengthen cultural competence throughout our agency.

| Training /Event | Description | Hours | Attendance | | Presenter |
|---|---|---|---|---|---|
| **Financial Understanding and Wellness**<br><br>01/10/2024 | Understand why financial gaps exist and explore key elements of financial wellness, including budgeting, goal setting, spending types, credit, and strategies | **1.5** | ACBHD staff and contracted provider staff | **9** | Cathy Jackson-Gent |
| **Community-Based Learning: Design Love & Life in 5 Shifts**<br><br>01/17/2024 | Emphasize the importance of activating loving experiences, short-circuiting negative experiences, and understanding one's true power in love through the three I's (Immediate, Inspired, Intelligent) | **1.5** | ACBHD staff and contracted provider staff | **21** | Julius Jackson |
| **Self-Care Becoming the Best You**<br><br>01/24/2024 | Bring awareness to self-care and how practicing self-care can help improve and maintain good mental health | **1.5** | ACBHD staff and contracted provider staff | **26** | Dr. Renisha Coleman |
| **Tobacco 101 and Tobacco Use Disparities**<br><br>02/02/2024 | Provide an introduction to tobacco use and basic treatment possibilities, as well as a deeper look into tobacco-use disparities in Alameda County | **1** | ACBHD administrative and/or clinical staff-funded substance use treatment and mental health programs | **28** | Tara Leiker, PhD |
| **Turning Your Dreams into Achievable Goals**<br><br>02/07/2024 | Learn how to make achievable goals to turn dreams into reality and how to create an action plan and break it down into manageable bite-size pieces to achieve success | **1.5** | ACBHD staff and contracted provider staff | **23** | Donna Quarles, Certified Life Coach |
| **Introduction to Family-Based Treatment for Treating Eating Disorders in Children and Adolescents**<br><br>02/14/2024 | Learn and practice principles of Family-Based Treatment to treat children and adolescents with eating disorders | **1.5** | ACBHD staff and contracted provider staff | **28** | Helen Savin |

| | | | | | |
|---|---|---|---|---|---|
| **Tackling Tobacco Together**<br><br>02/21/2024 | Take a deep dive into tobacco cessation treatment within priority populations | **3.5** | ACBHD administrative and/or clinical staff-funded substance use treatment and mental health programs | **23** | Tara Leiker, PhD |
| **Helping Behavioral Health Clients Succeed with Tobacco Treatment Medication**<br><br>02/22/2024 | Learn about tobacco-treatment medication and behavior modification and how to explore these treatment options with clients and successfully address tobacco- use disorder | **1.25** | ACBHD administrative and/or clinical staff-funded substance use treatment and mental health programs | **27** | Cathy McDonald, MD, MPH |
| **Developing Effective Communication Strategies for Crisis Intervention in Behavioral Health**<br><br>02/29/2024 | Cover key concepts related to crisis intervention, including common crisis situations, reactions to crisis, and the role of communication in crisis intervention | **7** | ACBHD staff and contracted clinical staff | **23** | Mary Wright, MSW |
| **Community Engagement and Participatory Approaches to Improving Community Health**<br><br>03/06/2024 | Deepen the understanding of participatory approaches to improve community health and the use of research justice as a tool to gain insight into the health needs of marginalized community members and to accelerate community engagement | **2** | ACBHD staff and contracted provider staff | **21** | Julia Chinyere Oparah |
| **Cultural Humility: Working in Partnership with Providers and Clients**<br><br>03/13/2024 | Review process of critical self-reflection, address power imbalances, develop partnerships with communities, and advocate for and maintain institutional accountability | **3** | ACBHD staff and contracted provider staff | **26** | Dr. Melanie Tervalon |
| **Intermediate Motivational Interviewing Skills or Professionals Working** | Enhance existing motivational interviewing skills, and identify ways to further integrate the | **7** | Administrative and/or clinical staff of Alameda County Public Health Department contracted provider organizations and | **19** | Sarah Solis, LCSW |

| | | | | | |
|---|---|---|---|---|---|
| **in Law Enforcement & Juvenile Justice**<br><br>04/22/2024 | Spirit of motivational interviewing | | ACBHD contracted substance use treatment and mental health programs | | |
| **Tobacco Treatment in Primary Care and Behavioral Health Setting**<br><br>04/23/2024 | Provide an overview of the epidemiology of tobacco use in the United States, and cover information on tobacco treatment approaches for the general public and those with behavioral health conditions | **1** | ACBHD Administrative and/or clinical staff-funded substance use treatment and mental health programs treatment and mental health programs | **30** | Dr, Maya Vijayaraghavan |
| **Structural Competency Workshop**<br><br>05/02/2024 | Promote health equity and appropriate patient care | **3** | ACBHD staff and contracted provider staff | **28** | Margaret Mary Downey, Leanne Marcotrigian, Katerina Melino |
| **Suicide Assessment and Intervention Adult Focus**<br><br>05/04/2024 | Explore feelings towards suicide and suicidal client; address common myths and perceptions about suicidal behavior; and cover suicide statistics | **3.5** | Mental health professionals or anyone in a position to work with adults experiencing a suicidal crisis | **27** | Staff of crisis support services in Alameda County |
| **What more can we do to help all clients recover from tobacco use challenges?**<br><br>05/06/2024 | Review evidence-based strategies to improve tobacco treatment in behavioral health settings | **1.5** | Physicians and psychiatrists at Alameda County Public Health Department -contracted provider organization and ACBHD- contracted substance use treatment and mental health programs | **22** | Catherine McDonald, MD, MPH |
| **Update on Medications for Tobacco Cessation**<br><br>05/14/2024 | Learn about the six FDA-approved medications used to treat tobacco-use disorder | **1** | ACBHD Administrative and/or clinical staff-funded substance use treatment and mental health programs treatment and mental health programs | **20** | Dr. Robin Corelli |

| | | | | | |
|---|---|---|---|---|---|
| **Adult Mental Health First Aid Training**<br><br>05/07/2024 | Gain confidence to be there for a friend, family member, or colleague, and receive basic mental health information to reduce stigma and enhance the safety net within communities | **7** | Non-clinically licensed staff, administrative staff and others who serve clients in Alameda County | **44** | MHFA certified instructors from Crisis Support Services of Alameda County |
| **Suicide Rates for Individuals Who Are Incarcerated**<br><br>05/31/2024 | Raise awareness of an overlooked population, all within the context of insights from a correctional psychologist with a decade of experience working with justice-involved individuals | **4.5** | ACBHD staff, mental health and substance use disorder provider staff, community- based organizations | **59** | Darius Campinha-Bacote, PsyD, HSP |
| **Tackling Tobacco Together: A Deep Dive into Tobacco Cessation Treatment within Priority Populations**<br><br>07/23/2024 | Learn the basics of tobacco-use disorder and the tobacco-control policies that exist within ACBHD and how to incorporate the tobacco-control policies into programs in a trauma-informed and individually sensitive way | **3.5** | Administrative and/or clinical staff of Alameda County Public Health Department contracted provider organizations and ACBHD contracted substance use treatment and mental health programs | **19** | Tara Leiker, PhD |

The WET unit aims to strengthen the capacity of providers to deliver clinical services that are culturally responsive and can improve the lives of all clients and their families. The Training Unit offers training opportunities for the ACBHD's staff, contracted CBO staff, individual providers, and other Alameda County agencies. The Training Unit hosts trainings facilitated by contracted trainers and also collaborates with the systems of care and other partners to offer continuing-education sponsorships and technical assistance. Through this collaboration, trainings can be tailored to meet the specific learning needs of staff from different systems of care. The unit provides continuing education for the following licensed professions:

- Clinical Social Worker
- Marriage and Family Therapist
- Professional Clinical Counselor
- Education Psychologist
- Psychologist
- Registered Nurse
- Vocational Nurse
- Addiction Professional
- Medical Doctor

WET supports a wide range of providers to establish a continuum of care that is inclusive of Alameda County residents. With Alameda County being one of the most culturally diverse areas, these trainings are important for providers to deepen their understanding and improve their skills to address clients' linguistic and cultural needs. Acknowledging this importance, we trained providers across 57 community-based agencies in FY 22-23 and offer over 25 trainings annually to strengthen the cultural competency of our workforce.

Training outcomes are measured using self-administered evaluations. Each training proposes measurable learning objectives to be achieved by the end of the training. Following the training, attendees evaluate whether the objectives are met using a Likert scale from 1-5 (strongly disagree to strongly agree). Across all our training, we have found providers give our training an overall rating of excellent.

Attendees also evaluate the training content, instructor, technology, accessibility, and program administration. At the end of every training, participants are encouraged to complete an evaluation and if they want continuing education credit, it is required. For all trainings, evaluation data results indicate all outcome measures are being met on an average of at least a 4 or 5 of the Likert scale, with 5 being "strongly agree."

We assess providers' skills and application of cultural competency trainings through several methods. Our WET Needs Assessment provides a snapshot of providers' perspectives with respect to workforce, education, and training needs in providing culturally responsive services. We use the data from this assessment to monitor skill gaps and training needs across our workforce. Many providers participating in the WET Needs Assessment reported that there is a significant demand within CBOs for high-quality evidence-based training that meets both the staff's clinical needs and professional licensing requirements. WET Provider Survey respondents also expressed interest in advanced training in specific therapeutic modalities and approaches, especially those that include certification. There is also interest among providers in participating in training series or advanced-skills development. Some of the topic areas mentioned in qualitative responses about topics for advanced training include:

**Family Therapy:** Advanced training in family systems therapy and evidence-based practices for working with families

**Suicide Prevention:** In-depth training on assessing and managing suicidal ideation and behavior

**Trauma-Informed Care:** Comprehensive programs on understanding and treating trauma, including complex trauma and PTSD

**Cognitive Behavioral Therapy (CBT):** Advanced certification in CBT for various mental health conditions

**Dialectical Behavior Therapy (DBT):** Training and certification in DBT for treating borderline personality disorder and other conditions

**Substance Use Disorders:** Specialized training in treating co-occurring mental health and substance use disorders, including medication-assisted treatment (MAT)

**Eating Disorders:** Many providers indicated a need for specialized training on eating disorders, including early identification, treatment modalities, and ongoing support strategies

**Cultural Competency:** Programs that include cultural humility and practices for working with diverse populations, ensuring that providers can deliver equitable and effective care

The WET Needs Assessment also allows us to identify support needed for staff to apply advanced skills after training. On the 2024 WET Provider Survey, providers reported needing more support to apply their skills in cultural humility and responsiveness (4%) and National CLAS Standards (3%). Systems of care and

contracted CBO providers are responsible for monitoring staff performance and application of evidence-based clinical practices, including cultural competency skills. Annually, systems of care report on providers' progress in applying skills and knowledge from cultural competency training on the CLAS Standards Implementation Survey. OES reviews and develops plans based on these survey findings.

Process for Incorporation of Client Training

A. Evidence of Annual Client Culture that includes a client's personal experience including:
- Culture specific expressions of distress
- Explanatory models and treatment pathways
- Relationship between client and mental health provider from cultural perspective
- Trauma
- Economic impact
- Housing
- Diagnosis/labeling
- Medication
- Hospitalization
- Societal/ familial/ personal
- Discrimination/ stigma
- Effects of culturally and linguistically incompetent services
- Involuntary Treatment
- Wellness
- Recovery
- Culture of being a mental health client

ACBHD offers several trainings that build participant's understanding of client culture and lived experience. These trainings center the client's personal experience to deepen providers' understanding of these communities and equip them to meet specific racially, ethnically, culturally, and linguistically diverse needs. In the 2024 WET Needs Assessment, providers reported feeling the most comfortable meeting the needs of Latino/ Hispanic communities. Providers did report a need for additional training to meet the needs of other ACBHD priority populations. The greatest provider-identified need for training was to support Native American/ Indigenous People (25%), as seen in Table 21.

***Table 21. Provider-Reported Need for Training to Meet the Needs of Priority Populations***

| Target Population | N | % |
|---|---|---|
| **Native American / Indigenous People** | 39 | 25% |
| **Asian American / Pacific Islander** | 31 | 19% |
| **Lesbian/Gay/Bisexual/Transgender//Questioning (LGBTQ+)** | 28 | 18% |
| **African American / Black** | 22 | 14% |
| **Transition-Aged Youth** | 23 | 14% |
| **Latino / Hispanic** | 14 | 9% |
| **Early-Childhood Mental Health** | 1 | 1% |
| **Asian American / Pacific Islander Family Support** | 1 | 1% |

*Source: 2024 WET Provider Survey*

*Table 22. Client Culture Trainings*

| Training /Event | Description | *Attendees* | *Date* | Presenter |
|---|---|---|---|---|
| **African American Technical Assistance & Training: Self Care Perimenopause and Menopause in Black Women** | Address some basic biological changes that are part of the normal life cycle for women and explore some of the mental health challenges that are a part of this process for Black women | **9** | 01.26.24 | Karinn Glover, MD, MPH |
| **Cultural & Community: An Indigenous Perspective on Healing from Historical & Contemporary Trauma** | Take a deep dive into community-defined healing practices and strategies for mental health and addiction recovery, with a special focus on practices to help address historical and contemporary trauma | **21** | 01.31.24 | Dr. Anton Treuer |
| **Introduction to Family-Based Treatment for Treating Eating Disorders in Children and Adolescents** | Learn and practice principles of Family-Based Treatment to treat children and adolescents with eating disorders | **26** | 02.14.24 | Helen Savin |
| **Environmental Impacts on African Americans Mental Health** | Examine historic and contemporary effects of environmental injustice and climate change on the mental health and well-being in BIPOC communities and review strategies to mitigate these impacts | **28** | 02.23.24 | Delane Casiano, MD & Karriem Salaam, MD |
| **Community Based Learning: Holding Space for Race and Other Considerations in the Counseling Field** | Support therapists and mental health counselors who are working with Black clients and delving into the nuanced intersections of race, identity, and mental health | **23** | 02.26.24 | Mahesh Francis and Iesha Brooks |

| | | | | |
|---|---|---|---|---|
| **Demystifying the Science Behind Psychiatric Medications** | Understand how psychiatric medications work in the brain, explore potential side effects, and learn about considerations specific to African American patients | **17** | 04.19.24 | Lester Love, MD & Shadi Doroudgar, Pharm.D, APh |
| **Decolonizing How We Serve Asian American Clients** | Review strategies for interpersonal, organizational, cultural, and structural change | **19** | 05.30.24 | Michael Liao |
| **Suicide Rates for Individuals Who Are Incarcerated** | Raise awareness of an overlooked population, all within the context of insights from a correctional psychologist with a decade of experience working with justice-involved individuals | **26** | 05.31.24 | Darius Campinha-Bacote, PsyD, HSP |
| **Sanamos Juntos: Understanding Latine/a/o/Mental Health** | PEERS' Latino Community Wellness Program goes through best practices and unpacks societal, cultural, and familial barriers that are culturally relevant and may be overlooked | **27** | 06.27.24 | Marcela Sabin<br>and<br>Luna Flores<br>of PEERS |
| **The Impact of Discrimination on Mental and Physical Health of African American Populations** | Explore the ways systemic racism and various kinds of discrimination impact the mental and physical health of marginalized populations in the United States | **3** | 06.28.24 | Karinn Glover, MD, MPH |
| **Navigating Intersectionality: Race and LGBTIA+ Identities in Behavioral Health** | Provide foundational knowledge of health equity issues facing the LGBTQIA+ community, focusing on the intersections of race and LGBTQIA+ identities. Using the principles of cultural humility, participants will critically examine how systems of care can offer a more affirming approach to services delivery for queer and trans community members, particularly those from BIPOC backgrounds. Increase ability to recognize that sexual orientation and gender are only two components of a whole person. | **48** | 07.23.24 | Koby Rodriguez<br>of ONTRACK |

Training offered by the WET Unit and OES support CBO providers and agency staff to address the unique needs of youth and families. ACBHD has offered over **14** trainings on supporting children, adolescents, transition-age youth, and their parents and/or caretakers, as seen in Table 23.

***Table 23. Training Plan for Youth and Families***

| Training/Event | Description | Hours | Attendance | | Date | Presenter |
|---|---|---|---|---|---|---|
| **Introduction to Family-Based Treatment for Treating Eating Disorders in Children and Adolescents** | Learn and practice principles of Family-Based Treatment to treat children and adolescents with eating disorders | **1.5** | ACBHD staff and contracted provider staff | **25** | 02.14.24 | Helen Savin |
| **Youth Experiencing Homelessness: A Focus on African American Adolescents and Experienced Trauma** | Grasp concepts related to the often-inevitable generational trauma African American youth may encounter while experiencing homelessness and additional trauma-focused interventions | **4.5** | Community-Based Organizations and ACBHD contracted Mental Health and Substance Use Disorder provider staff | **16** | 03.22.24 | Darius Camphina-Bacote, PsyD, HSP |
| **Youth Mental Health First Aid** | Introduces adults who work with youth to the unique risk factors and warning signs of mental health problems in adolescents; builds understanding of the importance of early intervention; and teaches participants how to help an adolescent in crisis or who may be experiencing a mental health challenge | **7** | Non-clinical staff, administrative support staff and paraprofessionals who serve in Alameda County | **18** | 03.28.24 | MHFA certified instructors from the Crisis Support Services of Alameda County |
| **Youth Focused Suicide Assessment & Intervention Training** | Explore their own feelings toward suicide and suicidal clients and learn methods of suicide risk assessment and screening tools that aid in determining risk and protective factors for youth populations | **3.5** | Mental health professionals and anyone in a position to work with children or adolescents | **14** | 06.11.24 | Cris Rita |

# Criterion VI

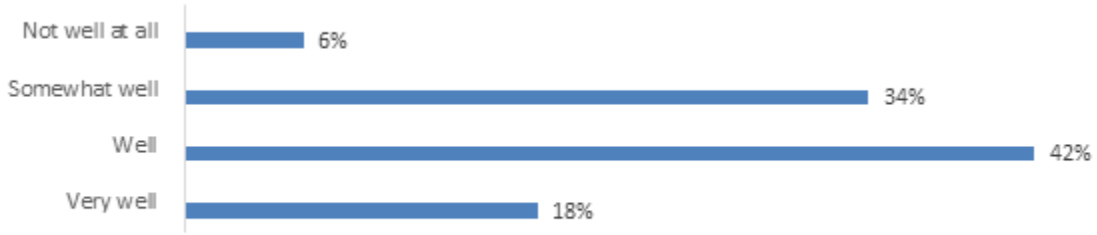
## *The County's Commitment to Growing a Multicultural Workforce: Hiring and Retaining Culturally Linguistic Competent Staff*

ACBHD is intentional in our recruitment and retention efforts to build a diverse and multicultural workforce. This commitment is critical to our system's ability to provide culturally and linguistically relevant services across Alameda County.

We have assessed recruitment, hiring, and retention needs through our MHSA three-year planning process and the 2024 WET Needs Assessment. Our MHSA plan covers fiscal years 2023-24 through 2025-26 and assessed data from 2020-2022. Our WET Needs Assessment, found in the Appendix, was completed in July 2024 and provides a snapshot of provider perspectives concerning workforce capacity, training, and education needs. These documents assess our current recruitment, hiring, and retention efforts, identify emerging needs and gaps, and guidance about which populations should be prioritized to meet beneficiary needs.

The WET Needs Assessment deepened our understanding of the WET Unit's influence on workforce diversity with its Behavioral Health Career Pipeline and Internship Programs and providers' perceptions of our strategies to create a diverse workforce. Providers reported highly valuing the contributions of multilingual and diverse staff, emphasizing the importance of building a workforce that reflects the cultural and linguistic diversity of our beneficiary population. The CBO partners participating in the WET needs assessment reported the retention of multilingual and diverse staff as a high-priority workforce need. Providers reported that their organizations retain staff well but face challenges with recruiting and hiring diverse staff. Respondents on the WET Needs Assessment's Provider Survey did not report significant challenges with overall staff retention, as shown in Figure 28.

***Figure 27. Provider-Reported Effectiveness of Staff Retention, N = 85***

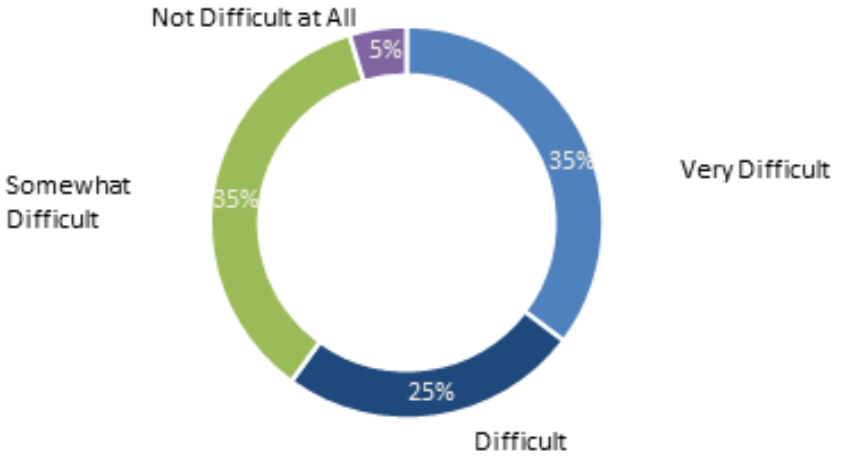



*Source: 2024 WET Provider Survey*

Providers did emphasize that the struggle to retain staff is particularly pronounced for SUD counselors, who receive less favorable compensation compared to their mental health counterparts. The bureaucratic duties of the job, including substantial paperwork and strict audit protocols, also make these positions less desirable.

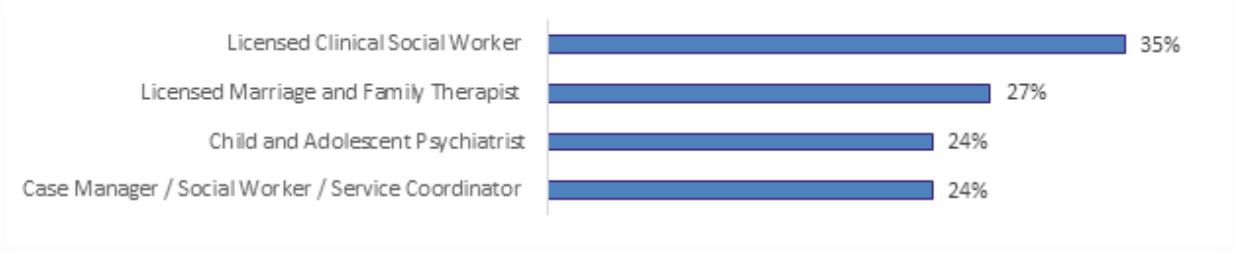
In the WET Needs Assessment, providers noted the biggest challenges in recruiting and hiring diverse staff. As seen in Figure 29, almost all providers reported some difficulty with filling open positions.

***Figure 28.*** ***Provider-Reported Difficulty in Filling Open Positions, N = 85***




Source: 2024 WET Provider Survey

***Figure 29.*** ***Percentage of Respondents Reporting Positions Most Challenging Recruit For, N = 85***




Source: 2024 WET Provider Survey

***Figure 30.*** ***Percentage of Respondents Reporting Positions Most Challenging to HIRE FOR, N = 85***

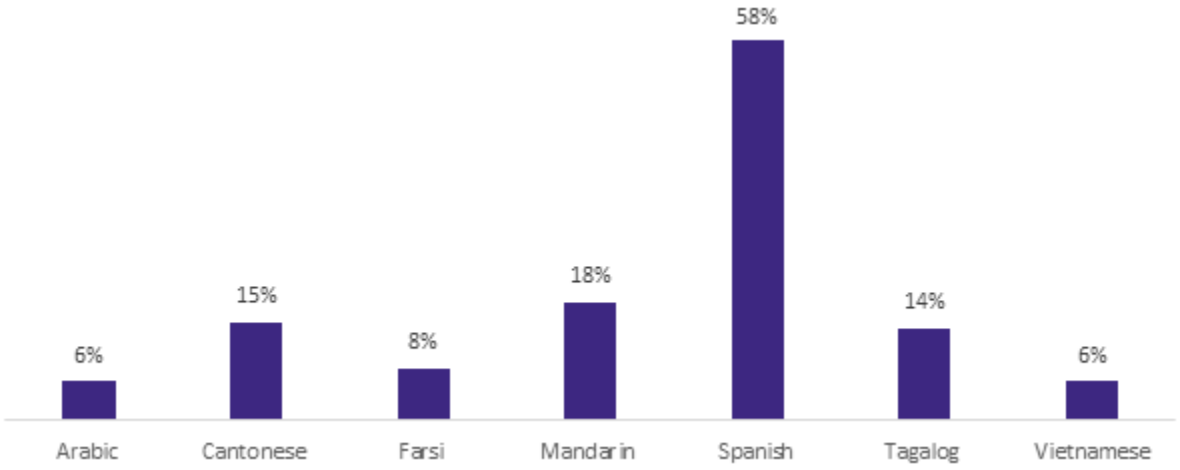

Source: 2024 WET Provider Survey

Providers participating in the WET needs assessment described the challenges in recruiting and retaining BIPOC clinicians, citing issues with noncompetitive salaries and benefits.

Those providers participating in the WET Needs Assessment also spoke to the critical need for enhanced linguistic diversity and cultural competence within the workforce. Provider feedback surfaced a significant shortage of staff who can effectively serve specific community groups, such as the growing Middle Eastern population, and underscored the need for increased language capacity, particularly in Asian languages.

Notably, over half of the needs assessment survey respondents reported using languages other than English with their clients, with Spanish being the most common (58%), as seen in Figure 31.

***Figure 31.*** ***Percentage of Providers Reporting Speaking Languages with Clients Other than English, N=85***




Source: 2024 WET Provider Survey

SUD providers participating in the needs assessment further emphasized the impact of limited linguistic capacity on their ability to provide ethical and effective care. Providers noted that often the evidence-based models they are required to use do not have documentation available in many languages other than English. Providers stated that when they do translate documents, it is often a long and expensive process.

To demonstrate our commitment to a multicultural workforce, ACBHD, and the WET Unit use multiple strategies to recruit and hire diverse staff including:

- Mental Health Career Pathways
- Internship Coordination and Residency Programs
- Financial Incentive
-

These strategies, coupled with our tabling at culturally specific events, aim to raise awareness of ACBHD career opportunities among unserved and underserved populations and increase their representation across our workforce. This section details our efforts across these strategies from our MHSA Three-Year Plan and WET Needs Assessment.

***Mental Health Career Pathways***

ACBHD supports the growth of our multicultural workforce by increasing the diversity of the behavioral health pipeline. As noted in our MHSA Three-year Plan, the WET Unit provided funding to the following programs to develop Mental Health Career Pathways:

- FACES for the Future Coalition
- Ohlone College Mental Health Programs
- Center for Empowering Refugees and Immigrants (CERI)
- Beats Rhymes and Life
- California State University East Bay (CSUEB)

WET partners with contracted organizations to implement the programs and/or activities outlined in Table 24.

***Table 24. Mental Health Career—Pathways Programs and Activities***

| Program | Activities |
|---|---|
| **FACES for the Future Coalition** | • The Bright Young Minds virtual conference on April 19–20, 2022, hosted in partnership with Eden Area Regional Occupational Program, provided 150 students from across southern Alameda County with workshops on trauma-informed practice, wellness, and grief recovery.<br>• Participation in senior capstone project panels and the Advisory Committee for the health pathway at Skyline High School in Oakland. Also provided student trainings and worked with teachers to identify more career pathways into behavioral health.<br>• Participation in the Youth Advisory Council, which supports students with direct mentorship, youth leadership, and a participation stipend.<br>• FACES Public Health Youth Corps, in partnership with Eden Area Regional Occupational Program (ROP), provided students with introductory training and certification in four professional skills: Mental Health First Aid, Basic Life Support / CPR, NARCAN (for opioid overdose intervention), and Stop the Bleed (for trauma and injury). |

| | |
|---|---|
| **Ohlone College Mental Health Programs** | • The Mental Health Advocacy Program cohorts provide students with a behavioral health career panel, a mentoring event, and service learning projects.<br>• The Mental Health Navigator Program provided eight students across four community colleges with opportunities to 91 case management services to their peers and create a podcast series.<br>• The Alameda County Behavioral Health Career Pipeline Scholarship and Mentorship Program provides financial scholarships to 11 students to support their undergraduate education and participation in a mentorship program. |
| **CERI** | • The program provides mental health career pathways, specifically to refugees and immigrants. |
| **Beats Rhymes and Life** | • The program increases educational pathways and training for TAY to enter human services professions by building skills in peer monitoring, artistic instruction, facilitation, and group work. |
| **CSUEB** | • The Early Childhood Mental Health Postgraduate Certificate Program builds capacity in a culturally diverse early- childhood mental health workforce to meet the social, emotional, and developmental needs of young children, from birth to five years old, and families in Alameda County. |

These programs increase of highly qualified professionals from impacted communities and prepare them to join our multilingual and multicultural behavioral health workforce.

To further support a diverse behavioral health pipeline, we facilitate an internship program to provide training that optimizes student learning, leadership, and overall support and development. One of our priorities in growing a multicultural workforce is to address cultural and linguistic diversity gaps across our interns. A quantitative analysis of intern demographic data from our WET Needs Assessment shows gaps in recruiting African American and Latino interns. From 2018 to 2023, ACBHD interns have become less racially and ethnically diverse, as seen in Table 25. FY 23-24 data were delayed due to the implementation of SmartCare and will be included in future reports.

*Table 25. Racial/Ethnic Diversity of ACBHD Interns, 2018–2023*

| Year | N | Black or African American | Asian | White | Hispanic/ Latino | Other |
|---|---|---|---|---|---|---|
| **2022-23** | 22 | 9% | 32% | 41% | 0% | 18% |
| **2021–22** | 18 | 22% | 11% | 28% | 28% | 11% |
| **2020–21** | 21 | 29% | 24% | 19% | 19% | 9% |
| **2019–20** | 31 | 16% | 23% | 29% | 32% | 0% |
| **2018–19** | 19 | 21% | 16% | 26% | 37% | 0% |

**Source: ACBHD Workforce Education, Training and Development Internship Program Data, Yellow Fin, 2018–2023**

While the percentage of Asian interns has doubled since 2018, the percentage of African American and Hispanic/Latino interns has decreased. We are prioritizing the recruitment of African American and Hispanic/Latino interns to address this gap. We are partnering with minority-serving colleges and institutions to raise awareness of our internship programs and increase the pool of applicants from these underrepresented communities. We also dedicate financial resources to these efforts to incentivize graduate interns from these communities. The effectiveness of these efforts is detailed in the Financial Incentives section.

The WET Needs Assessment also found linguistic diversity of ACBHD interns has decreased over the last five years. As seen in Table 26, the percentage of interns speaking Cantonese/Mandarin has increased since 2018, while the percentage of interns speaking Vietnamese has decreased. These trends highlight a need to increase the representation of interns who speak Vietnamese, which is one of our threshold languages. We are offering incentives to Vietnamese-speaking graduate-level interns to increase recruitment as detailed in the Financial Incentives section.

*Table 26. Linguistic Diversity of ACBHD Interns, 2018–2023*

| Year | N | English | Cantonese/ Mandarin | Spanish | Vietnamese |
|---|---|---|---|---|---|
| **2022–23** | 22 | 64% | 4% | 14% | 4% |
| **2021–22** | 18 | 55% | 0% | 28% | 0% |
| **2020–21** | 21 | 52% | 0% | 24% | 0% |
| **2019–20** | 31 | 55% | 7% | 29% | 3% |
| **2018–19** | 19 | 42% | 0% | 21% | 11% |

**Source: ACBHD Workforce Education, Training and Development Internship Program Data, Yellow Fin, 2018–2023**

As detailed in the MHSA Three-Year Plan, we have facilitated a Mental Health Asian Workforce Pipeline Program in partnership with the Korean Community Center of East Bay (KCCEB) to increase the diversity of Asian languages across interns. In FY 21-22, KCCEB trained 6 MSA/MA/MFT students from CSU East Bay, Dominican University, and Palo Alto University. The cohort spoke Korean, Japanese, Cantonese, and Mandarin in addition to English and offered services in Korean, Cantonese, Mandarin and English. Four interns focused on school-based services at Alameda Science and Technology and San Leandro High School with Asian and Pacific Islander children, families, and adults and two interns supported Korean and Chinese seniors. Our Department could implement a similar internship program focused on Vietnamese speakers to further support our growth of a multilingual pipeline. We are strengthening relationships with more Asian American and Pacific Islander (AAPI) community-based organizations for our HEAL (Healing Model, Enhancing Capacity, Advertising and Learning) program. With the HEAL program's focus on increasing utilization across the AAPI community, we are also recruiting more diverse AAPI interns and staff.

***Financial Incentives***

To address pipeline diversity gaps and increase recruitment of African American, Hispanic/Latino and Vietnamese-speaking interns, ACBHD offers financial incentives through its Graduate Intern Stipend Program (GISP). As noted in the MHSA Three Year plan, the 10th cycle of the GISP, launched in August 2021, awarded 21 stipends of up to $6,000 each for 720 internship hours. Of the 21 awardees, 98% represented diverse communities of Alameda County. As seen in Tables 27, most awardees were Hispanic/Latino (43%). We are prioritizing increasing representation of African American interns in GISP through our partnership with institutions and college with larger proportions of African American students.

*Table 27. 2021-22 Graduate Intern Stipend Awardees by Race/ Ethnicity, N=21*

| Race/Ethnicity | N | % |
|---|---|---|
| African American | 5 | 24% |
| Asian | 5 | 24% |
| Caucasian | 2 | 9% |
| Hispanic/Latino | 9 | 43% |

*Source: MHSA Three-Year Plan for FY 23/26*

As seen in Table 28, majority of GISP awardees were Spanish-speaking (57%). There was a low representation of Vietnamese-speaking interns emphasizing the need to strengthen our partnership with community-based organizations and institutions with larger Vietnamese-speaking populations.

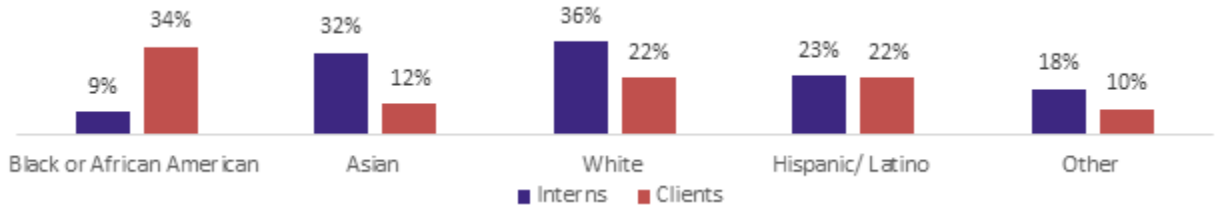
*Table 28. 2021-22 Graduate Intern Stipend Awardees by Threshold Language, N=21*

| Language | N | % |
|---|---|---|
| English | 4 | 19% |
| Mandarin | 1 | 5% |
| Spanish | 12 | 57% |
| Vietnamese | 1 | 5% |

*Source: MHSA Three-Year Plan for FY 23/26*

When comparing the cultural and linguistic diversity of our current and emerging workforce, there is an evident need for ACBHD to continue our efforts to recruit, hire and retain a diverse behavioral health staff and interns. ACBHD interns are not representative of the racial, ethnic, and linguistic backgrounds of the general client population. As seen in Figure 33, the WET Needs Assessment found the most incongruence in racial and ethnic diversity among African American / Black beneficiaries and interns. This gap reinforces the need to increase the recruitment of African American interns found in the WET Needs Assessment intern analysis. While the analysis found a gap in Hispanic and Latino interns, the proportion of Hispanic and Latino interns aligns with the proportion of beneficiaries.

***Figure 32.*** ***Racial/Ethnic Diversity of ACBHD Interns (N = 22) and Clients (N = 28,108), 2022–2023***




*Source: ACBHD Workforce Education, Training and Development Internship Program Data, Yellow Fin, 2023; Mental Health Services Demographic-Ethnicity Data, Yellow Fin, FY 2022–2023*

The WET Needs Assessment also found incongruencies between the racial/ethnic diversity of ACBHD direct service staff and clients. Direct service staff includes providers employed by ACBHD and community-based organizations. While the intern data shows the need to recruit more African American interns, we have made strong progress in recruiting African American staff and narrowing the gap between African American staff and beneficiaries. We have not made as much progress in recruiting Latino/Hispanic staff. While there was alignment in the proportion of Hispanic and Latino beneficiaries and interns, there is a large incongruence among Hispanic/Latino direct service staff and the general population. As shown in Figure 34, the proportion of Hispanic/Latino staff is 7x less than the proportion of Hispanic/Latino beneficiaries.

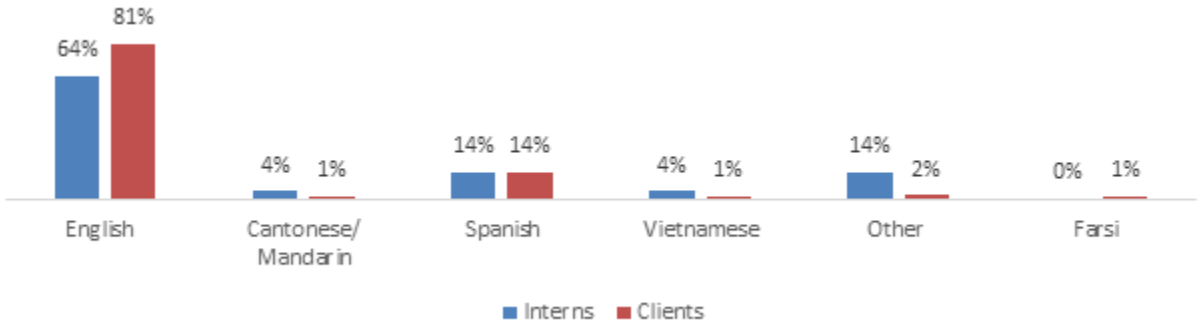
***Figure 33.*** ***Racial/Ethnic Diversity of ACBHD Staff (N=2,632) and Clients (N = 28,108), 2022–2023*** [35]


*Source: ACBHD MHS Staff Demographics-Ethnic Group Data, Yellow Fin, 2023; Mental Health Services Demographic-Ethnicity Data, Yellow Fin, FY 2022–2023*

The WET Needs Assessment found the highest penetration rate for Medi-Cal beneficiaries among the Alaska Native or American Indian population. There is a need to increase recruitment and hiring of Alaska Native or American Indian interns and staff to reflect this representation of Medi-Cal beneficiaries.

The linguistic capacity of interns mostly reflects languages spoken among the ACBHD's general population, as seen in Figure 35. There is a need for more interns who speak Farsi to meet the linguistic needs of the emerging Middle Eastern newcomer community. Those who speak Farsi also represent the highest penetration rate (4.6%) of the Medi-Cal population. Although Farsi is not a threshold language, this gap represents a broader need for our department to respond to the linguistic needs of newcomers. We are providing resources in Farsi and other languages and partnering with external partners, so our department staff can be better prepared to engage growing newcomer communities across Alameda County through their diverse dialects. We established a newcomer welcome website that can be used by this community and translated into various languages, including Dari and Pashto.

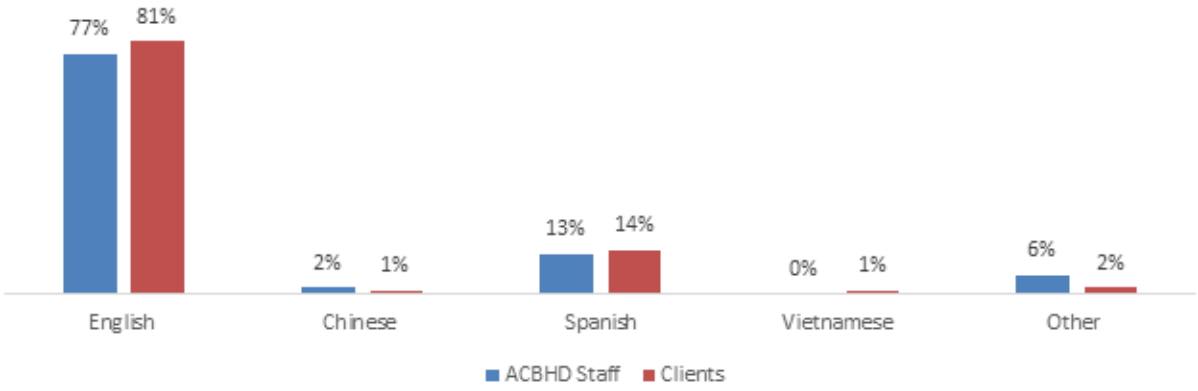
***Figure 34. Languages Spoken by ACBHD Interns (N = 22) and Clients (N = 28,108), 2022–2023[36]***




*Source: ACBHD Workforce Education, Training and Development Internship Program Data, Yellow Fin, 2023, and Mental Health Services Demographic – Primary Language Data, Yellow Fin, FY 2022–2023*

While the intern data found the greatest need to recruit Farsi-speaking interns, we have made progress in recruiting staff with linguistic capacity aligned with beneficiaries. As seen in Figure 36, the linguistic capacity of staff mostly reflects languages spoken among the ACBHD's general population, except for Vietnamese. Additional staff is required to address the linguistic needs of about 280 Vietnamese-speaking beneficiaries. Data for FY 23-24 was delayed due to SmartCare implementation.

***Figure 35.*** **Languages Spoken by ACBHD Staff (N = 2,632) and Clients (N = 28,108), 2022–2023[37]**




*Source: ACBHD MHS Staff Demographics-Language Data, Yellow Fin, 2023; Mental Health Services Demographic-Primary Language Data, Yellow Fin, FY 2022–2023*

Mapping and planning for technical assistance and team-building opportunities to address systemic and cultural bias awareness and strengthen communication within the forensic system of care.

Offer an improved and newly designed website and increase the utilization of social media, podcasts, and listening sessions. WET is currently actively reaching out to appropriate agencies to offer technical assistance. There have been three requests for technical assistance in this new fiscal year.

ACBHD has implemented the below strategies to grow a multicultural and multilingual pipeline and workforce. Some of the successes across our pipeline programming include:

- **Office of Peer Support Services (POCC)**
- **Office of Family Empowerment (OFE)**
  - Peers Certified Scholarship Program
- **Ohlone College Mental Health Programs:**
  - Ohlone College's Curriculum Committee approved the proposed request to transition the Mental Health Advocacy Program into a two-series noncredit certificate program titled 'Certificate of Completion in Community Mental Health" I and II. This approval means that Ohlone will no longer need ACBHD funding and instead will receive apportionment dollars from the state for enrollment.
- **The Beats Rhyme for Life:**
  - Program has expanded high school outreach partners to include Rudsdale, Skyline, and Latitude High Schools in addition to Oakland High, Met West, Oakland School of the Arts, & Castlemont.
- **Korean Community Center of East Bay (KCCEB):**
  - In 2023, an intern moved into a staff role at KCCEB providing clinical case management and counseling services to monolingual Korean speaking immigrants and other API youth, adults, and family

- **KCCEB is exploring applying for Medi-Cal** contracts in order to be able to support moderate-to-severe clients and also have a place for interns to continue serving this population.
- **KCCEB** has also been recruited to be part of a five-year grant opportunity with University of Southern California (USC) to develop a Center of Excellence, advancing behavioral healthcare for AANHPI communities while reducing behavioral health-related disparities.

ACBHD has implemented strategies to increase our recruitment and retention of multicultural and multilingual staff. Some of the successes across our staff recruitment and retention efforts include:

- Program/Initiative: ACBH, in partnership with the Alameda County General Services Agency (GSA) department, is in the process of purchasing a property at 1912 MLK Way in Oakland for the development of the African American Wellness Hub Complex (HUB)
- Program/Initiative: Successes have included strengthened community partnerships and an increased community footprint. By partnering with community coalitions and groups, we are working with community groups to identify effective strategies for recruitment

Along with successes, implementing these strategies has taught us that growing a multicultural workforce is an iterative process. Our department needs to assess community cultural and linguistic needs. While we strive to be more proactive, we provide multicultural and multilingual services in response to ever-changing needs. The result of evolving needs requires that ACBHD be kept abreast of the consistent change in our community.

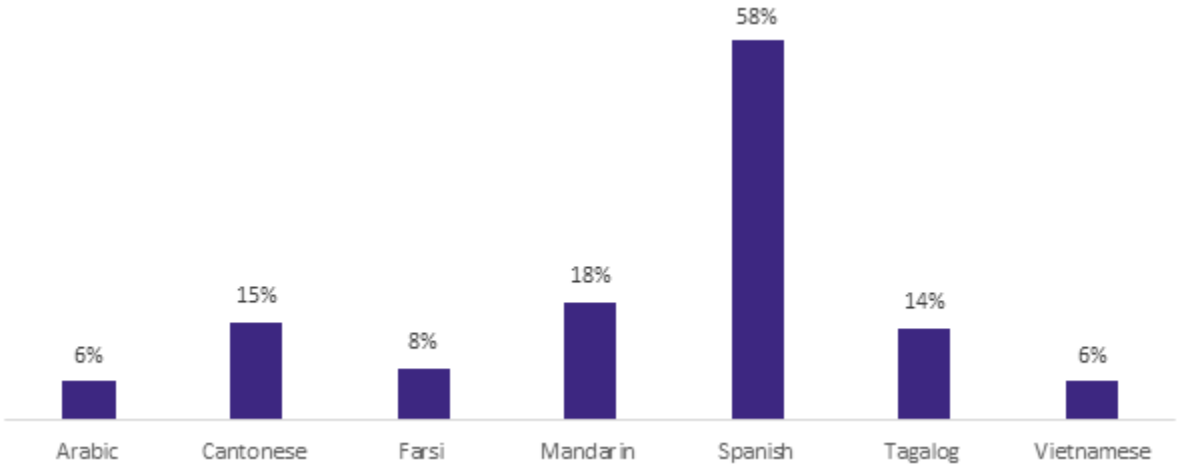
As we continue to diverse our workforce, we anticipate needing assistance with training on recruitment and retention efforts for each of the communities represented in Alameda County.

# Criterion VII
## *Language Capacity*

## I. Increase bilingual workforce capacity

In our WET Needs Assessment, we learned that participating providers speak a range of languages with clients other than English, as seen in Figure 37.

***Figure 36.** Percentage of Providers Reporting Speaking Languages with Clients Other than English, N = 85*




*Source: 2024 WET Provider Survey*

While staff have a wide linguistic capacity, there is still a need to build bilingual staff capacity, especially clinicians. To address this provider-identified need, we plan to share workforce-capacity findings with human resources and systems of care to adapt hiring and recruiting strategies. We have also established partnerships with agencies that can support our staff to serve multilingual beneficiaries.

As previously noted, the linguistic capacity of staff mostly reflects languages spoken among ACBHD's general population. As noted in our MHSA Three-Year Plan, we have hired more multilingual staff, especially with capacity in our threshold languages, Spanish and Chinese. Multilingual staff recruited and retained across our MHSA and CSS programing include:

- Specialty Mental Health Services to older adult AAPI Pilot in City of Fremont: Two bilingual full-time clinicians
- Supportive Services for TAY with Fred Finch Youth and Family Services: One bilingual Spanish-speaking Peer Mentor and one bilingual Spanish-Speaking Clinical Supervisor
- Greater Hope Full-Service Partnership: Limited bilingual Spanish-speaking staff
- Language ACCESS Asian: All bilingual clinicians
- La Familia's Spanish Language ACCESS: Most clinicians and all staff and interns are bilingual
- La Familia's Service Team Program: All bilingual staff

- Schreiber Center: Bilingual psychiatrist
- Behavioral Health-Primary Care Integration Project: Care Coordination: Several therapists and care coordinators are bilingual
- Felton Institute's (RE)Mind and BEAM Early Psychosis Program: Bilingual master's level care manager
- Zero Suicide Program: Spanish-speaking Hospital Follow Up Supervisor
- School-Based Behavioral Health: ASCEND program at Oakland Academy of Knowledge, Sequoia and Think College Now: Bilingual clinicians
- School-Based Behavioral Health program at East Oakland Pride Elementary School: One full-time Spanish speaking bilingual staff member
- Mental Health Association of Alameda County Family Education Resource Center: Spanish speaking outreach coordinator

Along with retaining bilingual staff, we are also working to recruit multilingual providers in the following programs:

- Asian Health Services' Service Program
- Crisis Support Services' Suicide Prevention Crisis Line

To demonstrate our commitment to increasing the language capacity of our system, we have dedicated $1.5 million to resources for interpreter services.

## II. Interpreter services to persons who have Limited English Proficiency (LEP)

Policies, procedures and practices for meeting clients' language needs, including the following:

- 24-hour phone line with statewide toll-free access to linguistic capability, including TDD or California Relay Service
- New technologies, such as video language conferencing, to grow language access
- Description of protocol for implementing language access through the county's 24-hour phone line with statewide toll-free access
- Training for staff who may need to access 24-hour phone line with statewide toll-free access

To further institutionalize our commitment to providing services to beneficiaries with Limited English Proficiency (LEP), we have implemented the following policies, procedures, and practices across ACBHD:

- 24/7 Language Assistance to Beneficiaries Policy: Established methods to provide language assistance to beneficiaries 24 hours per day, seven days per week
- Phone Line Assistance: All ACBHD providers have access to GLOBO services to meet the linguistic needs of beneficiaries with LEP. Providers can call the GLOBO number to receive language support in the following languages:

- Vietnamese
- Spanish
- Mandarin/ Cantonese
- Somali

- Portuguese
- Nepali
- Tongan
- Arabic
- Punjabi
- Mandingo
- Russian
- Mongolian
- Cambodian
- Fuzhou
- Toishan
- Dari
- Pashto
- Mam
- Khmer
- Urdu
- Tigrinya
- Japanese
- Vietnamese
- Hindi

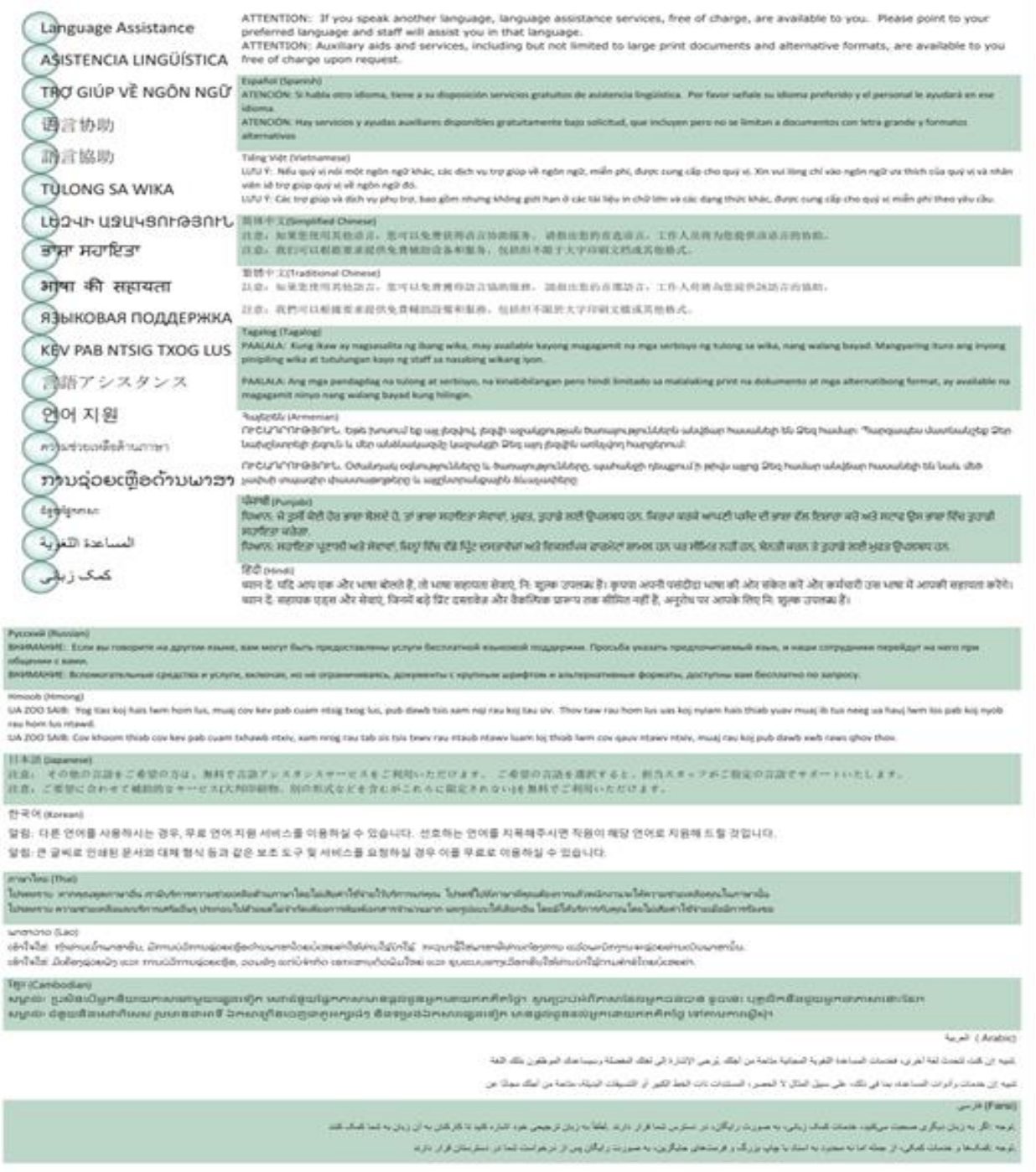
**In-person Interpretation & Translation Access**: Our community-based providers also have access to in-person interpretation through the following external partners:

- Accent on Languages (Plan Admin)
- AllWorld Language Consultants, Inc.
- CAL Interpreting & Translations (CRISIS)
- Cayuse Civil Services (Adults)
- EXCEL (SUD)
- GLOBO Language Solutions, LLC
- Hanna (Forensic)
- Interpreters Unlimited (Children)

In-person interpretation covers 150 languages, including but not limited to the threshold languages - Spanish, Farsi, Arabic, Traditional Chinese, Simplified Chinese, Tagalog, Vietnamese, Korean, and Khmer (Cambodia) and the following:

- American Sign Language Hmong Samoan
- Arabic Ilocano Serbian
- Armenian Indonesian Shanghainese
- Bengali Italian Sinhalese
- Bosnian
- Braille Materials Japanese Somali
- Burmese Korean Spanish
- Cambodian Laotian Swahili
- Cantonese
- Malay
- Mam Tagalog
- Hindi Russian Hakka
- Certified Deaf Interpreters Mandarin Tamil
- Czech Mien Thai
- Dari Mongolian Tibetan
- Dutch Nepali Tigrinya
- Farsi Oromo Taishanese
- French Pashto Tongan
- Fukienese Polish Turkish
- German Portuguese
- Urdu
- Ukrainian
- Gujarati Punjabi Vietnamese
- Hakka Romanian German

*Figure 37. Language Assistance Poster*



Along with Department-wide policies, we have also made the following accommodations in our service provision for those with LEP:

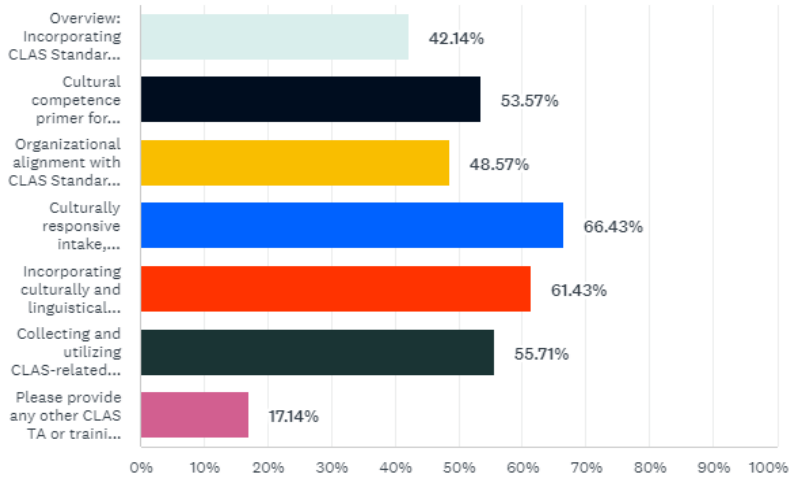
- Bilingual staff: We have over 15 bilingual staff that beneficiaries can access through our ACCESS program.
- Interpretation services: We offer interpretation services in 25 languages.
- Translation services: We offer our documents in 25 languages through translation by external partners.

To better assess our department's linguistic capacity gaps and develop additional accommodations, we convened the Language, Interpretation, and Translation Workgroup for three months in 2024. This group, comprised of providers across our system, developed the following practices and procedures to better meet client language needs of:

- Providing more annual training
- Adding additional providers to the LIT network

Although we continue to make progress in meeting our clients' linguistic needs, we have had challenges in community-based providers not having access to document translation services. Providers participating in the WET Needs Assessment cited the need for dedicated translation services for English-speaking clinicians due to the high cost and long wait to translate documents. To address this challenge, we have expanded access to our translation vendors to all ACBHD providers, including those in community-based organizations. Working through these challenges has taught us that the needs of our community are diverse. To ensure ACBHD is aware of and addresses the diverse needs our team attends community meetings and holds forums where we listen. Adding listening sessions to our community engagement will allow community members to inform ACBHD of their needs and aid us in identifying potential gaps in service delivery.

Providing ongoing technical assistance and guidance in the culturally responsive intake, assessment, treatment, and recovery services, was scored as needed by clients as shown in the chart below.



We offer bilingual staff and interpreters for our threshold languages at all service entry points. The contact points providing multilingual support include the following:

- **ACCESS:** All providers and beneficiaries can access interpreters for our threshold languages through our ACCESS line
- **Website translation:** All website users can translate the site into our threshold languages

***Figure 38. Interpretation Service Fliers***



When beneficiaries are offered interpreter services, it is documented that these services were offered in SmartCare. For phone line services, the documentation includes the phone numbers involved in the service provision, the language used, and the date, time, and length of the call.

To expand our capacity to assist in our threshold languages during operating hours, we contract with linguistically proficient agencies. Those contracted agency staff include the following:

- Tiburcio Vasquez Health Center (Spanish, English, Tagalog, Farsi)
- Mental Health Association of Alameda County (Spanish, Tagalog, Mandarin, Farsi/Dari)
- Telecare Corp (Spanish, Tagalog, Mandarin, Farsi/Dari, Chinese, English)
- Alameda Family Services (Arabic, Chinese, Spanish, Tagalog, Mandarin, Farsi/Dari, Korean)

These contracted providers expand our capacity through the previously mentioned interpretation and translation vendors.

In seeking contracted interpreters that provide a high level of language competence, we evaluated proposals on the strength of the contractor's interpreter pool and multilingual capability. We include the following language in our contracts with interpretation and translation vendors to ensure that our interpreters remain trained and language competent. Per the Executed Contract, Exhibit A, Section VIII: H:

> ***Linguistic Capability and Accessible Format***
> *The County is responsible for ensuring that services are linguistically-responsive and provided in languages including but not limited to the County threshold languages of English, Spanish, Arabic, Chinese (spoken: Cantonese and Mandarin; written: Traditional and Simplified), Farsi, Tagalog, and Vietnamese and any other threshold languages added at a later date. Contractor shall provide language access to clients in the client's preferred language through bilingual staff and/or through the ACBH Language Line.*

## III. Provide Services to All LEP Clients Not Meeting the Threshold Language Criteria at All Points of Contact

We also aim to meet the needs of those LEP beneficiaries who speak languages outside of our threshold languages. Specifically, we provide support to growing communities speaking the following languages:

- Farsi
- Korean
- Tagalog
- American Sign Language

For those beneficiaries with linguistic needs outside of our threshold languages, we implement the same language assistance policies, procedures, and practices. These policies include the previously detailed: 24/7 Language Assistance to Beneficiaries Policy, phone line assistance, and in-person interpretation and translation services.

When clients speaking languages outside of our threshold languages seek services, we link them to culturally and linguistically appropriate services first through our ACCESS line. If GLOBO does not have the language capability needed, clients are then connected to one of our contracted vendors via phone. Providers have the number to access contracted vendors to also directly schedule in-person interpretation.

***Policies, Procedures and Practices That Comply With The Following Title VI of the Civil Rights Act of 1964:***

1. Prohibiting The Expectation That Family Members Provide Interpreter Services
2. A Client May Choose to Use a Family Member of Friend as an Interpreter After Being Informed of the Availability of Free Interpreter Services
3. Minor Children Should Not Be Used as Interpreters

To build our inclusive continuum of care, it is important that we can support all languages spoken across Alameda County. We ensure that we have the resources to prevent children from having to serve as interpreters and empower beneficiaries to choose a family member or friend as an interpreter or access our free services with the following contract language with external vendors. Per the Executed contract:

> *Contractor shall comply with applicable regulation, included but not limited to: Title VI of the Civil Rights Act of 1964 Section 2000d, as amended, prohibiting discrimination based on race, color, or national origin in federally funded programs; Title VIII of the Civil Rights Act of 1968 (42 USC 3601 et seq.) prohibiting discrimination on the basis of race, color, religion, sex, handicap, familial status or national origin in the sale or rental of housing; Title IX of the Education Amendments of 1972 (regarding education programs and activities); the Age Discrimination Act of 1975 (45 CFR Part 90), as amended 42 USC Sections 6101 – 6107), which prohibits discrimination on the basis of age; Age Discrimination in Employment Act (29 CFR Part 1625); Title I of the Americans with Disabilities Act (29 CFR Part 1630) prohibiting discrimination against the disabled in employment; Title II of the Americans with Disabilities Act (28 CFR Part 35) prohibiting discrimination against the disabled by public entities; Title III of the Americans with Disabilities Act (28 CFR Part 36) regarding access; Title VIII of the Civil Rights Act of 1968 (42 USC 3601 et seq.) prohibiting discrimination on the basis of race, color, religion, sex, handicap, familial status or national origin in the sale or rental of housing; Section 1557 of the Patient Protection and Affordable Care Act; Title 2, Division 3, Article 9.5 of the Government Code, commencing with Section 11135; the Drug Abuse Office and Treatment Act of 1972, as amended, relating to nondiscrimination on the basis of drug abuse; the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; and Confidentiality of Alcohol and Drug Abuse Patient Records (42 CFR Part 2, Subparts A – E). Contractor shall comply with the provisions of the Fair Employment and Housing Act (Government Code, § 12900 et seq.) and the applicable regulations promulgated thereunder (California Code of Regulations, Title 2, § 11000 et seq. and Title 2 Division 4 § 7285.0 et seq.). The applicable regulations of the Fair Employment and Housing Council implementing Government Code section 12990, set forth in Subchapter 5 of Chapter 5 of Division 4.1 of Title 2 of the California Code of Regulations are incorporated into this contract by reference and made a part hereof as if set forth in full. Contractor shall comply with Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as*

*supplemented by regulation at 41 CFR part 60, "Office of Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor;" Executive Order 11246 (42 USC 2000(e) et seq. and 41 CFR Part 60) regarding nondiscrimination in employment under federal contracts and construction contracts greater than $10,000 funded by federal financial assistance; Executive Order 13166 (67 FR 41455) to improve access to federal services for those with limited English proficiency; the Rehabilitation Act of 1973, as amended (29 USC Section 794), prohibiting discrimination on the basis of individuals with disabilities; or (38 U.S.C. 4212) of the Vietnam Era Veteran's Readjustment Assistance Act.*

# Criterion VIII
## *Adaptation of Services*

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

Our commitment to expanding and integrating client and family members into a more equitable system of care is evident in ACBHD equity-centered strategic plan. In the plan, we prioritize the hiring of Community Health Workers (CHWs) or peer specialists to increase culturally responsive care and remove barriers to healthcare across communities. We also recognize the opportunity to leverage the expertise of those with lived experience to provide support and resources to community specific resources. These peer and family-driven initiatives are championed by the OES, Office of Peer Support Services (OPSS) and Office of Family Empowerment (OFE) within the HED.

ACBHD provides a variety recovery and wellness programs across our systems of care that are client-driven or operated, as seen in Table 29.

*Table 29. Client-Driven/Operated Wellness and Recovery Programs*

| Program Name | Responsibility |
|---|---|
| **Office of Peer Support Services (OPSS)** | ▪ Collaborating with the community to support Alameda County as a leader in certifying Peer Support Specialists<br>▪ Ensuring that peer support services and trainings are available and accessible |
| **Office of Family Empowerment (OFE)** | ▪ Provide technical assistance and family perspectives to ACBHD network<br>▪ Offering coaching, training and support to family members in working groups and councils<br>▪ Leading co-Learning projects<br>▪ Facilitating Parent Cafés<br>▪ Developing Parent's Tools to Thrive and other Family Centered Curriculum and activities |
| **Peers Organizing Community Change (POCC)** | ▪ Improve the quality of life for Alameda County residents who have mental health or mental health and substance use issues |

| | |
|---|---|
| | ▪ Provide the consumer perspective to the ACBHD network |

Collectively, these client-driven programs are leading the following efforts to support the Department's recovery and wellness focus:

- In July 2023, a proposal to increase peer and family member compensation from $20 to $35 was approved. Currently, formal policies and procedures are being developed to implement this practice change with guidance from peers and family support specialists across ACBHD.
- In January 2024, the Alameda County Peer/ Family Member Peer Support Specialist Certification scholarship program was implemented to subsidize the fees for the application, exam, or reinstatement for California Medi-Cal Peer Support Specialist Certification. To date, there have been over 60 applicants for the scholarship program.
- OFE facilitated Psychiatry Advanced Directive training and Care Court training for family dialogue groups
- OFE supported family member participation in the 2024 California Mental Health Advocates for Children and You Annual Conference and facilitation of:
- Parents and Caregivers Deep Dive Session
- Experiencing the Lived Experience Workshop with 17 attendees who all reported the workshop met their expectation
- Strengthening Families Workshop with 24 attendees who all reported the workshop met their expectations
- OPSS facilitated a townhall on SB43 for families and peers

Of the client-driven/operated programs we offer, below are a few examples of those offering racially, ethnically, culturally, and linguistically specific including the following:

- Language Interpretation
- Asian Health Services (AHS)
- Pacific Services
- LaFamilia
- LaClinica
- Native American Health Center
- Jewish Family and Community Services
- Korean Community Center for the East
- Center for Empowering Refugees and Immigrants
- RAMS & Pacific Islander Wellness Initiative
- The Hume Center

## II. Responsiveness of mental health services

To build a culturally appropriate behavioral health system, we have established programs and processes that allow us to be responsive to client needs.

ACBHD established a working relationship with a wide range of beneficiary cultural preferences. By partnering with HEAL (Healing Model, Enhancing Capacity, Advertising and Learning) program. The HEAL program's focus on increasing utilization across the AAPI community through integrated primary and behavioral health care. The program uses an interdisciplinary framework to provide clients with Western and Eastern medical techniques. Community members are invited to participate in free services and activities, including weekly outreach events, designed by an AAPI Patient Advisory Board.

ACBHD informs community members covered by Medi-Cal and other health coverage, of the availability of the HEAL program with innovative marketing through flyers, media, and direct community engagement was a recent Wellness Fair held in unincorporated Hayward.

We have assessed factors of our service provision to ensure services and supports are accessible to culturally and linguistically diverse populations.

*Location, transportation, hours of operation or other relevant areas*

To minimize barriers associated with assessing services, we offer the majority of services through community-based providers at facilities across Alameda County. These collaborations ensure that ACBHD are located throughout the county and are responsive to community need. These community-based providers meet beneficiaries where they are and minimize challenges to accessing services, such as service hours and transportation. Per the executed contract:

Contractor's care coordination services shall consist of the following: i. Coordinating with medical and mental health care providers to monitor and support comorbid health conditions; ii. Discharge planning, including coordinating with SUD treatment providers to support transitions between levels of care and to recovery resources, referrals to mental health providers, and referrals to primary or specialty medical providers; and iii. Coordinating with ancillary services, including individualized connection, referral, and linkages to community-based services and supports including but not limited to educational, social, prevocational, vocational, housing, nutritional, criminal justice, transportation, childcare, child development, family/marriage education, cultural sources, and mutual aid support groups.

All of our services are offered in ADA-compatible facilities to ensure they are accessible to people living with physical disabilities. To accommodate the needs of clients living with other disabilities, we also provide signage throughout building in braille. As previously noted, our interpretation and translation vendors also have capacity to support American Sign Language and braille.

ACBHD has been intentional in our efforts to ensure that our system is trauma-informed. In partnership with Trauma Transformed, we have trained over 377 ACBHD staff through meaningful training designed to address the trauma embedded in existing systems and transform every part of existing systems into healing organizations. These trainings include cross sections of our workforce,

including administrative support, clinical and non-clinical staff, and leadership, to understand the impact of trauma. These trainings help our teams develop strategies to work together to develop shared language and practices that make our facilities more welcoming for all beneficiaries.

ACBHD worked to eliminate the stigma associated with seeking mental health services by providing over 80% of our services in community-based settings. Our behavioral health-primary care integration program integrates behavioral health care with primary care. Examples of these program offerings focus on the following areas and populations:

- Asian American and Pacific Islanders
- AXIS
- Tri-Valley
- BACH
- Fremont Path
- La Clinica
- Silva Clinic
- Lifelong
- Native American

# I. Quality of Care: Contract Providers

## A. Evidence of how contractor's ability to provide culturally competent mental health services are taken into selection

ACBHD services are primarily provided by contracted Community Based Organization (CBO) providers. To demonstrate our commitment to the contractor's ability to provide culturally responsive care, we include the following language in all executed Contracts in EXHIBIT A-1 STANDARD REQUIREMENTS:

G. Culturally and Linguistically Appropriate Services (CLAS) To ensure equal access to quality care by diverse populations, Contractor shall adopt the Federal Office of Minority Health Culturally and Linguistically Appropriate Service (CLAS) national standards as outlined online at: https://thinkculturalhealth.hhs.gov/clas/standards. Contractor shall have, implement, and monitor a plan to enhance implementation of CLAS Standards throughout its organization, and shall work with ACBH and other partners to enhance service utilization for different populations including but not limited to American Indians/Alaskan Natives and other priority populations. See section IX.B. for annual training requirements. H. Linguistic Capability and Accessible Format The County is responsible for ensuring that services are linguistically-responsive and provided in languages including but not limited to the County threshold languages of English, Spanish, Arabic, Chinese (spoken: Cantonese and Mandarin; written: Traditional and Simplified), Farsi, Tagalog, and Vietnamese and any other threshold languages added at a later date. Contractor shall provide

language access to clients in the client's preferred language through bilingual staff and/or through the ACBH Language Line. Contractor shall ensure its written materials that are critical to obtaining services are available in threshold languages and alternative formats. Contractor shall ensure that visual-impaired, hearing-impaired and other special needs audiences are provided material information in formats that provide the most assistance in making informed choices.

Contractor shall comply with all applicable provisions of the Dymally-Alatorre Bilingual Services Act (Government Code sections 7290-7299.8) regarding access to materials that explain services available to the public as well as providing language interpretation services. Contractor shall comply with the applicable provisions of Section 1557 of the Affordable Care Act (45 CFR Part 92), including, but not limited to, 45 CFR 92.201, when providing access to: (a) materials explaining services available to the public, (b) language assistance, (c) language interpreter and translation services, or (d) video remote language interpreting services.

The executed contract for FY 23-24, Substance Use Disorder, DMC-ODS, Scope of Work, Section C, subsection 1 states:

iii. Care Coordination services,9 which shall consist of the following:

a. Coordinating with medical and mental health care providers to monitor and support comorbid health conditions;

b. Discharge planning, including coordinating with SUD treatment providers to support transitions between levels of care and to recovery resources, referrals to mental health providers, and referrals to primary or specialty medical providers; and

c. Coordinating with ancillary services, including individualized connection, referral, and linkages to community-based services and supports including but not limited to educational, social, prevocational, vocational, housing, nutritional, criminal justice, transportation, child care, child development, family/marriage education, cultural sources, and mutual aid support groups.

## II. Quality Assurance: Current or Planned Processes to Assess Quality of Care

We use a variety of metrics to assess the quality of care for all beneficiaries and demonstrate our commitment to providing culturally responsive support and services. These data include our RBA evaluation metrics, client feedback, and staff surveys.

## A. List, if applicable, of outcome measures, identification and descriptions of culturally relevant consumer outcome measures

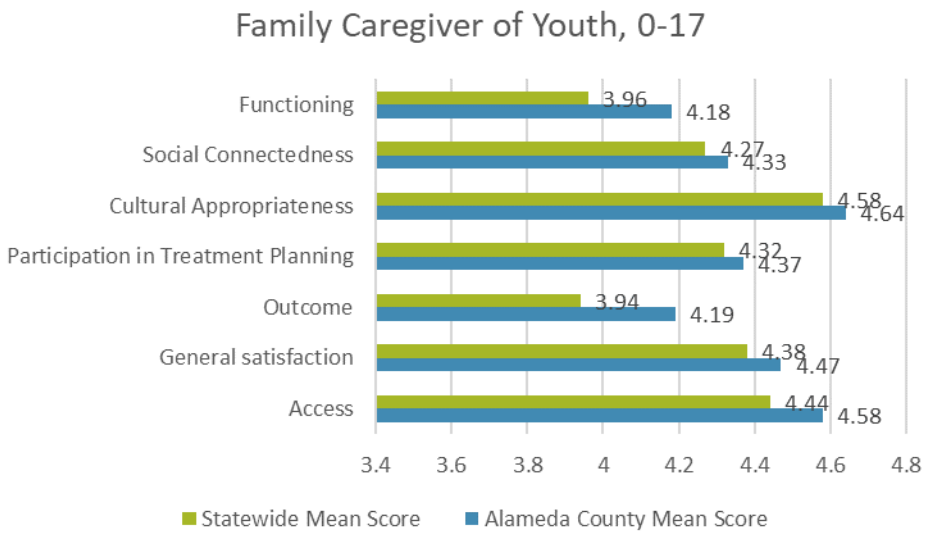
We systemically collect client feedback to identify effective strategies for quality assurance. Client mental health services satisfaction is assessed by collecting Consumer Perception Survey data with the Mental Health Statistics Improvement survey tool.[1]

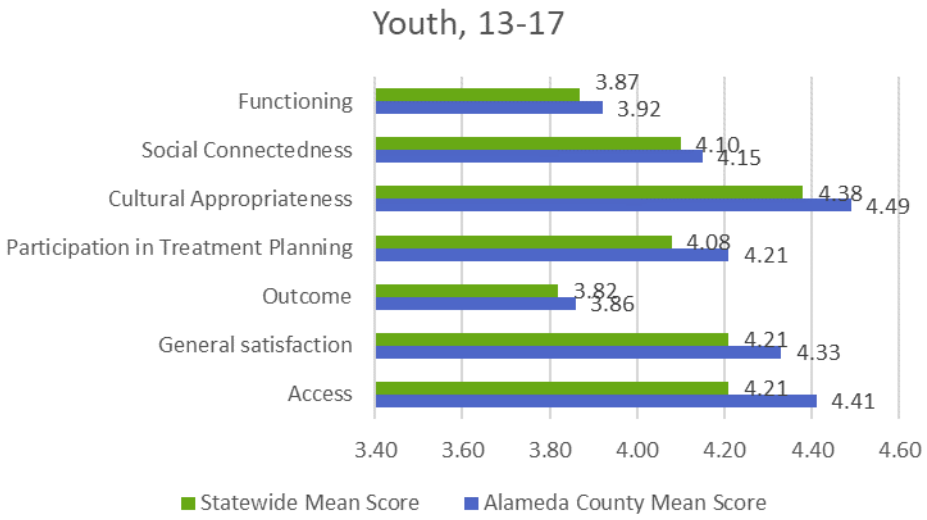
This survey is administered as a paper survey or online in English or Spanish to patients receiving mental health services from publicly funded mental health programs across California. Statewide collection is coordinated by the UCLA (University of California, Los Angeles) Integrated Substance Abuse Programs. Aggregated data is shared with ACBHD's Quality Improvement team to integrate findings into program and service development.

In FY 23-24, 71.89% of ACBHD's family, youth, adult, and older adult clients completed the Consumer Perception Survey. Most respondents had received services for longer than a year. Across all beneficiary groups, majority of beneficiaries reported receiving services and written information in the language they prefer. As seen in Figure 40 and 41, majority of beneficiaries reported satisfaction scores comparable or higher than the statewide mean. The satisfaction domains that could use the most improvement for all beneficiaries is the perception of social connectedness, functioning and outcome of services.

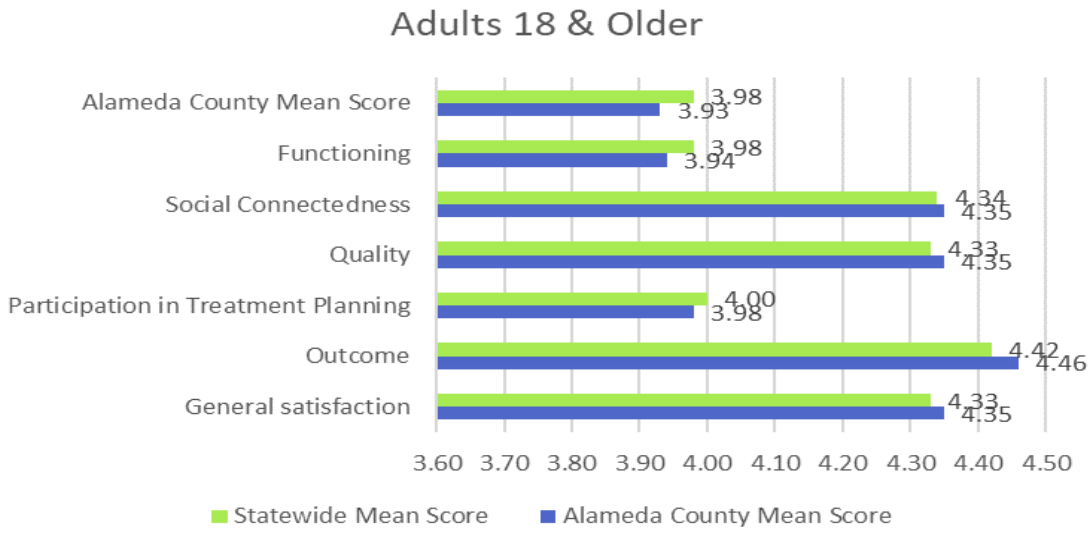
[1]. Information about Consumer Perception Survey was collected through discussions with Michelle Manor with the data warehouse team and on the UCLA website (https://www.uclaisap.org/mh-consumer-perception-survey.html )

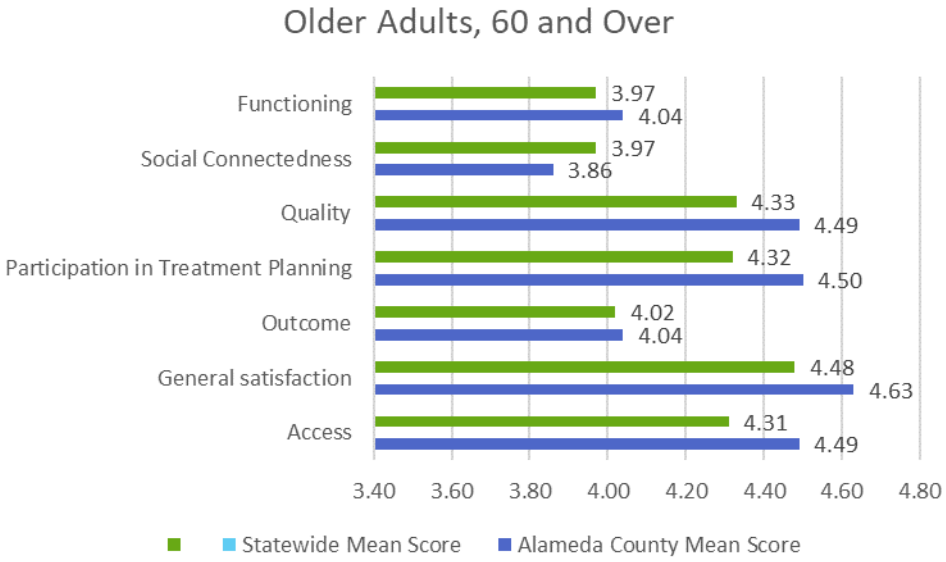
*Figure 3. Satisfaction Scores by Domain, Youth*




*Source: CPS Statewide Comparison Scores 2024*



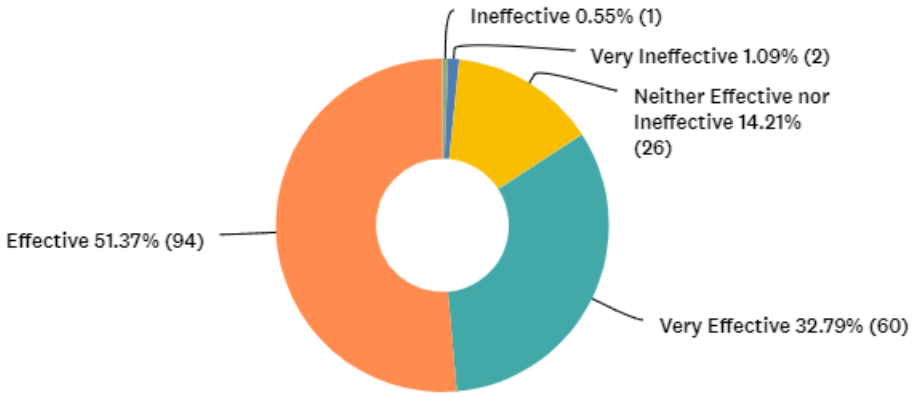

*4. Satisfaction Scores by Domain, Adult*

*Source: CPS Statewide Comparison Scores 2024*

## B. Methods used to measure staff experience or opinion of organization's ability to value cultural diversity in its workforce

In the 2024 WET Needs Assessment, we assessed providers' perception of our workforce. Specifically, we asked about the effectiveness of the pipeline to prepare a diverse workforce. Almost half of providers (47%) reported ACBHD pipeline program as somewhat effective (32%) or not at all effective (15%) at preparing a diverse workforce, as seen in Figure 42.

*Figure 5. Provider-Reported Effectiveness of WET Pipeline Programs in Preparing a Diverse Workforce, N = 85*




*Source: 2024 WET Provider Survey*

## C. Description of process for Medi-Cal and non-Medi-Cal client Grievance and Compliant/Issues Resolution Process data is analyzed and any comparison rates with general and ethnic beneficiaries

To ensure the quality of our services is improved based on beneficiary experience, we have implemented processes and procedures to analyze data from grievance or complaint issues. ACBHD executed contracts contain the following language to ensure contracted providers and community members are informed. This language is found in EXHIBIT A-1 STANDARD REQUIREMENTS, VII, Section C (see appendix C):

C. Grievances and Appeals Contractor shall comply with the ACBH Consumer Grievance and Appeal Processes policy. Consumer grievances shall be defined as dissatisfaction with ACBH

services in areas that shall include but are not be limited to: Contractor's service provision, Contractor's employees, the location of services, access/availability, or any other matter concerning the provision of Medi-Cal services. Consumer grievances shall be directed to the Consumer Assistance toll-free line at 1-800-779-0787 per the policy noted above. Contractor shall direct all ACBH consumers who wish to file an appeal for an adverse benefit determination to the ACBH Consumer Assistance toll-free line.

# Conclusion

ACBHD remains steadfast in our commitment to actualizing our vision of a culturally and linguistically responsive system that can meet the needs of all Alameda County residents. We are centering cultural competency in our navigation of an evolving legislative and behavioral health landscape in California. Key legislative changes, such as the proposed changes under Proposition 1, are significantly shaping the cultural competency needs of providers within the ACBHD network. The diverse cultures and languages across Alameda County are also informing how the HED supports providers to provide culturally and linguistically relevant services. While we have made progress in addressing some behavioral health disparities, there are gaps in outcomes that we must work to close. We will continue to identify emerging disparities through insights from our providers and beneficiaries. This on-the-ground expertise helps our department be more proactive instead of reactive in developing support and services. We will apply the strategies outlined in this CCP across our behavioral health system as we move toward advancing cultural competency. We hope to see an impact in our system and also in other county agencies that will align in our efforts.

# Appendix A

## National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care

The National CLAS Standards are intended to advance health equity, improve quality, and help eliminate health care disparities by establishing a blueprint for health and health care organizations to:

***Principal Standard:***

1. Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

***Governance, Leadership, and Workforce:***

2. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.

3. Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.

4. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

***Communication and Language Assistance:***

5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.

6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.

7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.

8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

***Engagement, Continuous Improvement, and Accountability:***

9. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.

10. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.

11. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.

12. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.

13. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.

14. Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.

15. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.

# Appendix B

## WET Needs Assessment Report

### EXECUTIVE SUMMARY

The Alameda County Behavioral Health Department (ACBHD) engaged Bright Research Group (BRG) to conduct the Workforce Development Education and Training (WET) Needs Assessment to assess existing strategies, current gaps, and emerging needs of the ACBHD's workforce. BRG utilized a mixed-methods approach comprised of focus groups with a total of 21 participants, as well as a survey with 85 respondents. The following key findings provide a snapshot of provider perspectives with respect to workforce, education and training needs:

#### Workforce Capacity and Needs

1. Hiring and recruiting staff reflective of the client population is both a priority and a challenge for community-based providers.
2. There is a shortage of bilingual and racially diverse staff, especially clinicians.
3. Providers who participated in the needs assessment reported experiencing challenges in meeting the complex health and social needs of their clients, which can contribute to burnout.
4. Providers expressed support for the critical role that the family and peer workforce can play in meeting their clients' needs and reported engagement efforts.
5.

#### Pipeline Programs and Preparation of a Diverse Workforce

1. Intern diversity does not align with the cultural and linguistic diversity of Alameda County's client population.
2. Supervisors and former interns reported mixed levels of satisfaction and effectiveness with the intern program.
3. Providers who participated in the survey offered recommendations to strengthen and improve the ACBHD intern programs.
4.

#### Training and Education Needs

1. Providers have mixed feedback on current WET unit offerings.
2. Providers have an interest in a variety of training formats and delivery and offered recommendations to improve WET trainings.

3. Providers reported a strong demand for rigorous trainings that enable them to deliver culturally responsive services to Alameda County's diverse client populations and specifically requested advanced clinical-skills training.
4. Providers feel most prepared to meet the needs of Latino/Hispanic communities but reported a need for training to engage clients across other ethnic and cultural backgrounds.
5. Providers expressed frustration with certain elements of the bureaucracy of the behavioral healthcare system and value up-to-date information.

Given these findings, BRG offers the following recommendations:

1. Sustain marketing efforts to promote WET training and education offerings with community-based providers.
1. Continue to offer advanced-skills trainings in topics suggested by providers.
2. Routinely gather training feedback from providers and share format and delivery preferences with contracted trainers to integrate them into future offerings.
3. Sustain training offerings for certified peer specialists and other peer and family professionals to support the professional development of the peer and family workforce.
4. Recruit interns for licensed clinical and case-management roles to address provider-identified workforce gaps.
5. Sustain and develop new strategies to increase the applicant pool of interns so that they better reflect the cultural, linguistic, and ethnic diversity of clients.
6. Share workforce-capacity findings with human resources and systems of care across the ACBHD to adapt hiring and recruiting strategies to address identified needs.

***Introduction***

The vision of the Alameda County Behavioral Health Department (ACBHD) is to ensure that its workforce is sufficient in size, diversity, and linguistic capacity to provide culturally responsive services and supports to clients and their families that center wellness, recovery, and resiliency. To achieve its mission, the Workforce Development Education and Training (WET) unit builds and expands the capacity of staff within the ACBHD and contracted community-based organizations (CBOs). The WET team supports the behavioral health workforce across Alameda County through the following strategies:

- Behavioral Health Career Pipeline Programs
- Retention and Financial Incentives
- Internship and Psychiatry Residency Programs
- Internship and Stipend Program
- Training and Continuing Education

The goal of the WET Needs Assessment is to assess the existing strategies, current gaps, and emerging needs of the ACBHD's workforce. The WET unit engaged Bright Research Group (BRG) to conduct the

assessment in 2024. This report documents the key findings and recommendations, which will be used to inform future WET unit programming and training offerings.

***Legislative Landscape***

The evolving legislative landscape in California is significantly shaping the training and education needs of providers within the ACBHD network and influencing the work of the WET unit. Key legislative changes, such as the implementation of CARE Courts and the amendments to the 5150 hold criteria through Senate Bill 43 (SB 43), are demanding a higher level of expertise and specialization from behavioral health providers. CARE Courts allow for court-ordered treatment plans for individuals with severe untreated mental illnesses, necessitating specialized training for behavioral health workers to effectively engage in the legal processes and deliver integrated care.[2] Additionally, SB 43 expands the definition of "gravely disabled" to include severe substance use disorders and incorporates telehealth assessments for 5150 holds. These changes require providers to be adept in new legal frameworks, telehealth technologies, and the comprehensive management of co-occurring mental health and substance use disorders, highlighting the need for robust evidence-based training programs.[3]

Moreover, the proposed changes under Proposition 1, which aim to redesign the Mental Health Services Act (MHSA), are set to require counties to redirect one-third of mental health dollars to housing interventions, potentially at the cost of broader behavioral health services.[4] With 35% of MHSA funds now earmarked for behavioral health services and supports, and at least 51% of this allocation directed toward early intervention for individuals under 25, the resources available for workforce education and training will be significantly reduced.[3] While the impact of Proposition 1's recent passing is still being determined, county-level leaders across California have concerns about the possible changes in prevention and early-intervention services, particularly for communities of color.[5] Given that the majority of county mental health funding is allocated to community services and supports, counties anticipate that the re-allocation of funding to the state could result in the cancellation of CBO contracts, a reduction in county-level staff, and disruptions in prevention and early-intervention programs and services.[3]

1. California Lawmakers Approved CARE Court. What Comes Next?," CalMatters
2. Bill Text—SB-402 Involuntary Commitment. (ca.gov)
3. "Understanding Proposition 1," California Budget and Policy Center (calbudgetcenter.org)
4. "Update: California Voters Narrowly Approve Prop. 1, Gavin Newsom's Mental Health Overhaul," CalMatters

***Methods***

BRG utilized a mixed-methods approach comprised of a provider survey, a CBO webinar, focus groups, interviews, and a review of background documents.

| Method | Sample Size |
|---|---|
| **WET Provider Survey** | 85 |
| **CBO Provider Webinar and Focus Groups** | 15 |
| **SUD Provider Focus Group** | 6 |
| **Key Informant Interviews with WET Leadership** | 3 |
| **Review of Background Documents and Existing Data** | N/A |

***WET Provider Summary***

The WET provider survey was an online survey that asked providers to answer multiple-choice and open-ended questions about training needs and priorities, workforce capacity, experience with pipeline programs, and organizational characteristics. Researchers used a "convenience sample," which is a non-probability sampling method used to gather input from a wide range of respondents. Convenience sampling does not guarantee a representative sample. The survey was distributed by the WET team to over 400 ACBHD staff providers and contracted CBO providers, who comprise over 80% of the ACBHD's workforce. The survey was completed anonymously. Respondents were incentivized to complete the survey with a drawing for a $25 electronic gift card. To enter the drawing, respondents completed a separate form that was not linked to their original survey in order to maintain confidentiality.

A total of 85 survey responses were collected, which represents a snapshot of provider perspectives regarding the workforce, education and training needs. There are over 3000 providers in the ACBHD network and results from the survey may not be representative of the general provider population. Most survey respondents described their workplace setting as a CBO (72%) or a community mental health / behavioral health agency (49%). All six of the ACBHD's systems of care were represented across survey respondents. The organizational demographics of respondents are shown in Table 1 below. For workplace setting and system of care, respondents were able to select more than one option. Please see the appendix for additional respondent demographic data, as well as the complete survey instrument.

*Table 2. Organizational Characteristics of Survey Respondents*

| | N | % |
|---|---|---|
| **Workplace Setting** | | |
| Community-Based Organizations | 61 | 72% |
| Community Mental Health / Behavioral Health Agencies | 42 | 49% |
| Hospital | 6 | 7% |
| School | 5 | 6% |
| Social Services Agency | 5 | 6% |
| Substance Use / Outpatient Setting Withdrawal Management | 5 | 6% |
| Peer Services | 3 | 4% |
| State and Regional Agency | 3 | 4% |
| Involuntary Treatment / Substance Use Disorder | 1% | 1% |
| **Organization Size** | | |
| More than 200 employees | 28 | 33% |
| 51–100 employees | 24 | 28% |
| 20–25 employees | 17 | 20% |
| Under 25 employees | 8 | 9% |
| 101–200 employees | 8 | 9% |
| **System of Care** | | |
| Child and Youth Services | 67 | 79% |
| Adult and Older Adult Services | 51 | 60% |
| Substance Use | 25 | 29% |
| Acute and Crisis Services | 20 | 24% |
| Psychiatry and Nursing Services | 19 | 22% |
| Integrated Primary Care Services | 15 | 18% |
| Forensic Services | 10 | 12% |

***Provider Focus Groups***

BRG facilitated a CBO provider webinar to gain insights about general organizational-level workforce and training needs. The WET team recruited 15 providers to attend the webinar. Most participants (93%) described their workplace setting as a community-based organization and/or a community mental health / behavioral health agency. Webinar participants represented all six of the ACBHD's systems of care, with the majority (60%) working in Child and Youth Services.

A separate small-group conversation among SUD providers was held to gain deeper insight about SUD provider specific needs and challenges. The SUD leadership team recruited six SUD providers to attend the focus group. Most participants (50%) served in program management or leadership roles, including program manager and director. Half of the participants had worked at their organization for one to three years, and the other half had tenures of over six years.

A thematic analysis of provider insights was conducted to determine trending themes from both focus groups. These themes were compared to themes across all data collection methods to identify key findings.

***Key Informant Interviews and Background-Document Review***

BRG reviewed the ACBHD and WET reports, presentations, and other background documents to better understand WET guiding priorities and the context and role of the WET team. The research team also conducted two interviews with Robert Farrow, ACBHD training officer, to better understand the WET unit's role within the ACBHD. Additionally, BRG conducted one key informant interview with Dr. Karyn Tribble, ACBHD director, to learn more about WET priorities and alignment with broader ACBHD workforce goals. This WET Needs Assessment report documents key findings and recommendations to support the ACBHD in strategically addressing the current gaps and emerging needs of its workforce.

**Key Findings: Workforce Capacity and Needs**

The ACBHD aims to be intentional in its recruitment and retention efforts, given Alameda County's diversity and ongoing labor challenges in the behavioral health sector. Through the needs assessment, the ACBHD wanted to understand the diversity of the workforce and the existing strategies to recruit and retain a diverse workforce. The WET unit contributes to preparing a diverse workforce through its Behavioral Health Career Pipeline and Internship Programs.

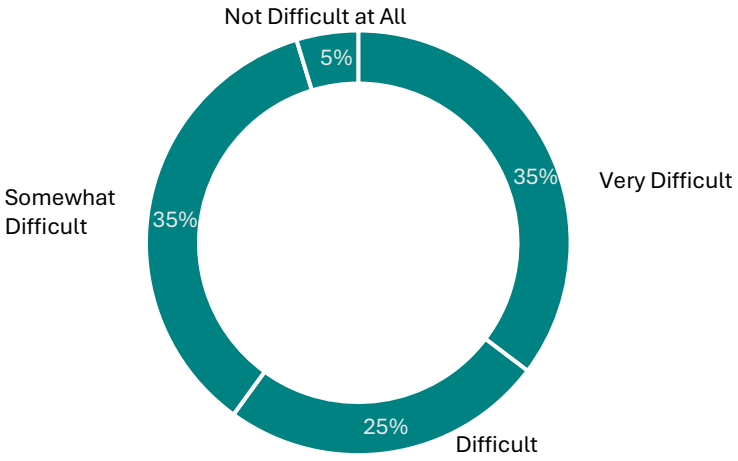
***Finding 1:*** ***Hiring and recruiting staff reflective of the client population is both a priority and a challenge for community-based providers.***

> *"There is a large Middle Eastern population in our Newark location, and we have no staff to reflect that population."*

The retention of multilingual and diverse staff is a high-priority workforce need for CBO partners. Providers reported during the CBO provider webinar that they highly value the contributions of multilingual and diverse staff, emphasizing the importance of building a workforce that reflects the demographics of the client populations their organizations serve. More attractive compensation packages offered by government agencies, especially at the county level, draw high-quality staff away from CBOs and compound these issues. These providers also emphasized that the struggle to retain staff is particularly pronounced for SUD counselors, who receive less favorable compensation compared to their mental health counterparts. The bureaucratic duties of the job include substantial paperwork and strict audit protocols, which make these positions less desirable.

The challenge of hiring and recruiting staff who match the cultural and linguistic backgrounds of the populations served was also cited as a concern in the WET provider survey. Overall, most providers reported that their organizations retain staff well but face challenges with recruiting and hiring diverse staff. As seen in the figure below, almost all providers reported some difficulty with filling open positions.

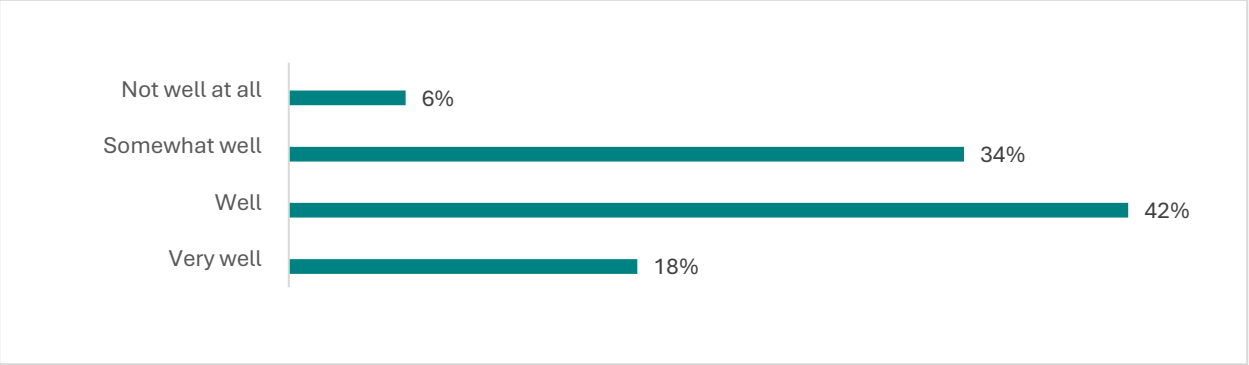
***Figure 6. Provider-Reported Difficulty in Filling Open Positions, N = 85***




*Source: 2024 WET Provider Survey*

In a budget-restrictive environment, employee retention is a high priority for the ACBHD's leadership. The survey respondents did not report significant challenges with staff retention, as shown in Figure 43.

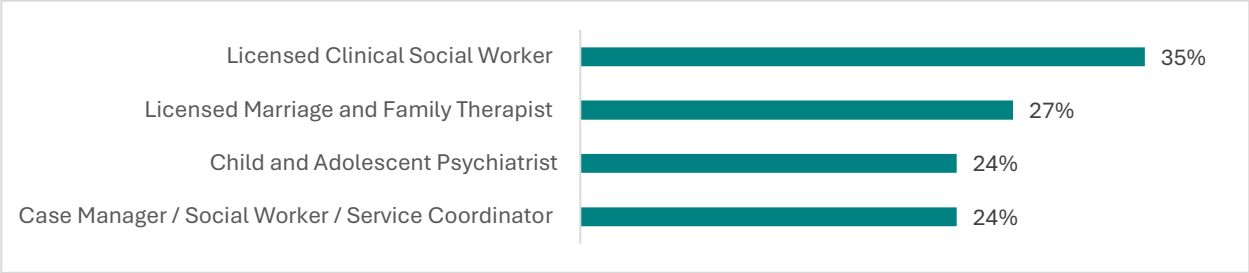
*Figure 7. Provider-Reported Effectiveness of Staff Retention, N = 85*




*Source: 2024 WET Provider Survey*

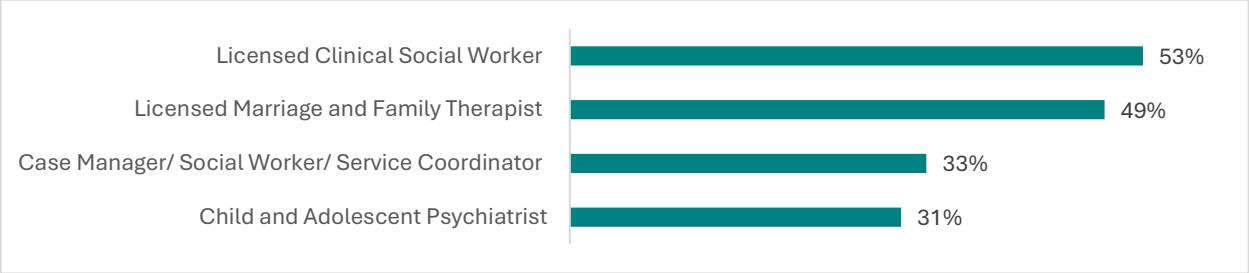
Providers who completed the survey noted the biggest challenges in recruiting and hiring. As seen in Figures 43 and 44, providers reported that licensed clinical roles were the most difficult positions to recruit and hire for.

***Figure 8. Percentage of Respondents Reporting Positions Most Challenging to Recruit For, N = 85***




*Source: 2024 WET Provider Survey*

***Figure 9. Percentage of Respondents Reporting Positions Most Challenging to Hire For, N = 85***




*Source: 2024 WET Provider Survey*

Moreover, during the CBO provider webinar, the small group conversation among SUD provider, and in the provider survey, providers described the challenges in recruiting and retaining BIPOC clinicians, citing issues with noncompetitive salaries and benefits.

> *"The lack of BIPOC clinicians is a significant issue, and we struggle to recruit and retain these essential staff members."*

***Finding 2:*** ***There is a shortage in bilingual and racially diverse staff, especially clinicians.***

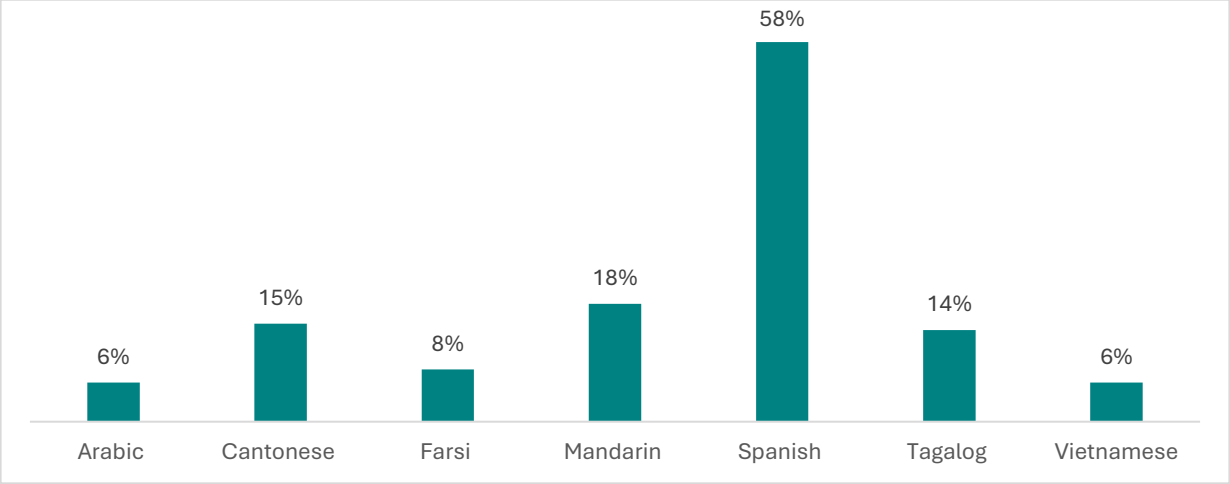
Providers spoke to the critical need for enhanced linguistic diversity and cultural competence within the workforce. Feedback from the CBO provider webinar, the provider survey, and the small group

> *"Not enough bilingual/bicultural mental health professionals to serve diverse underserved/unserved immigrant and refugee communities."*

conversation among SUD providers surfaced a significant shortage of staff who can effectively serve specific community groups, such as the growing Middle Eastern population, and underscored the need for increased language capacity, particularly in Asian languages.

Notably, over half of the survey respondents reported using languages other than English with their clients, with Spanish being the most common (58%), as seen in Figure 5. Respondents were able to select more than one language option, including "other." Providers reported speaking "other," including an Alaska Native Language, French, Ki'che', Italian, Russian, Khmer, Tibetan, Nepali, Rwandan, Tigrinya, Korean, Japanese, and Punjabi.

***Figure 10. Percentage of Providers Reporting Speaking Languages with Clients Other than English, N= 85***




*Source: 2024 WET Provider Survey*

SUD providers further emphasized the impact of limited linguistic capacity on their ability to provide ethical and effective care. Providers noted that often the evidence-based models they are required to use do not have documentation available in many languages other than English. Providers stated that when they do translate documents, it is often a long and expensive process.

> *"It makes me feel really uncomfortable signing clients up for things that they don't understand."*

***Finding 3:*** ***Providers who participated in the needs assessment reported experiencing challenges in meeting the complex health and social needs of their clients, which can contribute to burnout.***

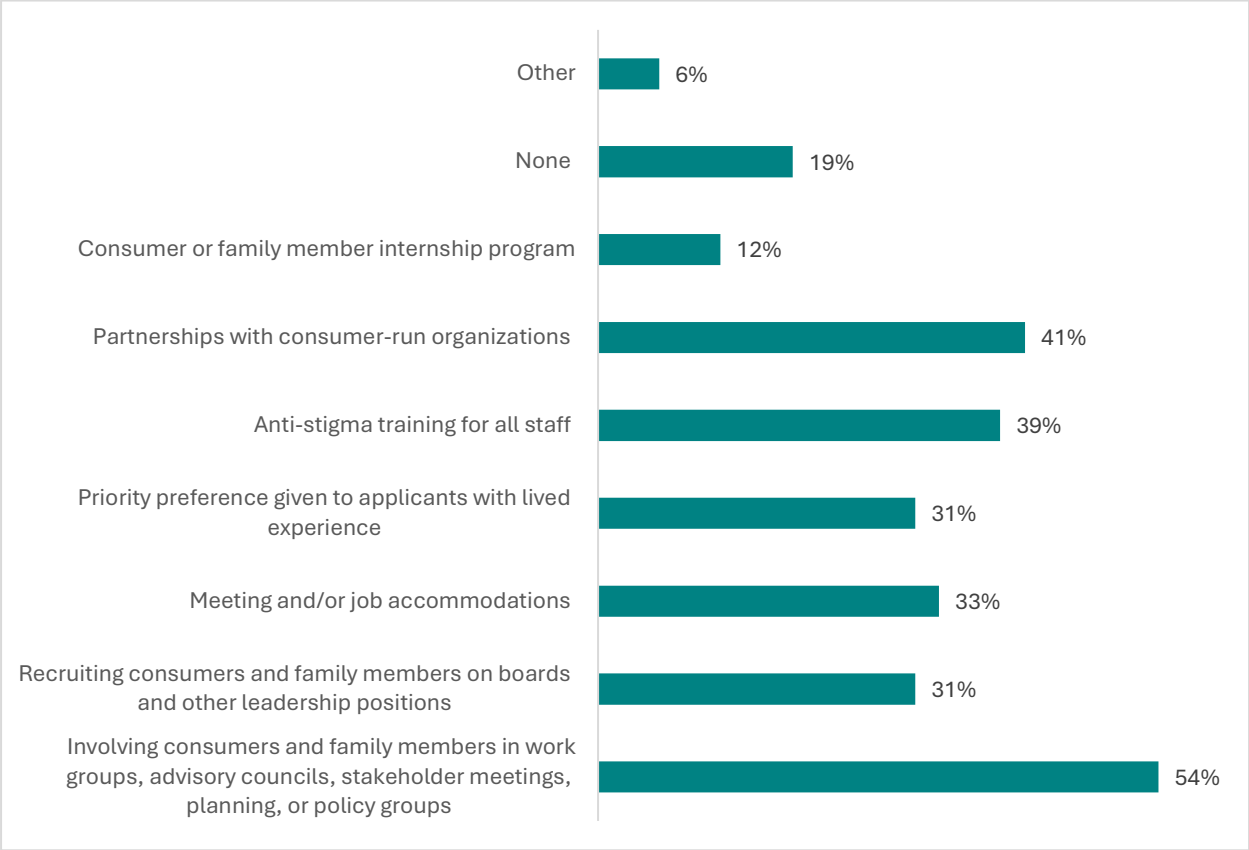
Some providers explained that a heavy workload and an inability to meet the complex and diverse needs of their client population lead to burnout and compromise the quality of care. Providers emphasized the complexity of their roles, which span therapy, case management, coordination, and coaching. In the provider survey, they pointed out the difficulties associated with serving populations affected by broader socioeconomic issues, such as poverty, housing, and food insecurity, and the lack of holistic services to meet these needs. Respondents highlighted the complex needs their clients are facing and the need for comprehensive wraparound services provided by a range of partners to address these needs. They spoke to gaps in the continuum of care, citing the need for dedicated translation/interpretation services for English-speaking clinicians and culturally and linguistically responsive substance use treatment. SUD providers noted that many clients on their caseloads were often living with co-occurring disorders and needed additional support to address their mental health needs.

***Finding 4:*** ***Providers expressed support for the critical role that the family and peer workforce can play in meeting their clients' needs and reported engagement efforts.***

Providers expressed support for the ACBHD's focus on expanding the family and peer workforce. The Office of Peer Support Services and the Office of Family Empowerment are primarily responsible for ACBHD's peer initiatives, though the WET unit provides training for the peer and family workforce. Survey respondents reported that they are actively working to expand their family and peer workforce, with over half of the respondents reporting that they engage peers and families (54%) in work groups and advisory councils. Respondents were able to select more than one option for peer

and family engagement. Figure 6 shows that provider organizations are utilizing a variety of methods to deepen their partnership with peers and family members.

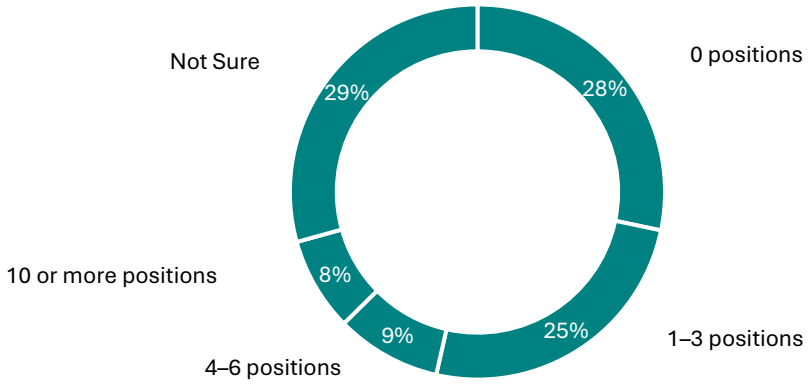
***Figure 11. Peer and Family Engagement in Organizations, N = 85***




*Source: 2024 WET Provider Survey*

Organizations are making progress with integrating peers and family members into their paid workforce. Overall, about 42% of providers reported that their organization had at least one designated peer or family-member position, as seen in the figure above.

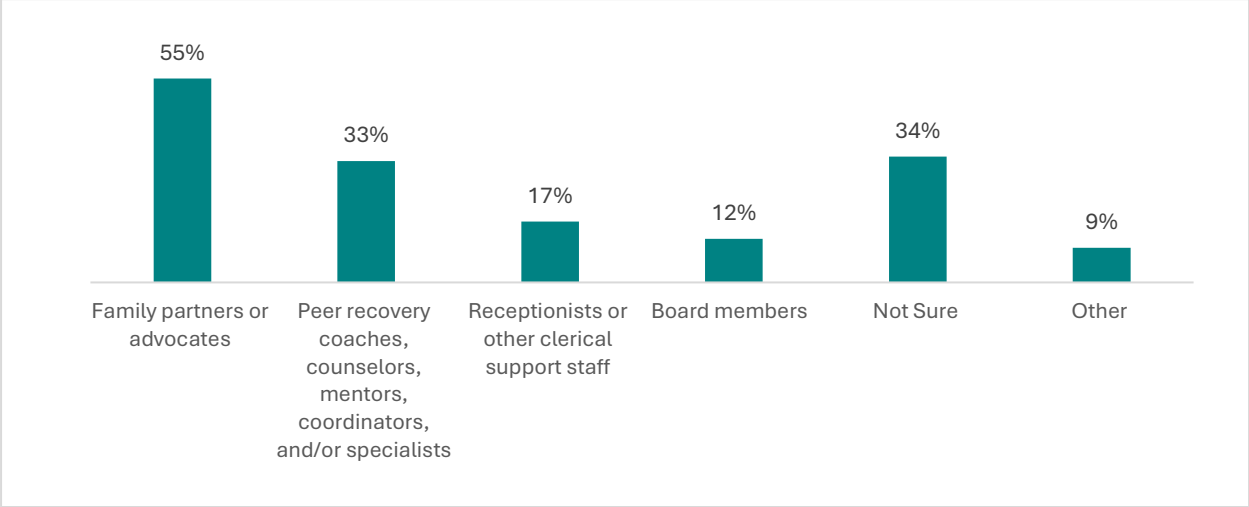
***Figure 12.** Provider-Reported Number of Designated Family or Peer Positions at Organization*




*Source: 2024 WET Provider Survey*

Peers and family members working at provider organizations most commonly serve as family partners, advocates, peer recovery coaches, counselors, mentors, coordinators, and/or specialists, as shown in Figure 48. About 9% of survey respondents reported peers serving in other leadership or staff roles, including as program directors, program specialists, managers, and mental health specialists.

***Figure 13.** Provider-Reported Roles for Peers and Family Members within Organizations, N = 85*



*Source: 2024 WET Provider Survey*

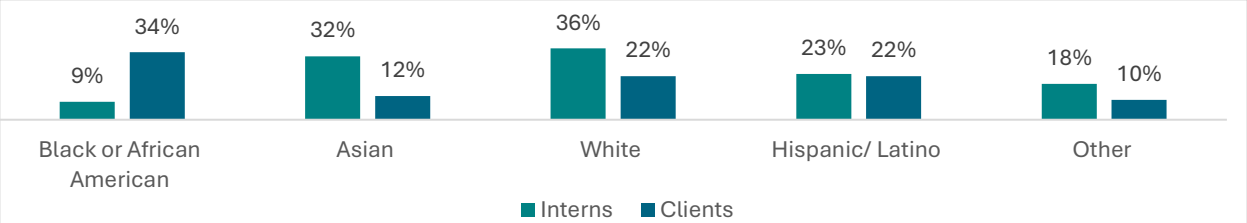
***Key Findings: Pipeline Programs and Preparation of a Diverse Workforce***

To achieve the ACBHD's vision for a workforce that is sufficient in size, the intern program currently prepares rising behavioral health professionals for future careers in the behavioral healthcare field. The mission of the ACBHD's internship program is to provide training that optimizes student learning, leadership, and overall support and development.

***Finding 1:*** ***Intern diversity does not align with the cultural and linguistic diversity of Alameda County's client population.***

ACBHD interns are not representative of the racial, ethnic, and linguistic backgrounds of the client population. As seen in Figure 9, there is the most incongruence in racial and ethnic diversity among African American / Black clients and interns.

***Figure 14. Racial/Ethnic Diversity of ACBHD Interns (N = 22) and Clients (N = 28,108), 2022–2023***




*Source: ACBHD Workforce Education, Training and Development Internship Program Data, Yellow Fin, 2023; Mental Health Services Demographic-Ethnicity Data, Yellow Fin, FY 2022–2023*

A quantitative analysis of intern demographic data shows gaps in recruiting African American and Latino interns. From 2018 to 2023, ACBHD interns have become less racially and ethnically diverse, as seen in Table 2. While the percentage of Asian interns has doubled since 2018, the percentage of African American and Hispanic/Latino interns has decreased.

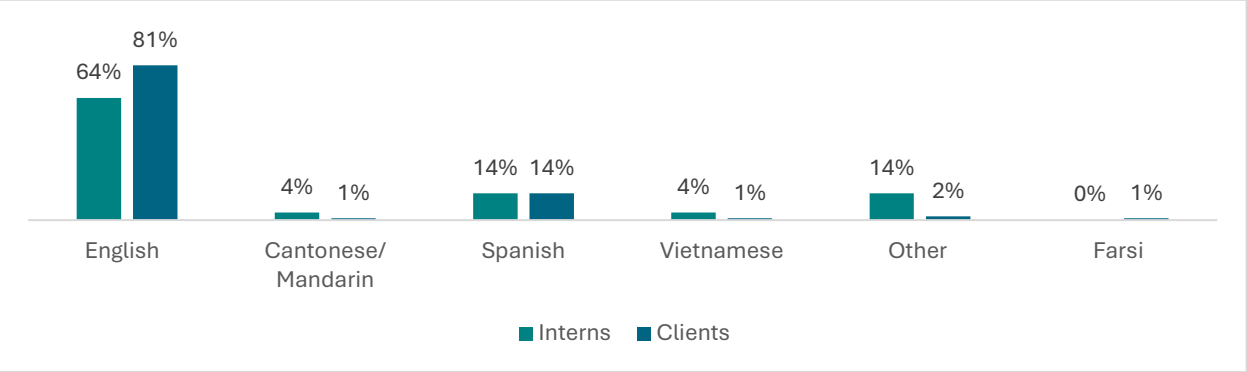
*Table 3. Racial/Ethnic Diversity of ACBHD Interns, 2018–2023*

| Year | N | Black or African American | Asian | White | Hispanic/ Latino | Other |
|---|---|---|---|---|---|---|
| 2022–23 | 22 | 9% | 32% | 41% | 0% | 18% |
| 2021–22 | 18 | 22% | 11% | 28% | 28% | 11% |
| 2020–21 | 21 | 29% | 24% | 19% | 19% | 9% |
| 2019–20 | 31 | 16% | 23% | 29% | 32% | 0% |
| 2018–19 | 19 | 21% | 16% | 26% | 37% | 0% |

*Source: ACBHD Workforce Education, Training and Development Internship Program Data, Yellow Fin, 2018–2023*

The linguistic capacity of interns mostly reflects languages spoken among the ACBHD's clients, as seen in Figure 10. There is a need for more interns who speak Farsi to meet emerging client language needs.

*Figure 15. Languages Spoken by ACBHD Interns (N = 22) and Clients (N = 28,108), 2022–2023*[6]




*Source: ACBHD Workforce Education, Training and Development Internship Program Data, Yellow Fin, 2023, and Mental Health Services Demographic-Ethnicity Data, Yellow Fin, FY 2022–2023*

5. The bar chart includes only languages that were noted in both intern and client data.

The linguistic diversity of ACBHD interns has decreased over the last five years, as seen in Table 3. While the percentage of interns speaking Cantonese/Mandarin has increased since 2018, the percentage of interns speaking Vietnamese and other languages has decreased.

***Table 4. Linguistic Diversity of ACBHD Interns, 2018–2023***

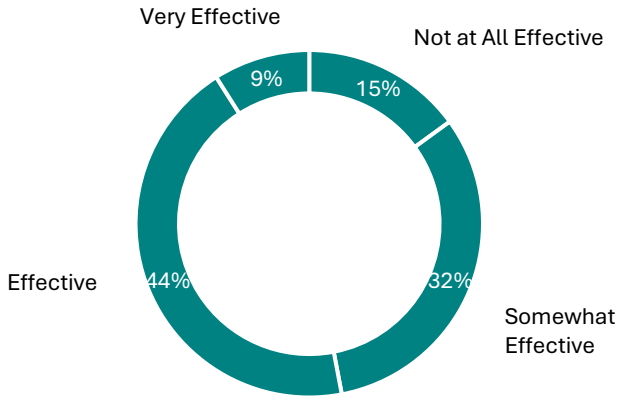
| Year | N | English | Cantonese/ Mandarin | Spanish | Vietnamese | Other |
|---|---|---|---|---|---|---|
| **2022–23** | 22 | 64% | 4% | 14% | 4% | 14% |
| **2021–22** | 18 | 55% | 0% | 28% | 0% | 17% |
| **2020–21** | 21 | 52% | 0% | 24% | 0% | 19% |
| **2019–20** | 31 | 55% | 7% | 29% | 3% | 3% |
| **2018–19** | 19 | 42% | 0% | 21% | 11% | 21% |

*Source: ACBHD Workforce Education, Training and Development Internship Program Data, Yellow Fin, 2018–2023*

***Finding 2:** Supervisors and former interns reported mixed levels of satisfaction and effectiveness with the intern program.*

Almost two-thirds of survey respondents (62%) reported serving as an intern supervisor or host. Less than half of these respondents (47%) would recommend being a supervisor to a colleague, and 18% were unsatisfied with their experience and would not recommend it to others. In addition, 47% of providers reported the program as somewhat effective (32%) or not at all effective (15%) at preparing a diverse workforce, as seen in the figure above.

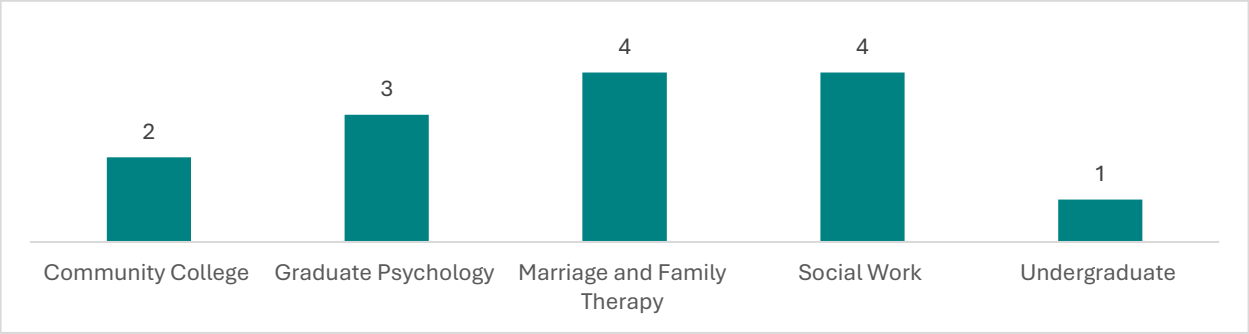
*Figure 16. Provider-Reported Effectiveness of WET Pipeline Programs in Preparing a Diverse Workforce, N = 85*




*Source: 2024 WET Provider Survey*

The small number of survey respondents (13) who had experience as an ACBHD intern means that the survey feedback cannot be generalized across ACBHD's workforce. While over half (7) of those who had participated would recommend the pipeline program to other students, almost one-fourth (3) would not recommend it. The majority of providers who responded were graduate-level interns in marriage and family therapy (4) and social work (4), as seen below.

*Figure 17. Provider-Reported Internship by Student Type, N = 13*

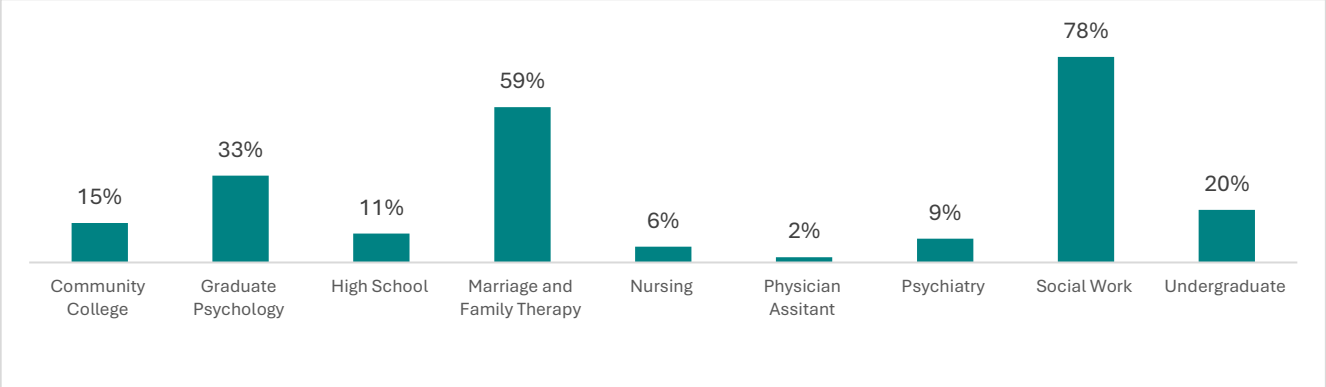



*Source: 2024 WET Provider Survey*

***Finding 3:*** ***Providers who participated in the survey offered recommendations to strengthen and improve the ACBHD intern programs.***

A majority of survey respondents reported hosting a wide range of student interns, with graduate-level students in marriage and family therapy (59%) and social work (78%) comprising the largest proportion, as shown in Figure 13, which aligns with the ACBHD's need for licensed clinical professionals.

***Figure 18. Provider-Reported Supervision by Student Intern Type, N = 53***




*Source: 2024 WET Provider Survey*

Qualitative-survey responses highlighted a need for interns with a range of levels of education, from associate to post-master level, to meet the needs of the communities they serve. Additionally, providers report a need for interns in roles ranging from SUD counselors to marriage and family therapists. They also recommended increasing opportunities for people with lived experience with behavioral health conditions and residents of Alameda County. Providers cited several structural barriers and challenges that make it difficult to find staff who are willing to take on the added responsibility of serving as an intern supervisor. They reported the following recommendations to improve the intern program:

- Adequate compensation and stipends for intern recruitment and retention, especially when attempting to recruit multicultural and multilingual interns
- More time and compensation for clinical supervisors
- Expanded infrastructure and space for hosting interns
- Additional professional development of interns as they advance in their careers, such as alumni networks and continued mentoring

During the small-group conversation among SUD providers, providers mentioned similar intern needs and noted Merritt College's Community Social Services / Substance Abuse (COSER) program as an effective SUD pipeline. They noted that incoming professionals still had a learning curve with the

documentation requirements of their role, including writing case notes and client briefs. SUD providers also cited the need to support incoming COSER graduates with the development of soft skills.

***Key Findings: Training and Education Needs***

Through trainings to agency staff and licensed clinicians, the WET unit aims to strengthen the capacity of providers to deliver clinical services that can improve the lives of clients and their families. The Training Unit offers training opportunities for the ACBHD's staff, contracted CBO staff, individual providers and other Alameda County agencies. The Training Unit hosts trainings facilitated by contracted trainers and also collaborates with the systems of care and other partners to offer continuing-education sponsorships and technical assistance. Through this collaboration, trainings can be tailored to meet the specific learning needs of staff from different systems of care. In FY 2021–2022, the Training Unit hosted 71 events and trained 2,469 people. The unit provides continuing education for the following licensed professions:

- Clinical Social Worker
- Marriage and Family Therapist
- Professional Clinical Counselor
- Education Psychologist
- Psychologist
- Registered Nurse
- Vocational Nurse
- Addiction Professional
- Medical Doctor

Through the needs assessment, the WET unit was looking to learn about current training gaps and how it could best address providers' emerging skills and knowledge needs.

***Finding 1: Providers have mixed feedback on current WET unit offerings.***

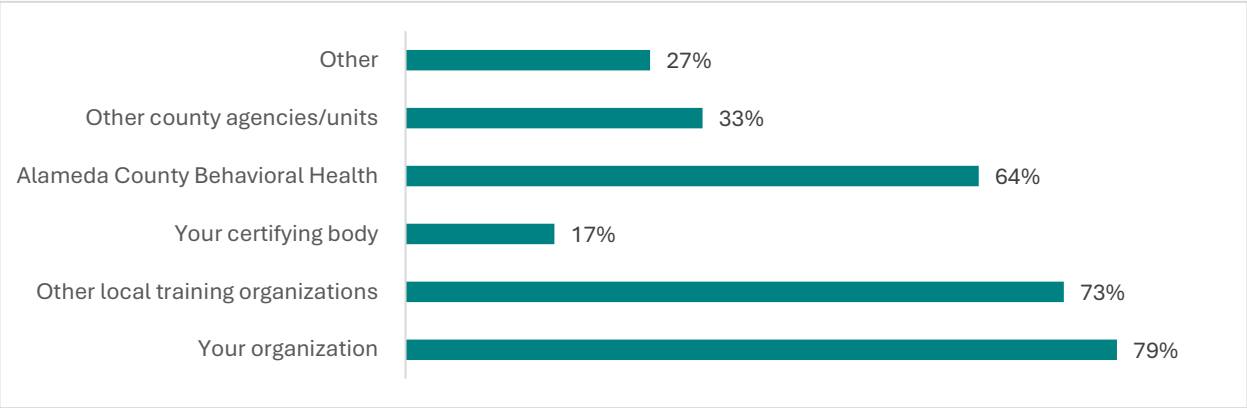
Most respondents were unfamiliar with the WET trainings, but those providers who participated in WET offerings reported satisfactory experiences. It is possible that survey respondents did not know that the trainings they participated in were organized by the WET unit. Of providers who reported participating in WET education programs, a majority (63%) would recommend the programming to a peer. Similarly, of those who had participated in WET training programs, almost half would recommend it to a colleague (42%), but 29% would not, as seen the figure below.

***Figure 19. Provider-Reported Likelihood to Recommend WET Education (N = 16) and Training (N = 38) to a Colleague***


Source: 2024 WET Provider Survey

Most survey respondents reported accessing training and education opportunities outside of the ACBHD to support their professional development. Over half of the respondents seek trainings internally from their organization (79%) or other local training organizations (73%), as shown in Figure 15. Providers reported accessing training, education, and professional development through national organizations. They sought trainings from the Centers for Disease Control and Prevention; the National Alliance on Mental Illness; statewide agencies, including the California Alliance and Catalyst Center; and online sites.

***Figure 20. Provider-Reported Training and Education Resources, N = 85***




*Source: 2024 WET Provider Survey*

***Finding 2:** Providers have an interest in a variety of training formats and delivery and offered recommendations to improve WET trainings.*

Qualitive-survey responses and the small-group conversation among SUD providers, uncovered that providers prefer more interactive and dynamic training options. Providers shared diverse perspectives regarding their preferred training format, which included a mix of in-person sessions to prevent multitasking and enhance engagement, as well as virtual meetings for convenience.

> *"Staff like to go to trainings, but it's more time required, and [there's] lots they will have to catch up on. Already feel overwhelmed with day-to-day tasks."*

When asked about their training needs in the survey, providers expressed a desire for more robust mechanisms for feedback and evaluation of training programs. They suggested implementing evaluative measures to ensure that trainings are effective, relevant, and skill based. While some providers were unaware that the WET unit offered trainings with certification, others felt that the quality of the training could be improved.

> *"I would like to work in tandem with you to help develop a more cohesive network of trainings in the county (amongst CBOs and ACBH)."*

Other training recommendations offered by survey respondents, SUD providers, and CBO webinar participants are:

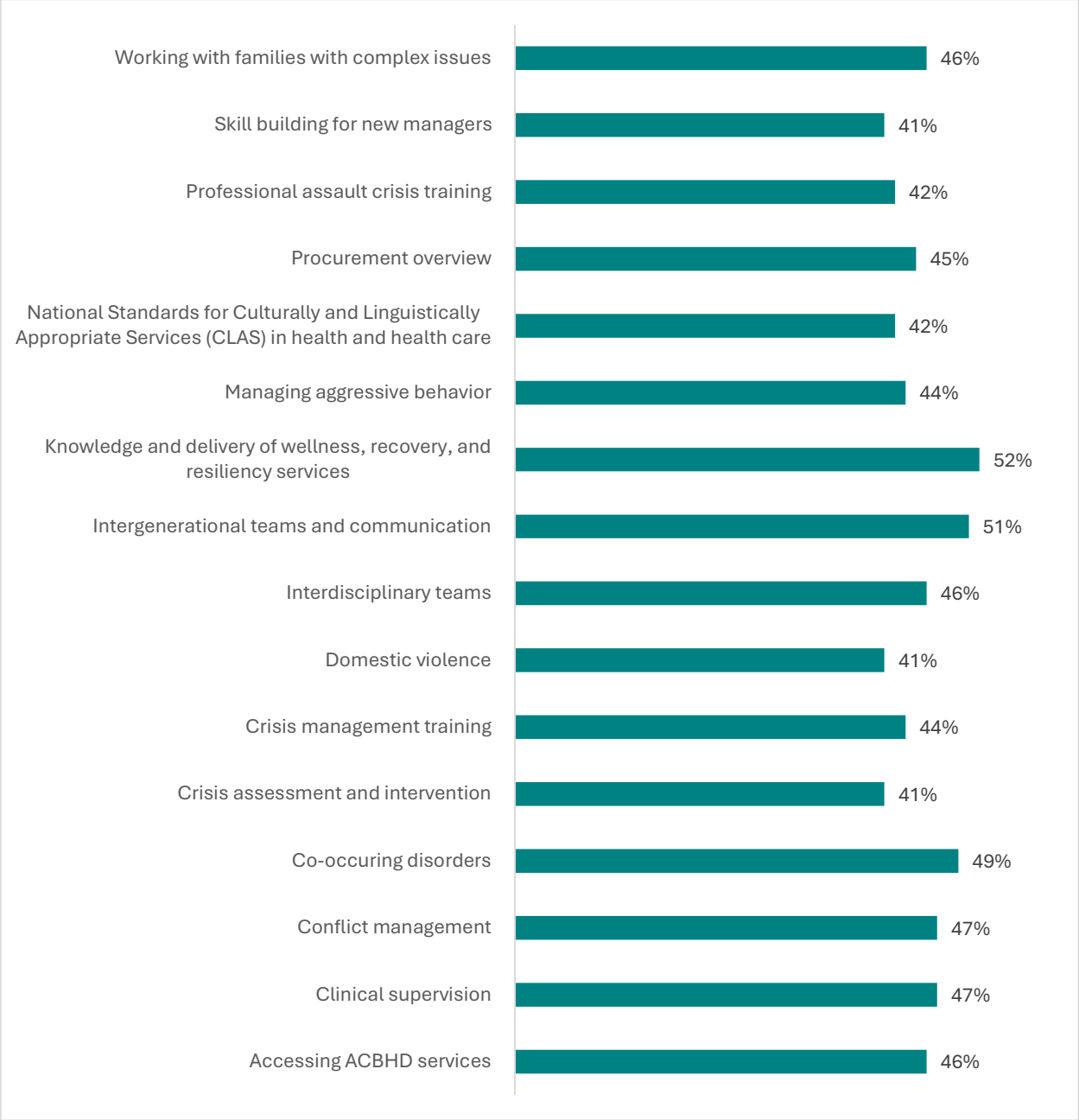
- The need to accommodate various schedules by offering training at different times of the day was also emphasized
- A desire to offer more input to the WET team around sharing resources and codeveloping training programs that meet CEU requirements
- More efficient administrative procedures for accessing and participating in training programs. They noted that bureaucratic hurdles can delay or hinder their ability to attend necessary trainings
- A preference for trainings that integrate real-world scenarios and case studies to practice applying knowledge
- Content offered as a train-the-trainer model to allow attendees to share knowledge and skills with providers across their organization

- A desire for trainings delivered by people with lived experience with behavioral health conditions
- A desire to offer the general public trainings in essential life skills, such as financial literacy, community trauma, and self-advocacy. They noted that these trainings could enhance self-understanding, development, and people's ability to effectively advocate within various systems

***Finding 3:*** ***Providers reported a strong demand for rigorous trainings that enable them to deliver culturally responsive services to Alameda County's diverse client populations and specifically requested advanced clinical-skills training***

The training topics that providers felt they needed more training support in varied. As seen in Figure 16, providers reported the highest need for additional training in areas related to clients' holistic needs and their own administrative duties.

*Figure 21. Percentage of Respondents Reporting Needing More Training Across Topics, N = 85*




*Source: WET Provider Survey*

Providers reported feeling well trained in areas related to service provision, such as clinical models, documentation, and collaborating with clients. Providers expressed a desire for trainings that increase their skills in implementing evidence-based practices and clinical skills. Some described current trainings as insufficiently advanced to strengthen clinical practices.

> *"A lot of the trainings have good titles, but they're complete fluff. Clinicians are discouraged to take these trainings. I keep hearing 'evidence based,' but I don't see evidence-based trainings."*

During the CBO provider webinar, many providers reported that there is a significant demand within CBOs for high-quality evidence-based training that meets both the staff's clinical needs and professional licensing requirements. Survey respondents also expressed interest in advanced training in specific therapeutic modalities and approaches, especially those that include certification. Overall, a majority of survey respondents (73%) reported that it was very important that trainings offer CEUs. There is also interest among providers in participating in training series or advanced-skills development. Some of the topic areas mentioned in qualitative responses about topics for advanced training include:

- **Family Therapy:** Advanced training in family systems therapy and evidence-based practices for working with families
- **Suicide Prevention:** In-depth training on assessing and managing suicidal ideation and behavior
- **Trauma-Informed Care:** Comprehensive programs on understanding and treating trauma, including complex trauma and PTSD
- **Cognitive Behavioral Therapy (CBT):** Advanced certification in CBT for various mental health conditions
- **Dialectical Behavior Therapy (DBT):** Training and certification in DBT for treating borderline personality disorder and other conditions
- **Substance Use Disorders:** Specialized training in treating co-occurring mental health and substance use disorders, including medication-assisted treatment (MAT)
- **Eating Disorders:** Many providers indicated a need for specialized training on eating disorders, including early identification, treatment modalities, and ongoing support strategies
- **Cultural Competency:** Programs that include cultural humility and practices for working with diverse populations, ensuring that providers can deliver equitable and effective care

***Finding 4:*** ***Providers feel most prepared to meet the needs of Latino/Hispanic communities but reported a need for training to engage clients across other ethnic and cultural backgrounds***

The majority of survey respondents did not cite the need for additional training to serve specific ethnic populations. Those who did cite a need reported the greatest need for training in order to support Native American / Indigenous People (25%), as shown in the figure below.

***Figure 22. Provider-Reported Need for Training to Meet the Needs of Priority Populations***

| ***Target Population*** | **N** | **%** |
|---|---|---|
| *Native American / Indigenous People* | 39 | 25% |
| *Asian American / Pacific Islander* | 31 | 19% |
| *Lesbian/Gay/Bisexual/Transgender//Questioning (LGBTQ+)* | 28 | 18% |
| *African American / Black* | 22 | 14% |
| *Transition-Aged Youth* | 23 | 14% |
| *Latino / Hispanic* | 14 | 9% |
| *Early-Childhood Mental Health* | 1 | 1% |
| *Asian American / Pacific Islander Family Support* | 1 | 1% |

*Source: 2024 WET Provider Survey*

During the CBO provider webinar, providers expressed interest in training programs that strengthen their ability to engage clients of diverse cultural backgrounds and respond to the emerging needs of their clients. Similarly, survey respondents also noted the importance of culturally specific and inclusive training programs that address the unique needs of diverse populations, such as LGBTQ communities, immigrant families, Asian and Pacific Islander communities, Middle Eastern populations, African American communities, and children and youth.

> *"The gaps in our team's skills include lack of East Asian–language support for our clients, families, and community and of assessments and evaluations reflecting cultural factors related to the AAPI population."*

***Finding 5:*** ***Providers expressed frustration with certain elements of the bureaucracy of the behavioral health care system and value up-to-date information.***

Providers explained that constant changes within the healthcare systems, especially new regulations and requirements, pose challenges and create barriers to care. Many respondents who were surveyed emphasized the need for timely information to help them stay compliant and effective in their roles. This includes access to training or briefings that cover new policy updates and regulatory changes. Many providers highlighted challenges in understanding and complying with various county-level policies and procedures. They mentioned that frequent changes to these requirements often lead to confusion and inefficiencies in service delivery.

**CONCLUSION AND RECOMMENDATIONS**

There are current workforce gaps in bilingual and racially diverse staff across community-based providers. Providers expressed challenges in the recruitment and hiring of staff who reflect the communities the ACBHD serves. Providers also cited clients' needs for holistic supports and recognize the opportunity to leverage the peer and family workforce to meet client needs. Overall, there is a need for a pipeline of professionals who represent diverse cultural, linguistic, and professional-training backgrounds. There is also an opportunity to raise awareness of the ACBHD's intern program among providers. Providers support interns as an effective means to grow the behavioral health workforce and meet emerging workforce gaps. Providers had varied experiences with current WET training offerings. Providers had keen insights about their emerging education needs. They expressed a desire for opportunities to give training feedback and offered suggestions for training topics, formats, and delivery methods.

Given these findings, the resource-restrictive environment, and the WET unit's scope of influence, BRG offers the following recommendations:

1. Sustain marketing efforts to promote WET training and education offerings with community-based providers
2. Continue to offer advanced-skills training in the following topics:
    - Understanding and assessing health conditions
    - Knowledge and delivery of "wellness, recovery, resiliency" services
    - Intergenerational teams and communication
    - Co-occurring disorders
    - Clinical supervision
    - Conflict management
    - Accessing ACBHD services
    - Interdisciplinary teams
    - Working with families with complex issues
    - Domestic violence

3. Routinely gather training feedback from providers and share format and delivery preferences with contracted trainers to integrate them into future offerings
4. Sustain training offerings for certified peer specialists and other peer and family professionals to support the professional development of the peer and family workforce
5. Recruit interns for the following roles to address provider-identified workforce gaps:
    - Licensed clinical social worker
    - Licensed marriage and family therapist
    - Case manager, social worker, and service coordinator
    - Child and adolescent psychiatrist
6. Sustain and develop new strategies to increase the applicant pool of interns so that they better reflect the cultural, linguistic, and ethnic diversity of clients, including the following:
    - Continue to collect intern demographic data
    - Offer a diversity stipend similar to peers (i.e., Multicultural Student Stipend Program)
    - Partner with minority-serving institutions for intern recruitment
    - Solicit ideas from other departments about how to give preference to interns who match the cultural, linguistic, and ethnic diversity of clients
7. Share workforce-capacity findings with human resources and systems of care across the ACBHD to adapt hiring and recruiting strategies to address identified needs

# APPENDICES

***Appendix A. WET Provider Survey***

**Introduction**

As valued stakeholders to Alameda County Behavioral Health (ACBH), the Workforce, Education and Training (WET) team wants to hear from community-based providers and organizations across ACBH systems of care. Please take about 20 minutes to complete this survey. The WET team wants to hear from you about:

- Your training and education needs
- Your perspective on the diversity of the workforce
- The effectiveness of pipeline programs to build the future workforce

The WET team is currently conducting a needs assessment in partnership with an independent research firm, Bright Research Group. The WET team will use survey results to inform their workforce, education and training programming. Results will not be used to assess your organization nor affect future contracting with your organization.

**Answers are Confidential**

We want your honest feedback and there will be no consequence for your honesty. Although there are questions that ask you to share information about yourself and your organization, your answers will be kept confidential. If there's a question you do not want to answer, you can skip it.

**Training and Education Needs**

1. How important is it to you that trainings offer continuing education credits?
   - ☐ Very important
   - ☐ Important
   - ☐ Somewhat important
   - ☐ Not important at all

2. Where do go to meet your training and education needs?
   - ☐ Your organization
   - ☐ Other local training organizations
   - ☐ Your certifying body
   - ☐ Alameda County Behavioral Health
   - ☐ Other county agencies/units
   - ☐ Other_____

3. What feedback do you have for the WET team about your training needs? You can provide feedback on training topics, content, format, certification, availability, etc. [Open-ended/Short text]

_____

4. How would you like to collaborate with the WET team? [Open-ended/Short text]

_____

5. What are the gap(s) in your or your team's skills or competencies? [Open-ended/Short text]

_____

   a. How can the WET team support you to address the gap(s)?
      _____

**Training and Education Needs Familiarity With Wet and Experience Accessing Pipeline Needs**

6. Which WET unit program have you participated in? (Check all that apply)

☐ Training Programs
   1. [Skip logic based on selection]
      How likely are you to recommend a WET training program to a peer or colleague?
      0 1 2 3 4 5 6 7 8 9 10

      *Not Likely* *Very Likely*

☐ Education Programs
   a. [[Skip logic based on selection]
      How likely are you to recommend a WET education program to a peer or colleague?
      0 1 2 3 4 5 6 7 8 9 10

      *Not Likely* *Very Likely*

☐ Pipeline Programs (Programs that are specifically designed to develop our future workforce capacities, including internships, fellowships, and conferences for high school students that promote skill building and exposure to the various behavioral health-oriented careers.)
   1. [Skip logic based on selection]
      How likely are you to recommend a WET training program to a peer or colleague?
      0 1 2 3 4 5 6 7 8 9 10

      *Not Likely* *Very Likely*

☐ None of the above

7. What are your training needs in the following areas? Select those that apply.

| **Training Area** | *I could use more support to apply skills in this topic in my role* | *I could use more training in this topic* | *I feel well trained in this topic* |
|---|---|---|---|
| Advanced assessment, differential diagnosis and treatment planning | | | |
| Basic Cognitive Behavioral Therapy (CBT) | | | |
| Clinical Supervision | | | |
| Co-occurring disorders | | | |
| Compassion Fatigue | | | |
| Crisis Assessment and intervention (Danger to self, danger to others, grave disability) | | | |
| Cultural humility and responsiveness | | | |
| Documentation | | | |
| Domestic Violence | | | |
| Knowledge and delivery of "wellness, recovery, resiliency" services | | | |
| Managing aggressive behavior | | | |
| Motivational Interviewing | | | |
| Post-traumatic stress disorder | | | |
| Resource sharing between consumers and providers | | | |
| Trauma Assessment and Interventions | | | |
| Understanding and assessing health conditions | | | |
| Wellness Recovery Action Planning (WRAP) | | | |
| Working collaboratively with clients and families | | | |
| Working with families with complex issues | | | |
| Other_____ | | | |

8. Were you a student intern with an ACBH contracted provider or system of care? Y/N

    1. [Skip logic if Y to #7] What type of student intern were you? (Check all that apply)
        - ☐ Community College
        - ☐ Graduate Psychology
        - ☐ High School
        - ☐ Marriage and Family Therapy
        - ☐ Nursing
        - ☐ Physician Assistant
        - ☐ Psychiatry
        - ☐ Social Work
        - ☐ Undergraduate
        - ☐ Youth and Young Adults not enrolled in school

    2. How likely are you to recommend this pipeline program to other students?

    0 1 2 3 4 5 6 7 8 9 10

    *Not Likely* *Very Likely*

9. Have you served as supervisor or host for student intern[s] at your organization? Y/N

    a. [Skip logic if Y to #8] What type of student intern[s] have you hosted? (Check all that apply)
        - ☐ Community College
        - ☐ Graduate Psychology
        - ☐ High School
        - ☐ Marriage and Family Therapy
        - ☐ Nursing
        - ☐ Physician Assistant
        - ☐ Psychiatry
        - ☐ Social Work
        - ☐ Undergraduate
        - ☐ Youth and Young Adults not enrolled in school

    b. How likely are you to recommend hosting a student intern to a colleague?

    0 1 2 3 4 5 6 7 8 9 10

    *Not Likely* *Very Likely*

10. In your opinion, how effective are the WET pipeline programs (programs that are specifically designed to develop our future workforce capacities, including internships, fellowships, and conferences for high school students that promote skill building and exposure to the various behavioral health-oriented careers) at preparing a diverse workforce?

    - ☐ Very effective
    - ☐ Effective
    - ☐ Somewhat effective
    - ☐ Not effective at all

11. What additional feedback do you have on how well the pipeline programs (programs that are specifically designed to develop our future workforce capacities, including internships, fellowships, and conferences for high school students that promote skill building and exposure to the various behavioral health-oriented careers) prepare a diverse workforce? [Open-ended/Short text]

_____

12. What level of internships are needed to address the needs of the communities you serve? [Open-ended/Short text]

_____

13. What infrastructure/staffing is needed to manage the interns at your organization effectively? [Open-ended/Short text]

_____

***Perspective on Workforce Shortages, Cultural Competence Needs and Family and Peer Workforce***

14. When it comes to hiring in your organization, how difficult is it to fill open positions?

    - ☐ Very difficult
    - ☐ Difficult
    - ☐ Somewhat difficult
    - ☐ Not difficult at all

15. How well is your organization retaining staff?
    - ☐ Very well
    - ☐ Well
    - ☐ Somewhat well
    - ☐ Not well at all

16. How well is your organization recruiting staff that reflect the client population you serve?
    - ☐ Very well
    - ☐ Well
    - ☐ Somewhat well
    - ☐ Not well at all

17. Which three roles are the most challenging to hire, retain and recruit diverse staff for? (Select first, second, third for only three roles)

| **Position/ Role** | *Most Challenging to Hire* | *Most Challenging to Retain* | *Most Challenging to Recruit Diverse Staff* | *N/A* |
|---|---|---|---|---|
| Case Manager/ Social Worker/ Service Coordinator | | | | |
| Certified Peer Specialist | | | | |
| Child and Adolescent Psychiatrist | | | | |
| Designated Consumer/ Family Member Personnel | | | | |
| Employment Services Staff | | | | |
| Executive and Management Staff | | | | |
| General Psychiatrist | | | | |
| Housing Services Staff | | | | |
| Licensed Clinical Social Worker | | | | |
| Licensed Marriage and Family Therapist | | | | |
| Mental Health Rehabilitation Counselor | | | | |
| Psychiatric Mental Health Nurse Practitioner | | | | |
| Substance Abuse Counselor | | | | |
| Other_____ | | | | |

18. How well prepared do you feel to meet the needs of the following target populations?

| **Target Population** | *Need more training* | *Somewhat Prepared* | *Well Prepared* | *N/A* |
|---|---|---|---|---|
| African American/Black | | | | |
| Asian American/Pacific Islander | | | | |
| Latinx/Hispanic | | | | |
| Lesbian/Gay/ Bisexual/Transgender /Questioning (LGBTQ+) issues | | | | |
| Native American/Indigenous People | | | | |
| TAY- Transition Aged Youth | | | | |
| Other: _____ | | | | |

19. What language(s) other than English do you speak with clients?

- ☐ Arabic
- ☐ Cantonese
- ☐ Farsi
- ☐ Mandarin
- ☐ Spanish
- ☐ Tagalog
- ☐ Vietnamese
- ☐ Other: _____

20. What are the gap(s) in services for the communities you serve? [Open-ended/Short text]

_____

a. How can the WET team support you to address the gap(s)?
_____

21. Which strategies does your organization use to engage and include peers and family members in service provision and/or practice and policy development?

- ☐ Involving consumers and family members in workgroups, advisory councils, stakeholder meetings, planning or policy groups
- ☐ Recruiting consumers and family members on boards and other leadership positions
- ☐ Meeting and/or job accommodations
- ☐ Priority preference given to applicants with lived experience
- ☐ Anti-stigma training for all staff
- ☐ Partnerships with consumer-run organizations
- ☐ Consumer or family member internship program
- ☐ None
- ☐ Other: _____

22. Does your organization hire certified peer specialists?

- ☐ Yes
- ☐ No
- ☐ Not Sure

23. How many designated peer or family member positions are there at your organization?

- ☐ 0
- ☐ 1-3
- ☐ 4-6
- ☐ 7-9
- ☐ 10 or more

24. What roles do peers and family members have within your organization?

- ☐ Family partners or advocates
- ☐ Peer recovery coaches, counselors, mentors, coordinators, and/or specialists
- ☐ Receptionists or other clerical support staff
- ☐ Board members
- ☐ Other_____

25. How interested are you in sharing information or developing public available trainings (for peers, family members, non-clinical staff and the general public) in the following areas? Select those that apply

| | *Not At All Interested* | *Somewhat Interested* | *Interested* | *Very Interested* |
|---|---|---|---|---|
| Access to mental health services | | | | |
| Family and/or consumer support | | | | |
| Stress management | | | | |
| 5150/5585 training | | | | |
| Other: | | | | |

**Demographics**

26. Please select the setting(s) that best represent your workplace. Select all that apply
- ☐ Community Based Organizations
- ☐ Community Mental Health/ Behavioral Health Agencies
- ☐ Hospital
- ☐ Involuntary Treatment/Substance Use Disorder
- ☐ Peer Services
- ☐ School
- ☐ Social Services Agency
- ☐ State& Regional Agency
- ☐ Substance Use/ Outpatient Setting
- ☐ Withdrawal Management

27. What is the size of your organization?
- ☐ Under 25 employees
- ☐ 25-50 employees
- ☐ 51-100 employees
- ☐ 101-200 employees
- ☐ More than 200 employees

28. Which system of care does your organization work in? Select all that apply
- ☐ Acute & Crisis Services
- ☐ Adult & Older Adult Services
- ☐ Child & Youth Services
- ☐ Forensic Services
- ☐ Integrated Primary Care Services
- ☐ Psychiatry and Nursing Services
- ☐ Substance Use

29. How long have you been at your organization?
- ☐ Less than one year
- ☐ 1-3 years
- ☐ 4-6 years
- ☐ 6-10
- ☐ Over 10 years

30. What is your highest level of education completed?
- ☐ High school degree or GED equivalent
- ☐ Associate's degree
- ☐ Bachelor's degree
- ☐ Master's degree
- ☐ Doctorate
- ☐ Other: _____

31. What is your current role?
- ☐ Case Manager/ Social Worker/ Service Coordinator
- ☐ Child and Adolescent Psychiatrist
- ☐ Designated Consumer/ Family Member Personnel
- ☐ Employment Services Staff
- ☐ Executive and Management Staff
- ☐ General Psychiatrist
- ☐ Housing Services Staff
- ☐ Licensed Clinical Social Worker
- ☐ Licensed Marriage and Family Therapist
- ☐ Mental Health Rehabilitation Counselor
- ☐ Psychiatric Mental Health Nurse Practitioner
- ☐ Substance Abuse Counselor
- ☐ Other_____

32. How long have you been in your current position?
- ☐ Less than one year
- ☐ 1-3 years
- ☐ 4-6 years
- ☐ Over 6 years

These questions are optional. Your answers are confidential. If you want to skip a question, just select prefer not to say.

33. What is your racial/ethnic identity (Select all that apply):
- ☐ American Indian or Alaskan Native
- ☐ Black/African American
- ☐ East Asian
- ☐ Latino/a/e

- ☐ Middle Eastern or North African
- ☐ Native Hawaiian or Pacific Islander
- ☐ South Asian
- ☐ Southeast Asian
- ☐ White
- ☐ Other_____
- ☐ Prefer not to say

34. Please select the language(s) you speak (Select all that apply):
- ☐ Arabic
- ☐ Chinese
- ☐ Farsi
- ☐ Spanish
- ☐ Tagalog
- ☐ Vietnamese
- ☐ Other: _____
- ☐ Prefer not to say

35. What is your gender identity?
- ☐ Female
- ☐ Male
- ☐ Gender non-binary
- ☐ Genderqueer
- ☐ Trans Female
- ☐ Trans Male
- ☐ Another gender identity: _____
- ☐ Prefer not to say

36. Do you have a disability?
- ☐ Yes
- ☐ No
- ☐ Prefer not to say

37. Which of the following lived experiences have you had? (Select all that apply)
- ☐ Living with mental health challenges
- ☐ Having a friend/family member living with mental health challenges
- ☐ Living with a substance use disorder
- ☐ Having a friend/family member living with a substance use disorder
- ☐ Experiencing a significant traumatic event
- ☐ Having a friend/family experience a significant traumatic event
- ☐ Living in the foster care system
- ☐ Having a friend/family member living in the foster care system
- ☐ None of the above

☐ Other:_____
☐ Prefer not to say

## *Appendix B. Demographics of WET Provider Survey Respondents*

| | | |
|---|---|---|
| **Race/Ethnicity** | | |
| American Indian or Alaskan Native | 2 | 3% |
| Black / African American | 15 | 19% |
| East Asian | 6 | 8% |
| Latino/Hispanic | 15 | 19% |
| Middle Eastern or North African | 1 | 1% |
| Native Hawaiian or Pacific Islander | 2 | 3% |
| South Asian | 3 | 4% |
| Southeast Asian | 2 | 3% |
| White | 33 | 41% |
| Other | 4 | 5% |
| **Language Spoken** | | |
| Cantonese | 1 | 1% |
| English | 54 | 74% |
| Farsi | 1 | 1% |
| Mandarin | 2 | 3% |
| Spanish | 15 | 21% |
| Tagalog | 2 | 3% |
| Other | 12 | 16% |
| **Educational Level** | | |
| High School Degree / GED | 3 | 4% |
| Some College | 4 | 5% |
| Associate Degree | 14 | 17% |
| Bachelor's Degree | 50 | 59% |
| Master's Degree | 12 | 14% |
| Doctorate | 2 | 2% |
| **Gender Identity** | | |
| Female | 66 | 83% |
| Male | 8 | 10% |
| Gender Non-binary | 1 | 1% |
| Gender Queer | 1 | 1% |

## *Appendix C. Professional Tenure of WET Provider Survey Respondents*

| | | |
|---|---|---|
| **Organizational Tenure** | | |
| Less than 1 year | 7 | 8% |
| 1–3 years | 19 | 22% |
| 4–6 years | 14 | 17% |
| 6–10 years | 16 | 19% |
| Over 10 years | 29 | 34% |
| **Current-Position Tenure** | | |
| Less than 1 year | 13 | 15% |
| 1–3 years | 30 | 35% |
| 4–6 years | 16 | 19% |
| Over 6 years | 26 | 31% |

# Appendix C

**EXHIBIT A-1 STANDARD REQUIREMENTS**

**SCOPE OF SERVICE REQUIREMENTS**

- Contractor shall provide, operate, and administer one or more of the following types of Mental Health (MH) programs: treatment, prevention, and/or other ancillary services.
- Contractor shall comply with all administrative regulations, standards, program requirements, policies, and procedures as specified by County, State, and Federal laws. Contractor shall be responsible for knowing and implementing mandatory ACBH policies and procedures as contained in, but not limited to:
- Alameda County Behavioral Health Care Services (ACBH) Quality Assurance (QA) Manual (hereafter ACBH QA Manual);1 ACBH Policy and Procedures Manual;2 and Applicable State-County Plans and Grant Agreements.3
- Contractor shall comply with all Federal and State requirements applicable to this agreement (based on services and funding), as may be amended from time to time.
- Contractor shall maintain written policies and procedures around specified requirements and shall be responsible for monitoring, oversight and accountability.
- Contractors not in compliance with contract provisions, or State or Federal law and/or regulation shall be immediately responsible for remedy. ACBH may, at its discretion, issue a Corrective Action Plan or Contract Compliance Plan. The cost to implement the Corrective Action Plan or Contract Compliance Plan shall be borne by the Contractor. Failure to address identified issues may result in further action by ACBH up to and including program termination, as specified in the ACBH Contract Compliance and Sanctions for ACBH- Contracted Providers Policy, and/or future debarment by Alameda County, as specified in any then current debarment policy (see Alameda County General Services Agency Debarment Policy approved on January 14, 2020).4

**A. Medi-Cal Program Oversight**

MH services shall be under the general supervision of the Director of ACBH.5 Pursuant to such Section, the aforementioned Director shall supervise and specify the kind, quality, and amount of the services and criteria for determining the persons to be served.

**SERVICE DELIVERY SITE REQUIREMENTS**

**Site Inspection/Site Visits**

ACBH, the Department of Health Care Services (DHCS), or any other applicable regulatory body has the right at all reasonable times to inspect or otherwise evaluate the work performed or being performed pursuant to this Agreement including premises in which it is being performed. If an inspection or evaluation is made of the premises of Contractor, Contractor shall provide all reasonable facilities and

assistance for the safety and convenience of the authorized representative in performance of their duties. All inspections and evaluations shall be performed in such a manner as will not unduly delay work for either Contractor or ACBH. Contractor shall notify ACBH of any scheduled or unscheduled external evaluation or site visits when it becomes aware of such visit. ACBH shall reserve the right to attend any or all parts of external review processes.

**Site Licenses, Permits, Certifications**

Contractor shall obtain and maintain during the term of this Agreement all appropriate licenses, permits, and certificates required by all applicable Federal, State, County and/or municipal laws, regulations, guidelines, and/or directives as may be amended from time to time for the operation of its facility and/or for the provision of services hereunder.

Contractor shall have and maintain a valid and current fire clearance at the specified service delivery sites where direct services are provided to clients.6

At least 30 days prior to the move of any program location or change of contracted hours of operation, Contractor shall complete a Program Change Request Form7 and submit it to their ACBH Contract Managers. The completed and fully routed Program Change Request Form shall serve as ACBH approval of change of program location or contracted hours of operation in lieu of a contract amendment. For Specialty Mental Health Services (SMHS) billing to Medi-Cal, Contractor shall obtain site certification by ACBH and shall be responsible for any gaps in ability to claim during a period where the site is not certified.

**Additional Requirements for Medi-Cal Programs**

Contractor shall be responsible for complying with DHCS Site Certification Requirements as specified in the ACBH QA Manual. Fire clearance shall be renewed prior to expiration and submitted to the ACBH Site Certification email at SiteCertification@acgov.org. For services delivered at school sites, Contractor shall follow ACBH Quality Assurance (QA) policies for school-based sites. For programs that are dispensing medications or seeking to dispense medications, Contractor shall ensure compliance with all of the requirements identified under the California Code of Regulations (CCR), Title 9, and under Section 16 of the ACBH QA Manual.

**Contractors providing MH treatment under Medi-Cal shall also have and maintain:**

- Medi-Cal certification for each program that bills to Medi-Cal;

**SERVICE PROVISION REQUIREMENTS**

**Informing Materials**

Contractor shall comply with policies, procedures and adherence guidelines pertaining to the distribution of the ACBH Consumer Informing Materials pertaining to Consumer Rights, and the posting of the ACBH grievance and appeal poster in each of the Alameda County threshold languages. Contractor shall ensure

that ACBH grievance and appeals materials are accessible to consumers without having to make a request (such as by placing hard copies in the reception area of service location).

**Conservatorship**

Contractors providing placement for a client who is under extended or permanent Lanterman-Petris-Short (LPS) Conservatorship shall seek approval and consent from the Public Guardian-Conservator prior to any placement or change in placement. Contractor shall notify the Public Guardian-Conservator in advance of any placement or change in placement for a client who is under a LPS Conservatorship 30-day hold.

**Additional Requirements for Medi-Cal Programs**

**Medi-Cal programs shall comply with the additional service provision requirements noted below.**

**Quality Assurance (QA) Plan**

Contractors providing Medi-Cal services shall have and maintain a QA Plan that meets the requirements of the ACBH QA Department. This plan shall be available on-site for review by ACBH and include Contractor's policies and procedures on such QA topics from the ACBH QA Manual.

**Authorizations**

Contractors providing Medi-Cal services shall comply with ACBH and DHCS requirements for authorization and reauthorization of services including, but not limited to the ACBH Policy on Authorization of Specialty Mental Health Services (SMHS).

**Enrollment and Other Health Coverage (Third Party Liability)**

Contractors providing Medi-Cal services shall check each client's insurance status upon client's first entry into their program (admission/episode opening) and at least monthly at the beginning of each month thereafter. Contractor shall provide or arrange for, through referrals or otherwise, assistance with benefits enrollment and/or re-enrollment where benefits do not exist, or coverage has lapsed. Contractor shall inform uninsured clients about options for health care coverage, including but not limited to Federal, State and local programs, such as Medi-Cal, Medicare, HealthPAC, or other sources of payment, such as private insurance. Contractor is responsible for the verification of benefits. For clients living in Alameda County who are Medi-Cal eligible and not currently enrolled in Medi-Cal, or have Medi-Cal from another County, Contractor shall make best efforts to enroll or transfer the client in or to Alameda County Medi-Cal from initial intake, and/or at any point at which the client becomes dis-enrolled. This aid shall include but is not limited to assisting clients whose Medi-Cal benefits need to be transferred to Alameda County when the client has established his/her primary residence in Alameda County.

**No Wrong Door**

Contractors providing Medi-Cal services shall comply with ACBH and DHCS requirements relating to No Wrong Door, including but not limited to the ACBH Policy on No Wrong Door for Mental Health.

**Notice of Adverse Benefit Determination (NOABD)**

Contractors providing Medi-Cal services shall provide beneficiaries with a NOABD under the following circumstances: 1) the denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit; 2) the reduction, suspension, or termination of a previously authorized service; 3) the failure of Contractor to provide services to consumer per timeliness standards issued by ACBH; 4) the failure to act within the required timeframes for standard resolution of grievances and appeals; and 5) the denial of a beneficiary's request to dispute financial liability, including cost sharing and other beneficiary financial liabilities. Contractor shall utilize the ACBH NOABD templates in threshold languages and adhere to the ACBH policy Notices of Adverse Benefit Determination for Medi-Cal Beneficiaries in areas including, but not limited to, reporting.

**Beneficiary Handbook**

Contractors providing Medi-Cal services shall be responsible for distributing the Guide to Medi-Cal Mental Health (MH) Services upon initial intake to enable clients to understand how to effectively use the behavioral health services to which they are entitled under Medi-Cal.

**Patients' Rights**

Patients' rights regarding Medi-Cal services shall be assured,8 and patient records shall comply with all appropriate State and Federal requirements.

**Clinical Documentation**

Contractors providing Medi-Cal services shall provide and maintain clinical documentation and practice standards that comply with regulatory requirements and with ACBH Clinical Documentation Standards as specified in the ACBH QA Manual. Updates and/or clarifications to clinical documentation standards may also occur via ACBH QA publications, including memos and training materials.

**CANS/PSC-35/ANSA**

Contractors providing SMHS Medi-Cal services shall implement the Child and Adolescent Needs and Strengths Assessment (CANS) and the Pediatric Symptom Checklist (PSC-35) for children, adolescents and youth; and the Adult Needs and Strengths Assessment (ANSA) for adults according to the procedures specified in the ACBH CANS, ANSA, and PSC-35 Implementation Policy and by the ACBH CANS/ANSA Coordinators. Exceptions are outlined in the ACBH CANS, ANSA, and PSC-35 Implementation Policy. Contractor may get a copy of the CANS from the primary Clinician/Service Provider.

**Continuity of Services/Discharge Planning**

- Contractor shall facilitate care coordination, continuity of care, discharge and exit planning in accordance with the ACBH QA Manual, State standards for SMHS, the ACBH Out of Network Access and Continuity of Care for Medi-Cal SMHS and SUD Services Policy, and other regulatory requirements. Discharge planning shall begin at intake.
- Contractor shall have a plan for the continuity of services to clients, including the maintenance and security of records. The continuity plan must provide for the transition of services and records in the event that a direct service staff should die or become unable to continue providing services, or in the event that a program closes.
- To the extent appropriate and based on client consent, Contractor shall coordinate and communicate with other care providers or care managers serving the client for the purpose of facilitating an effective transition and to prevent negative outcomes such as victimization, crisis, or homelessness.

## STAFFING REQUIREMENTS

**Level of Staffing**

Contractor shall maintain the minimum direct service and/or administrative positions necessary to support the contracted services and shall maintain any further requirements as specified for each program in the Exhibit A–Scope of Work. Contractor shall notify the ACBH Program Contract Manager within five business days of any change and/or vacancy in direct service staffing that is anticipated to decrease contracted service delivery by more than 25 percent during the contract period.

**Disclosure of Ownership, Control and Relationship Information**

Contractor shall submit updated disclosures to ACBH on an annual basis, upon request, and at least 30 days prior to any anticipated change and within five days after any executed change in the organization's ownership, name and/or Federal Tax Identification pursuant to 42 Code of Federal Regulations (CFR) 455.104. Any person with a five percent or greater ownership interest shall also be subject to requirements set forth in 42 CFR 455.416.

**Notice of Changes in Key Personnel**

- Contractor shall immediately inform ACBH in writing of any staffing changes in the following positions or the equivalent positions within Contractor's organizational structure: Chief Executive Officer (CEO)/Executive Director, Chief Financial Officer (CFO)/Accountant, Other Contract Signatory, Billing Contact, Quality Assurance (QA) Director/Manager, Board Member, Programmatic or Administrative Contact(s), Medical Director (MD), or any other position of significance to the contractor's fulfillment of this contract or the clinical care of ACBH beneficiaries. Contractor shall notify ACBH by submitting to the ACBH Program Contract Manager a Provider/Program Change Notification Form.9

- Contractor shall notify ACBH Information Systems (IS) within five business days if any of its staff with access to protected health information (PHI) or personally identifiable information (PII) through ACBH's applications (e.g., ACBH Billing System, Clinician's Gateway, Yellowfin) no longer need this access due to separation from the organization, change in functions or death so that ACBH can terminate/revoke access. Contractors shall notify ACBH of changes in employees, volunteers, Board Members, and agents of Contractor, non-clinical and clinical, providing and/or supporting Federally-funded services and/or goods under this Agreement. This notification shall be made through the ACBH Staff Number Request E-Form.10

**Experience, Expertise and Training**

- Contractor shall maintain a management and/or executive team as appropriate for the size and needs of the agency. The management and/or executive team shall include at minimum, a CEO or Executive/Program Director and, for contracts over $1,000,000, a Compliance Officer and a CFO or Finance Director/Accountant with at least five years of education, training, and/or experience in finance or business administration.
- Contractor shall maintain staffing with professional experience and expertise in providing evidence-based, culturally, and linguistically appropriate services, particularly for any designated priority populations that Contractor has agreed to serve. Contractor shall ensure annual training of all applicable employees, volunteers, board members, owners, and/or agents who are providing and/or supporting services under this Agreement on Administrative and Compliance Requirements, in areas including but not limited to: documentation standards, billing requirements, Culturally and Linguistically Appropriate Standards (CLAS), Annual Compliance/Code of Conduct, and Health Insurance Portability and Accountability Act (HIPAA)/Privacy and Security.
- Contractor's trainings shall comply with any associated ACBH policies contained in the ACBH QA Manual, or the ACBH Policy Manual. HIPAA/Privacy and Security training must be completed within ten days of onboarding a new staff. Contractor shall ensure that staff have the training, experience, and scope of practice consistent with any applicable regulatory boards and/or requirements prior to offering or rendering services.

**Organizational Chart and Job Descriptions**

Contractor shall have, maintain, and provide to ACBH upon request job descriptions and an organizational chart reflecting the current operating structure including the Board of Directors and staffing. ACBH reserves the right to request additional information about organizational staffing in situations including but not limited to those in which questions or concerns emerge as to whether services are and will continue to be delivered in accordance with the requirements of this Agreement.

**Credentialing/Certification of License**

Contractor shall maintain a pre-hire process to ensure that supervisors and staff are appropriately trained, credentialed and/or licensed without restrictions and provide services to clients within their individual scopes of practice and within any restrictions noted on the credential or license. Contractor shall ensure

that staff register and maintain a valid provider profile with The Council for Affordable Quality Healthcare (CAQH)- ProView and attest to the accuracy of their profile information every 120 days and at initial credential verification and every recredentialing event thereafter. Contractor shall comply with the ACBH Credentialing and Re-Credentialing Policies, and shall work with ACBH to demonstrate compliance with regulatory requirements. Contractor shall maintain procedures to ensure that all direct service staff receive appropriate supervision and maintain any Continuing Education (CEs) units or Continuing Medical Education (CME) credits as required by their respective credentialing body and as outlined in the ACBH QA Manual.

**Provider Application and Validation for Enrollment (PAVE)**

Contractor shall ensure that all of its required clinical staff, who are rendering SMHS to Medi-Cal beneficiaries on behalf of Contractor, are registered through DHCS' Provider Application and Validation for Enrollment (PAVE) portal, pursuant to DHCS requirements, the 21st Century Cures Act and the Centers for Medicare and Medicaid Services (CMS) and Children's Health Insurance Program (CHIP) Final Rule.11 SMHS licensed individuals, required to enroll via the "Ordering, Referring and Prescribing" (ORP) PAVE enrollment pathway (i.e. PAVE application package) available through the DHCS https://www.dhcs.ca.gov/provgovpart/Pages/PAVE.aspx, include: Licensed Clinical Social Worker (LCSW), Licensed Marriage and Family Therapist (LMFT), Licensed Professional Clinical Counselor, Psychologist, Licensed Educational Psychologist, Physician (MD and DO), Physician Assistant, Registered Pharmacist/Pharmacist and Certified Pediatric/Family Nurse Practitioner. Interns, trainees, and associates are not eligible for enrollment.

**Exclusion Lists**

- Contractor is obligated to comply with applicable federal debarment and suspension regulations, in addition to the requirements set forth in 42 CFR Part 1001, including but not limited to those related to the U.S. System for Award Management.12
- If Contractor subcontracts with or employs an excluded party, County or DHCS has the right to withhold payments, disallow costs, or issue a Corrective Action Plan (CAP), as appropriate, pursuant to Health and Safety Code (HSC) 11817.8(h).
- Contractor is responsible for performing the following Exclusion Checks prior to hiring a potential employee to ensure the employee is not suspended, debarred, excluded or otherwise ineligible for participation in government funded healthcare programs:

**California Department of Health Care Services Medi-Cal Suspended and Ineligible Provider List;**

- U.S. Department of Health and Human Services Office of the Inspector General (OIG) List of Excluded Individuals and Entities; U.S. System for Award Management; and Social Security Administration Death Master File.
- Contractor shall conduct these Exclusion Checks prior to granting any staff person access to personal, sensitive or confidential information (PSCI).
- Contractor shall comply with applicable Federal and State suspension, debarment, and exclusion laws and regulations, including, without limitation, ongoing monitoring. Contractor shall comply

with the ACBH Exclusion Screening Policies and shall work with ACBH to demonstrate compliance with regulatory requirements.

- Contractor shall ensure that employees, volunteers, Board Members, and agents of Contractor, both clinical and non-clinical, who are providing and/or supporting services under this Agreement are included in Contractor's Staff Roster on file with ACBH and are in good standing with CMS and DHCS and are not on any list of providers who are excluded from participation in Federal health care programs or on the Medi-Cal Suspended and Ineligible Provider List.13

**Compliance Program/Code of Conduct**

Contractor shall ensure that each of its staff comply with the ACBH Ethical Conduct Code in the ACBH QA Manual and with all professional organizations that apply to their credential, certification, registration, and/or licensure. For each employee, volunteer, board member, owner and/or agent who is providing and/or supporting services under this Agreement, Contractor shall maintain on file a signed Code of Conduct meeting the requirements set forth in the ACBH QA Manual. ACBH may, from time to time, revise such requirements, and Contractor shall, if necessary, obtain newly signed Code of Conduct documents meeting those requirements.

**Criminal Background Consent**

Contractor shall ensure that all employees consent to criminal background checks, including fingerprinting when required under State law or by the level of screening based on risk of fraud, waste, or abuse as determined for that category of provider. Contractor shall ensure that any person with a five percent or more direct or indirect ownership interest in Contractor's organization consents to a criminal background check and submission of fingerprints within 30 days upon request from CMS or DHCS pursuant to 42 CFR 455.434.

**Confidentiality Statement**

Annually, Contractor shall collect a signed ACBH Confidentiality Statement or a Confidentiality Statement approved by the ACBH Privacy Officer as specified by ACBH from any staff who will have access to PSCI through this Agreement prior to granting any staff person access to PSCI and annually thereafter. Contractor shall comply with the ACBH Policy on Privacy, Security and Confidentiality Statement of Client Services, Records and Information.

**Retention of Employee Records**

Contractor shall retain employee files for credentials, licensure and completed trainings for the period of at least ten years from date of service, end of Medi-Cal or Medicare Advantage or Medicare Part D contract period, or audit completion, whichever is later.14 ACBH recommends a record retention period of at least 15 years from the date of service for programs billing to Medi-Cal and Medicare. Evidence of credentials and training shall be furnished to ACBH upon request.

***TOBACCO, ALCOHOL, AND SUBSTANCE USE POLICIES***

**Drug-Free Workplace**

Contractor shall provide a drug-free workplace in accordance with regulatory requirements.15 Contractor must notify the ACBH Program Contract Manager within five days if any employee is convicted or pleads nolo contendere to a criminal drug statute violation occurring at any County-funded facility or work site.

**Norms Around Substance Use**

Contractor shall recognize the importance of policies and norms supporting abstinence from the use of alcohol and illicit drugs and shall prohibit the use of alcohol and illicit drugs on all program premises, as well as at any event funded in any way by County, whether on or off the program premises. Contractor agrees that information produced through these funds, and that pertains to alcohol or drug related programs, shall contain a clearly written statement that there shall be no unlawful use of alcohol or drugs associated with the program.

**Provider Tobacco Policies and Consumer Treatment Protocols**

For programs operating under a Master (versus Services As Needed) Contract, Contractor shall implement the ACBH Provider Tobacco Policies and Consumer Treatment Protocols as specified in the ACBH Policy Manual. Treatment providers shall follow the ACBH guidance around Medi-Cal claiming when tobacco use impacts client recovery. Smoking shall not be a factor in eligibility for services or discharge unless the smoking is occurring in violation of state or local law.

**Smoke-Free Workplace Certification**

United States Public Law 103-227 (Title X, Part C), also known as the Pro-Children Act of 1994, imposes restrictions on smoking in facilities where certain federally funded children's services are provided. The Act prohibits smoking within any indoor facility (or portion thereof), whether owned, leased, or contracted, that is used for the routine or regular provision of: 1) kindergarten, elementary, or secondary education or library services, or 2) health or day care services that are provided to children under the age or 18. The law applies if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable Federal funds is Medicare or Medicaid; or facilities where Women, Infants, and Children (WIC) coupons are redeemed. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible party. By signing this Agreement, Contractor certifies that it will comply with the requirements of the Pro- Children Act of 1994 and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Pro-Children Act of 1994.

***CLIENT RECORDS, DATA, PRIVACY, AND SECURITY REQUIREMENTS***

**Confidentiality and Secure Communications**

Contractor shall comply with all applicable Federal and State laws and regulations pertaining to the confidentiality of individually identifiable protected health information (PHI) or personally identifiable information (PII) including, but not limited to,