Humboldt County Department of Health & Human Services

Behavioral Health

Cultural Competence Plan Updated 2025

Contents

Criterion 1: Commitment to Cultural Competence 3
- I. County Mental Health System Commitment to Cultural Competence 3
- II. Recognition, value, and inclusion of diversity within the system 7
- III. Designated Cultural Competence/Ethnic Services Manager 15
- IV. Budget Resources for Cultural Competence Activities 16

Criterion 2: Updated Assessment of Service Needs 17
- I. General Population 17
- II. Medi-Cal Population and Client Utilization 19
- III. MHSA Community Services and Supports (CSS) 21
- IV. MHSA Prevention and Early Intervention (PEI), ... 23
- V. MHSA Workforce Education and Training (WET) 27

Criterion 3: Strategies and Efforts for Reducing Disparities 27
- I. Target populations with disparities 27
- II. Disparities in each of the populations 27
- III. Strategies for reducing those disparities. 29
- IV. Measurement and monitoring of activities / strategies for reducing disparities. 38
- V. What has been working well and lessons learned 39

Criterion 4: Integration of the Client/Family Member/Community Committee 42

Criterion 5: Culturally Competent Training Activities 44
- I. Annual Cultural Competence Training Requirement 44
- II. Process for the incorporation of Client Culture Training throughout the mental health system. 52

Criterion 6: Commitment to Growing a Multi-cultural Workforce 52

Criterion 7: County Mental Health System Language Capacity 61
- I. Bilingual Workforce Capacity 61
- II. Interpreter Services 62
- III. Provide bilingual staff and/or interpreters for threshold languages 67
- IV. Provide services to all LEP clients not meeting the threshold language criteria 70
- V. Translated documents, forms, signage, and client informing materials 70

Criterion 8: County Mental Health System Adaptation of Services 72
- I. Client driven/operated recovery and wellness programs. 72
- II. Responsiveness of mental health services 75
- III. Quality Assurance 80
- **Attachments** 87

Criterion 1: Commitment to Cultural Competence

I. County Mental Health System Commitment to Cultural Competence

Humboldt County Department of Health and Human Services (DHHS) Behavioral Health is committed to the provision of culturally competent services that are effective, equitable, understandable, respectful and responsive to diverse cultural practices and beliefs, including beliefs about health and behavioral health. Behavioral Health services are delivered in a consumer's preferred language and with consideration of the individual's or family's culture. Because this Cultural Competence Plan (CCP) covers a behavioral health program that includes Substance Use Disorder (SUD) programs, it is important to combine the Cultural and Linguistic Standards (CLAS) required by SUD programs with the Department of Health Care Services (DHCS) Standards required for Mental Health Plans (MHP). In most cases the requirements are similar.

Humboldt County is located on the coast of northwestern California, 225 miles north of San Francisco and 70 miles south of the Oregon border. The County is rural in nature, with a population of 134,623 spread over 3,573 square miles, or 37.7 persons per square mile. Forty-nine percent of residents live within the incorporated areas while over half of residents live in the outlying rural areas of the County. Eureka is the largest community in the County and is the county seat of government. The County is home to eight federally recognized American Indian Tribes: Yurok, Karuk, Hupa, Wiyot, Cher-Ae Heights Indian Community of Trinidad Rancheria, Bear River Band of Rohnerville Rancheria, Blue Lake Rancheria, and Big Lagoon Rancheria.

DHHS is an integrated Health and Human Services Agency under the State's Integrated Services Initiative (AB315 Berg) and includes the former Departments of Mental Health, Public Health, Employment Training, Veterans Services, Public Guardian and Social Services. Effective May 2020, DHHS Mental Health was renamed DHHS Behavioral Health. DHHS Behavioral Health is responsible for responding to psychiatric crises in the community, providing emergency psychiatric services and inpatient psychiatric services.

The DHHS and Behavioral Health commitment to cultural competence and responsiveness is reflected at all levels through:

- DHHS Mission and Vision
    - Mission: To reduce poverty and connect people and communities to opportunities for health and wellness
    - Vision: People helping people live better lives
- Behavioral Health Vision and Intention. The language in italics was new in 2021 to reflect the strengthened commitment to racial and cultural equity.

    - Vision: We are committed to engaging in relationships that are authentic, caring, respectful and inclusive to be responsive to the needs of the staff and community we serve.
    - Intention: To use relationships to create a culture that *advances racial and cultural equity, dismantles systemic and structural racism,* and promotes and sustains health, wellness, and recovery.
- DHHS Behavioral Health Strategic Plan. The language in italics was new in 2021 to reflect the strengthened commitment to racial and cultural equity.
    - Fiscal Solvency: Responsibly maximizing revenue and decreasing/managing expenditures, *with a conscious consideration of how this advances, or hinders, racial and cultural equity,* to be able to provide needed mental health and substance use disorder services to the community.
    - Collaboration: Attend to relationships to decrease barriers, strengthen partnerships, *and advance racial and cultural equity* in order to achieve collective impact goals as effectively and efficiently as possible.
    - Workforce Development: Supporting a healthy and engaged, *racially and culturally diverse* workforce to grow in knowledge, skills, and abilities, and to have consistent opportunity to develop as leaders.
    - Service Delivery: Offering a continuum of high quality and accessible services that are culturally responsive and tailored to the unique needs of those we serve.
    - Compliance and Quality: Assuring all programs and services are provided in a compliant and high-quality manner, *with a conscious consideration of how they advance, or hinder, racial and cultural equity,* by utilizing data and internal processes to inform decision making at all levels.
- DHHS BH Equity Plan: is a three-year roadmap implemented in early 2025 that aligns BH initiatives with the Department of Health & Human Services' (DHHS) Racial Equity Strategic Plan. It operationalizes equity through five interconnected strategies—focused on two types of workforce development, policy change, accountability, and community partnerships—with explicit timelines, leads, and measurable outcomes. This plan was developed by leadership, with the assistance of Stepping Stone Consulting. There was also a series of listening sessions with BH staff, and this information was used to guide finalization of the plan.
- Kauffman and Associates: As part of workforce development and community partnership efforts, Behavioral Health partnered with Kauffman and Associates, Inc. (KAI) to strengthen engagement with local Tribal communities. In 2025, KAI facilitated four Tribal Engagement Sessions focused on improving relationships, understanding Tribal behavioral health needs, and supporting access to culturally responsive services. Sessions included discussions on Tribal experiences with County Behavioral Health, current collaboration successes and challenges, strategies for meaningful partnership, and identification of next steps for on-going engagement. Participating Tribes and organizations included United Indian Health Services, Karuk, Yurok, Hoopa, Bear River, Two Feathers, K'ima:wa, and Trinidad Social Services. Key recommendations from these sessions emphasized formalizing Tribal–County communication and collaboration through clear MOUs/MOAs, standardized referral and information-sharing processes, and strengthened critical incident review practices.

Additional recommendations included expanding collaborative staffing models, creating cross-training opportunities for Tribal and County staff, supporting Tribal initiatives through identifying funding and infrastructure supports, and planning joint trainings and community engagement activities to support a more coordinated Tribal–County Behavioral Health partnership.

- DHHS Racial Equity Strategic Plan:
    - Behavioral Health participates and aligns with the work outlined by the plan, which was rolled out to all BH staff in 2022. Currently, the Racial Equity Steering Committee is working on an updated version of the strategic plan.
    - Designed in partnership with the Racial Equity Steering Committee and Department of Health and Human Services leadership.
    - The long-term goal of the equity work in the strategic plan and throughout DHHS is to develop an organization that is anti-racist, or actively working to advance equity by dismantling systemic and structural racism within the agency and the community. The plan is broken down into six main goals:
        - Develop a permanent Cultural and Racial Equity Team to facilitate Equity efforts across DHHS.
        - Training and coaching for all staff.
        - Coach, support, and prepare staff in supervisory roles.
        - Develop External and Internal Racial Equity Coaching Capacity.
        - Improve hiring, recruitment, and retention.
        - Listen to, understand, and improve experiences of Black, Indigenous, and People of Color (BIPOC) staff within DHHS.
- DHHS BH Managers meetings: One meeting per month focused on equity; DHHS contracts with Stepping Stone Consulting and Humboldt Area Foundation.
    - Monthly meeting with Directors and Deputies.
    - Monthly meeting with the BH Administrative Team.
    - Meeting to support Behavioral Health Managers in developing equity-related skills and implementing racial equity efforts across programs.
    - Training opportunities, activities, and discussions on racial equity topics (e.g. implicit bias).
    - Establish an arena to discuss roll out of the BH Equity Plan and DHHS Racial Equity Strategic Plan across departments while providing support so that goals and time frames are met.
- DHHS Behavioral Health Strategic Initiatives are being worked/redesigned with the implementation of the BH Equity Plan.
    - Improve Program outcomes that support the triple aim of better care, better health, and better value.
    - Provide integrated and coordinated team-based care with a focus on hard to engage clients.
    - Improve workforce recruitment, retention, and training to meet current client care needs.
    - Utilize data to improve and inform clinical and program decisions.
    - Align electronic health record system to meet regulations and best business practices.

- Promote a working environment that values open communications and efficient teamwork.
- Roll-out California Advancing and Innovating Medi-Cal (CalAIM) plans of transforming and strengthening Medi-Cal to offer people services that are more equitable, coordinated, and follow a person-centered approach.
- Partner with CalMHSA to transition to a new Electronic Health Record (EHR) with the intent of establishing consistent workflows, configuration, and functionality.
- Communicate staffing challenges and department barriers through leadership memos that keep existing staff informed of strategies/initiatives being implemented to help improve work life quality.

- Policies, Procedures, and Practices. Three policies and procedures were developed in 2021 that focus on racial and cultural equity. The foundational policy's purpose is "To set forth the intention of Humboldt County Behavioral Health (BH) to work to advance racial and cultural equity by dismantling systemic (institutional) and structural racism and structural inequality, and to set the foundation for all actions and decisions made by BH and its staff in this regard." A second policy's purpose is "To ensure that all Behavioral Health policies, procedures and forms will be developed and reviewed with a conscious consideration to advance racial and cultural equity and dismantle systemic (institutional) and structural racism and structural inequality." A Policy, Procedure and Form Review Tool was developed and is in use to implement this policy. The Ethnic Services Manager (ESM) now reviews all new policies, existing policies that are due for review, forms and documents using the Tool to identify language that could be changed or added to advance racial and cultural equity. From September 2024 through September 2025, a combined total of 222 Behavioral Health policies, procedures, and forms received ESM review. The ESM review tool received an update at the end of 2025 to be able to better document recommendations and describe additional data collection strategies that may stem from such recommendations. The purpose of the third policy is "To ensure that Behavioral Health budgets are developed and reviewed with a conscious consideration to advance racial and cultural equity and dismantle systemic (institutional) and structural racism and structural inequality." An existing Budget Planning Questionnaire was modified to implement this policy. The revised Budget Questionnaire was first used during the budget cycle in early 2022. Several other already existing policies and procedures address cultural responsiveness and will be set forth in this document. For example, 100.106, Quality Improvement, section 1.4 reads: "To encourage respect for the individual clients' rights of self-determination, including such concepts as cultural and linguistic preference, timely access to needed services, alternatives to treatment and providers, participation in healthcare decisions, and rights to make grievances and appeals."
- DHHS Behavioral Health Cultural Responsiveness Committee: Discussed in Criterion 4
- DHHS Racial Equity Steering Committee, formed in August 2020, has continued to meet regularly and in the past four years has developed a Racial Equity Plan, Training Plan, an online training on equity terms, a new Foundations of Racial Equity training, and began investigating Bias Education and Response Team (BE/RT) logistics. In early 2022 the DHHS Racial Equity Manager was hired. The Behavioral Health Ethnic Services Manager is a member of this Committee.

- Community Outreach, Engagement and Involvement. This is discussed further in the next section.

II. Recognition, value, and inclusion of diversity within the system

Humboldt County DHHS Behavioral Health recognizes and values the inclusion of racial, ethnic, cultural, and linguistic diversity through practices and activities that demonstrate community outreach, engagement, and involvement efforts with identified racial, ethnic, cultural, linguistic, and other relevant small county cultural communities with behavioral health disparities. Community members, clients and family members are involved in several ways.

- The Humboldt County Behavioral Health Board maintains a membership comprised of at least 50% of members who have lived experience as a client or family member and two members who represent transition age youth.
- DHHS Behavioral Health sponsored education and planning meetings as part of the MHSA Community Program Planning Process (CPPP). These meetings invite people to gather to discuss behavioral health services. The stakeholder meetings held in the process of updating the Mental Health Services Act (MHSA) Three-Year Plan Update and the MHSA Annual Updates are examples of this, where the MHSA Coordinator sponsors community meetings, which take place in person, virtually via Zoom, or in a hybrid format.
- During the 2023-2026 Three-Year Plan planning, a Community Survey was made available to the community as a method of gathering input in a broader way. The survey was distributed during community meetings, emailed to various distribution lists, and broadcasted by the DHHS Media team in various radio stations along with various local news sources.
- DHHS Behavioral Health participation in existing community meetings where behavioral health services, education, and planning are discussed. These meetings are sponsored by local community-based organizations and associations that represent and/or serve diverse community members. In these instances, a Behavioral Health staff person attends and requests that behavioral health services planning be on the agenda for a specific meeting. This dramatically increases the number and diversity of individuals providing input. Much of the MHSA community input gathered for the Three-Year Plan and Annual Updates come in this way. Some examples are the meetings of the Northern Humboldt Family/Community Resource Centers, the Family Advisory Board, the Eastern Humboldt Services Group, Southern Humboldt Working Together, Promotores de Humboldt meetings, and more.
- Through the Community Program Planning Process and recommendations provided through the Cultural Responsiveness Committee (CRC), input to create an outreach position specific to Spanish-speaking communities was integrated in the MHSA 2023-2026 Three-Year Plan, which received Board of Supervisor approval on June 27th, 2023. With the inclusion and budgeting of this position, Behavioral Health intends to recruit a Spanish-speaking individual to provide culturally responsive outreach to Hispanic/Latino(a) communities to foster better understanding of available Behavioral Health services.

- Additionally, the CRC engaged in three important projects:
  1) Welcoming Environments Part 2 (WEP 2) project. This project was a continuation of work that started in 2019 but was put on hold due to the COVID-19 pandemic. The design and decoration of waiting areas where clients are seen, specifically reception lobbies and waiting areas, can reflect an environment that is welcoming to the client's, staff's or visitor's culture. The CRC assessed how welcoming Behavioral Health (BH) environments are to diverse cultural and ethnic groups by using a human-centered design lens. There are two components to WEP 2: 1) Environment assessments 2) A staff and client survey. This project is discussed in greater detail in Criterion 3.
  2) Equity Plan: Within the Equity Plan, the CRC is working on developing tasks and identifying resources for positions at all levels to clarify what it looks like to do equity work well and to communicate expectations that this work is a collective effort; this is an ongoing effort that will carry over into 2026. The CRC also created equity questions that were incorporated into the DHHS 2025 Workforce Development Survey, which were asked to all staff across DHHS.
  3) Internal Outreach: Given the tasks outlined under the Equity Plan, the CRC requested additional staff participation. The CRC distributed a flyer along with a CRC New Member registration form. The CRC gained three additional members through this effort.

MHSA Community Involvement

Participants in the MHSA community engagement process reflect the diversity of Humboldt County, including individuals with experience as clients and family members; current and former foster youth; transition age youth; DHHS administration; program providers; community-based and organizational providers of local public health, behavioral health, social services, and vocational rehabilitation services; and agencies that serve and/or represent diverse racial and ethnic groups, and unserved/underserved, Native American, and rural communities.

Below are examples of community partners with which DHHS Behavioral Health participates:

- Humboldt County Transition Age Youth Collaboration
- Family and Community Resource Centers
- Law Enforcement Chiefs Association Humboldt
- United Indian Health Services
- Suicide Prevention Network
- 0-8 Mental Health Collaborative
- First 5 Humboldt
- NAMI (National Alliance on Mental Illness)
- Family Advisory Board
- *Promotores de Humboldt*
- DHHS Behavioral Health organizational providers
- Humboldt Allies for Substance Use Prevention
- Behavioral Health Board
- Youth Advocacy Board

- Open Door Clinics
- K'ima:W Medical Clinic
- Southern Humboldt Working Together
- DHHS Employee Services
- DHHS Public Health
- DHHS Social Services

Community outreach, engagement, and involvement is clearly demonstrated in the Mental Health Services Act (MHSA) planning process. During the planning process for the 2025-2026 Annual Update, conducted from December 2024-April 2025[1], 115 individuals attended one of eleven stakeholder meetings and/or provided input via email for the Draft 2025-2026 Annual Update. Of these, approximately 49% provided demographic information. The following tables reflect this demographic data.

Residence Location	Percent
Northern Humboldt	38%
Eureka	43%
Eel River Valley	5%
Southern Humboldt	7%
Eastern Humboldt	2%
Other/Unknown	5%

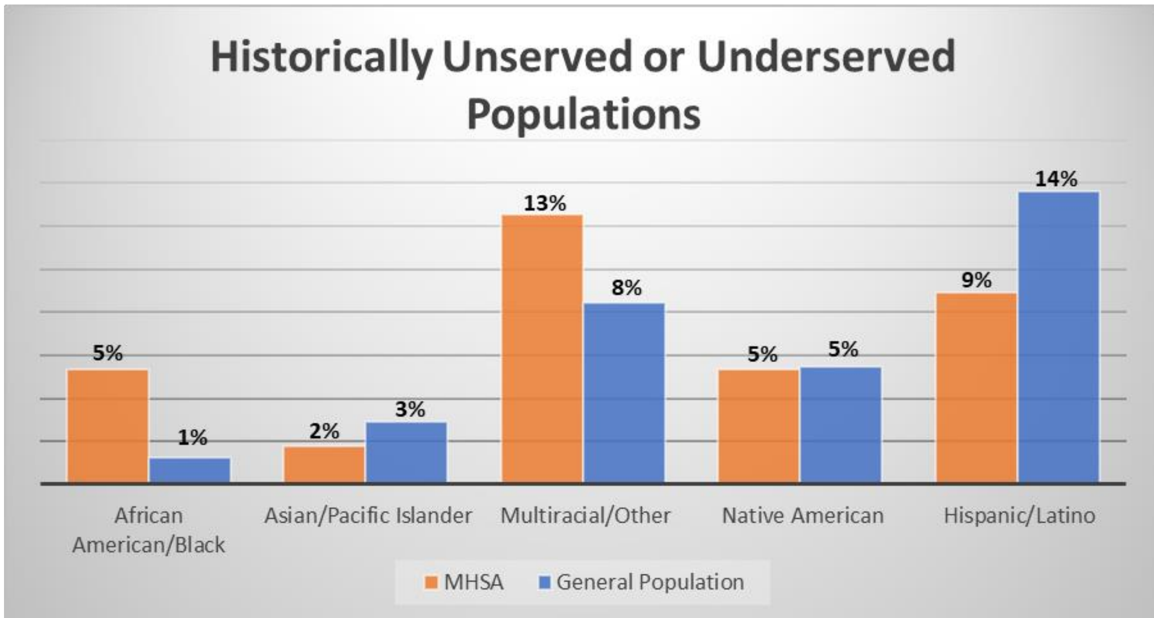
Ethnicity	Percent
White/Caucasian	66%
Hispanic/Latino	9%
Native American or Alaska Native	5%
Multiracial/Other	13%

Age Group	Percent
16-25	27%
26-59	57%
60+	16%

As seen in the chart below, African American/Black stakeholders was 5% as, compared to 1% of

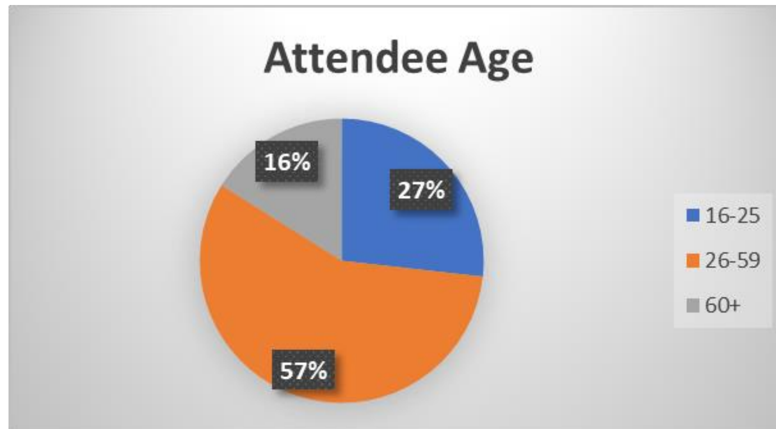
[1] MHSA community program planning process data, 2024-2025. Tables and charts on the following pages reflect data gathered from demographic forms collected during the planning process.

the general population. The Asian/Pacific Islander participants that attended MHSA stakeholder meetings was 2%, as compared to the 3% of the general population. For Multiracial/Other participants the participation in the MHSA stakeholder process was 13%, as compared to the 8% of the general population. Native American/Alaska Native participants were 5%, as compared to the 5% of the general population. Hispanic/Latino stakeholders were 9% of participants as compared to 14% of the general population.



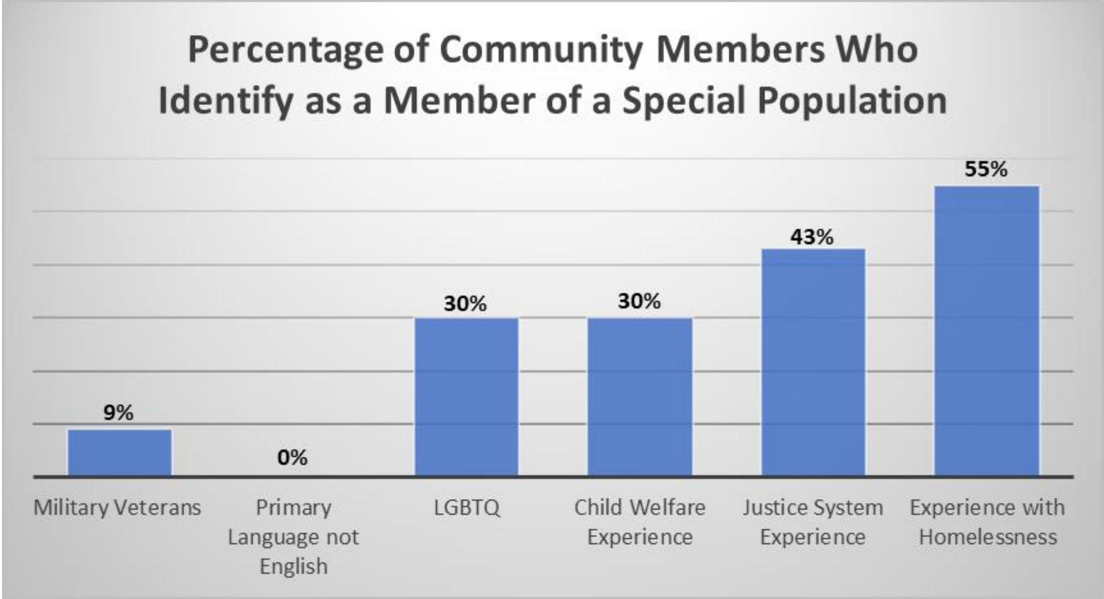
For those completing the demographic form English was the primary language for almost all providing input. As of March 2024, the County has reached the minimum number to classify Spanish as its Threshold Language. This will be monitored for changes and the BH Quality Improvement team is looking into any implications for translation needs. It should be pointed that Behavioral Health has made sure to have Spanish postings and translations readily available in past years regardless of not having a threshold designation.

Capturing and tracking the age range of those providing input is also important, as transition age youth have been identified as an underserved population. As the chart below illustrates, 27% of those providing input were transition age youth between ages 16-25, with 57% reporting being adults between ages 26-59, and 16% being older adults aged 60 and over.



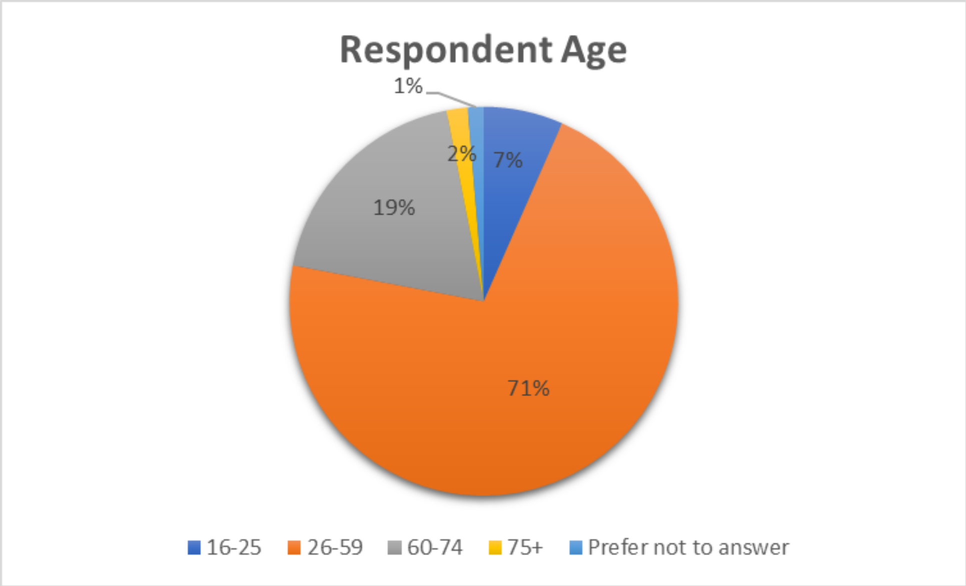
Community members with lived experience as clients of behavioral health services and family members of clients are two important populations to capture and track as their direct experience with services is vital to the success of program planning. Fifty-two percent of those participating in the stakeholder process were diagnosed with a serious mental illness (SMI). Seventy percent were family members of those who have been diagnosed with a serious mental illness. Eighty-two percent were friends of someone with serious mental illness.

Military veterans, the LGBTQ community, people who have experienced homelessness, and people who have experienced the justice system or child welfare services are also tracked, as they are traditionally underserved populations. Nine percent identified as military veteran, thirty percent identified as LGBTQ, 30% had child welfare experience, 43% had justice system experience, and 55% of participants had experience with homelessness.

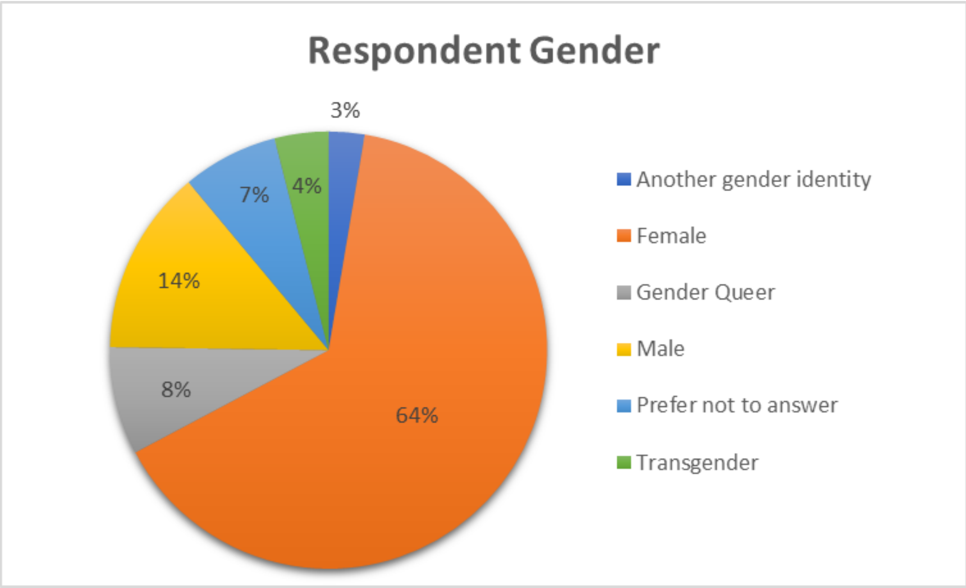


Community Survey Results
As mentioned in the previous section, the community survey is a strategy used by Behavioral Health to gather local input in a broader way during the development of MHSA Three-Year Plans, with the next community survey slated to take place during the development of the 2026-2029 Three-Year Plan/Integrated Plan. The survey was made available on November 2022 and was closed in February 2023. Community members were asked to provide demographic information. Out of the 229 individuals that completed the survey, 194 (85%) said it was their first time filling out the survey. Fifteen percent (15%) had taken the survey in previous planning processes for MHSA. One person did not answer the question.

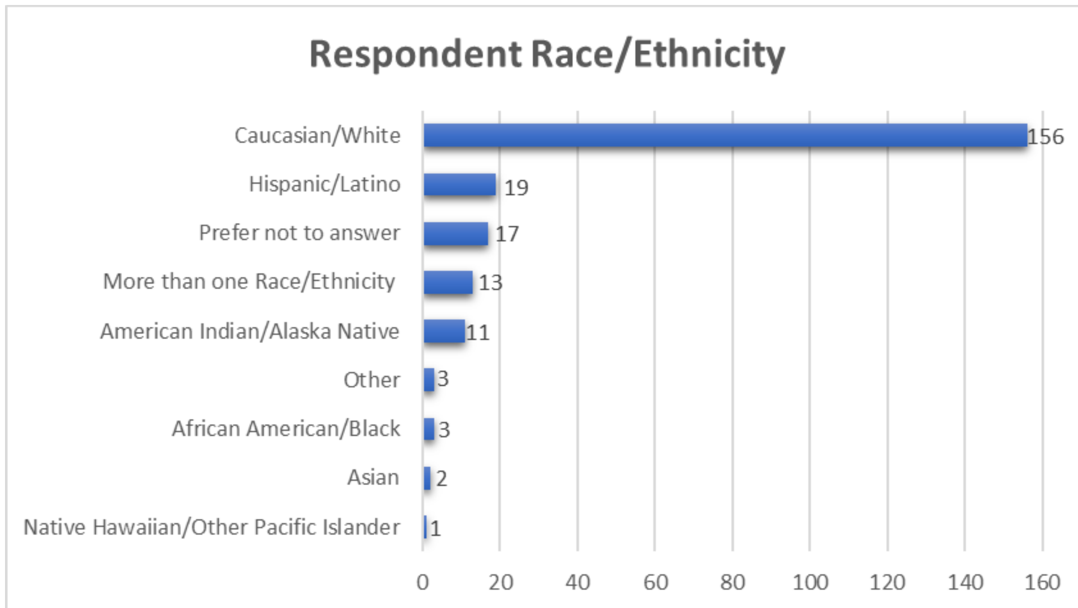
Six and a half percent of survey respondents were ages 16-25, 71.4% were ages 26-59, 18.9% were ages 60-74, 1.8% were ages 75+, and 1.3% did not answer.



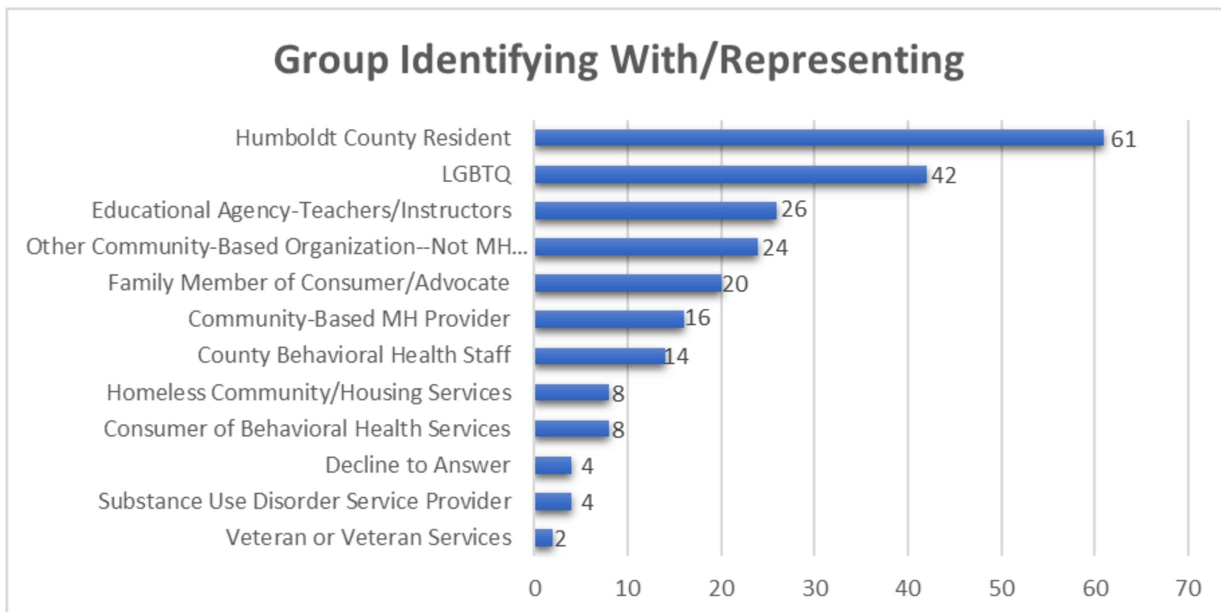
Eight percent of respondents were gender queer, 64.6% female, 13.7% male, 4% transgender, 2.7% were another gender identity, and 7.1% did not answer.



Out of the 229 respondents, 156, 69.3%, were Caucasian/White; 13 respondents, 5.8%, were Multiracial; 19 respondents, 8.4%, were Hispanic/Latino; 11 respondents, 4.9%, were American Indian/Alaska Native; 3 respondents, 1.3%, were Other; 3 respondents, 1.3%, were African American/Black; 1 respondent, .4%, were Pacific Islander; and 2 respondents, .9%, were Asian. 17 respondents, 7.6%, did not answer.

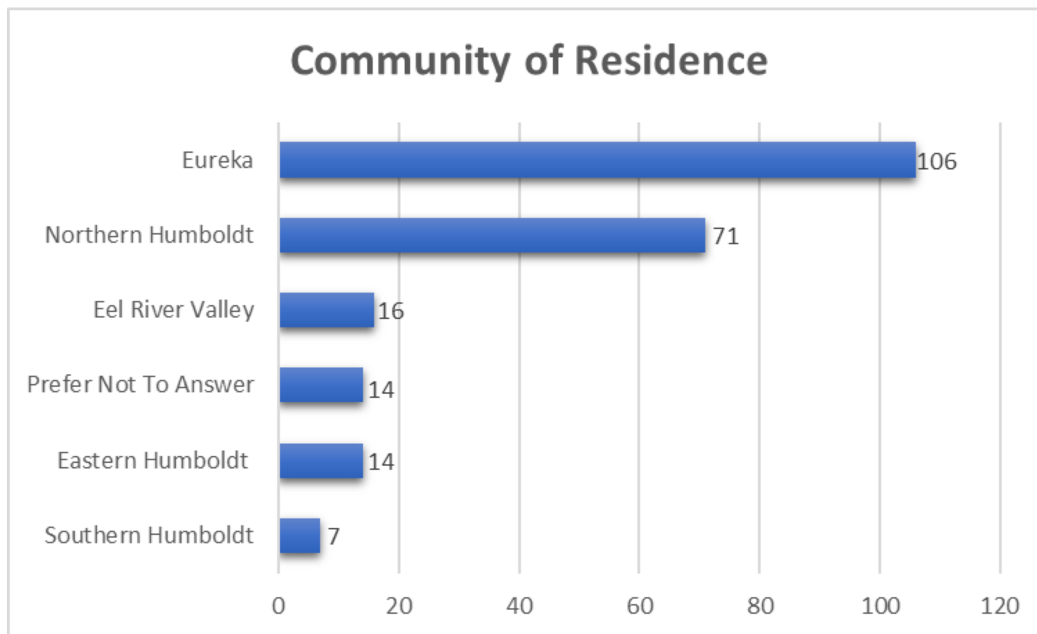


Survey respondents were asked to identify the group they primarily identify with or represent. 11.6% indicated educational agency; 27.1% indicated an interested member of the community; 10.7% indicated other; 3.6% indicated mental health client/consumer; 8.9% indicated family member of a client/consumer; 10.7% indicated another community based organization, not mental health; 7.1% indicated a community mental health provider; 6.2% indicated county behavioral health staff, 1% were affiliated with veteran services; 18.7% LGBTQ; 2% substance use disorder service provider; and 3.8% identified with homeless community/housing services.



Survey respondents were asked to identify the city, zip code, or community in which they reside. Most respondents resided in the Humboldt Bay area—Eureka, Arcata and McKinleyville—177 respondents. The Eel River Valley, including Fortuna, Rio Dell, and Ferndale,

had 16 respondents, followed by Southern Humboldt, including Redway, Weott, Garberville, and Petrolia, at 7 respondents. There were 14 respondents from Hoopa, Weitchpec and Willow Creek in Eastern Humboldt. Fourteen people declined to answer the question.



III. Designated Cultural Competence/Ethnic Services Manager

The duties and responsibilities of the DHHS Behavioral Health Ethnic Services Manager are overseen by the Behavioral Health Director. It is the responsibility of both the Ethnic Service Manager and the Behavioral Health Leadership Team to ensure the development and delivery of behavioral health services to meet the diverse cultural, ethnic, and linguistic needs of clients and family members. The Ethnic Services Manager:

- Is a member of the DHHS Behavioral Health Management Team.
- Is a member of and co-facilitator for the Behavioral Health Cultural Responsiveness Committee.
- Is a member of the Outpatient Continuous Quality Improvement (OP-CQI) Committee.
- Facilitates provision of cultural training to behavioral health staff.
- Facilitates broad and diverse stakeholder representation in the program planning process.
- Participates in the development of the Cultural Competency Plan and the Mental Health Services Act Plans and Updates, and coordination of the components of MHSA Plans.
- Receives data reports on the racial/ethnic and cultural demographics of individuals participating in or being served by Mental Health Services Act programs and activities and includes data in reports and recommendations.

- Is a participant in the Superior Region Ethnic Services Manager conference calls.
- Is a member of the California Behavioral Health Directors Association (CBHDA) Cultural Competency, Equity, and Social Justice Committee (CCESJC), and participates in monthly conference calls and meetings.
- Is a member of the DHHS Racial Equity Steering Committee.
- In 2023/24 was a member of a county-wide Diversity, Equity, and Inclusion Committee designed to develop recommendations that can improve internal county processes.

IV. Budget Resources for Cultural Competence Activities

DHHS Behavioral Health does not have a specific budget dedicated to cultural competency activities. Cultural competence is considered an over-arching value that is embedded in all programs and activities throughout the department.

The following programs include specifically funded services for culturally diverse groups:

- Humboldt County Transition Age Youth Collaboration (HCTAYC) and the Youth Advocacy Board
- Homeless Outreach
- Rural Outreach through Regional Services
- Two Feathers Native American Family Services to serve Native youth through providing behavioral health services, as a county organizational provider
- MHSA-funded Local Implementation agreements, which have historically involved community partners that provide culturally responsive services. Examples include the Bear River Band of Rohnerville Rancheria, Queer Humboldt, and Centro del Pueblo.

Department-wide services include:

- Cultural training
- Bilingual staff employed at the Department receive a pay differential.
- Full time Interpreter/Translator staff person
- Contract Interpreters/Translators
- 24-hour Language Line
- Culturally appropriate behavioral health services, such as those provided by the TAY Division, contract with Two Feathers Native American Services serving Native youth, and HCTAYC initiatives for LGBTQ+
- Racial Equity work to address structural and systemic racism through the DHHS Racial Equity Steering Committee. This group has developed a Racial Equity Plan, Training Plan, and an online training on equity terms.
- Compensation for culturally and linguistically competent providers who have passed the County bilingual proficiency exam, or who have indicated experience and qualifications on the Interpreter/Translator Resume, and for non-traditional providers/healers through referral to Two Feathers Native American Services and to United Indian Health Services.

- Incorporation of the Latinx Liaison Position in the MHSA 2023-2026 Three-Year Plan and 2025-2026 Annual Update and their corresponding budgets. This position will improve outreach efforts within Behavioral Health and be culturally responsive to local Hispanic/Latino(a) communities.

Criterion 2: Updated Assessment of Service Needs

I. General Population

According to the Census data from the 2024 American Community Survey (ACS), 4% of residents are American Indian/Alaskan Native, 3% are Asian/Pacific Islander, 2% are African American, 69% are White, 15% are Hispanic/Latino, and 8% are multiracial or other.

Race/Ethnicity	Number of Residents	Percentage
African American/Black	2,245	2%
Asian/Pacific Islander	3,524	3%
Multiracial/Other	10,272	8%
American Indian/Alaskan Native	5,029	4%
Hispanic/Latino	19,378	15%
White	91,932	69%
Total	132,380	100%

Foreign-born residents are approximately 6.6% of the total population. Approximately half of those who are foreign born are naturalized citizens. In addition, approximately 49% of those foreign born are from Latin and North America.

Foreign Born Population by Region of Birth	Number of Residents	Percentage
Africa	124	1%
Oceana	219	3%
North America	345	4%
Europe	1,583	18%
Asia	2,540	29%
Latin America	3,903	45%
Total Foreign Born	8,714	6.6% of Total Population

Residents who speak a language other than English at home are 11% of the population. Of those who do not speak English at home, 4,432 (3% of total population) do not speak English “very well”.

Primary Language: Language Spoken at Home - Population 5 years and over	Number of Speakers In Humboldt County	Percentage of Speakers In Humboldt County	Number of Speakers Who Report Not Speaking English "Very Well"	Percentage of Speakers Who Report Not Speaking English "Very Well"
Asian/Pacific Islander	2,473	2%	1,228	50%
Other Indo-European	2,152	2%	604	28%
Spanish	8,980	7%	2,533	28%
Other Languages	827	1%	67	8%
English	112,616	89%		
Total	127,048	100%	4,432	3%

Of the residents who are 25 years and older, 92% are high school graduates and 35% have a bachelor’s degree or higher[2]. Approximately 12.4% of residents are grandparents who are responsible for their grandchildren[3]. Fifty percent of the population is female and 50% is male. Median family income is $81,260. The median income for a male full-time worker is $37,251 and for female full-time workers it is $29,839.[4]

Age Range	Number of Residents	Percentage
Children 0-14	19,546	15%
Youth Age 15-24	20,814	16%
Adults 25-59	56,188	42%
Older Adults 60+	35,832	27%
Total	132,380	100%

Gender	Number of Residents	Percentage
Female	67,905	51%
Male	64,475	49%
Total	132,380	100%

[2] ACS S1501 EDUCATIONAL ATTAINMENT
[3] ACS S1002 GRANDPARENTS
[4] ACS S1903 ACS 1-Year Median Income

II. Medi-Cal Population and Client Utilization

During 2024, the California External Quality Review Organization (EQRO) vendor named Behavioral Health Concepts Inc. (BHC) stopped providing counties with data used to quantify disparities. Due to this limitation, data presented in Criterions 2 and 3 were adjusted to capture Humboldt County Medi-Cal utilization. The following four tables show the average number of eligible Humboldt County Medi-Cal recipients per month and their percentage of the total population, as well as Client Utilization in Calendar Year 2024. These four tables include all clients using services, with and without Medi-Cal. The data source for most of the data in the past was Behavioral Health Concepts (BHC), Behavioral Health's External Quality Review Organization (EQRO). BHC is no longer the EQRO for DHCS and is no longer providing the data to counties. As a result, another system called CalSAWS, was used to obtain information on primary language. CalSAWS data for 2024 shows a different total number for the Medi-Cal population.

Race/Ethnicity	Number of Consumers Utilizing DHHS-BH Services (with and without Medi-Cal)[2]	Percentage of Consumers Utilizing DHHS-BH Services (with and without Medi-Cal)
African American/Black	91	2%
Asian/Pacific Islander	103	2%
Multiracial	403	7%
American Indian/Alaskan Native	412	8%
Hispanic/Latino	460	9%
Other/Unknown	1,384	26%
White	2,537	47%
Total	5,390	100%

Primary Language	Number of Consumers Utilizing DHHS-BH Services (with and without Medi-Cal)4	Percentage of Consumers Utilizing DHHS-BH Services (with and without Medi-Cal)
American Sign Language (ASL)	7	0.1%
Asian/Pacific Islander Languages	18	0.3%
Spanish	46	1%
Other/Unknown	1,422	26%
English	3,897	72%
Total	5,390	100%

Gender	Number of Consumers Utilizing DHHS-BH Services (with and without Medi-Cal)[6]	Percentage of Consumers Utilizing DHHS-BH Services (with and without Medi-Cal)
Unknown	78	>1%
Female	2,462	46%
Male	2,850	53%
Total	5,390	100%

Age	Number of Consumers Utilizing DHHS-BH Services (with and without Medi-Cal)	Percentage of Consumers Utilizing DHHS-BH Services (with and without Medi-Cal)
0-5	129	2%
6-17	1,122	21%
18-59	3,532	66%
60+	607	11%
Total	5,390	100%

As previously stated, the tables above showed the numbers and percentages for all consumers utilizing BH services regardless of payor (Medi-Cal or non-Medi-Cal) for those services.

Humboldt County Client Utilization for Language
As already discussed, BHC's data did not include primary language. Thus, the comparison was made between utilization of services for all clients, regardless of payor, with data from the Electronic Health Record and the Medi-Cal population data in the CalSAWS system.

Primary Language	Number of Medi-Cal Recipients[3]	Percentage of Medi-Cal Recipients	Number of Consumers Utilizing DHHS-BH Services (with and without Medi-Cal)4	Percentage of Consumers Utilizing DHHS-BH Services (with and without Medi-Cal)
American Sign Language	21	<1%	7	0.1%
Asian/Pacific Islander Languages	702	1%	18	0.3%
Spanish	6,398	6%	46	1%
Other/Unknown	306	<1%	1,422	26%
English	101,106	93%	3,897	72%
Total	108,533	100%	5,390	100%

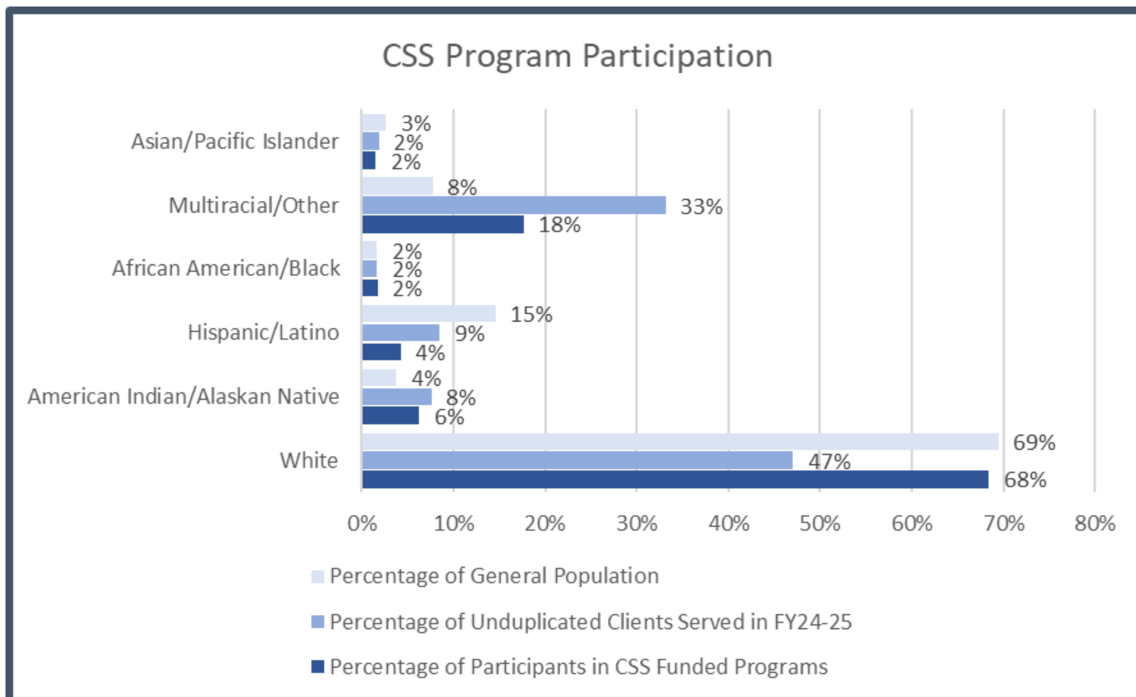
III. MHSA Community Services and Supports (CSS)[5]

The MHSA CSS client data represents a subset of the Client Utilization data for those clients who are receiving services in a MHSA CSS funded program. CSS programs with client data for 2024 are Comprehensive Community Treatment (CCT)/Full Service Partnership and Older and Dependent Adults. Data for the CCT Program comes from the State of California Data Collecting and Reporting system (DCR) and data for Older and Dependent Adults comes from the electronic health record (EHR).

The table below shows the number and percentage, by race/ethnicity, served by CSS programs, the unduplicated count of clients served in the fiscal year, and the general population.

Race/Ethnicity	Number of Participants in CSS Funded Programs	Percentage of Participants in CSS Funded Programs	Number of Unduplicated Clients Served in FY24-25	Percentage of Unduplicated Clients Served in FY24-25	General Population in Humboldt County	Percentage of General Population
White	271	68%	2,537	47%	91,932	69%
American Indian/Alaskan Native	25	6%	412	8%	5,029	4%
Hispanic/Latino	17	4%	460	9%	19,378	15%
African American/Black	7	2%	91	2%	2,245	2%
Multiracial/Other	70	18%	1,787	33%	10,272	8%
Asian/Pacific Islander	6	2%	103	2%	3,524	3%
Total	396	100%	5,390	100%	132,380	100%

[5] Humboldt County Behavioral Health Electronic Health Records.



American Indian/Alaskan Native makes up 6% of CSS clients, 8% of total clients and 4% of the general population. Two percent are Asian/Pacific Islander CSS client and total clients served; and makes up 3% of the general population. African American makes up 2% of CSS clients, 2% of total clients and 2% of the general population. White makes up 68% of CSS clients, 47% of those with served in FY24-25 and 69% of the general population. Hispanic/Latino makes up 4% of CSS clients, 9% of total clients and 15% of the general population. Multiracial/Other makes up 18% of CSS clients, 33% of those total clients served and 8% of the general population.

Primary Language	Number of Participants in CSS Funded Programs	Percentage of Participants in CSS Funded Programs	Number of Unduplicated Clients Served in FY24-25	Percentage of Unduplicated Clients Served in FY24-25	General Population in Humboldt County*	Percentage of General Population*
Asian/Pacific Islander	0	0.0%	18	0%	2,473	2%
Spanish	1	0.3%	46	1%	8,980	7%
Other/Unknown	16	4%	1,422	26%	2,979	2%
English	379	96%	3,897	72%	112,616	89%
Total	396	100%	5,390	100%	127,048	100%

Age	Number of Participants in CSS Funded Programs	Percentage of Participants in CSS Funded Programs	Number of Unduplicated Clients Served in FY24-25	Percentage of Unduplicated Clients Served in FY24-25	General Population in Humboldt County*	Percentage of General Population
0-5	0	0%	129	2%	19,546	14%
6-17	0	0%	1,122	21%	20,814	15%
18-59	209	53%	3,532	66%	56,188	41%
60+	187	47%	607	11%	35,832	26%
Total	396	100%	5,390	100%	136,132	100%

Those clients aged 0-5 make up 0% of CSS clients, 2% of the total clients served, and 14% of the general population. Those age 6-17 make up 0% of CSS clients, 21% of the total clients served, and 15% of the general population. Those 18-59 make up 53% of CSS clients, 66% of clients served, and 41% of the general population. Clients 60+ make up 47% of CSS clients, 11% of the clients served, and 26% of the general population.

Gender	Number of Participants in CSS Funded Programs	Percentage of Participants in CSS Funded Programs	Number of Unduplicated Clients Served in FY24-25	Percentage of Unduplicated Clients Served in FY24-25	General Population in Humboldt County	Percentage of General Population
Female	199	50%	2,790	47%	68,403	50%
Male	193	49%	3,120	53%	67,729	50%
Total	396	100%	5,910	100%	136,132	100%

Females make up 50% of CSS clients, 47% of the total clients served and 50% of the general population. Males make up 49% of CSS clients, 53% of total clients served and 50% of the general population.

IV. MHSA Prevention and Early Intervention (PEI)[6],[7]

For all but one program, the MHSA PEI data represents those who have participated in PEI activities <u>and</u> completed a demographic form. Because of the nature of many PEI activities—trainings, media campaigns, community education—there are many more people reached than are reflected in the small number who fully complete a demographic form. Some people may

---

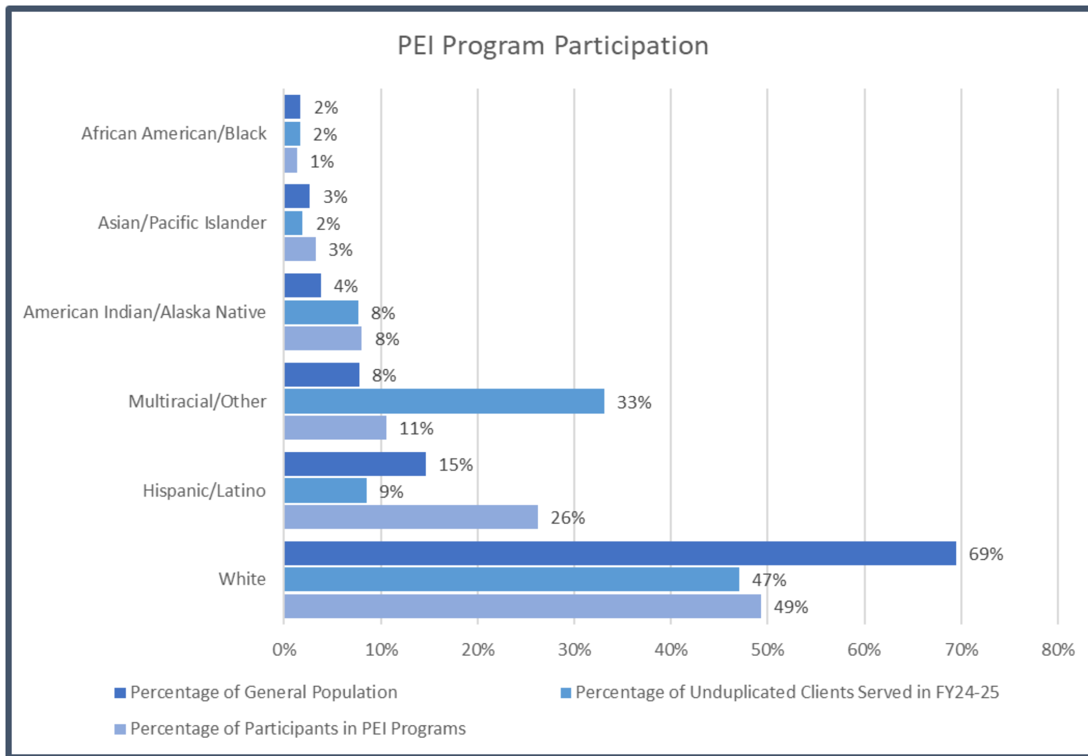
[6] Humboldt County Department of Health and Human Services, MHSA Prevention and Early Intervention spreadsheets and reports, FY 2024-25.
[7] California Department of Education https://www.cde.ca.gov/ds/sd/

only complete some of the nine categories of demographic form questions. Some people decline to complete the survey at all, and as it is a voluntary survey, they have that right. In addition, people participating in a PEI activity are not, for the most part, behavioral health clients. FY 24-25 improved over past year due to the end of the COVID-19 shelter-in-place order and a return to normalcy for many programs. The one program for which data is pulled from another source is Multi-Tiered System of Support (MTSS). For this program, data is pulled from the California Department of Education. The tables below show the number and percentage, served by PEI programs, the unduplicated count of clients served in the fiscal year, and the general population.

Race and Ethnicity

Race/Ethnicity	Number of Participants in PEI Programs	Percentage of Participants in PEI Programs	Number of Unduplicated Clients Served in FY24-25	Percentage of Unduplicated Clients Served in FY24-25	General Population in Humboldt County	Percentage of General Population
Unknown	258	1%				
White	9,510	49%	2,537	47%	91,932	69%
Hispanic/Latino	5,066	26%	460	9%	19,378	15%
Multiracial/Other	2,032	11%	1,787	33%	10,272	8%
American Indian/ Alaska Native	1,553	8%	412	8%	5,029	4%
Asian/Pacific Islander	635	3%	103	2%	3,524	3%
African American/Black	249	1%	91	2%	2,245	2%
Total	19,305	100%	5,390	100%	132,380	100%

American Indian/Alaska Native makes up 8% of PEI participants, 8% of the total unduplicated client served in the fiscal year, and 4% of the general population. Asian/Pacific Islander makes up 3% of PEI participants, 2% of the client served, and 3% of the general population. African American makes up 1% of PEI participants, 2% of the clients served, and 2% of the general population. White makes up 49% of PEI participants, 47% of the clients served, and 69% of the general population. Hispanic/Latino makes up 26% of PEI participants, 9% of the clients served, and 15% of the general population. Multiracial/other makes up 11% of PEI participants, 33% of the clients served, and 8% of the general population.



Primary Language

Those whose primary language is English make up 86% of PEI participants, 72% of the clients served, and 89% of the general population. Those whose primary language is Spanish make up 5% of PEI participants, 1% of the clients served, and 7% of the general population. One percent of PEI participants' primary language are Asian and Pacific Island languages. For 9% of PEI participants, the primary language was unknown/other. L

Primary Language	Number of Participants in PEI Programs	Percentage of Participants in PEI Programs	Number of Unduplicated Clients Served in FY24-25	Percentage of Unduplicated Clients Served in FY24-25	General Population in Humboldt County*	Percentage of General Population*
Asian/Pacific Islander	185	1%	18	0%	2,473	2%
Other Indo-European	0	0%	0	0%	2,152	2%
Spanish	894	5%	46	1%	8,980	7%
English	16,515	86%	3,897	72%	112,616	89%
Unknown/Other	1,664	9%	1,429	27%	827	1%
Total	19,259	100%	5,390	100%	127,048	100%

Age

PEI demographic forms collect data on age as defined by MHSA. For MHSA, Children are ages 0-15, Transition Age Youth are ages 16-25, Adults are 26-59, and Older Adults are age 60+. Except for the Older Adult category, this is different than how Medi-Cal defines age. The chart below indicates the number and percentages using both MHSA and Medi-Cal definitions.

Age	Number of Participants in PEI Programs	Percentage of Participants in PEI Programs	Number of Unduplicated Clients Served in FY24-25	Percentage of Unduplicated Clients Served in FY24-25	General Population in Humboldt County	Percentage of General Population
Children 0-5 (Medi-Cal)			129	2%	5,332	4%
Children 0-15 (MHSA)	14,379	74%				
Children 6-17 (Medi-Cal)			1,122	21%	18,706	14%
Transition Age Youth 16-25 (MHSA)	3,238	17%				
Adults 18-59 (Medi-Cal)			3,532	66%	72,510	55%
Adults 26-29 (MHSA)	1,628	8%				
Older Adults 60+ (MHSA & Medi-Cal)	56	<1%	607	11%	35,832	27%
Not stated/Unknown	13	0%				
Total	19,314	100%	5,390	100%	132,380	100%

Sex/Gender

Forty seven percent of PEI participants were male, 45% female, 8% Unknown/Other. This is compared to 53% male clients served and 49% male General Population. Total Female clients served were 46% and 51% of General Population.

Gender	Number of Participants in PEI Programs	Percentage of Participants in PEI Programs	Number of Unduplicated Clients Served in FY24-25	Percentage of Unduplicated Clients Served in FY24-25	General Population in Humboldt County	Percentage of General Population
Male	9,049	47%	2,850	53%	64,475	49%
Female	8,639	45%	2,462	46%	67,905	51%
Other/Unknown	1,630	8%	78	1%		
Total	19,319	100%	5,390	100%	132,380	100%

V. MHSA Workforce Education and Training (WET)

WET is discussed in Criterion 6.

Criterion 3: Strategies and Efforts for Reducing Disparities

I. Target populations with disparities

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

For most PEI programs, the MHSA data represents those who have participated in PEI activities and completed a demographic form. Because of the nature of many PEI activities—trainings, media campaigns, community education—there are many more people reached than are reflected in the small number who fully complete a demographic form. Some people may only complete some of the nine categories of demographic form questions. In addition, the data reflects the people participating in a PEI activity rather than those people that may be served as a mental health client. The one program that is an exception to obtaining PEI data through demographic forms is the Multi-Tiered System of Support (MTSS). Due to the nature of the MTSS activities, demographic data for Fiscal Year 2024-25 (the most recent available) was obtained from the California Department of Education website.

During 2024, the California External Quality Review Organization (EQRO) vendor named Behavioral Health Concepts Inc. (BHC) stopped providing counties with data used to quantify disparities. Due to this limitation, data presented in Criterions 2 and 3 were adjusted to capture Humboldt County Medi-Cal utilization.

II. Disparities in each of the populations

Disparity is the condition of being unequal and is a noticeable difference between one or more things. Disparity usually refers to a difference that is unfair. In this section, a simple descriptive analysis is used to describe the differences in the data. As mentioned in the introduction of Criterion 3, Medi-Cal Population data only captures Humboldt County utilization numbers and therefore cannot compare numbers at the state level due to no longer getting data from the state.

Medi-Cal Population (CY 2024 data). When looking at Medi-Cal populations within Humboldt, 2% of consumers identified as Asian/Pacific Islander, 2% as African American/Black, 9% as Hispanic/Latino, 8% as American Indian/Alaskan Native, 7% as Multiracial, 26% as

Other/Unknown, and 47% as White.

MHSA Community Services and Supports (CY 2024 data). There is a difference in serving the Hispanic/Latino population (4% of CSS clients and 15% of the general population). There is a slight difference in serving Asian/Pacific Islander (2% of CSS clients and 3% of the general population). There is a difference in serving children ages 0-5 (none served in CSS) and in serving children 6-17 (none served in CSS). As for language disparities, .3% of CSS participants identified Spanish as their primary language, with Spanish making up 7% of the general population. There is no data available on the LGBTQIA Medi-Cal population to identify differences.

MHSA Prevention and Early Intervention (2024-25 data from PEI spreadsheets and 2024-25 data from California Department of Education). When looking at data presented in Criterion 2, there do not appear to be any striking disparities. This is mainly due to not having state-level Medi-Cal utilization data. For calendar year 2024, Hispanic/Latino populations comprised 26% of PEI participation with the general population being 15%; for Multiracial/Other it was 11% from PEI programs when compared to 8% of the General Population; for American Indian/American Native populations comprised 8% of PEI participation when compared to 4% of the General Population; for African American/Black populations comprised 1% of PEI participation when compared to 2% of the General Population; and Asian/Pacific Islander populations was 3% of PEI participation when compared to 3% of the General Population.

Workforce Education and Training (September 2024 Employee Services data). In looking at Employee Services data alone, White is overrepresented in the BH workforce when compared to the client population served and the general population (69% workforce, 47% client population, 72% general population). There are fewer American Indian/American Natives in the workforce than clients served (3% workforce, 8% clients served, 3% general population). The African American/Black workforce is greater compared to clients served and the general population (3% workforce, 2% clients served, 1% general population). For Asian/Pacific Islander the percentage of the workforce and the percentage of clients served are both smaller when compared to the general population, though both workforce and clients served percentages are equal (2% workforce, 2% clients served, 3% general population). For Multiracial/other/unknown the percentage of the workforce is less than the clients served (10% workforce, 33% clients served, 8% general population). For Hispanic/Latino the percentage in the workforce and clients served varies by five percent (14% workforce, 9% clients served, 13% general population).

DHHS Workforce Development Survey. In November and December 2025 DHHS Quality Management Services (QMS) conducted an online DHHS Workforce Development Survey. The purpose of the survey was to assess the state and make-up of the current workforce; assess the state of the workplace culture at DHHS as perceived by staff; gather opinions about the development and promotional opportunities at DHHS; gauge staff familiarity with agency projects and initiatives; and collect branch or division specific information. This branch/division specific information included questions specifically for BH staff. The response rate of BH staff to

the survey was 17%. Results for BH show the following:

- 69% White
- 3% American Indian/Alaska Native
- 15% Hispanic/Latino
- 7% Multiracial

- 3% Preferred not to answer
- 54% Female, 41% Male, and 5% Unknown/Preferred not to answer

The Workforce Development Survey also indicated that 3% of survey respondents identified as Queer, 3% as Pansexual, zero identified as gay or lesbian, 8% as bisexual, and 15% preferred not to answer. There is no Medi-Cal data with which to compare this but as of October 2025, data from the Medical Records system shows there are 52 female-to-male transgender clients, 20 male-to-female transgender clients, and 58 are another gender identity.

III. Strategies for reducing those disparities.

In this section, progress on addressing the strategies from the 2023 Plan will be discussed, and any new/revised strategies for the upcoming year will be detailed.

Strategies addressing race/ethnicity disparities.

1. Policies and Procedures addressing racial and cultural equity. As discussed in last year's Cultural Competence Plan, three new policies were developed in 2021 that address BH's commitment to racial and cultural equity. The foundational policy's purpose is "To set forth the intention of Humboldt County Behavioral Health (BH) to work to advance racial and cultural equity by dismantling systemic(institutional) and structural racism and structural inequality, and to set the foundations for all actions and decisions made by BH and its staff in this regard." A second policy's purpose is "To ensure that all Behavioral Health policies, procedures and forms will be developed and reviewed with a conscious consideration to advance racial and cultural equity and dismantle systemic (institutional) and structural racism and structural inequality." A Written Materials Review Tool was developed and is in use to implement this policy. The Ethnic Services Manager (ESM) now reviews all new policies, and existing policies that are due for review, using the Tool to identify language that could be changed or added to advance racial and cultural equity. In 2025, approximately 170 policies/forms were reviewed by the ESM. The purpose of the third policy is "To ensure that Behavioral Health budgets are developed and reviewed with a conscious consideration to advance racial and cultural equity and dismantle systemic (institutional) and structural racism and structural inequality." An existing Budget Planning Questionnaire was modified to implement this policy. The revised Budget Questionnaire was used starting during the budget cycle in 2022. Additionally, in late 2024 the policy template used in the Behavioral Health branch was updated by the Quality Improvement

department to be ADA compliant. Policies are slowly being transitioned into the new ADA template, with a total of 170 policies being converted into this new format in 2025.

2. Staff training and development opportunities that are inclusive and bring a culturally diverse perspective to staff, including when appropriate attendance by community members and groups.

a) During 2021 the DHHS Racial Equity Steering Committee (RESC) developed a Racial Equity Strategic Plan that includes a high-level goal for training and coaching. This goal includes a training plan that was implemented in 2022. One of the trainings developed by the Steering Committee is a training on equity terms. This training is mandatory for all DHHS staff and is online on the NEOGOV platform. The training includes 24 terms with definitions. Several of the terms include video links that focus on the term. The BH Ethnic Services Manager is an active member of the Steering Committee.

b) In 2023, DHHS worked with Stepping Stone Consulting to develop two new trainings: "Implicit Bias – An Introduction" and "Foundations of Racial Equity." The DHHS Racial Equity Steering Committee worked closely with Stepping Stone Consulting in the development of the Implicit Bias training, which was made available through the NEOGOV online platform. The Implicit Bias training is a mandatory 1-hour course for all DHHS employees and serves as an introduction to the concept of implicit bias and as a prerequisite training to Foundations of Racial Equity. Foundations of Racial Equity is a mandatory 4-hour live training that takes place via Zoom. Foundations of Racial Equity was designed to allow employees to interact with each other through scenarios to explore the use of new concepts (e.g., implicit bias, color blindness, etc.).

c) A Cultural Awareness training was developed as the BH mandatory annual cultural competence training and was assigned to all BH staff through the NEOGOV online platform. Criterion 5 sets forth the participation results of this training as well as other cultural competence training for FY 2022/23.

d) BH Managers Training and Leadership Development meetings. At one meeting per month, BH Managers participate in a focused learning opportunity on a racial/cultural equity topic. During the past year these topics have included a presentation on the DHHS Racial Equity Plan and its rollout; targeted universalism; an activity having to do with why Black, Indigenous, and People of Color (BIPOC) don't always bring their authentic selves to work; Native American heritage month discussions, expectations for DHHS leaderships with ongoing equity work; an activity on implicit bias; conversations on privilege; a learning activity on coded language and microaggressions; activities that promote bias-free hiring practices that are more inclusive to historically marginalized/oppressed candidates; and how to engage in anti-racism work.

e) In 2024, BH began working with Kauffman and Associates, Inc. (KAI). KAI is assisting leadership in strengthening relationships and engagement with local tribes, to better understand the behavioral health needs of the Tribal community, and to support access to

services. In October 2024, KAI conducted a virtual training on Tribal Public Health 101, for the leadership team and managers.   An in person follow up training on this same topic, was conducted in November 2024. KAI will offer an additional training for direct service providers in 2025. Additionally, KAI assisted in the development of a series of Tribal Engagement Sessions with local Tribal leaders and County BH leadership, to engage in dialogue around prioritizing Tribal perspective and working with California Tribes, among other things. Criterion 1 contains more information of the Tribal Engagement Sessions.

f) The Department of Health Care Services (DHCS) released Behavioral Health Information Notice (BHIN) 25-019 in 2025. Through this BHIN, counties operating as Behavioral Health Plans must ensure that all staff, subcontractors, and downstream subcontractors who have direct contact with members complete an evidence-based Transgender, Gender-Diverse, or Intersex (TGI) cultural competency training. Counties must collaborate with qualified TGI-serving organizations to develop and deliver a curriculum that meets all elements outlined in statute and the working group recommendations. Humboldt County is in the process of contracting with OutCare Inc. to provide this training.

3. Behavioral Health Cultural Responsiveness Committee (BHCRC) projects.

a. *Mental Health Services for the Spanish-speaking community.* A focus on this topic was first started in 2018 as the Latino Outreach Project. Its intent was to develop a Spanish language public service announcement (PSA). Because there was no funding to further the project it was not implemented. In 2021 the focus was reignited with the intent of creating another recommendation for addressing the mental health services needs of the Spanish-speaking community. Three BHCRC meetings were focused on the topic with participation from BH staff and community members. Instead of moving forward with a PSA, a different recommendation was sent to BH Administration for approval in January 2022. This recommendation is summarized below:

1. Recruit and hire a Spanish-speaking, culturally proficient individual to provide outreach and act as liaison to the Hispanic/Latino/Spanish-speaking Humboldt County community. Activities will include:

--Participate in Mobile Outreach visits and events that take place in communities where there is a large population of Spanish-speaking individuals, such as Fortuna
--Attend Community health fairs
--Attend local events where the distribution and sharing of information about BH is appropriate and Hispanic/Latino/Spanish-speaking individuals are expected to attend
--Provide cultural coaching to BH staff

The need for position is supported by stakeholder input gathered via the Community Program Planning Process (CPPP) under the Mental Health Services Act (MHSA) for the 2020-2023 Three-Year Plan and subsequent Annual Updates. BH leadership incorporated a “Latinx Liaison” as a proposed Prevention and Early Intervention initiative within the MHSA 2023-2026 Three-Year

Plan. The incorporation of this position aligns with the elements identified in the CRC recommendation. Local stakeholders expressed a great amount of support for this initiative. As of June 27th, 2023, the 2023-2026 Three-Year Plan and its budget received Board of Supervisor approval. With the approved plan and budget now in place, BH is developing the job description and preparing for recruitment efforts to fill this new position.

b. *Welcoming Environments Part 2.* Due to the COVID-19 pandemic restrictions this project was placed on hold until business returned to usual and BH sites were more routinely seeing clients. This project was reviewed by the CRC in 2022 and adjusted accordingly to fit with current COVID-19 regulations, ensure culturally competent care, optimize surveys to fit current regulations, and include client feedback in a more effective manner. Efforts were made to include people with lived experience. The CRC partnered with the Behavioral Health Board to have two of their members along with two Transition Age Youth (TAY) help with conducting environment assessments for this project.

c. BH *Equity Plan progress*. Within the Equity Plan, the CRC is working on developing tasks and identifying resources for positions at all levels to clarify what it looks like to do equity work well and to communicate expectations that this work is a collective effort; this is an ongoing effort that will carry over into 2026. The CRC also created equity questions that were incorporated into the DHHS 2025 Workforce Development Survey, which were asked to all staff across DHHS.

4. MHSA Local Implementation Agreements (LIAs). Local Implementation Agreements provide funds for community organizations to implement locally developed projects for prevention and early intervention. These projects must focus on early intervention, outreach for increasing recognition of early signs of mental illness, prevention, access and linkage to treatment, stigma and discrimination, and suicide prevention. In 2024 six Local Implementation Agreements were approved for funding. The LIAs for Bear River Band and Centro del Pueblo address race/ethnicity and education. These projects concluded in 2025:

Bear River Band of the Rohnerville Rancheria: Mental Health Outreach and Awareness in Native Communities Series 2

The Bear River Band hosted 4 outreach events specifically tailored to engage Tribal youth and their families. The first event served as an introduction and discussion about Mental Health within the Bear River tribal youth community and helped connect people to Tribal Social Services. The first event gathered information used to design and implement the topics of the other 3 events. Each event included printed educational material that participants took home with them. Food was provided as well as activities to bring engagement to the events, and mental health swag to decrease the stigma of mental illness. This project met the Senate Bill (SB) 1004 priority of providing culturally competent prevention and early intervention services.

Centro del Pueblo Movimiento Indígena Migrante: Sembrando Esperanza: La Campaña de Medios y Alcance Para Prevenir el Suicidio Juvenil (English translation: Cultivating Hope: A Campaign of Efforts and Outreach to Prevent Juvenile Suicide)

With Local Implementation Agreement funding, Centro del Pueblo expanded their Sembrando Esperanza program, which focuses on Latinx and Indigenous youth suicide prevention efforts. Efforts included: a bilingual awareness social media campaign, a Spanish podcast, presentations and workshops across the county to inform folks about early intervention, suicide prevention, linkage to services, and stigma and discrimination reduction. These activities were expanded to various regions of Humboldt County through LIA funding, which also assisted in covering equipment costs to create a new media platform. This project met the SB 1004 priority of culturally competent and linguistically appropriate prevention and intervention services.

In July 2025 five Local Implementation Agreements were approved and will conclude in 2026. Two of the approved projects address race/ethnicity and education: 1) Black Humboldt will provide culturally responsive mental health support and healing spaces for BIPOC folk in Humboldt via cultural exchange groups, affinity spaces, art therapy, and mental health access and linkage events/workshops. Through these events, Black Humboldt aims to offer opportunities for personal and professional networking, resource sharing, and joy-centered community engagement. The project is also intersectional in nature, meaning it is inclusive to folks who are 2S/LGBTQIA+, disabled, experienced poverty or incarceration, unhoused, youth, and elders; 2) The Redwood Community Action Agency (RCAA) will train Case Workers and leadership staff (a total of 13 staff) in Breathwork and Emotional Freedom Techniques (tapping) facilitation practices. Once trained, staff will provide education and training to participants within the RCAA ecosystem. This project is tied to the holistic case management framework and aims to relieve stress and promote relaxation, reduce anxiety, and to identify, explore, resolve "limiting thinking and habits of behavior," and appropriately work towards healing the effects of trauma.

In addition to the strategies discussed above, existing strategies will continue to be implemented through the Department as a whole and through Behavioral Health specifically. These existing strategies are described in Section V below, What's Been Working Well.

Strategies addressing age disparities. DHHS Behavioral Health continued its work with First 5 Humboldt and the 0-8 Mental Health Collaborative to provide funding opportunities for agencies that serve children ages 0-5 and their families. Past and current collaboration includes partnering with these groups to fund ACES Collaboration grants that address Adverse Childhood Experiences, and grants through Measure S funding, which was County funding to address health and safety needs in the community. Last year's Local Implementation agreement with Two Feathers Native American Family Services, referenced above, also included cultural groups for parents and children ages 0-5.

Three of the Local Implementation Agreements approved to start in July 2024 and concluded in 2025 focused on young children and their families.

First 5 Humboldt: Early Childhood Mental Health Prevention and Early Intervention through Evidence Based Parent Education and Home Visiting

With LIA funding, First 5 Humboldt trained and certified 4 of their Family Support Navigators in Family Spirit, an evidence-based home visiting intervention program. Once training was done, First 5 Humboldt began offering this new program to families throughout Humboldt County in conjunction with local partners (e.g. UIHS, K'ima:w, Open Door). This project meets the SB 1004 priority of childhood trauma prevention and early intervention.

Northern United—Humboldt Charter Schools: Building Bridges to Wellness: Comprehensive Mental Health Support for Student Success

LIA funding was used to cover costs associated with supplies and training two additional staff in evidence-based student mental health supporting practices such as Charter Strong and Social Emotional Learning (SEL) restorative practice interventions. The program focused on students facing high mental health needs, as identified through a needs assessment survey. The needs assessment survey highlighted concerns related to depression, anxiety, isolation, and behaviors impacting the learning environment. The training and supplies covered through LIAs helped equip staff to respond to their population's needs. This project meets the SB 1004 priorities of 1) childhood trauma prevention and early intervention, 2) early psychosis and mood disorder detection and intervention and mood disorder and suicide prevention programming that occurs across the lifespan, 3) early identification programming of mental health symptoms and disorders.

Southern Humboldt Family Resource Center: Parent Project – Changing Destructive Adolescent Behavior

The Southern Humboldt Family Resource Center hosted two 10-week sessions of The Parent Project during the 2024-2025 academic school year (started in September). The Parent Project has been offered in Northern Humboldt for multiple years and has proven to be successful. The organization expanded this service delivery into the Southern Humboldt region. LIA funding was used to cover material expenses, transportation, and childcare during sessions. This project meets the SB 1004 priorities of 1) childhood trauma prevention and early intervention, 2) early psychosis and mood disorder detection and intervention and mood disorder and suicide prevention programming that occurs across the lifespan, 3) early identification programming of mental health symptoms and disorders.

Three of the Local Implementation Agreements approved in 2025 focus on young children and their families.

First 5 Humboldt: Expanding Developmental Screening in First 5 Playgroups
First 5 Humboldt will expand and support developmental screenings for young children ages zero to five in Humboldt County using evidence based developmental screening materials and methods. First 5 will contract with an Infant-Family and Early Childhood Mental Health (IFECMH) specialist to offer Facilitating Attuned Interactions (FAN) training. FAN is a nationally recognized training model focused on improving the communication skills of professionals who serve families, with the goals of strengthening the provider-parent relationship and parent-child relationship. The FAN training will serve at least 20 people who work with families and young children, including First 5 Humboldt staff, playgroup leaders, and additional local providers as space allows. This project meets the SB 1004 priority childhood trauma prevention and early intervention.

Fortuna Union High School District (FUHSD)—Fortuna Union High School District Annual Community Resource Fairs and Guides
FUHSD will use LIA funding to implement two annual Community Resource Fairs at Fortuna High School to provide students, parents, and staff with access to essential local mental health and community services. Since Fortuna High is a centralized location, it would provide accessibility for all students in the district. The first event will take place in the Fall as part of Back-to-School Night, and aims to provide parents and guardians with access to local agencies and organizations that offer mental health support, housing, assistance, educational resources, and other essential services. The second fair will take place in the spring and will focus on students and staff during school hours to ensure maximum participation and engagement. This project meets the SB 1004 priority childhood trauma prevention and early intervention.

Southern Humboldt Family Resource Center: Southern Humboldt Parent Project, Loving Solutions, and Parent Support Groups
The SoHum FRC will host and facilitate three 10-week sessions of The Parent Project, Loving Solutions, Positive Parenting Program in Spanish, and 10 monthly Parenting Support Groups in the 2025-2026 academic school year. This project requires a lot of time and resources, and Southern Humboldt presents barriers to participation, such as expensive materials, transportation to class location, childcare during class time, and time commitment/duration of class time. LIA funding will remove and ease these barriers for families by covering the cost of the educational materials, providing childcare for parents with younger children who have no other childcare option and providing a meal during the weekly two-hour class and monthly support group. This project meets the SB 1004 priority childhood trauma prevention and early intervention.

For older adults, MHSA Community Services and Supports will continue to support the Older Adults Program. This interdisciplinary team includes Social Services social workers, Public Health nurses, a psychiatrist, Behavioral Health clinicians and case managers. The team conducts multi-disciplinary team meetings, provides case management planning, investigates suspected abuse and neglect, and provides linkage to the full range of services. Behavioral

Health staff remove barriers to access and provide mental health screening and assessment services, consultation, education, and wellness/recovery focused clinical services and supports. The Older Adults Program also includes an outreach, prevention and education component. In fiscal year 2024-2025, 120 individuals were contacted by the Mental Health Clinician through this outreach component.

Additionally, one of the LIAs approved in July 2025 and set to conclude in 2026 focuses on the older adult population:

Humboldt Senior Resource Center: Increasing Treatment Modalities for Humboldt County Older Adults

The Humboldt Senior Resource Center will expand its access to mental health care for older adults by training its clinicians in the application of Neurofeedback. The training will strengthen the capacity to provide early intervention and prevention for conditions such as depression, anxiety, cognitive decline, and trauma-related symptoms. This project meets the SB 1004 priorities of 1) Early psychosis, mood disorder detection, intervention and suicide prevention programming that occurs across the lifespan; 2) strategies targeting the mental health needs of older adults.

Strategies addressing language disparities. In 2024, Spanish was identified as the only non-English language that met the threshold requirements set by DHCS. Because DHHS BH recognizes the need for linguistically competent care for all clients, the BHCRC has identified strategies to address disparities for non- proficient English speakers. Some of these strategies have been completed in the past few years, and efforts continue to be underway for others.

Accomplishments over the years include revising the Interpreter Policy and Procedure and training staff on that procedure; monitoring the use of interpreters by language and program; translating program specific information brochures into Spanish; translating MHSA stakeholder materials into Spanish; and having a Spanish language interpreter available at MHSA stakeholder meetings. The MHSA Program Manager became certified in Spanish biliteracy by the County of Humboldt at the end of 2022, which makes it possible for them to engage with local, monolingual, Spanish-speaking communities along with translating documents in a more responsive manner. These strategies will be continued. In addition, the BH Quality Improvement unit has improved capturing data regarding the use of interpreters from paper format to electronic. Reports can now conveniently be run out of the Electronic Health Record.

Humboldt County established a Diversity, Equity, and Inclusion (DEI) committee that has representation from departments across the county, including the DHHS-Behavioral Health branch. Through this committee, there is a system of recommendation development that are similar to the Cultural Responsiveness Committee. The main difference with the recommendations developed by the DEI Committee is that, if accepted by the county, the recommendations can change an overall function across the whole county. Currently, the DEI Committee presented the recommendation to develop a policy or procedure around interpretation and translation services and improved biliteracy certification opportunities to

county employees. The goal of this recommendation is to create a more culturally responsive workforce. These recommendations were accepted by the county and were integrated in the county's strategic plan. It should be noted that members of this DEI Committee have a 1-year term.

Strategies addressing LGBTQIA disparities. The strategy to address this disparity was to improve data collection. Without data, disparities cannot be determined. There is no Medi-Cal data on the LGBTQIA population, and it is unknown if there will be a move at the State level to start collecting it. As discussed in last year's Plan, the choices for gender identity were further expanded to include Genderqueer, Unsure/Questioning and I prefer not to answer. As of October 2025, data from the Medical Records system shows there are 52 female-to-male transgender clients, 20male-to-female transgender clients, and 58 are another gender identity.

Improved data collection about this population also happened through the DHHS Workforce Development Survey, as discussed in last year's Plan. The data from the 2025 survey showed that 3% of survey respondents identified as Queer, zero identified as gay or lesbian, and 8% identified as bisexual. Conversations with DHHS Employee Services revealed that information on gender identity cannot be fully collected as it is confidential information and cannot be asked of employees or staff.

The Humboldt County Transition-Age Youth Collaboration (HCTAYC) has worked on policy recommendations for the LGBTQI+ population and developed thorough action steps backed by community data/surveys. These policy recommendations have been presented to Behavioral Health Administration and are listed below:

1. Develop a county oversight structure to ensure well-being and accountability to LGBTQI+ & Two-Spirit Transition Age Youth.
2. Youth-serving organizations collaborate to create a new Humboldt County LGBTQI+ & Two-Spirit TAY Resource Center with youth-friendly hours, staff, and a central location for youth on public transportation routes.
3. Ensure all Humboldt County youth-serving agencies promote environments in which LGBTQI+ & Two-Spirit youth are safe, treated respectfully, and have full access to services.
4. Ensure all Humboldt County youth-servicing agencies follow the laws, requirements, and responsibilities of TAY-serving agencies with respect to LGBTQI+ & Two-Spirit Youth.
5. Develop safe families and living environments for LGBTQI+ & Two-Spirit Youth.
6. Design specialized community health, mental health, sexual health and substance use services to address unique challenges of LGBTQI+ & Two-Spirit Youth.
7. Launch an outreach and access campaign to increase awareness about the programs and services available in Humboldt County and ensure youth access to those supports.
8. Increase utilization of peer professionals who reflect the diversity of LGBTQI+ & Two-Spirit Transition Age Youth.

Strategies addressing workforce disparities. Programs are actively involved in recruitment efforts by providing more recruitment specifications, including specific requests such as

“bilingual preferred,” tailoring job descriptions, and by actively pursuing/accepting feedback from the community when it comes to where job openings are advertised as a means of promoting a more diverse and culturally competent work force. While a direct correlation between these recruitment practices and an increase in staff from diverse cultures cannot be drawn, the Employee Services database shows an increase in staff identifying as Hispanic from 16 in 2018, 24 in 2019, 27 in 2020, 23 in 2021, and 28 in 2022. In 2025 this number increased to 36. This increase may be attributed to the county’s recovery from the COVID-19 pandemic, which has a direct influence in BH’s ability to hire new staff. Aside from this, roll out of the Racial Equity Strategic Plan along with trainings that focus on equity may have improved hiring methods.

DHHS continues to recruit and hire peer coaches for positions in the Transition Age Youth Division; Regional Services; Hope Center, MIST, and Comprehensive Community Treatment. As of October 2025, one of the 12 peer support staff identify as African American.

Behavioral Health has a close working relationship with the Housing, Outreach and Mobile Engagement (HOME) program, which is a program under the Social Services branch of DHHS. HOME has Behavioral Health positions integrated within the program. These positions are under the clinical oversight and direction of BH and offer supports to ensure success in housing and other HOME services. DHHS also continues to recruit and hire peer coaches for HOME with an emphasis on the importance of a recovery model that individuals with lived experience bring much value to.

DHHS has registered HRSA sites for student loan repayment programs and recruits through that site for diverse staff. Currently, there are 10 HRSA registered sites.

DHHS also collaborates with Cal Poly Humboldt to implement a distance education program for Bachelor of Social Work and Master of Social Work. This provides current county residents and human service workers a career path. The Master of Social Work Program offers a specialty in Native American/Tribal Communities.

Finally, as discussed further in Criterion 6, BH is participating in the Superior Region Workforce Education and Training (WET) program, which aims to increase the recruitment and retention of behavioral health staff through peer scholarships, graduate student stipends, and loan repayment programs.

IV. Measurement and monitoring of activities / strategies for reducing disparities.

Data to measure and monitor activities and strategies is obtained from the following sources:

- United States Census

- Electronic Health Record for client data
- Behavioral Health Concepts/California External Quality Review Organization, for Medi-Cal approved claims data
- DHCS Behavioral Health Information Systems (BHIS) and Department of Health Care Services (DHCS) threshold language data
- CalSAWS
- Data Collection and Reporting (DCR) for MHSA CSS Full-Service Partnership (FSP) data
- BH Quality Improvement Dashboard Client Concerns/Grievances (by ethnicity) and Change of Provider Requests (by ethnicity and gender)
- MHSA PEI spreadsheets for PEI participant demographics
- California Department of Education
- California Department of Health Care Access and Information (HCAI) (formerly Office of Statewide Health Planning and Development)
- DHHS Employee Services database
- DHHS Workforce Development Survey
- DHHS Quality Management Services (QMS) Evidence Based Practices Dashboards
- DHHS Integrated Progress & Trends Report

V. What has been working well and lessons learned

Strategies in the Department as a whole, that benefit Behavioral Health, and have been working well, include the following:

- Interpretation and translation services with contracted interpreters/translators, a DHHS Interpreter/Translator job classification, and bilingual staff have all worked well. The Translator/Interpreter Job Classification has proven to be a very successful strategy and has allowed programs and staff to communicate with clients both in writing and orally in a more effective and efficient manner than the on-call contracted interpreters/ translators.
- Cultural service matching is honored when appropriate and available. The client and/or family's choice of provider is used.
- Partnering with culturally specific organizations at an agency level to identify service gaps and culturally appropriate service delivery options has been successful. This partnering has also led to the ability to provide culturally appropriate referrals for cultural and spiritual resources.
- DHHS Quality Management Services (QMS) includes a spectrum of evaluation services from data management, data verification, statistical analysis, and interpretation, to written progress reports. These written reports include the Evidence Based Practices Dashboards and the Integrated Services and Trends Report. QMS services increase the Department's capacity for outcomes-based program planning and improvement and offer a measure of how a program or service, over time, affects the community. QMS also continues to build system capacity to develop, coordinate, and integrate resources to provide workforce development opportunities to staff, clients, parents, families, community partners, and providers.

- The Humboldt Practice Model (HPM) arose out of a five-year California Partners for Permanency grant to reduce long-term foster care. In Humboldt County, Native American children are disproportionally represented in the foster care system, so grant activities were focused on working closely with the Native American community to develop HPM. In 2017, training on the HPM was rolled out to staff in DHHS Behavioral Health, and an adaptation of HPM for BH and other DHHS branches is near finalization.

  As a result of HPM, DHHS Child Welfare Services contracts with Native American Cultural Coaches to provide coaching and support to social workers who have cases in the Native American community. Because some of these cases also have DHHS Behavioral Health involvement in the family teams, the Cultural Coaches have also been available for coaching and support to Behavioral Health clinicians and case managers who are part of the family team. The Cultural Coaches have provided valuable insight and strategies for working with Native American families in a culturally respectful manner.

Strategies in DHHS Behavioral Health that have been successful include the following:

- <u>Flexible service provision.</u> Rural communities in the county face difficulty in accessing transportation to the Eureka area, where most county services are located. The mobile outreach component of the HOME Program addresses this barrier through using mobile engagement vehicles to provide culturally appropriate services, with efforts focused on reducing cultural and ethnic barriers to access that tend to exist in more traditional mental health settings. This outreach provides an integrated response with Social Services, Behavioral Health, and Public Health as an outreach program for individuals with a variety of physical, behavioral, and social needs as well as prevention and education activities, thereby reducing the stigma associated with accessing behavioral health services. The program links with and provides support to existing community organizations such as Family and Community Resource Centers, community clinics, and Tribal Organizations in order to reach those previously unserved and underserved populations in those areas of the county. During the COVID-19 pandemic, telehealth services were expanded and are available to any client who has phone service or an internet connection capable of supporting telehealth appointments via Zoom, Webex, or FaceTime.

  The Regional Services Program and the McKinleyville Family Resource Center provide clinicians, case managers, and substance abuse counselors in the Eastern, Northern, and Southern regions of the County. Some staff reside in those areas, and some travel from Eureka on a weekly basis to provide services wherever the clients may be.

  The Mobile Intervention Services Team (MIST) also provides outreach and services to people with severe mental illness who experience homelessness. Services were provided in Eureka and Arcata from 2016 through June 2020. Because MHSA funding for MIST ended in June 2020, MIST no longer works in Eureka. However, the City of Arcata received grant funding

for the program and staff are now working with the Arcata Police Department to continue these services. MIST also received Behavioral Health Justice Intervention Services (BHJIS) grant funding, which will aid the program with embedding Behavioral Health staff into Humboldt County Sheriff's Office patrol operations to co-respond to mental health calls. Through the BHJIS grant, MIST will be able to provide a wide range of appropriate services, both for immediate crises and follow up in the least restrictive manner possible.

- Providing psychiatric telemedicine services to Southern and Eastern Humboldt County residents. Telemedicine in these outlying areas provides greater access to behavioral health services as well as reduced cost and inconvenience to clients.
- Collaboration and Coordination. Children and Adults Behavioral Health staff have been meeting with K'ima:W Medical Center staff on the Hupa Tribe Reservation over the past four years to discuss ways in which there can be better collaboration and coordination of services for those residing on the reservation. During the past years these meetings have been held virtually due to the COVID-19 pandemic.
- The Comprehensive Community Treatment (CCT)/Full Service Partnership program makes available intensive community services and supports (e.g. housing, medical, educational, social, vocational, rehabilitative, or other needed community services) to achieve recovery. Personal Services Coordinators (PSCs), including peer clients and peer family members whenever possible, provide services in the community, which alleviates the potential challenge for clients to travel to the main clinic locations.
- Children's Behavioral Health clinicians travel to various locations throughout Humboldt County to provide assessments, counseling, case management, peer/parent support services, and crisis services. They work closely with families, regional Family Resource Centers, Tribes, and schools to determine needs and determine how best to provide services. Services can be provided in the field, including in the Wellness Center at Hoopa High School on the Hupa Reservation. Telehealth services through Zoom are available if needed/requested by clients or families. One crisis clinician is dispatched to Emergency Rooms and Same Day Services in Eureka to evaluate minors who are in crisis. In addition, there is a case manager assigned to the Children's Mobile Response Team.
- There are Mobile Response Teams for Adult and Children's Services that provide crisis intervention in the field to address an immediate crisis in the least restrictive manner possible. The Teams can provide face-to-face counseling and supportive interventions, assessment of mental health (including 5150/5585 evaluations), facilitation of transportation to the Crisis Stabilization Unit, coordination of appropriate community-based services, and provide family support services.
- Cultural training has provided staff an improved knowledge of the diverse cultures in our community as well as an increased understanding of how their own cultural beliefs and values influence their interactions with co-workers and clients.
- Transition Age Youth. Through stakeholder input and educational activities, BH has implemented both administrative and service delivery initiatives that have resulted in culturally appropriate services for racially and ethnically diverse Transition Age Youth. These include:
    - Creation of the TAY Division itself, serving the TAY "culture."

- Trainings focused on cultural competence/cultural humility with curriculum developed by youth and focused on youth culture.
- SUD policy recommendations with focus on youth
- Addressing stigma and discrimination through trainings, youth leadership development and a pre/post Stigma Discrimination Reduction survey
- Policy recommendations for serving LGBTQI+ youth.
- Founding of the Humboldt Houseless Youth Support Collaboration to better serve and document youth impacted by homelessness.

Criterion 4: Integration of the Client/Family Member/Community Committee

The purpose of the Behavioral Health Cultural Responsiveness Committee (BHCRC) is to strengthen Behavioral Health's ability to provide client, family and community-driven, culturally and linguistically responsive services to Humboldt County's diverse population. The efforts of BHCRC will be guided by the values of wellness, recovery, inclusion, respect, social justice, equality and equity as they collaborate with all divisions and programs of Behavioral Health to promote client/family/community-driven and culturally responsive engagement, attitudes and practices. The BHCRC is a subcommittee of the Behavioral Health Continuous Quality Improvement Committee.

The BHCRC was the Mental Health Cultural Competence Committee through May 2020. The name was changed to reflect DHHS Mental Health's name change to DHHS Behavioral Health, and to better reflect Committee members' thinking about the word "competence." Concurrent with the name change the BHCRC developed a Vision and Mission, which it had not had before.

Vision: To strengthen our commitment to building relationships that are authentic and culturally responsive to the needs of both community and staff.

Mission: To support and advise DHHS Behavioral Health to strengthen its ability to provide client, family, and community-driven, culturally and linguistically responsive services to Humboldt County's diverse populations, guided by the values of wellness, recovery, inclusion, respect, social justice, equality and equity.

In 2020 the Committee developed and implemented a webpage on the Humboldt County website at https://humboldtgov.org/2837/Cultural-Responsiveness-Committee. The webpage includes the Purpose, Vision, Mission and Goals of the BHCRC, meeting times, facilitator names and a contact email. In 2021 another webpage, Cultural Responsive Resources, was developed to include links to resources that community members could find helpful. Categories include Community Partners, LGBTQ+, Latinx, Native American & Tribal Communities, Black & African

American, and Asian & Pacific Islander. These resources are found at https://humboldtgov.org/2881/Cultural-Responsive-Resources

The goals of the BHCRC includes those established in the Humboldt County Cultural Competency Plan submitted to the California Department of Health Care Services. The Committee's objectives will be based on the Plan. Projects will be guided by the following framework:

- Develop and maintain a broadly representative committee that is reflective of this community.
- Continue to identify disparities and service needs through analyzing data.
- Develop, articulate and implement current culturally specific service delivery strategies.
- Identify training opportunities for all staff to increase cultural awareness and foster inclusivity.
- Identify advocacy training opportunities for unserved and underserved cultural groups.
- Strengthen the hiring and retaining of culturally and linguistically competent staff.
- Improve language capacity.
- Continue to improve the ability to identify and provide (or refer) clients to culturally relevant programs.
- Assess the degree to which Behavioral Health environments are welcoming to diverse cultures and implement strategies to increase the sense of welcoming.

The BHCRC is composed of active members from Behavioral Health programs, including Administration, MHSA/BHSA, Substance Use Disorder Treatment, Children's Behavioral Health and the Transition Age Youth Division. In addition to the active members there are approximately twenty other staff members who are on the distribution list to receive information about BHCRC activities. The BHCRC meets monthly, no less than ten times each year. During the COVID-19 pandemic the BHCRC met monthly and virtually via the WebEx or Zoom platforms. The BHCRC is co-facilitated by a Program Manager in the Performance Management/Quality Improvement Unitand the MHSA/BHSA Coordinator/Ethnic Services Manager with support this past year from a consultant from Stepping Stone. At times the BHCRC has had community member involvement, and it is always a committee objective to recruit the active participation of community members.

DHHS Behavioral Health's approach to consumers and family member involvement is multifold. The BHCRC is a subcommittee of DHHS Behavioral Health's Continuous Quality Improvement Committee (CQI), and consumer involvement in quality improvement activities is a priority and made a part of the Quality Improvement Work Plan. Consumer employees such as Peer Coaches and Parent Partners are represented in both BHCRC and CQI.

The projects and activities conducted by the BHCRC in 2024 are discussed in Criterion 3.

Criterion 5: Culturally Competent Training Activities

I. Annual Cultural Competence Training Requirement

A. Three-Year Training Plan:

1. Steps taken to provide training to 100% of staff over a three-year period

The objective is that all Behavioral Health related staff (administration, management, direct service and support staff), and organizational providers participate in at least one cultural competency training annually.

Almost 400 behavioral health staff need cultural competency training. Staff will primarily obtain these trainings through the Relias and NEOGOV E-Learning management systems, which serve as online portals for staff to access a variety of trainings; including a new training called Exploring Racial Equity: Common Terms. Prior to the COVID-19 pandemic, staff sometimes traveled out of the area if there were opportunities and funding available. Also, prior to COVID-19, on occasion cultural competence trainings were provided by the Humboldt County Department of Health and Human Services, Humboldt County Office of Education, Cal Poly Humboldt, the Equity Alliance of the North Coast, LatinoNet and other community partners. As these trainings become available, staff may be able to attend if budget and workload allows.

The Relias E-Learning management system was rolled out to all of DHHS Behavioral Health in February 2018. Relias has a course catalog of over 500 courses. The course catalog currently includes multiple competence topics including but not limited to Cultural Diversity; 10 Steps to Fully Integrating Peers into your Workforce; A Culture-Centered Approach to Recovery; Advocacy and Multicultural Care; Infusion of Culturally Responsive Practices; On-Boarding and Cultural Development; Cultural Competence & Sensitivity in the LGBTQ Community; Cultural Dimensions of Relapse Prevention; Groundwork for Multicultural Care; Cultural Competence Training: Advancing Recovery Practices; Cultural Competence; Cultural Issues in Treatment for Paraprofessionals; Mindfulness, Meditation & Spirituality as Tools for Recovery.

In addition to the courses available in the Relias course catalog, six online trainings developed by DHHS Behavioral Health are also available on the county intranet page, and/or in Relias. These are Peer Coaches & Parent Partners Cultural Competency Training; Documenting Chosen Gender Identity and Gender Expression; Introduction to Recovery Oriented Practices; Cultural Competence Training: Working with Interpreters; Mental Health Language Line; and The

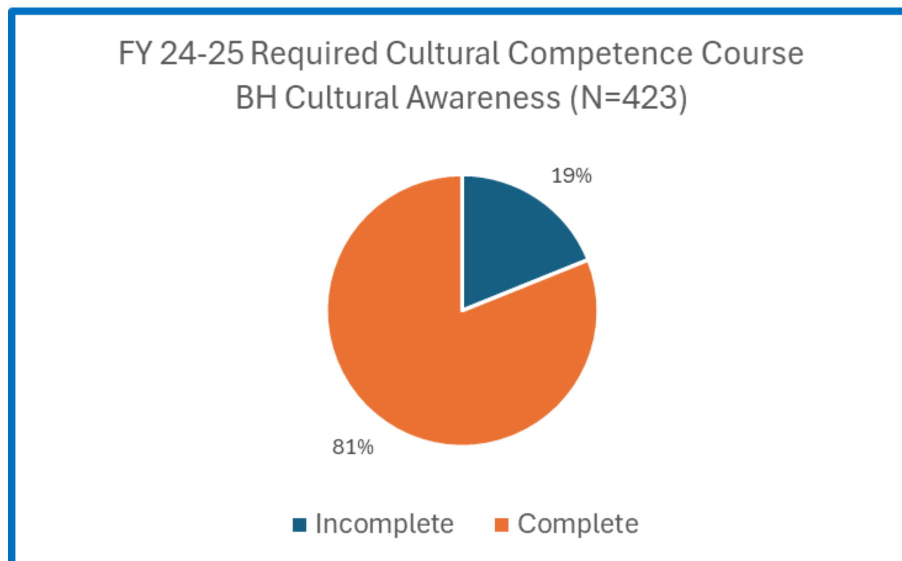
Recovery Model. A policy on Room Assignments for Transgender Patients has been placed in Relias and staff have been assigned to review the policy and certify that they have read it. Regardless of the strategy utilized or what agency is providing the trainings, training opportunities are well advertised through email and flyers or bulletins to staff, stakeholders, and community members, as well as directly assigned to staff members in Relias and NEOGOV.

2. How cultural competence has been embedded in all trainings

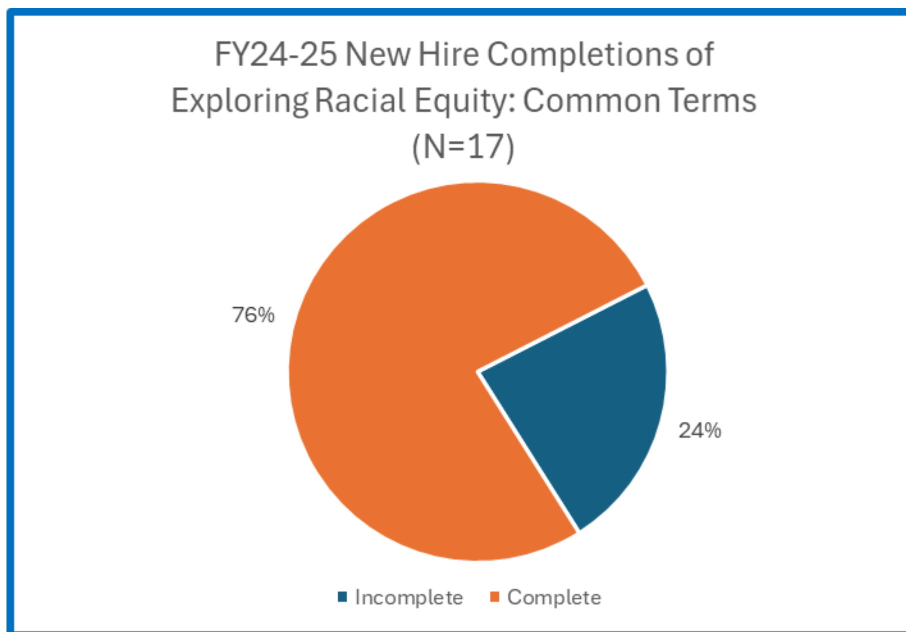
As appropriate, Humboldt County DHHS and DHHS Behavioral Health include cultural competence components in trainings where applicable. Examples include the Milestones of Recovery Scale outcome measure training, Introduction to DHHS for new hires and Behavioral Health compliance training, which includes an overview of the work of the Cultural Responsiveness Committee.

3. A report list of annual training for staff with attendance by job function.

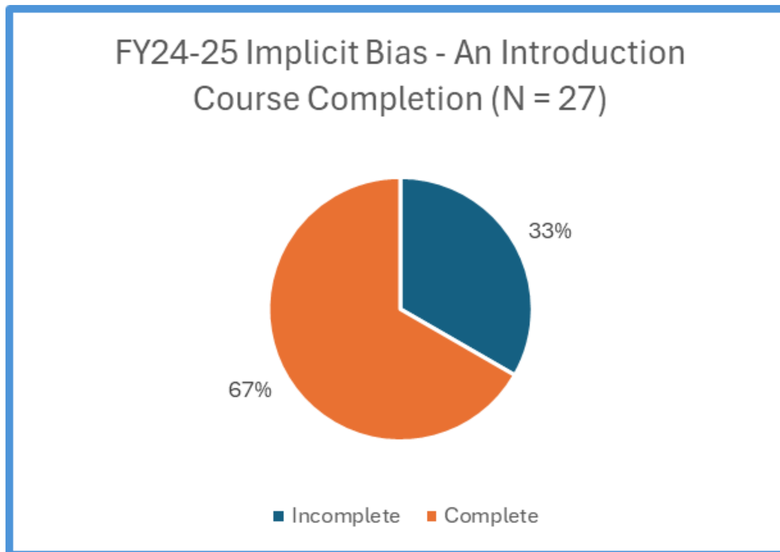
In FY 2024-2025, all Behavioral Health staff were required to complete the Behavioral Health – Cultural Awareness Training on NEOGOV. The Behavioral Health – Cultural Awareness training serves as an introduction to cultural awareness as well as the Cultural Responsiveness Committee and its function. This new course was developed through the efforts of the Cultural Responsiveness Committee and launched May 4, 2021. The NEOGOV e-learning platform was used to allow for greater staff participation and ease of use as this would allow staff without access to Relias to easily access the training online during the COVID-19 public health emergency. There was a total of 423 staff enrolled in the training. 343 (81%) completed the course, 80 (19%) were incomplete.



In FY 2022-2023, all Behavioral Health staff were required to complete the DHHS Racial Equity Steering Committee training titled Exploring Racial Equity: Common Terms training on NEOGOV. The Exploring Racial Equity: Common Terms training serves as an introduction and primer for racial equity terms and broader efforts that are being developed and implemented by DHHS leadership through the Racial Equity Strategic Plan. This course was developed through the efforts of the Racial Equity Steering Committee and was launched December 2021. The NEOGOV e-learning platform was used to allow for greater staff participation as the course was developed for all county staff and to easily access the training online during the COVID-19 public health emergency. There was a total of 394 BH staff enrolled in the initial one-time training with a 95% completion rate. The Exploring Racial Equity: Common Terms training is utilized as part of the onboarding process for new staff and must be completed within 30 days of hire. New hire completions rates for FY 2024-25 were 76%.

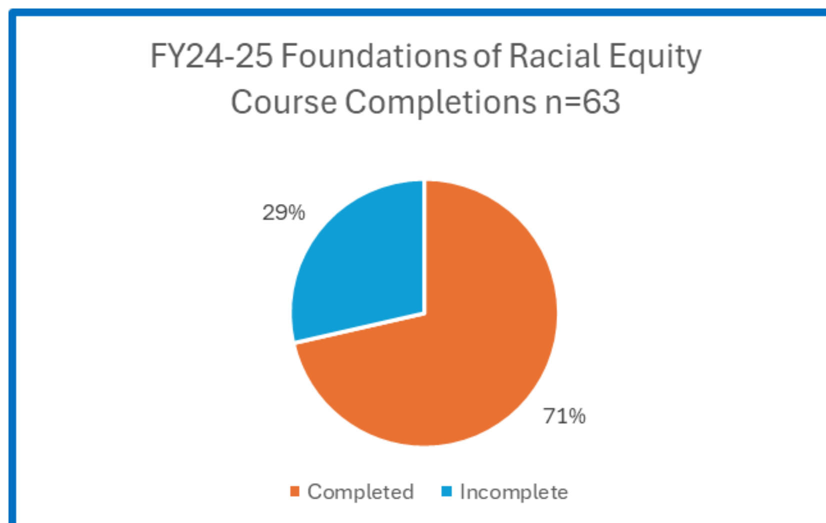


As shown on the graph below, DHHS launched an online Implicit Bias training in 2024. The training is offered through the NEOGOV online learning platform. This training was created by Stepping Stone Consulting and its development was overseen by the DHHS Racial Equity Steering Committee. A total of 27 staff were enrolled in the course in 2025. 18 staff have completed the course and 9 staff remain incomplete. The Implicit Bias training is a prerequisite to a training called "Foundations of Racial Equity."



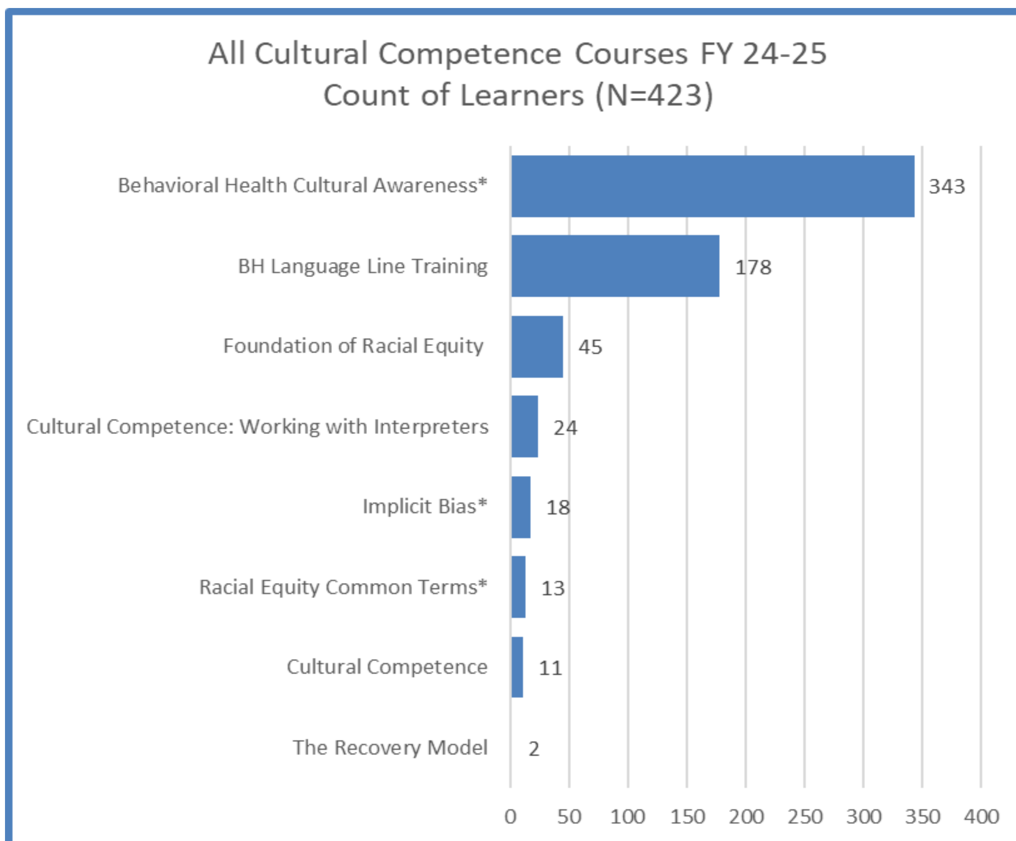
Foundations of Racial Equity:

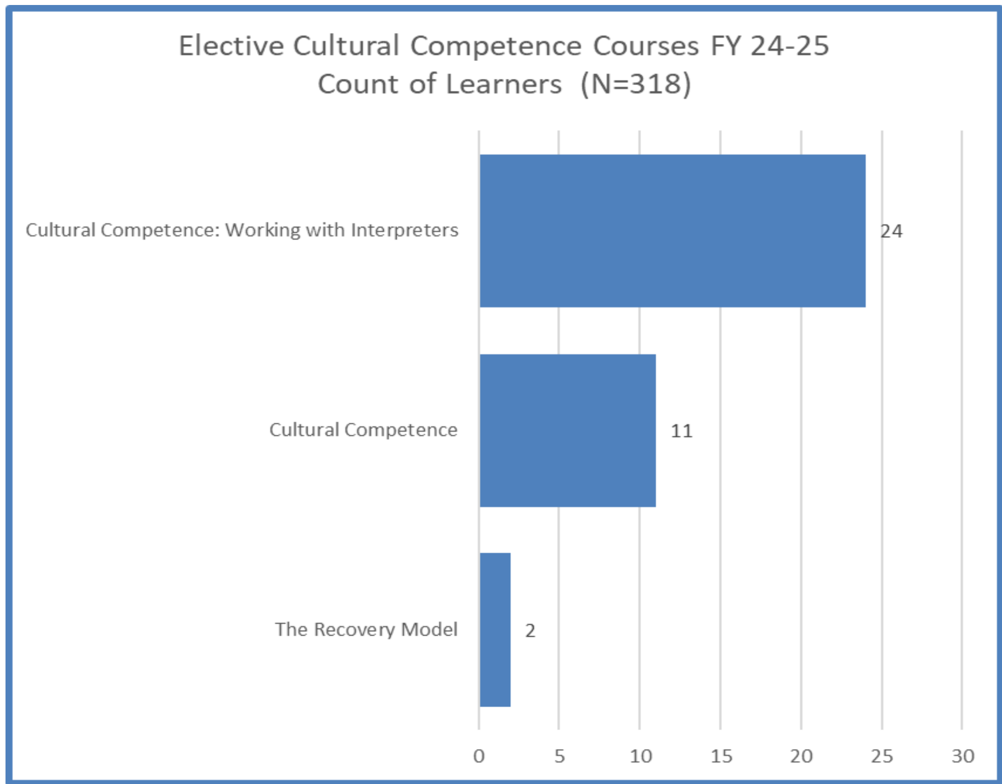
Since 2023, DHHS offered a 4-hour Foundations of Racial Equity training for all staff. The training was done virtually in real time and built on concepts learned in the Exploring Racial Equity: Common Terms and Implicit Bias – An Introduction training. This workshop offered an opportunity to deepen understanding of the four dimensions of racism, explore how racism affects the workplace and human services fields, and learn strategies for addressing implicit bias and racism in organizations. A grand total of 61 live sessions were conducted across DHHS by the end of 2024, with 1023 overall participants. In 2025, 2 additional live sessions were conducted across DHHS, with a total of 43 participants attending. For FY 24-25, 63 BH staff were enrolled in the course. 45 staff completed the course and 18 are incomplete. Course completion rate was 71% for Behavioral Health Staff.



Behavioral Health staff also completed elective courses in Relias and NEOGOV. In FY 2024-2025, staff completed 568 hours of cultural competence trainings. When compared to 318 current

enrolled users in the BH Learning Management System (LMS), this indicates only 12% of BH staff completed additional cultural competence trainings in the Relias LMS. Despite the increased access to NEOGOV and Relias staff elective decreased to 37 elective completions in FY24-25 from 233 in FY23-24. It should be mentioned that since these courses are not mandatory in nature, their completion rate will fluctuate from year-to-year. With the continued availability of the Cultural Awareness Training and the addition of the Exploring Racial Equity Common Terms, Implicit Bias, and introduction of the 4hr Foundations of Racial Equity, cultural competence training hours decreased overall to date to 568 credit hours completed and 634 total staff completions. Under one of the goals outlined in the strategic plan, there is work being conducted to develop a permanent cultural and racial equity team to facilitate equity efforts across DHHS, which involved hiring a new Racial & Cultural Equity Manager that oversees the Racial Equity Steering Committee and helps facilitate the roll out of the DHHS-wide Racial Equity Strategic Plan. The committee is identifying and/or developing a variety of training courses that will be incorporated into the annual required cultural competence training courses, a goal that is outlined in the strategic plan.





Cultural Competence Course	Hours Completed	Job Functions Trained
The Recovery Model	2	BH CLINICIAN, PEER COACH III
Cultural Competence	6	ADMIN ANALYST I, BH CLINICIAN I, MEDICAL OFFICE ASSISTANT I, OFFICE SERVICES SUPRVSR, SENIOR ACTIVITY THERAPIST, SUBSTANCE ABUSE COUNSELOR (I,II,TRNEE), SUPERVISING BH CLINICIAN
Racial Equity Common Terms*	10	ADMIN ANALYST (I,II), BEHAVIORAL HEALTH CASE MANAGER II, CONTRACTOR, INTERN, MEDICAL OFFICE ASSISTANT I, BH CASE MANAGER I, BH CLINICIAN I, BH MAINTENANCE CUSTODIAN, MENTAL HEALTH WORKER I, OFFICE ASSISTANT I, PEER COACH I, SENIOR FISCAL ASSISTANT, STAFF SERVICES SPECIALIST

Cultural Competence Course	Hours Completed	Job Functions Trained
Implicit Bias*	9	ADMIN ANALYST I, BH CASE MANAGER (I,II), BH CLINICIAN I, BH MAINTENANCE CUSTODIAN, BH NURSE II, CONTRACTOR, HEALTH AND HUMAN SERVICES DEPUTY DIRECTOR - INFORMATION SERVICES (M/C), INTERN, MEDICAL OFFICE ASSISTANT I, MENTAL HEALTH WORKER (I,II), PEER COACH I
Cultural Competence: Working with Interpreters	12	ADMIN ANALYST II, BH CASE MANAGER I, BH CLINICIAN I, MEDICAL OFFICE ASSISTANT I, PEER COACH III, SENIOR PROGRAM MANAGER, SUBSTANCE ABUSE COUNSELOR (I,II, Trainee), SUPERVISING BH CLINICIAN
Foundation of Racial Equity	180	ADMIN ANALYST (I, II), ADMINE SECRETARY, BH CASE MANAGER (I, II), BH NURSE II, CONTRACTOR, DEPARTMENT PROGRAMMER, DIRECTOR OF DIETARY SERVICES, DIRECTOR OF PSYCHIATRIC NURSING, DISCHARGE PLANNER, INFORMATION SYSTEMS ANALYST (I,II), INFORMATION SYSTEMS TECHNICIAN, LABORATORY ASSISTANT II, MAIL SERVICES DRIVER, BH CLINICIAN (I,II) , MENTAL HEALTH WORKER II, OFFICE ASSISTANT (I,II), OFFICE SERVICES SUPERVISOR, PEER COACH III, SENIOR FISCAL ASSISTANT, SENIOR LABORATORY ASSISTANT, SENIOR MEDICAL OFFICE ASSISTANT, SENIOR PROGRAM MANAGER, SUBSTANCE ABUSE COUNSELOR (I,II,TRAINEE), SUPERVISING MENTAL HEALTH CLINICIAN

Cultural Competence Course	Hours Completed	Job Functions Trained
BH Language Line Training	178	ACTIVITY THERAPIST, ADMIN ANALYST (I,II), ADMINISTRATIVE SECRETARY, BH CASE MANAGER (I,II), B H CLINICIAN (I,II), CERTIFIED PEER SUPPORT SPECIALIST , CHILD CARE WORKER, DEPUTY BRANCH DIRECTOR, DIRECTOR - PSYCHIATRIC NURSING, DIRECTOR OF DIETARY SERVICES, DISCHARGE PLANNER, EXECUTIVE SECRETARY, HEALTH CLIENT SERVICES WORKER, BH COOK, M H WORKER (I,II) , MEDICAL OFFICE ASSISTANT (I,II), MEDICAL RECORDS MANAGER, BH DIRECTOR, BH MAINTENANCE CUSTODIAN, NURSE CASE MANAGER, OFFICE SERVICES SUPRVSR , PEER COACH I, PHYSICIAN/PSYCHIATRIST, PROGRAM MANAGER, PSYCHIATRIC NURSE, PSYCHIATRIC TECH (I,II), SENIOR PROGRAM MANAGER, SOCIAL WORKER, SR BH MAINTENANCE CUSTODIAN, SR MEDICAL OFFICE ASSISTANT, SR MH WORKER, SR SUBSTANCE ABUSE COUNSELOR, STUDENT PLACEMENT, SUBSTANCE ABUSE COUNSELOR (I,II,TRNEE), SUPERVISING BH CLINICIAN, SUPERVISING PSYCHIATRIC NURSE
Behavioral Health Cultural Awareness*	172	DHHS - BH ALL STAFF (95 Unduplicated Staff Positions)
	568	

B. Annual cultural competence training topics shall include: cultural formation, multicultural knowledge, cultural sensitivity, cultural awareness, social/cultural diversity, interpreter training in MH settings, training staff in use of MH Interpreters

Trainings over the past three years have included Exploring Racial Equity Common Terms, multicultural knowledge, cultural sensitivity, cultural awareness, social/cultural diversity, and training staff in use of interpreters. These are listed in the table above. In August of 2020 UC Davis offered a four-part webinar series on Anti-Racist Practice. The course included foundational anti-racist practice, disproportionality and systemic racism, implicit bias and microaggressions, and allyship. This course has since been added to the county's learning management system NEOGOV. Many Behavioral Health staff have taken this training, and discussed the topic during staff meetings, leadership meetings and at the Cultural Responsiveness Committee.

II. Process for the incorporation of Client Culture Training throughout the mental health system.

A. Evidence of an annual training on Client Culture that includes a client's personal experience inclusive of racial, ethnic, cultural, linguistic, and relevant small county cultural communities.

Cultural trainings provided in Relias often include the consumer perspective via imbedded video clips with interviews, or role-played scenarios. The Cultural Responsiveness Committee hosted a learning activity done by the Hope Center regarding "Mental Health Stigmas and Actions We Can Take Against Them." Through this activity, attendees received a unique peer focused understanding on language and actions that often create or increase stigma in the mental health community. Attendees were encouraged to consistently seek ways to improve self-awareness and advocacy when encountering stigmatizing language/behaviors.

B. The training plan must also include, for children, adolescents, and transition age youth, the parent's and/or caretaker's personal experiences with family focused treatment, navigating multiple agency services, and resiliency.

Going forward, through increased collaboration with the local Family Advisory Board, Youth Advocacy Board as well as peer coaches and parent partners, staff will continue to explore options to hold cultural trainings with involvement of people with lived experience and their family members via Webex/Zoom, or in-person as appropriate.

Criterion 6: Commitment to Growing a Multi-cultural Workforce

A. Extract and attach a copy of the Mental Health Services Act (MHSA) workforce assessment submitted to DMH for the Workforce Education and Training (WET) component.

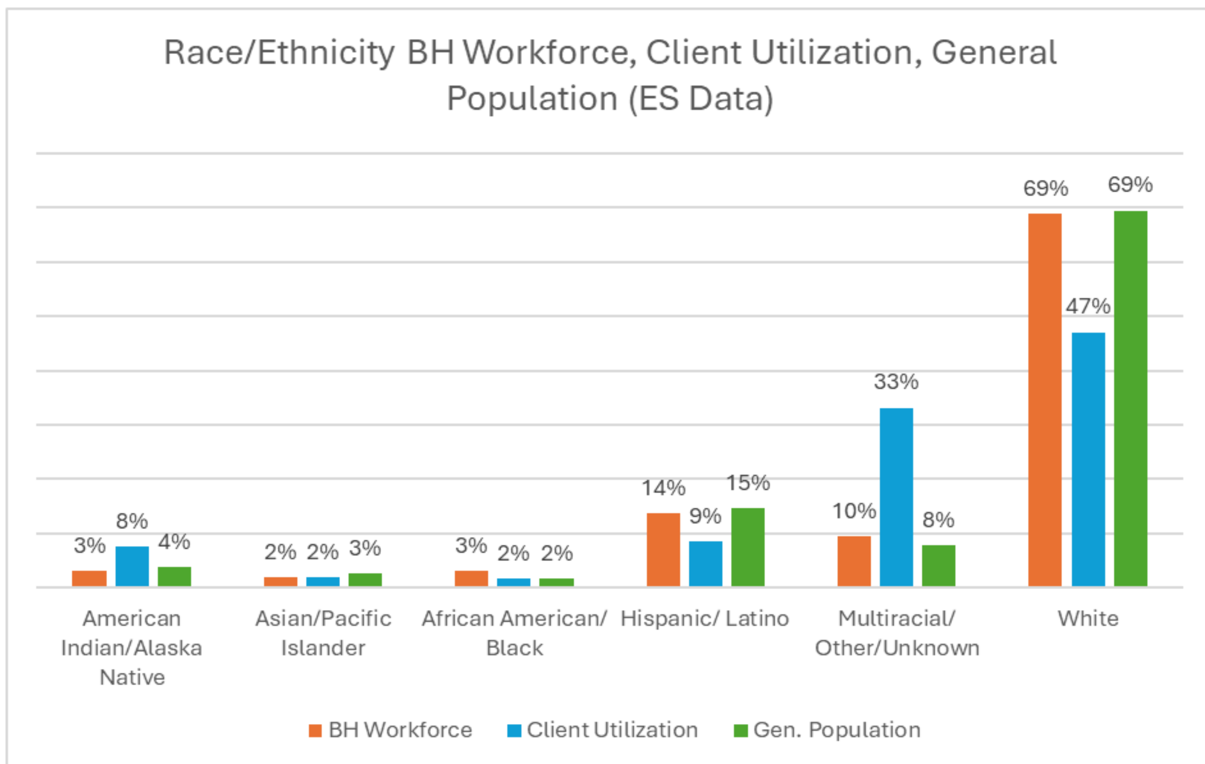
Workforce data is provided below.

B. Compare the WET Plan assessment data with the general population, Medi-Cal population, and client utilization.

Data for this section was obtained from two sources: the DHHS Employee Services database and the DHHS Workforce Development survey. The Employee Services database includes all Behavioral Health (BH) staff as of October 2025. The DHHS Workforce Survey was a voluntary survey and was completed by 16% of BH staff. Each of these is presented in the sections below.

1. **DHHS Employee Services (ES) data**[8]

Race/Ethnicity	ES #	ES %	Number of Unduplicated Clients Served in FY 24-25	Percentage of Unduplicated Clients Served in FY24-25	General Population in Humboldt County	Percentage of General Population
American Indian/Alaska Native	8	3%	412	8%	5,029	4%
Asian/Pacific Islander	5	2%	103	2%	3,524	3%
African American/ Black	8	3%	91	2%	2,245	2%
Hispanic/ Latino	36	14%	460	9%	19,378	15%
Multiracial/ Other/Unknown	25	10%	1,787	33%	10,272	8%
White	181	69%	2,537	47%	91,932	69%
Total	263	100%	5,390	100%	132,380	100%



American Indian/Alaska Native makes up 3% of the workforce, 8% of clients, and 4% of the general population. Asian/Pacific Islander makes up 2% of the workforce, 2% of clients, and 3% of the general population. African American/Black makes up 3% of the workforce, 2% of the

[8] Humboldt County Department of Health and Human Services, Employee Services database (EMPS), October 2025.

clients served, and 2% of the general population. Hispanic/Latino makes up 14% of the workforce, 9% of the clients served, and 15% of the general population. Multiracial /other/unknown make up 10% of the workforce, 33% of the clients served, and 8% of the general population. White makes up 69% of the workforce, 47% of the clients served, and 69% of the general population.

In looking at Employee Services data alone, it is apparent that White is overrepresented in the BH workforce when compared to the client population served and the general population. For the Native American population, the percentage is the same for BH workforce when compared to the general population, but both are lower when compared to clients served. The African American/Black workforce is greater compared to clients served and the general population. For Asian/Pacific Islander the percentage of the workforce is roughly the same, though both are less than the general population. For Multiracial/other/unknown the percentage of the workforce is greater than the clients served and lower than the general population. For Hispanic/Latino the percentage in the workforce and clients served varies by 1%, though both are less than the general population.

The tables below, with data gathered from the Employee Services database, show the racial/ethnic distribution of the workforce by type of job. The chart below the tables provides a visual reference for this distribution. This data shows that the White population is greatly overrepresented in the Managerial/Supervisory category, and overrepresented in the Licensed Direct Services category and the Support staff category, as compared to the general population of Humboldt County.

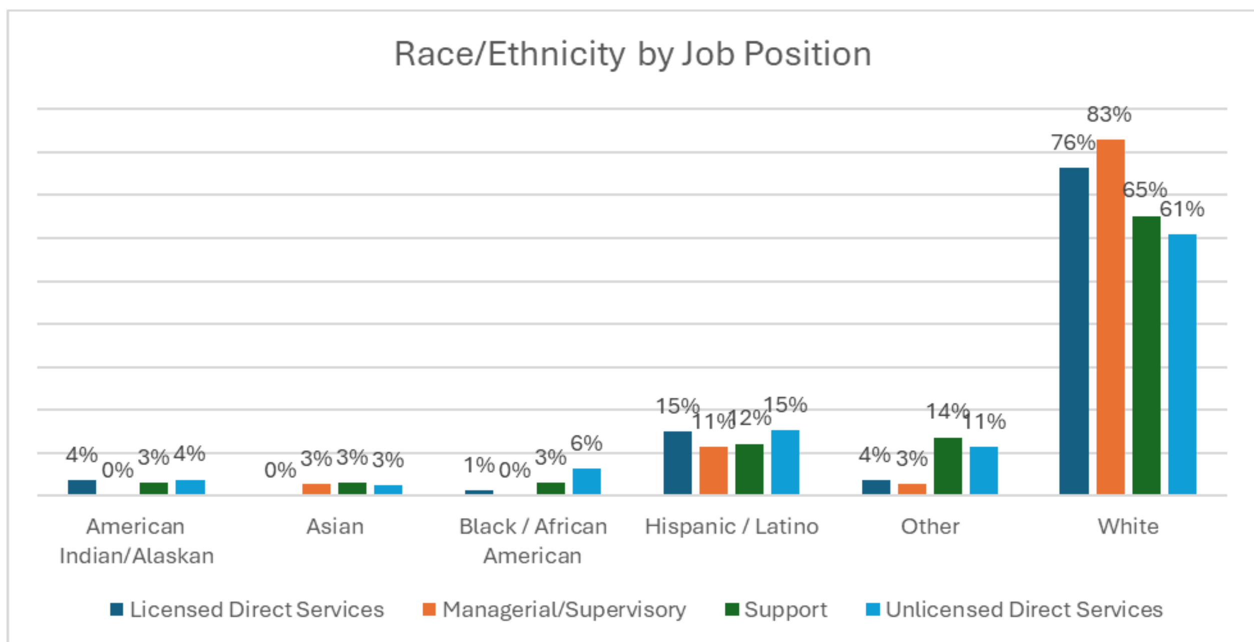
Unlicensed Direct Service Staff	Native American	Asian/ Pacific Islander	African American/ Black	Hispanic/ Latino	Multiracial/ Other/ Unknown	White	Total
Other	0	0	0	2	2	2	6
MH Worker	2	0	1	3	2	6	14
Peer Support	0	0	1	0	1	12	14
Case Mgr.	1	2	3	7	4	28	45
Totals	**3**	**2**	**2**	**12**	**9**	**48**	**79**

Licensed Direct Service Staff	Native American	Asian/ Pacific Islander	African American/ Black	Hispanic/ Latino	Multiracial/ Other/ Unknown	White	Total
Other Licensed	0	0	0	1	1	0	2
Psychiatric Tech	0	0	0	0	0	1	1
SUD Counselor	0	0	0	0	1	9	10
BH Nurse	0	0	1	3	1	20	25

Licensed Direct Service Staff	Native American	Asian/ Pacific Islander	African American/ Black	Hispanic/ Latino	Multiracial/ Other/ Unknown	White	Total
Clinician	3	0	0	8	3	31	45
Totals	**3**	**0**	**1**	**12**	**6**	**61**	**83**

Managerial and Supervisory	Native American	Asian/ Pacific Islander	African American/ Black	Hispanic/ Latino	Multiracial/ Other/ Unknown	White	Total
Supervising Psych. Nurse	0	0	0	2	0	3	5
Supervising Clinician	0	0	0	0	1	12	13
Mgrs., Supervisor, Dir., Deputies	0	1	0	2	0	14	17
Totals	**0**	**1**	**0**	**4**	**1**	**29**	**35**

Support Staff	Native American	Asian/ Pacific Islander	African American/ Black	Hispanic/ Latino	Multiracial/ Other/ Unknown	White	Total
Other Support Staff	0	1	0	1	2	6	10
Clerical	1	0	0	2	3	18	24
Analyst, IS, QI, ES, Fiscal	1	1	2	5	4	19	32
Totals	**2**	**2**	**2**	**8**	**9**	**43**	**66**

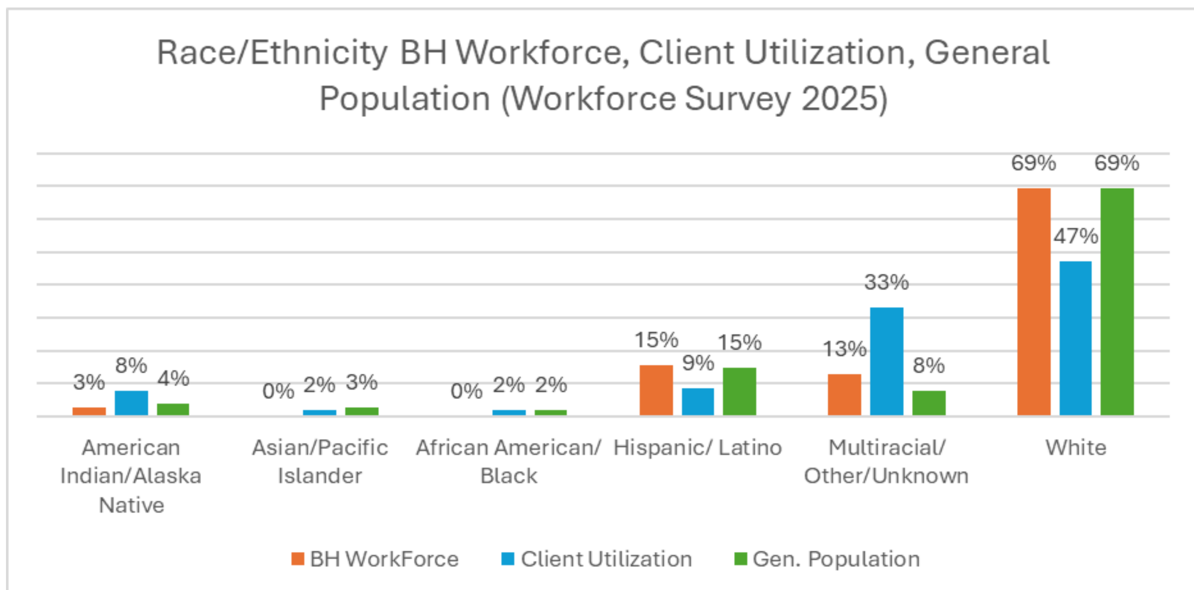


Four Behavioral Health staff receive the bilingual pay differential for speaking another language as well as English. These are one Case Manager, one Program Manager, one Program Coordinator, and one Supervising Behavioral Health Clinician. There may be more staff who speak a language other than English but do not receive the bilingual differential, but this information is not available in the DHHS Employee Services database. It is a positive trend that the number of staff who are Hispanic/Latino increased from 16 in 2018 to 36 in 2025.

2. **Workforce Demographics Using DHHS Workforce Development Survey**

In late November through early December 2025 DHHS Quality Management Services (QMS) conducted a workforce survey of all DHHS staff. It should be noted that this survey will be conducted every other year. The survey had break out sections for each Branch of the agency to complete, with specific questions for each Branch. A total of 235 DHHS staff completed the survey. Sixteen percent (39 responses) of workforce surveys were completed by BH staff. Thirty-one percent of BH staff completed the survey. Data from that survey showed the following for BH staff:

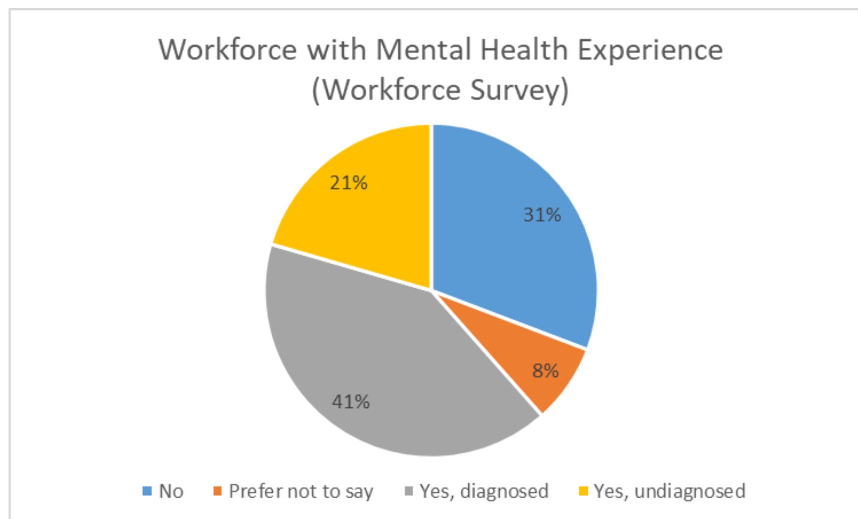
- Five percent are ages 20-30; 8% are ages 31-40, 26% are ages 41-50; 41% are ages 51-60; 18% are ages 60+.
- Sixty-nine percent are White, 3% are American Indian/Alaska Native, 15% Hispanic/Latino, 13% are Multiracial, 0% are Asian/Pacific islander, 0% are African American, and 5% preferred not to answer. This is depicted on the chart below.



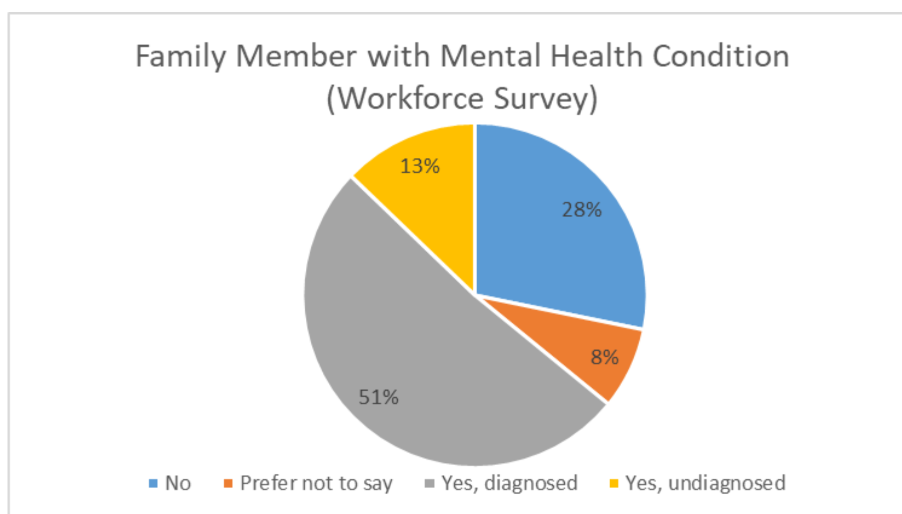
- Four people indicated they speak Spanish as well as English; two speak French one speaks Portuguese; one speaks another language not on the survey and three use American Sign Language. English is the only language spoken by the remainder.
- Seventy-two percent are heterosexual, 3% Queer, 3% Pansexual, 8% Bisexual and 15% preferred not to answer this question.
- For current gender identity, 54% are female, 41% are male and 5% people preferred not

to answer.

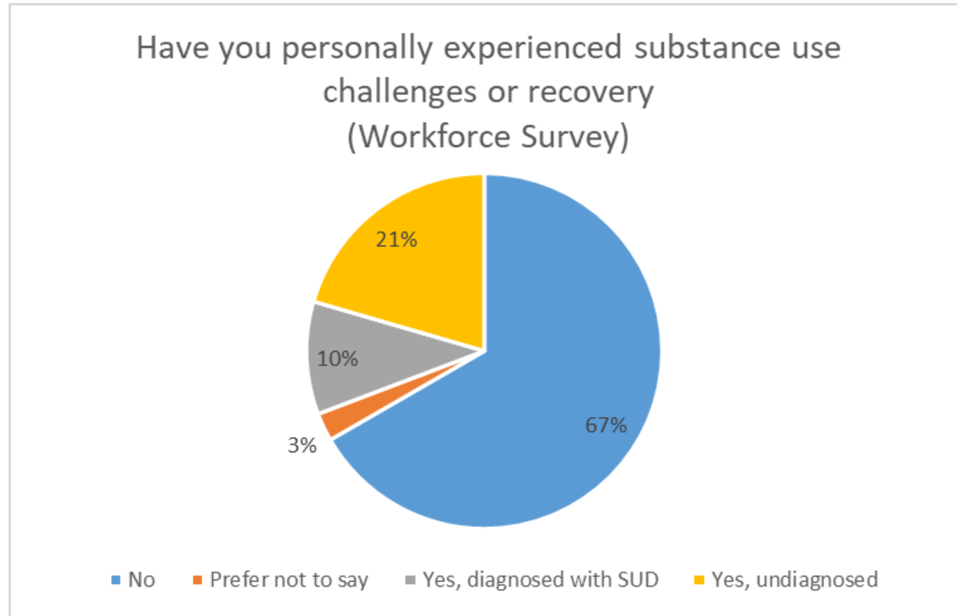
- Fifty-seven percent have no disability, 10% have a chronic health condition, 7% have a physical/mobility issue, 2% have a learning issue, 5% have a hearing, and 5% have a vision issue. Fourteen percent preferred not to answer.
- Thirty-eight percent of staff have lived experience with homelessness. Examples being: lived on the streets, in a shelter, or couch surfed. Fifty-nine percent have not experienced these conditions and 3% preferred not to answer.
- Forty-one percent have experienced a diagnosed mental health condition, 21% have experienced an undiagnosed mental health condition, 31% have not experienced a mental health condition, and 8% preferred not to answer. This is depicted in the pie chart below.



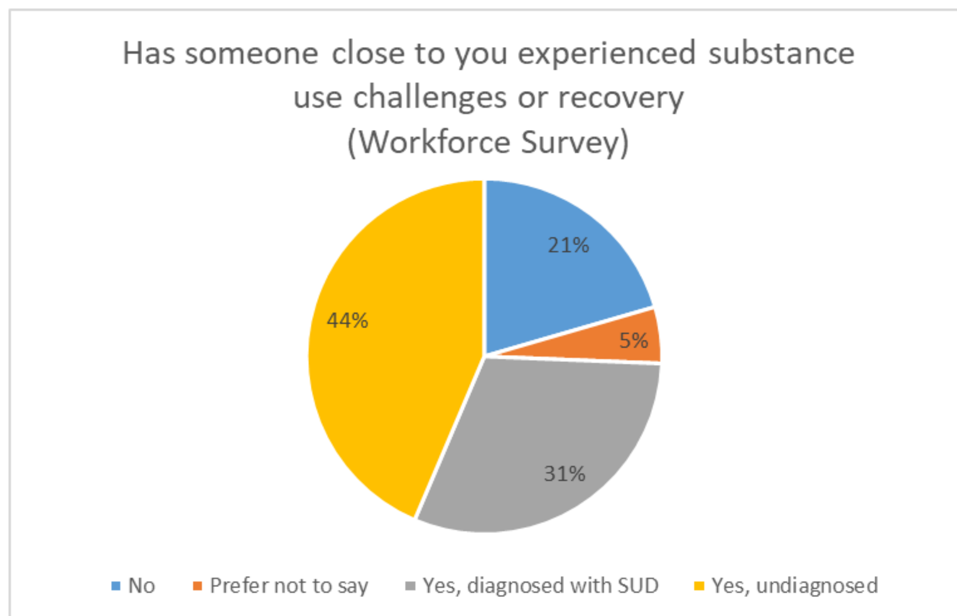
- Fifty-one percent have a family member with a diagnosed mental health condition, 13% have a family member with an undiagnosed mental health condition, 28% do not have a family member with a mental health condition, and 8% preferred not to answer. This is depicted in the pie chart below.



- Ten percent have personally experienced diagnosed substance use challenges and recovery, 21% have experienced undiagnosed substance use challenges and recovery, 67% have not experienced substance use challenges and recovery, and 3% preferred not to answer. This is depicted in the pie chart below.



- Thirty-one percent have someone close who has experienced diagnosed substance use challenges and recovery, 44% have experienced undiagnosed substance use challenges and recovery, 21% have not experienced someone close with substance use challenges and recovery, and 5% preferred not to answer. This is depicted in the pie chart below.



In looking at the Workforce Development survey results it is again apparent that White is somewhat overrepresented in the workforce. However, the greatest disparity between the workforce, clients served, and the general population is found in the Hispanic/Latino category.

C. Summary of targets reached to grow a multicultural workforce

The goals to grow a multicultural workforce, as stated in the 2009 Workforce Needs Assessment, were 1) to increase the number of staff who are proficient Spanish speakers from six to 14 fulltime equivalent positions, 2) to increase staff who are proficient Hmong speakers from one to four fulltime equivalent positions, 3) to increase peer client and family member staff from seven and a half to 16 fulltime equivalent positions, and 4) increasing the number of staff who are individuals from the county's local communities and identify as Hispanic/Latino, Asian/Pacific Islander, and Native American. These goals have remained consistent over the years since 2009, as only the goal of increasing peer staff has been explicitly met. In fiscal year 19/20 there were 19 full-time equivalent peer personnel. Unfortunately, due to staff leaving during the COVID-19 pandemic, this number dropped to 13 in 2022. However, as can be seen in the results from the DHHS workforce survey, 40% of the workforce has a diagnosed mental health condition and 11% an undiagnosed condition, and 58% have a family member with a diagnosed mental health condition and 15% an undiagnosed condition. Thus, while the number of staff with the job title of "peer" and "parent partner" is limited, the number of staff who are actually peers and family members is large.

Workforce strategies identified in the Cultural Competence Plan of 2011 have been reiterated in the Plans and Updates since that time and will be continued. These are:

- Advertising all job recruitments at culturally specific locations and through culturally specific organizations. This has been done, with job announcements sent to LatinoNet, the Promotores distribution list, and to local tribes. DHHS Employee Services regularly asks recruiting programs for recruitment distribution lists to expand the reach of activities. Postings to Facebook and Instagram have also been added as recruitment tools.
- The distance learning programs through Cal Poly Humboldt continue to provide county residents and human service workers a career path. The Master of Social Work Programs offer a specialty in Native American/Tribal Communities. This has been successful in bringing new social workers to the agency.
- Staff development opportunities, as discussed in Criterion 5.
- The employment and job training outreach of the Mobile Outreach program of HOME have reached outlying areas of the county that have a larger representation of Native American and Latino populations. One of the Mobile Outreach staff is bilingual in Spanish and is consistently available to provide information and linkages in Spanish.

New workforce strategies since 2020 include the following:

Increasing the number of Health Resource and Service Administration (HRSA) certified sites. In September 2020 there were seven HRSA sites. Application to certify an additional three sites was made, and these were approved. BH now has ten HRSA certified sites, which means those who are working there can receive educational loan repayment.

Workforce Education and Training (WET) Regional Partnership activities in the Superior Region. These activities were originally scheduled to begin in 2021, but a delay in receiving the contract from California Mental Health Services Authority (CalMHSA), the fiscal agent for the funds, prevented beginning them until 2022. WET support for the Loan Repayment Program was advertised in the spring, and applicants were approved in the summer. A total of nine individuals were approved to receive a Loan Repayment Award. The Peer Scholarship Program has been advertised with an application deadline of September 30, 2022, and three peers were awarded in June 2023. Round 3 of Loan Repayment was conducted in 2024, with a total of 10 people being awarded. It is hoped that these supports will increase the numbers in the BH workforce through providing monetary support for committing to work in the public mental health system for a specified period of time.

One component of the WET Regional Partnership activities, the retention component, did begin in 2021 because the contract for the activities was with the California Institute of Behavioral Health Solutions (CIBHS). These retention activities focused on trainings for the Superior Region. Training topics for fiscal year 2021-2022 were: Building the Beloved Community Through Cultural Humility; Systemic Barriers to Health Equity; What Happened to YOU-- Trauma-Informed ACEs Assessment, Prevention and Intervention; Self-Care, Burnout, Compassion Fatigue; Applied Motivational Interviewing; Engaging and Supporting People with Co-Occurring Conditions: Learning and Practicing Interventions that Work; Integrated Care in Rural Communities; Understanding Social Isolation and Loneliness; Using Telehealth to Address Vicarious Trauma and Promote Self-Care and Self-Compassion.

The DHHS Racial Equity Steering Committee has developed a Racial Equity Plan which includes strategic goals and objectives. One high level goal is to improve hiring, recruitment and retention. Objectives under this goal are to obtain baseline data; improve the hiring selection process; and improve retention of Black, Indigenous, People of Color (BIPOC) staff. The Ethnic Services Manager is an active member of the Steering Committee, was involved in the development of the Racial Equity Plan and will be involved in implementation of the objectives.

D. Share lessons learned on efforts in rolling out county WET implementation efforts.
Being a part of a government agency with its own rules and guidelines for recruitment of employees is a challenge. County Human Resources changed recruitment practices in 2017 to allow more program input into job descriptions and recruitment strategies. So far, there has only been an increase in the number of Hispanic/Latino employees, but it is hoped that over time the number of diverse employees will increase.

E. Identify County technical assistance needs.

While trainings for Behavioral Health staff on working with interpreters are available, there is a need for training for interpreters in how to work with clinicians and other direct services staff. Humboldt County workforce would benefit from trainings offered to interpreters locally or via virtual platforms.

Criterion 7: County Mental Health System Language Capacity

I. Bilingual Workforce Capacity

A. Evidence of dedicated resources and strategies to grow bilingual staff capacity, including:
1. WET Plan evidence
The original Workforce Education and Training Plan included the goals to increase the number of staff who are proficient Spanish speakers from six to fourteen fulltime equivalent positions and staff who are proficient Hmong speakers from one to four fulltime equivalent positions. These goals have not yet been met, even though strategies such as advertising all job recruitments at culturally specific locations, providing a career path through HSU distance learning programs or expanding the number of HRSA certified locations to get education loan repayment have been attempted for several years. See Criterion 6, I.C above for more information about WET.

DHHS still participates in a "grow your own" effort with local educational systems and with community-based organizations serving the growing Latino community. This includes participation in school-based job and career fairs, cultivation of community connections through *Promotores* serving the area, and assuring that information about tuition and loan support programs reach potentially eligible students in the cultural and language groups of Humboldt County. DHHS, through its Housing, Outreach and Mobile Engagement (HOME) program, is providing employment and job training information in their mobile engagement vehicles. These vehicles serve the outlying areas of the county that are populated by Native American and Latino people on a regular schedule. One of the vehicle coordinators is bilingual in Spanish. One or multiple Spanish speaking staff always travel with the vehicle to provide services in Spanish. This strategy may also assist in building workforce likely to remain in the community.

DHHS Behavioral Health staff are encouraged to sign up for vocational Spanish courses in Medical Terminology, provided through the local Cal Poly Humboldt and College of the Redwoods.

DHHS Behavioral Health actively seeks to attract qualified bilingual candidates for intern placements in Licensed Vocational Nursing through College of the Redwoods and individual therapy through Humboldt State University's Master of Social Work program. Some of these internships have resulted in hiring former interns after graduation.

DHHS Behavioral Health participates in the National Health Service Corps Loan Repayment Program (HRSA). Ten Behavioral Health program sites are certified HRSA sites. Since 2022, Behavioral Health has been participating in the Superior Region WET Partnership program. This was discussed further in Criterion 6.

Eligible and interested Behavioral Health staff are encouraged to take the Spanish Bilingual Proficiency Examination administered through the County Human Resources Department. DHHS has a job classification titled Interpreter/Translator. This classification is not limited to a particular language and can be used by multiple programs. DHHS Public Health has two allocated full time Spanish/English Interpreter/Translator positions whose assignments include interpreting for integrated programs.

2. As already stated, DHHS Behavioral Health has four staff who receive the bilingual pay differential.

3. Total dedicated resources for interpreter services
The total dedicated resources for interpreter services in addition to bilingual staff was approximately $15,000 in Fiscal Year 2024-2025. (source: Department of Health and Human Services Finance Department). This includes Behavioral Health expenditures for contracted interpreters and language line services, and the Department of Health and Human Services' Interpreter/Translator position.

Job Title	Number of Spanish Bilingual Proficiency Tested Staff
Case Manager	1
Program Coordinator	1
MHSA/BHSA Program Manager	1
Supervising Behavioral Health Clinician	1

Additional resources include Bilingual Specialty Pay for staff who passed the county Spanish Bilingual Proficiency Examination and work in a position that is formally designated as needing bilingual language skills, and potential loan repayment awards under the WET Regional Partnership grant Repayment Program. Currently DHHS Behavioral Health employs one Case Managers, one Program Manager for MHSA/BHSA, one Program Coordinator within HOME, and one Supervising Behavioral Health Clinician who have passed the Spanish Bilingual Proficiency Examination.

II. Interpreter Services

A. Policies, Procedures, and Practices, including:

1. 24-hour phone line

DHHS-Behavioral Health has policies, procedures and practices in place for meeting client's language needs, including a 24/7 telephone line with state-wide toll-free access that has linguistic capability via Language Line services to meet any future threshold language of the county, as well as all other languages prevalent in the county, spoken by beneficiaries of DHHS Behavioral Health.

A Text Telephone (TTY) can be connected to DHHS Behavioral Health's statewide toll-free number for use with deaf, hearing-impaired or speech-impaired callers. Receptionists and staff are also trained to utilize California Relay Services.

Below is a list of policies regarding language capacity. For the full text of these policies and procedures see Attachments.

Attachment 1: Policy 100.603 Selection of Interpreters

Attachment 2: Policy 100.604 Access to Interpreters and Culturally and Linguistically Competent Providers

Attachment 3: Policy 100.605 Obtaining Interpretation, Translation and Telephone Services for Clients with Physical Impairments or Limited English Proficiency

Attachment 4: Policy 100.606 Speech to Speech Relay Service

Attachment 5: Policy 100.607 Text Telephone (TTY) Use

Attachment 6: Policy 100.608 Access to Interpreter Services – Language Line Use

Attachment 7: Policy 100.617 Translation of Written Materials

2. Video Remote Interpreting
DHHS Behavioral Health will utilize its existing contract provisions with Language Line Services, Inc. to activate remote video interpreting including Sign Language. DHHS Behavioral Health has started the process by involving the Information Systems group to guide acquisition of appropriate equipment and how to set up the functions needed to connect a video interpreter across programs and systems of care. This is an ongoing project with Information Systems that is still pending implementation during the time this report was created.

3. Protocol for implementing language access
DHHS Behavioral Health has implemented the following protocol: The toll-free Access number for Humboldt County DHHS Behavioral Health is 1-888-849-5728. This phone line is answered by the receptionists at the main clinic (720 Wood Street, Eureka) during regular business hours. Calls after regular business hours are forwarded to an answering service, Access Point LLC (formerly known as Lacuna Health). If the caller does not speak English Language Line services are utilized. All staff at Access Point have been trained to utilize California Relay services. The

Behavioral Health Quality Improvement unit provided Access Point with an updated script to use when answering calls, and worked with the answering service on optimizing instructions for their call operators as well as improving call operator performance in following the script.

All Behavioral Health front office and direct service staff are trained to access Language Line services for calls coming in from persons who have limited English proficiency. DHHS Behavioral Health has created several trainings that are available to staff through the Relias e-Learning platform and /or on the county intranet website. Training participation is being tracked via Relias. These trainings are entitled "Serving Clients when English is not their Primary Language; "Working with Interpreters", and "Behavioral Health Language Line Training". They include information about California Relay Services.

B. Evidence that clients are informed in writing in their language, of their rights to language assistance services.
It is the policy of DHHS Behavioral Health to assure that the Informing Materials (including the Beneficiary Handbook) be provided to beneficiaries when they first access services and upon request. Beneficiary brochures printed in English and Spanish are provided upon request and made available at the lobbies of all its access points and in all contracted providers' waiting areas.

The Beneficiary Handbook includes information about a beneficiary's right to receive written information in the threshold language and that DHHS Behavioral Health must make oral interpreter services available free of charge for people who speak other languages. DHHS Behavioral Health does not currently have a threshold language but makes informing materials available in Spanish regardless.

In addition, a bilingual English-Spanish sign named "Did you know?" along with the poster "Interpretation Services available" (the latter also assisting in language identification) are posted in the lobbies of all access points and programs, including contracted providers.

Informing Materials are located visibly within easy reach of people living with disabilities, and accessible without staff assistance at all service delivery locations. When requested, staff are available to explain to a client the contents of Informing Materials.

At time of the initial assessment, staff will provide the client with an Informing Materials Packet and ask the client to sign DHHS-BH Form #1196 Informing Materials Packet – Client Acknowledgement. Documentation that this information was provided is entered into the client's record by submitting the completed Form #1196.

Staff, whether employed by DHHS Behavioral Health or a Contract Provider, are responsible for keeping a current supply at each location. The Provider Relations Coordinator will provide all Access Points and Contract Providers with printed Beneficiary Brochures and Informing Materials as well as posters and signage to display and make available in their lobbies and/or waiting rooms within three days of receipt of a request. DHHS Behavioral Quality Improvement

unit periodically checks access points for compliance with all posting requirements.

C. Evidence that persons are accommodated who have Limited English Proficiency (LEP) by using bilingual staff or interpreters.
DHHS Behavioral Health prohibits the expectation that families provide interpreter services for their family members who are receiving or requesting services, although this can be facilitated at the client's specific request and with appropriate releases. Minor children should not be used as interpreters.

DHHS Behavioral Health has implemented the following procedure to accommodate persons who have LEP. All front office and direct service staff are trained on the following steps to provide appropriate interpreter services to clients.

Step 1: Identify language spoken. If in doubt, use Language Line services for language identification assistance or when face to face with a client, use Language Identification Card or Interpreting Services Available poster.
Step 2: Offer the client free interpreter service by providing the Interpreter List composed of local community providers.
Step 3: If the client declines to use a local interpreter, staff will contact Language Line Services.
Step 4: If steps 2 and 3 fail to meet the client's needs, or client declines those services, ask client if he or she prefers to have an adult family member or other support provide the interpreter services.
Step 5: Document steps 1 through 4 in client's chart.
Appropriate translated materials are distributed or posted at all points where clients access the behavioral health system.

DHHS Behavioral Health maintains a current Provider Directory in electronic form and provides a paper version upon request. It includes information about cultural capabilities, linguistic capabilities and specialties for each licensed, waivered, or registered behavioral health provider and licensed substance use disorder services provider employed by or contracted with DHHS Behavioral Health to deliver Medi-Cal services.

This list is updated monthly and offered to clients during the intake process, where clients are also informed in a language that they understand that they have the right to free language assistance services. A link to the directory, which is posted on the Behavioral Health public facing website, is posted in the lobbies of all access points, and at Contract Provider sites.

When a client requests a specific provider from the Provider Directory, DHHS Access Staff will review the request and make every effort to link the client with the provider of his/her choice as appropriate.

D. Historical challenges on items A, B, and C. Lessons Learned
While DHHS Behavioral Health's training plan includes training on accessing interpreters, occasionally staff members are not familiar with the use of language line services and therefore

do not meet the needs of Limited English Proficiency clients at initial contact call-ins. There are comprehensive onboarding processes in place that include accessing interpreters in the training plan. To monitor for quality of Access calls, the DHHS Behavioral Health Quality Improvement unit conducts monthly test calls in a non-English language and regularly reports results at the Outpatient Quality Improvement Committee meetings. This strategy assures that issues are detected and addressed immediately.

Historically it has been a challenge to recruit and retain diverse staff members who are bilingual. As stated in Criterion 2, approximately 72% of Humboldt County's population is White, 13% Hispanic/Latino, 3% Native American, 3% Asian/Pacific Islander, 1% African American, and 8% are multiracial or other.

Bi-lingual employees are encouraged to test for Spanish Bilingual Proficiency through the County Human Resources Department. Currently four DHHS Behavioral Health staff members have been certified as bilingual (see section I. Bi-lingual Workforce Capacity above). Historically, passing both the written and oral part of the exam has been challenging. Standards are high because certification does not only attest for interpretation capability but also the ability to translate complex legal documents. Key for passing is being proficient in both English and Spanish. The County Human Resources Department does not give out study guides or other materials prior to the test.

DHHS Behavioral Health maintains an Interpreter List comprised of community members who have contracted for interpretation services. This list, including instructions on how to access a community interpreter, is made available to DHHS Behavioral Health staff on the county intranet website. It continues to be challenging to develop a certification and credentialing mechanism for those interpreters. Community interpreters interested in contracting with Behavioral Health are asked to provide an Interpreter / Translator Resume that assesses each individual's translation skills and credentials, interpretation skills and credentials, cultural competencies, and specialties. Currently there are only 4 Spanish language Interpreters on the list.

It has been a challenge to maintain the interpreter list due to interpreters relocating or taking fulltime employment. In the past year many have discontinued services with the county due to retirement and the requirement of maintaining a county business license. This latter issue is challenging due to the cost of the business license, when work from the county is not guaranteed and fluctuates greatly from month to month. Additionally, coordinating appointments with these individuals can be difficult because they have other work obligations and limited availability. Another challenge is the interpreters' varying levels of ability and areas of experience.

There are no challenges concerning informing clients in writing in their primary language of their rights to language assistance services. Appropriate signage and informing materials are widely available.

E. County technical assistance needs

While the California Department of Health Care Services has made available a Mental Health Interpreter Training Curriculum to county mental health programs, there is a need for Interpreter Training geared towards meeting the needs of small counties. DHHS Behavioral Health would benefit from interpreter trainings offered locally at low cost. DHHS Behavioral Health's Language Line provider offers Interpreter Certification online courses. However, these are cost prohibitive for locally contracted interpreters as they work few hours under contract and would have to pay out of pocket.

III. Provide bilingual staff and/or interpreters for threshold languages

A. Evidence of availability of interpreter and/or bilingual staff
DHHS Behavioral Health checks the California Health and Human Services (CHHS) open data portal quarterly for threshold language updates. Quarterly certified eligible counts by month of eligibility, county, and threshold language have been posted since January 2015 to the most recent reportable month. Humboldt County has not met the threshold of 3,000 Medi-Cal beneficiaries or 5 percent of total Medi-Cal beneficiary population, whichever is lower, going back to January 2015.

Program	Number of Spanish Bilingual Proficiency Tested Staff
Children's Behavioral Health	1
HOME	1
MHSA/BHSA	1
Mobile Response Team	1

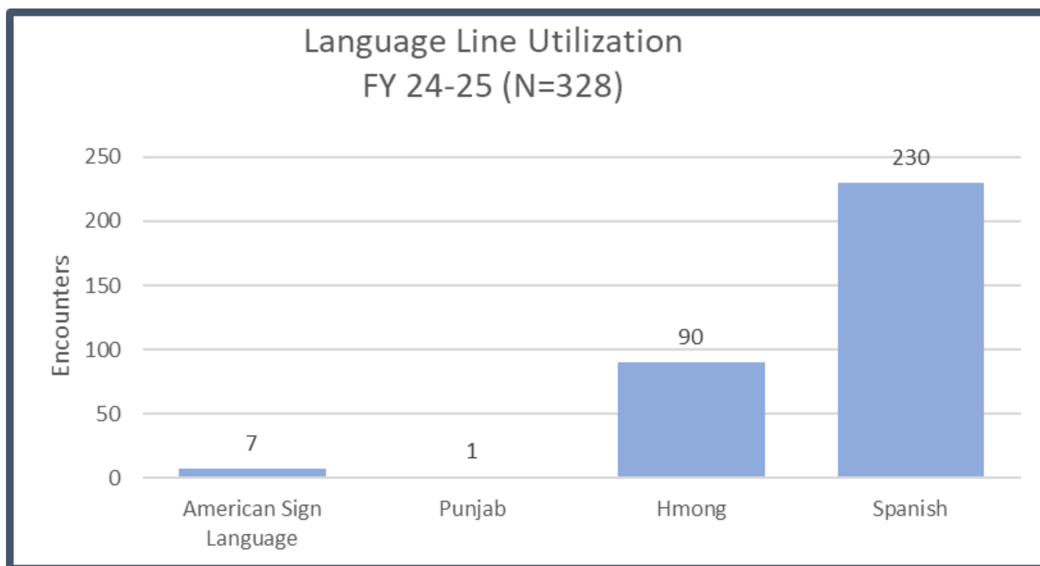
The DHHS Employee Services unit reports that the department currently (as of September 2023) employs four bilingual (English/Spanish) staff receiving bilingual specialty pay. These employees have been certified as bilingual by the Human Resources Director following achieving a passing score on the proficiency exam. Their functions are Case Managers for Mobile Response Team (1); one Program Coordinator for HOME (1); one Program Manager for MHSA/BHSA (1); and a Supervising Behavioral Health Clinician at Children's Behavioral Health (1).

DHHS Behavioral Health maintains an interpreter list composed of contracted local community providers, with 4 Spanish interpreters and currently no Hmong interpreter available. Front office and direct services staff are instructed to offer clients the use of a community interpreter before utilizing the telephonic language line. Clients are given an interpreter list that includes the name and contact number of each interpreter and the language they interpret. DHHS Behavioral Health clinical staff contacts client-selected interpreters from this list to arrange for their services.

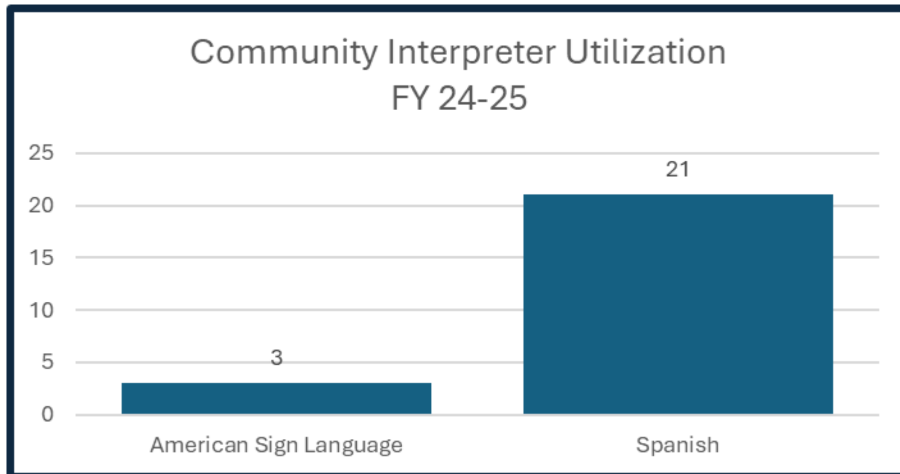
DHHS has a job classification titled Interpreter/Translator. This classification is not limited to a particular language and can be used by multiple programs. DHHS Public Health is actively recruiting for one of two full time Spanish/English Interpreters/Translators who are bi-lingual and bi-cultural. The interpreters' assignments include interpreting for integrated programs as well as document translation.

B. Evidence that interpreter services are offered and provided and recording of response to offer.
It is the policy of DHHS Behavioral Health to offer and provide interpreter services to Behavioral Health beneficiaries. Use of interpretation services is captured in the electronic Health Record (Avatar) Progress Note forms. Any encounters using interpreter services to assist a beneficiary (Language Line Services, on-site interpreter or a staff member who is using bilingual language skills) are documented. DHHS Behavioral Health Quality Improvement runs quarterly reports from Electronic Health Record data to monitor use and documentation of interpretation services. These reports are reviewed by the Cultural Responsiveness Committee.

In Fiscal Year 2024-25, 328 encounters required Language Line Services. The chart below shows these encounters broken out by language used.



In Fiscal Year 2024-25, 24 client encounters required community interpreter services. The chart below shows these encounters broken out by language used.



C. Evidence of providing linguistically proficient staff or contracted services during regular day operating hours

As stated above in section III. A, four DHHS Behavioral Health staff members receive bilingual pay. Their functions are a Case Manager for Mobile Response Team (1); one Program Coordinator for HOME, one Program Manager for MHSA/BHSA (1); and a Supervising Behavioral Health Clinician for Children's Behavioral Health (1).

DHHS Behavioral Health maintains an interpreter list composed of contracted local community providers. In FY23-24 QI made necessary updates to Interpreter selection and documentation process in alignment with County's purchasing policies for professional services. The refresh of the Community Interpreter List is still ongoing. However, there is a noted drop in community interpreters in the area. Several Spanish translators in the area have retired and discontinued services. As of October 2025, there are only 4 Spanish interpreters and no Hmong interpreters who have completed interpreter list renewal packets, which are required, to be included on the Community Interpreter List. These community providers are contracted and can be accessed when the need for interpretation arises. Humboldt County DHHS has two full-time Interpreter/Translator positions assigned to Public Health. However, as stated above, one of these positions is currently vacant. The positions are available to provide interpretation services in integrated programs that are collaborations between Behavioral Health and Public Health programs and translates documents for Behavioral Health upon request.

As mentioned in section III. B., the Electronic Health Record provides reporting capabilities that serve as the mechanism to track the use of interpretation services.

D. Evidence that interpreters are trained and monitored for language competence.
The Department of Health and Human Services "County Qualification Assessment Process for Bi-lingual Proficiency" is as follows:
The County Human Resources (HR) Department periodically administers a Spanish Bilingual Proficiency Examination to eligible and interested County employees. Employees are made aware that in order to receive Bilingual Specialty Pay they must not only pass the test(s) but

must also be in a position that is formally designated by the department as needing the skills of someone who is proficient in both English and Spanish. Programs who need employees with either oral only, or oral and written proficiency in Spanish, or are aware of an eligible bi-lingual staff member are advised to contact DHHS Employee Services to discuss their needs. Eligible staff may complete the Bilingual Proficiency Exam Registration Form online, submit the form to their hiring authority/supervisor for pre-approval, and then submit the form to the County HR department for review and final approval. Upon final approval the HR department will contact the staff with further instructions regarding the oral and/or written exam process. Bilingual allocations are subject to rotational status depending on program needs. Since Specialty Pay is based on the specific position, it may be discontinued if the employee receiving it transfers or promotes to another position.

Contracted Community Interpreters provide a resume indicating their experience and credentials prior to contracting.

IV. Provide services to all LEP clients not meeting the threshold language criteria

A. Policies, procedures and practices for referring and linking to culturally and linguistically appropriate services.
DHHS Behavioral Health's policy on access to interpreters and culturally and linguistically competent providers is all-inclusive and does not distinguish between clients who speak a potential threshold language versus those who speak other languages. See Section II. A. above, referenced Policy and Procedure 0100.604.

B. Written plan for assisting such clients.
As stated above, DHHS Behavioral Health's policy and procedure on access to interpreters and culturally and linguistically competent providers is all-inclusive and does not distinguish between clients who speak a potential threshold language versus those who speak other languages. Therefore, DHHS Behavioral Health does not require a separate plan for such clients.

C. Policies, procedures and practices that comply with Title VI of the Civil Rights Act of 1964
DHHS Behavioral Health prohibits the expectation that families will provide interpreter services for their family members who are receiving or requesting services, although this can be facilitated at the client's specific request and with appropriate releases. The expectation that minor children should not be used as interpreters is clearly spelled out in policy & procedure 0100.604 (referenced above in Section II. A.) and is included in staff training materials about working with interpreters.

V. Translated documents, forms, signage, and client informing materials

A. Written information for threshold languages
As stated above in III., Humboldt County has met the threshold of 3,000 Medi-Cal beneficiaries or 5 percent of total Medi-Cal beneficiary population, whichever is lower, that speak a language other than English, going back to at least January 2015. DHHS Behavioral Health provides translated clinical and non-clinical documents for the purpose of information and education to clients with Limited English Proficiency (LEP) and their family members as outlined in policy and procedure 0100.617 Translation of Written Materials (referenced above in Section II. A.) The procedure includes a mechanism for ensuring accuracy of translated materials in terms of both language and culture. Informing materials translated into Spanish are available in the waiting areas of all service access points. The bi-annual Consumer Perception Survey, client comment cards and the patient satisfaction survey at the psychiatric health facility are available in Spanish. Beneficiary problem resolution and fair hearing materials, confidentiality statement, release of information, informed consent, health history form, service orientation brochures for clients and a variety of educational materials are available in Spanish as well.

B. Evidence in clinical chart that clinical findings are communicated in clients' preferred language
As stated above in Section III.B., DHHS Behavioral Health captures the use of interpretation services in the electronic Health Record Progress Note forms.

Any encounters using interpreter services to assist a beneficiary (Language Line Services, on-site interpreter, or a staff member who is using bilingual language skills) are documented. DHHS Behavioral Health Quality Improvement runs quarterly reports from Electronic Health Record data to monitor use and documentation of interpretation services. These reports are reviewed by the Cultural Responsiveness Committee.

C. Consumer satisfaction survey translated into threshold languages, including summary of results
As of mid-2024, Humboldt County has Spanish as a threshold language. DHHS Behavioral Health participates in the bi-annual Consumer Perception Survey administered by DHCS, using the translated survey forms as needed. Results are reported out at Continuous Quality Improvement Committees, distributed to all Behavioral Health staff via a staff bulletin, and made available to clients in the lobby of the main clinics. The return rate of surveys completed in Spanish language remains very low, between zero and three total surveys during each collection period over the past six years. Due to this low participation, DHHS Behavioral Health has not translated the survey results into Spanish.

D. Report mechanisms for ensuring accuracy of translated materials for both language and culture
As stated above in Section V. A., DHHS Behavioral Health provides translated clinical and non-clinical documents for the purpose of information and education to clients with Limited English Proficiency (LEP) and their family members as outlined in policy and procedure 0100.617 Translation of Written Materials (referenced above in Section II. A.) The procedure includes a mechanism for ensuring accuracy of translated materials in terms of both language and culture.

Pertinent Informing Materials, signs, brochures, posters, and forms are translated by either the DHHS Public Health's Translator/Interpreter or a qualified contracted community interpreter. These translations always undergo a second review by either bi-lingual staff who have passed the county bi-lingual proficiency exam, or a qualified contracted community interpreter/translator.

DHHS Behavioral Health's contract with LanguageLine Solutions, Inc. covers translations as well, and LanguageLine Solutions is used for all translations of clinical documents upon a client's request.

E. Report mechanisms for ensuring translated materials are at appropriate reading level (6th grade)
Per DHHS Behavioral Health's policy, clinical staff may review the translated version of a document with clients to assess the level of understanding as indicated. If clients consistently identify wording that reflects a more regional or colloquial form of expression, or wording that is hard to understand, clinical staff informs the Quality Improvement Coordinator to explain and request changes. DHHS Behavioral Health also has available Microsoft Word's readability statistics feature that analyzes documents for readability in English and Spanish language ("Flesch-Kincaid Grade Level"), indicating how many years of education a person needs in order to understand the level of writing. DHHS Behavioral Health adjusts contents based on these mechanisms.

Criterion 8: County Mental Health System Adaptation of Services

I. Client driven/operated recovery and wellness programs.

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

The Humboldt County Department of Health and Human Services is dedicated to the provision of human services with a holistic approach. This includes behavioral health and substance use disorder services. All services promote emotional health and mental wellness and to treat illness. The Department is dedicated to providing all services/programs in a client/family/community driven manner based on recovery and wellness principles that are responsive to cultural differences. The Department continuously evaluates the effectiveness of services and programs for the purpose of quality improvement. Two programs in Behavioral Health are designed to operate specifically as client driven.

The Hope Center serves unserved and underserved populations of transition age youth, adults

and older adults who have mental health challenges and their family members. The Center meets the need in the community to provide a safe, welcoming environment based on the dimensions of wellness from Substance Abuse Mental Health Services Administration (SAMHSA), and the resources necessary for people with and without a mental health diagnosis and their families to be empowered in their choices to be self-sufficient. The Hope Center provides prevention activities that reduce stigma and discrimination and provide access and linkage to treatment. These activities contribute to the reduction of all seven of the negative outcomes that may result from untreated mental illness. These negative outcomes are suicide, incarcerations, school failure or dropout, unemployment, prolonged suffering, homelessness, and removal of children from their homes.

Hope Center staffing consists of a full time Peer Coach III who oversees the Center along with Peer Coach I and II positions. Peer Support is an evidence-based practice that is recognized by the State of California as billable service through Medi-Cal for licensed Peer Support Specialists. Due to legislation changes, all Peer Support staff have the opportunity to be certified through CalMHSA as Peer Support Specialists. Many of them have completed their certification already. The Peer Certification test is administered by CalMHSA and will allow for Medi-Cal to be billed for the service of Peer Support creating an additional funding mechanism to help sustain peer programs, including the HOPE Center.

Hope Center goals are to:

- Build on the dimensions of wellness.
- Incorporate recovery pathways.
- Validate strengths and honor the person.
- Build sustainable living skills.
- Build community engagement through tabling events and other outreach efforts.
- Promote self-advocacy.
- Keep Hope Center a safe location for all participants.
- Develop an inviting community space alongside an educational setting.
- Encourage individuals to find their personal strengths and identify their personal recovery goals.
- Develop a more sustainable hybrid setup, to allow access to all who want to participate.
- Link community members to services through use of the Warm Line.
- Reduce stigma and discrimination within the system of care and the broader community.
- Break the stigma of “us and them.”

The Center works from the recovery pathways: Hope, Choice, Empowerment, Recovery Environment, Spirituality (purpose/meaning). The Center provides many resources including classes, self-advocacy education, peer support, system navigation, and linkage to services in the community. Outreach efforts are made by Hope Center peer staff to people with a behavioral health diagnosis. Events that have been coordinated by the Hope Center with this purpose in mind include annual Arts Alive nights, where participants’ art is shown at an actual art gallery; May Is Mental Health Month Community Walk; Quarterly Community BBQ’s; participation and

advocacy at the local Behavioral Health Board. There are also plans of creating a stronger community connection by tabling at local events. The Hope Center has introduced Recovery Innovations "My Wellness plan" course to the curriculum as well as a reading club focused on individuals' experiences with mental health. In 2018 the Hope Center created an Advisory Board made up of four participants and a staff member. The Advisory Board's purpose is to be a voice for the Center and give input to staff. Participants meet once a month to discuss topics of concern, ideas, and thoughts about Mental Health and the role of the Center in the community. The Hope Center has consistent and active members of the community who contribute services such as outreach, education, and coordination of special events.

A total of 1,561 unduplicated participants for FY 2024-2025 were recorded. The number of duplicated participants is 2,335 for FY 2024-2025, which includes individual peer support on site, in Zoom meetings, in-person with social distancing and masking as well as recently added hybrid classes. Of the 185 individuals who completed demographic forms, 6% were ages 16-25, 63% were ages 26-59, and 16% were age 60+. Fifteen percent did not respond to the question. Thirty-one percent of Hope Center participants were female, 55% male, and 14% did not respond to the question. Sixty-three percent of Hope Center participants were White, 12% were Multiracial/Other, 9% were Hispanic/Latinx, 3% were American Indian, and 3% were Asian/Pacific Islander. Ten percent did not respond to the question. Nine percent identified as LGBTQ, 63% had experience with homelessness, 65% had been diagnosed with a serious mental illness (SMI), 38% had a family member diagnosed with SMI, and 7% had military experience.

The second client-driven program is a part of the Transition Age Youth (TAY) Division, serving youth and young adults ages 16-26. The TAY Division consists of co-located DHHS services including Behavioral Health, Extended Foster Care, Independent Living Skills, and the Humboldt County Transition Age Youth Collaboration (HCTAYC). TAY taps into supports and services from other DHHS programs as well, including Public Health, Employment Training, CalFresh, Medi-Cal and Substance Use Disorder services. TAY also collaborates with community partners such as Juvenile Probation, Community Resource Centers through St. Joseph Providence Health, and Family Resource Centers.

The HCTAYC component of the TAY Division is client driven. HCTAYC fosters positive youth development, youth advocacy and leadership, community engagement, and promotes youth wellness. HCTAYC provides a youth voice that informs system policy, regulation, and practice at the local, state, and national levels with the purpose of cultivating better outcomes for unserved and underserved youth with a severe mental illness or who are at a significantly higher than average risk of developing a severe mental illness. The program directly impacts the TAY system of care, making it more responsive to young people's needs, resulting in these larger system outcomes. It also directly attends to the lives of system-impacted youth at-risk of, or struggling with, mental health challenges through the development of resilience and self-efficacy via leadership. It is the result of this advocacy program that needed systems and services, such as the creation of the TAY Division in 2012, have come to fruition. This advocacy

has also contributed to the passage of legislation and state policy, including the Foster Care Bill of Rights, Foster Care Psychotropic Medication Management, and the California Department of Social Services implementation of CANS. These policies have all significantly contributed to the statewide transition-age youth system of care's ability to best serve youth.

HCTAYC demographic information was obtained from 221 demographic surveys completed by individuals participating in 40-MHSA-funded events or trainings between July 1, 2024, and June 30, 2025. These are duplicated responses as one person could complete more than one survey having attended multiple events. Sixty-four percent (64%) of the people who responded to the demographic survey selected *White*. One percent (1%) selected *Asian*. Four percent (4%) selected *American Indian/Alaska Native*. Two percent (2%) selected *Black/African American*. Six percent (6%) selected *Hispanic/Latino*. Sixteen percent (16%) selected *More than One*. Seven percent (7%) selected *I Prefer Not to Answer*. . The primary language of participants was roughly 96% English. One percent (1%) of remaining responses reported Spanish as their primary language, one percent (1%) preferred not to answer and one percent (1%) reported being bilingual.   Ten percent (10%) of the survey participants were within 16-18 years old and seventy-one (71%) reported being 19-25 years old. However, HCTAYC youth engaged people of all ages in trainings, presentations, community coalitions, and policy recommendation outreach efforts. Sixteen percent (16%) reporting being 26-59, while three percent (3%) reported being 60+ years of age.
While 54% of survey respondents reported an assigned birth sex of female, 33% identified female as their gender identity. Twenty-six percent (26%) of survey respondents reported an assigned birth of male, twenty percent (20%) identified male as their gender identity. Nine percent (9%) reported identifying as non-binary, fourteen percent (14%) as transgender, six percent (6%) as genderfluid, five percent (5%) as genderqueer, and one percent (1%) as two-spirit. Eight percent (8%) of respondents identified with more than one of the available options and four percent (4%) preferred not to answer.

Out of 240 participants, fifty-five percent (55%) reported experiences with homelessness, thirty-four percent (34%) had not, and eleven percent (11%) preferred not to answer.

Out of two hundred and forty respondents, twenty percent (20%) reported past involvement in the juvenile justice system, seventy-five percent (75%) reported no such involvement, and five percent (5%) preferred not to answer.

II. Responsiveness of mental health services

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

mental health provider.

The TAY Division, as discussed above, is a culturally specific program for transition age youth. At this time there are no other culturally specific programs provided by DHHS. However, DHHS consistently provides referrals to community based, culturally appropriate services. Native Americans can seek mental health counseling services directly through United Indian Health Services (UIHS) or through their own tribes, such as the Yurok, Wiyot, or Hupa Tribes. Referrals can be made to UIHS or another tribal counseling program. Two Feathers Native American Family Services is an organizational provider with DHHS Behavioral Health, translating traditional wellness practices into Medi-Cal billable services as appropriate under the specialty mental health services waiver. Additionally, there are Mental Health Services Act (MHSA)funds allocated to support the Yurok Tribe to become an organizational provider for the county.

In addition to direct referrals to culturally specific programs, DHHS Behavioral Health makes available the following resources. These are widely distributed in the community and are available in Behavioral Health programs' public access areas, in contract provider clinics, and in non-profit organizations such as Humboldt 211.

- Humboldt Community Resource List with information and links to organizations providing services in over forty categories. Resources include those specific to Native Americans, Spanish-speakers, LGBTQ community, seniors, youth, and disability. This is available in print format as well as online by searching the Humboldt County website for "Humboldt Community Resource List."
- Behavioral Health's informational flyer about its programs.

In addition to the availability of the Language Line for interpretation services, DHHS Behavioral Health has an interpreter list with resources for Spanish and Hmong speakers. If a client speaks one of these languages, they have the option of requesting a live interpreter or using the Language Line, free of cost.

B. Evidence that the county informs clients of the availability of the above listings in their member services brochure.

Clients are informed about the availability of alternatives and options of cultural/linguistic services in the Behavioral Health Access Brochure, Beneficiary Handbook, and the updated 2023 Programs and Services Guide. Additionally, DHHS Behavioral Health developed informational materials that can be accessed via a newly established QR code that consumers can scan with their smartphones to learn about available services along with a Behavioral Health Resource Menu. Employees are encouraged to acquire updated business cards that contain the QR code with an email address along with the phone number to the crisis line.

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

In addition to providing clients with the Beneficiary Booklet, DHHS Behavioral Health has implemented the policy titled "Community Information and Education Plans." This policy states that Behavioral Health will provide information to underserved populations in the community to enable access to specialty mental health services. Information is disseminated through distribution of flyers and brochures, participation in community presentations, forums, and meetings, coordination with physical health care, and via outreach by case managers and other clinical staff. In addition, Behavioral Health ensures that the Informing Materials (including a list of current providers with culture-specific information, Problem Resolution Processes and Advance Directives) is provided to clients when they first access services and upon request. Beneficiary Brochures printed in English and Spanish are provided upon request and made available in the lobby areas of all access points including with contract providers. In addition, the Housing, Outreach and Mobile Engagement (HOME) program, discussed further in section D. below, provides information about cultural and linguistic services available.

In May 2024, with collaboration of the DHHS Media team, Behavioral Health updated its policy templates to be ADA compliant. As policies reach their review date, they are being converted into the ADA compliant template to improve accessibility.

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

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

The HOME program focuses on bringing services and supports to facilitate the ease with which individuals can access services and supports. The Behavioral Health integration with HOME as well as Regional Services engage clients by meeting them in the communities in which they live. These programs address the barrier of rural community access to services, most of which are based in Eureka. HOME staff travel to provide their outreach and services to the further corners of Humboldt County. There is also a Mobile Engagement Vehicle (MEV), a converted RV which acts as rolling office space and visits communities located throughout Humboldt County. There are regularly scheduled visits to Northern, Eastern and Southern Humboldt as well as the Eel River Valley. Some services, such as counseling, may require an appointment, but other services can be had right on the spot at the MEV. These services also link with and provide support to existing community organizations such as Family Resource Centers, Community Resource Centers, community clinics, and Tribal Organizations.

The Housing component of HOME also focuses on bringing services and supports to where people are. HOME staff provide services and supports to five different housing projects. The first housing project supported by MHSA funding is in Arcata and has 15 studio apartments for behavioral health clients. Another housing project in Eureka has 15 subsidized apartments. In Eureka, construction was completed in 2020 at another 50-unit apartment building with community and meeting space for tenants. This development has 25 units for eligible DHHS

clients. A fourth project completed in 2021 is a 25-unit project in Rio Dell. This project is individual small homes with all utilities and amenities that are fully ADA compliant for eligible clients. In 2022, another housing project was completed in the Pine Hill area of Eureka with 30 units for homeless individuals. For all projects, HOME and Behavioral Health staff provide services on-site. There are also resident services staff on site. In addition to clinical services, recreational and volunteer opportunities open to all residents to assist community integration and to reduce stigma are available. All projects also include community spaces for events, supportive services, and recreation.

The Mobile Intervention and Services Team (MIST) serves people in Arcata with severe mental illness who are homeless and have frequent contact with law enforcement. Through use of the Behavioral Health Justice Intervention Services (BHJIS) grant, MIST will continue to embed Behavioral Health staff into Humboldt County Sheriff's Office patrol operations to co-respond to mental health calls. This will allow MIST to continue to provide a wide range of appropriate services, both for immediate crises and follow up in the least restrictive manner possible.

Additionally, MHSA funding is allocated for a partnership with the City of Eureka to help fund the Crisis Alternative Response of Eureka (CARE) program. The program will support Humboldt County Behavioral Health's ability to implement 24-hour mobile crisis benefit services. The goal of these mobile crisis response services is to provide person and family-centered care that de-escalates and resolves crises before more restrictive interventions become necessary. The CARE program works with adults, older adults, transition-age youth, and children experiencing or at risk of experiencing a crisis within the City of Eureka.

The Regional Services program addresses rural community access and provides behavioral health clinicians, case managers and a substance abuse counselor in the Eastern Humboldt and Southern Humboldt regions of the County. Staff are either based at one of the DHHS outlying offices or travel to meet clients where they are.

The Comprehensive Community Treatment (CCT)/Full Service Partnership program makes available intensive community services and supports (e.g. housing, medical, educational, social, vocational, rehabilitative, or other needed community services) to achieve recovery. Partnership Services Coordinators/Case Managers can provide services to clients in their own homes, which can alleviate the potential challenge for clients to travel to the main clinic locations.

DHHS Children's Behavioral Health (CBH) clinicians travel to various locations throughout Humboldt County to provide assessments, counseling, case management and crisis services. They work closely with regional Family Resource Centers, Tribes, and Schools to determine where the need is. Clients who have been assessed and are waiting to be assigned to a counselor are offered a walk-in appointment. One crisis clinician is dispatched to Emergency Rooms in Eureka to evaluate minors for crisis needs. In addition, there are two case managers that respond to minors in crisis.

Humboldt BRIDGES to Wellness staff work in partnership with the Humboldt County Office of Education to provide short-term, school-based behavioral health intervention and support to students across the county who are in crisis or at risk of crisis. The program is school-based, and services are available and accessible through public schools throughout the County.
Both the Children's Mobile Response Team and the Adult Mobile Response Team provide short-term behavioral health crisis intervention and support in Humboldt County.

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

Humboldt County was under Department of Justice review regarding ADA accessibility in facilities and has been putting in place the processes and building updates for other County, non-Behavioral Health buildings. While work has been ongoing, all the remediations ordered by the consent decree have not yet been completed. Once those priorities are met all County Facilities will be fully assessed for ADA compliance. Some buildings rented by Behavioral Health have already had work performed on the outside of the buildings - ramps and parking lots - to create better access. These improvements are found at the locations housing Outpatient Services, Sempervirens, and Crisis Services; at the HOME program; and at the Children's Behavioral Health Clinic at Humboldt Plaza.

In order to create a welcoming environment to clients of diverse cultural backgrounds, Behavioral Health has implemented the following:

- Artwork produced by people with lived experience is on display on the walls of program waiting areas and group therapy rooms as well as at the Crisis Stabilization Unit. This artwork can be purchased and is rotated regularly with new pieces. Posters produced by the Youth Training Project are posted in lobby areas.
- Spanish language posters and Spanish educational materials are available and have been distributed to programs for posting.
- "Every BODY has an issue" first place winning poster of the 2010 Prevention and Early Intervention Program to reduce stigma and discrimination related to mental health is also widely posted throughout the agency.
- Posters promoting acceptance of Lesbian/Gay/Bisexual/Queer/Questioning/ Transgender youth obtained from the Y.O.U.T.H. (Youth Offering Unique Tangible Help) Training Project are posted throughout DHHS.
- In 2024 the Cultural Responsiveness Committee continued its Welcoming Environments project by having a client and staff survey and conduct environment assessment on many Behavioral Health facilities. A list of recommendations and findings will be provided to BH leadership at the end of the year for review.

3. Locating facilities in settings that are non-threatening and reduce stigma, including co-location of services and /or partnerships, such as primary care and in community settings.

As an integrated agency, the Humboldt County Department of Health and Human Services Behavioral Health staff is co-located with other DHHS programs including but not limited to:

- Child Welfare Services and Children's Behavioral Health Clinic, including the Mobile Response Team and Foster Care Unit, are co-located at Humboldt Plaza.
- Child Welfare Services are integrated with the Extended Foster Care Unit in the TAY Division.
- CalWORKs Program, providing services to clients who have mental health, substance use, or domestic violence issues to address barriers to employment.
- Older Adults and Dependent Adults Program, a partnership between Social Services, Adult Protective Services, In Home Support Services, Public Health Nursing, and Behavioral Health.
- Expanded Outpatient Medication Support Services, providing medication support to people with a serious mental illness residing in remote rural areas utilizing video conferencing equipment.

Some outpatient programs, such as Older Adults and Healthy Moms, are located in mixed residential and business areas, therefore reducing the stigma attached to receiving services at the main Behavioral Health clinic. Over the past several years, DHHS has worked with partners in the McKinleyville area to develop The Center at McKinleyville, which began providing services in 2022. This is a one-stop location for services, information, and activities for community members in the McKinleyville area. Services currently provided by the McKinleyville Family Resource Center (MFRC), DHHS, and Open Door Community Health Center are located together so that community members have one place to go to access a wide variety of services. This site is a non-stigmatizing community setting. The Center is not a DHHS facility. Leadership and decision-making are shared between the MFRC, DHHS, and Open Door, with MFRC as the primary partner to ensure community voice will guide decisions. Additionally, DHHS has opened a new clinic site in Fortuna. Services provided at the Fortuna Clinic include Children's Behavioral Health staff who focus on children, youth, and families in the greater Fortuna area (Eel River Valley). This includes those who are currently involved with, or are at risk of, Child Welfare involvement due to mental health and substance use disorders.

III. Quality Assurance

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

A. Grievances and Complaints: Provide a description of how the county mental health process for Medi-Cal and non-Medi-Cal client Grievance and Complaint/Issues Resolution Process

data is analyzed and any comparison rates between the general beneficiary population and ethnic beneficiaries.

The Quality Improvement unit of Humboldt County DHHS Behavioral Health ensures that individuals receive thoughtful and timely response to requests for problem resolution, including grievances, appeals, requests for change of provider, requests for culture-specific providers, and requests for second opinions. The Quality Improvement Coordinator (QIC) or designee coordinates, facilitates, logs, and tracks all requests for problem resolution. The QIC or designee is the assigned staff member responsible for responding to clients' questions regarding the status of their requests for problem resolution. Trended data from the problem resolution process is utilized in the Quality Improvement program in order to improve quality of care. All requests for problem resolution are reported to DHHS Behavioral Health's Outpatient Continuous Quality Improvement Committee on a quarterly basis. DHHS Behavioral Health Quality Improvement unit submits the required Managed Care Program Annual Report (MCPAR) to the Department of Health Care Services every year by October 1, this process was formerly called the Annual Beneficiary Grievance and Appeal Report (ABGAR) but switched to the MCPAR in 2023.

For an analysis of disparities, there are two areas to review: 1) MCPAR results (grievances only) and 2) all concerns, including grievances, requests for second opinions, and requests for change of provider.

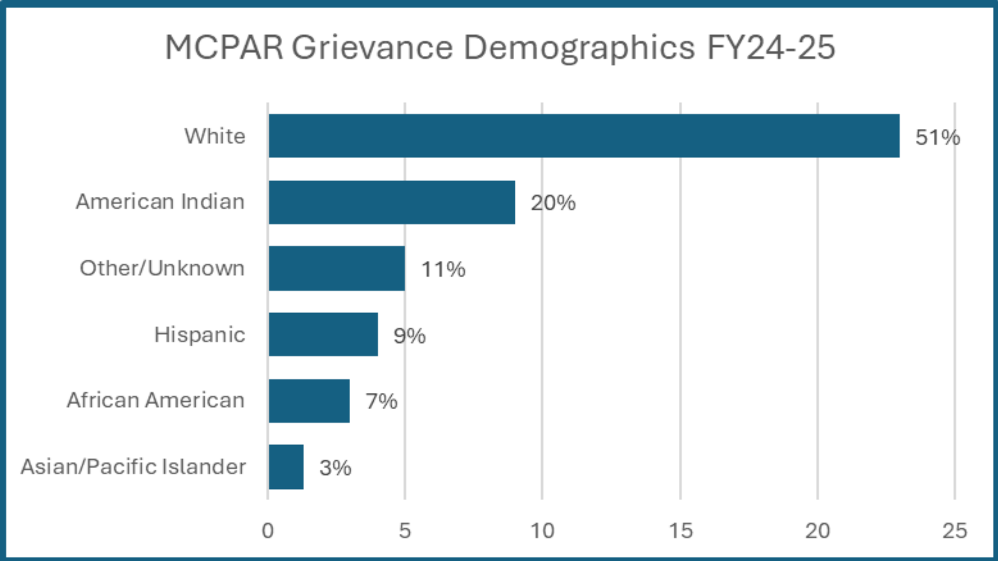
Grievance Only Disparity Analysis

The table below shows grievances by category in the MCPAR reports for FY 23-24 through FY 24-25. All grievances were resolved according to protocol, and there were zero grievances filed under the category "Cultural Appropriateness." Due to the transition to the MCPAR, the "Cultural Appropriateness" category that would normally be part of the ABGAR no longer exists.

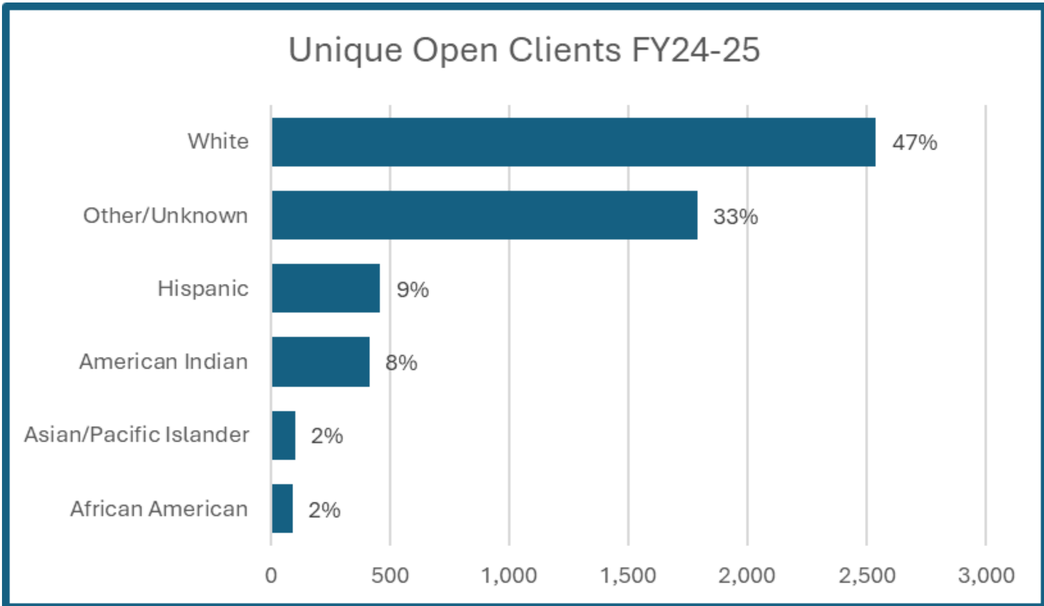
Managed Care Program Annual Report (MCPAR) GRIEVANCES			
CMS NUMBER	INDICATOR	TOTAL COUNT FY 23-24	TOTAL COUNT FY 24-25
D1.IV.10	Resolved	53	57
D1.IV.11	Active	6	0
D1.IV.14	Timely Resolution	46	28
Number of grievances resolved by plan during the reporting period related to the following services: (A single grievance may be related to multiple service types and may therefore be counted in multiple categories below.)			
D1.IV.15c	Inpatient	13	34
D1.IV.15d	Outpatient	40	23
Number of grievances resolved by plan during the reporting period related to the following reasons: (A single grievance may be related to multiple reasons and may therefore be counted in multiple categories below.)			
D1.IV.16a	Related to Customer Service	1	4
D1.IV.16b	Related to Case management	0	2
D1.IV.16c	Access to Care	0	0
D1.IV.16d	Quality of Care	42	28
D1.IV.16e	County (Plan) Communication	0	0
D1.IV.16f	Payment/Billing issues	0	0
D1.IV.16g	Suspected Fraud	0	0
D1.IV.16h	Abuse, Neglect or Exploitation	1	0
D1.IV.16i	Lack of Timely Response	0	0
D1.IV.16j	Denial of Expedited Appeal	0	0
D1.IV.16k	Filed for other reasons	9	23

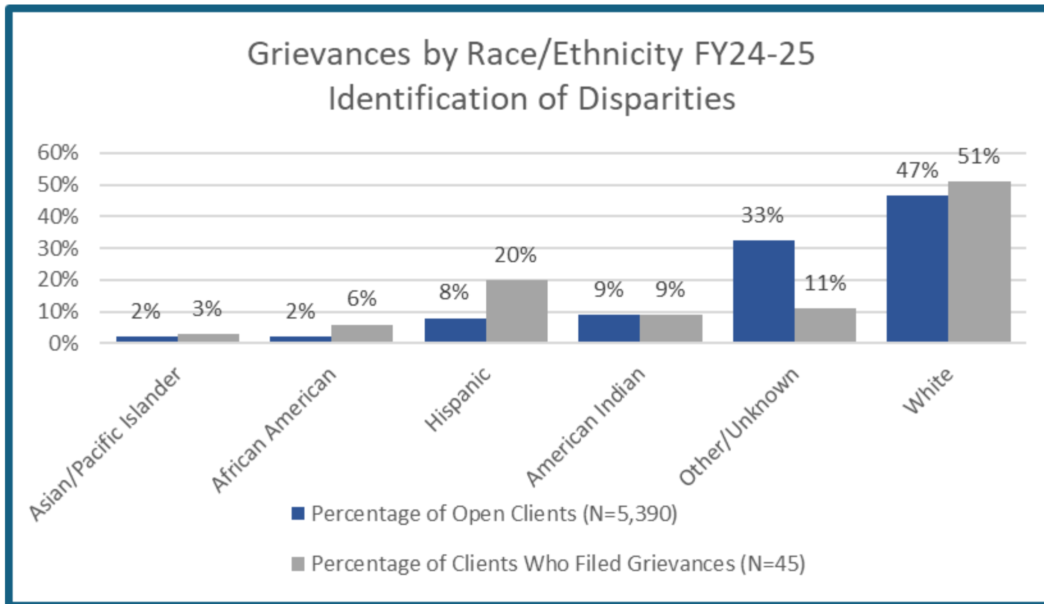
Grievances are reviewed from the perspective of potential ethnic disparities. In order to determine if certain ethnic groups are over- or underrepresented in filing concerns, client demographic data of unique beneficiaries receiving services are compared to QI client grievance data. The data sources for this analysis are Avatar reports and Behavioral Health QI Grievance Database. Ethnicity percentages are based on number of unique clients (children or adults receiving outpatient and/or inpatient services) who had an open episode during FY 24-25 (N=5,390); and number of unique unduplicated clients who filed grievances in FY 24-25 (N=45).

MCPAR FY24-25 Race/Ethnicity	Unique Clients Who Filed Grievances	Percentage
Asian/Pacific Islander	1	3%
Other/Unknown	5	11%
African American	3	7%
Hispanic	4	9%
American Indian	9	20%
White	23	51%
Total	45	100%



Race/Ethnicity	Unique Open Clients	Percentage
Asian/Pacific Islander	103	2%
African American	91	2%
American Indian	412	8%
Hispanic	460	9%
Other/Unknown	1,787	33%
White	2,537	47%
Total	5,390	100%



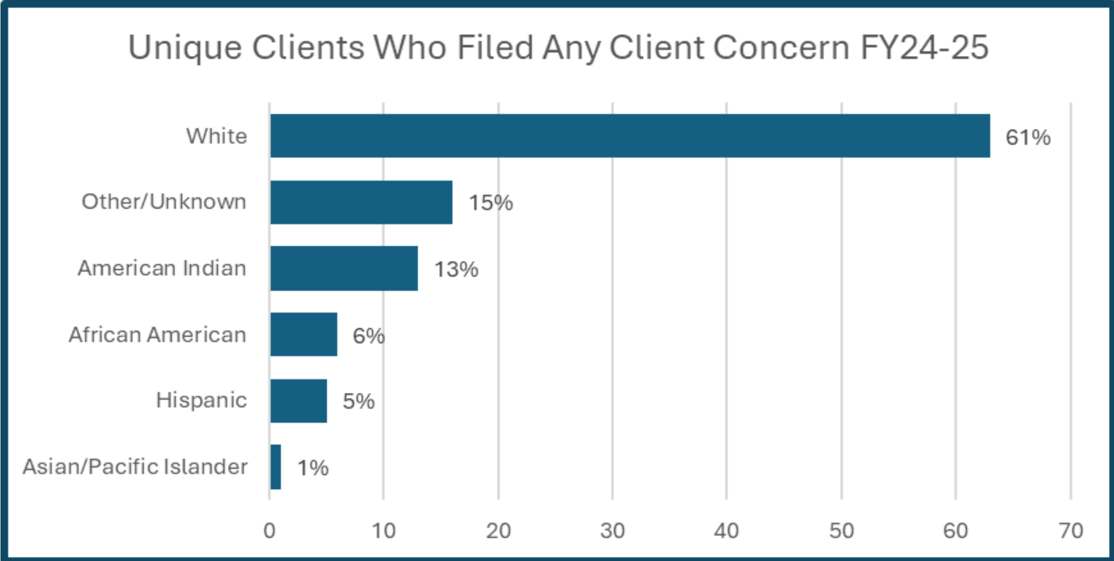


The data show that Whites are overrepresented in relation to their population in our system of care. Of forty-five grievances filed, 51% were filed by Whites, 20% were filed by Hispanics, and 11% were filed by the Other/Unknown category. American Indians were represented at 9%, African American were 6%, while Asian and Pacific Islanders were at 3%.

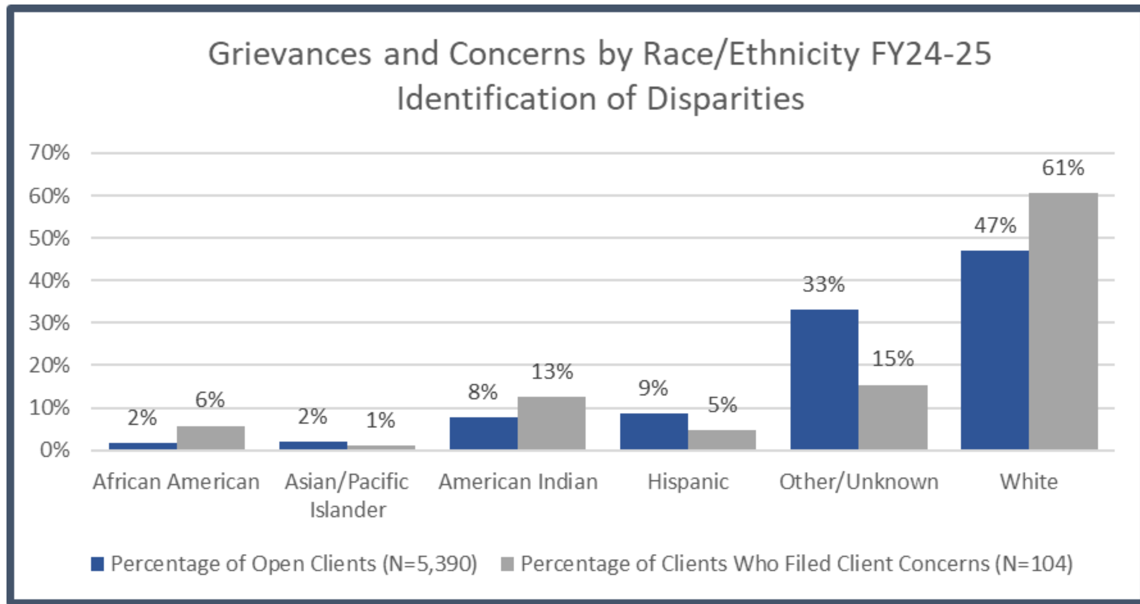
All Grievances and Concerns Disparity Analysis

In this section, client demographic data of unique beneficiaries with an open episode in FY 24-25 (N=5,390) are compared to the number of unique clients who filed grievances and concerns including requests for second opinion and request for change of provider in FY 24-25 (N=104). The data sources for this analysis are same as above. All concerns were resolved according to protocol.

Race/Ethnicity	Unique Clients Who Filed Any Client Concern	Percentage
African American	6	6%
Asian/Pacific Islander	1	1%
Hispanic	5	5%
Other/Unknown	16	15%
American Indian	13	13%
White	63	61%
Total	104	100%



Race/Ethnicity	Percentage of Open Clients (N=5,390)	Percentage of Clients Who Filed Client Concerns (N=104)
Asian/Pacific Islander	2%	1%
African American	2%	6%
American Indian	8%	13%
Hispanic	9%	5%
Other/Unknown	33%	15%
White	47%	61%
Total	100%	100%



A total of 104 unique unduplicated grievances and concerns were filed. Sixty-one percent of grievances were filed by Whites, and 5% were filed by Hispanics. American Indians were 13%, and Asian/Pacific Islander were 1%. African Americans were 6% and lastly Other/Unknown were underrepresented at 15% in comparison to their population size in the Behavioral Health system of care.

This analysis shows that White is overrepresented in having grievances and concerns in relation to their population size in the system of care. For Hispanic, there is only a 4% difference in having grievances and concerns in relation to the population size in the system of care. However, none of these grievances and concerns were related to cultural appropriateness, so no firm conclusions can be drawn from this analysis. Of note is the trend shows a slight decrease in the number of grievances, 45 in FY24-25 compared to 49 in FY 23-24. Overall concerns saw a slight decrease to 104 in FY 24-25 from 107 in FY23-24. As noted in the MCPAR Report above, 40% of grievances were received in Outpatient services with 60% being received for Inpatient services. 59% of Client Concerns were request for Change of Provider.

The trainings and efforts of the Racial Equity Steering Committee's launch of Implicit Bias Training in NEOGOV, and the ongoing Behavioral Health Cultural Awareness training, Training led to increased awareness of implicit bias and cultural sensitivity and are likely correlated to the impact on the slight disparities observed regarding grievances and concerns. This data will continue to be monitored over time.

Attachments

Attachment 1:Policy 100.603 Selection of Interpreters

Attachment 2: Policy 100.604 Access to Interpreters and Culturally and Linguistically Competent Providers

Attachment 3: Policy 100.605 Obtaining Interpretation, Translation and Telephone Services for Clients with Physical Impairments or Limited English Proficiency

Attachment 4: Policy 100.606 Speech to Speech Relay Service

Attachment 5: Policy 100.607 Text Telephone (TTY) Use

Attachment 6: Policy 100.608 Access to Interpreter Services – Language Line Use

Attachment 7: Policy 100.617 Translation of Written Materials

Attachment 8: Policy 0100.150 Racial and Cultural Equity in Behavioral Health

Attachment 9: Policy 0100.151 Racial and Cultural Equity Document Review in Behavioral Health

Attachment 10: Policy 0100.152 Racial and Cultural Equity Buget Review in Behavioral Health

Attachment 11: Policy 0704.460 Client Problem Resolution Process

HUMBOLDT COUNTY DEPARTMENT OF
HEALTH & HUMAN SERVICES - BEHAVIORAL HEALTH
Policy & Procedure

Policy Number	**0100.603**
Policy Title	**SELECTION OF INTERPRETERS**
Program	ADMINISTRATION
Affects	ALL
Effective date	03/27/1998
Revision dates	12/21/2023
Review dates	11/02/98,12/21/99, 01/03/01, 02/22/02,09/20/04,09/05/08, 12/11/10, 01/05/12, 3/20/12,08/30/12, 12/20/13, 01/14/14, 10/18/17, 9/25/19, 11/22/2022
BH Director Approval date	01/11/2024

PURPOSE

Department of Health and Human Services – Behavioral Health (DHHS-BH) maintains a list of community Interpreters.

DEFINITION(S)

POLICY

DHHS – BH will assure availability of Interpreters who are utilized for interpreter services to clients.

PROCEDURE

1. Interpreter Selection:
   DHHS - BH will maintain a list of available persons to interpret in threshold languages and languages that are prevalent in the community per observation of personnel providing direct service to the community. The Interpreter List will, when possible, include the following information about each interpreter: name, contact number/email, HIPAA trainings, background check information, interpretation skills and credentials, specialties, cultural competency training, compensation rate, availability, and the language for which they are providing interpreter services.

2. Potential Interpreters will be provided an orientation packet on mental health practices, including information about access to services, beneficiaries' rights, and confidentiality of mental health information. The packet includes the following forms to be completed and signed by the interpreter and returned to the Performance Management Unit (PMU): Interpreter Agreement, Declaration of Confidentiality, Independent Contractor and Sole Proprietorship Mandated Reporting Form (V- 13-39), Request for Taxpayer Identification Number and Certification Form (W-9) and a copy of a valid Humboldt County business license.

3. The Interpreter is responsible for submitting to the DHHS – BH Financial Services a reimbursement invoice for services provided to beneficiaries. The Invoice for Interpreters form is included in the orientation packet.

3.1. Total invoices for Professional Services shall not exceed $1,000.00 per interpreter/translator per fiscal year as defined in the County of Humboldt Purchasing Policy for Professional Services $1,000.00 and under. Services totaling over $1,000 will require prior approval from Administration and a fully executed Professional Service Agreement from the translator/interpreter.

4. Once all required documents have been received and approved by the PMU (Deputy Director or designee), the interpreter will be placed on the Interpreter List.

5. The original documents (Interpreter Agreement, Declaration of Confidentiality, Independent Contractor and Sole Proprietorship Mandated Reporting Form (V-13-39), Request for Taxpayer Identification Number and Certification (W-9) Form and a copy of a valid Humboldt County business license) are then forwarded to the Budget Specialist in Behavioral Health Financial Services. A copy will be kept at PMU.

6. As the Interpreter List is updated it will be available to programs.

7. Behavioral Health staff can receive approval from their supervisor and may contact an approved interpreter from the Interpreter List directly to arrange for their services.

FORM(s)/ATTACHMENTS

Interpreter Agreement Declaration of Confidentiality
Independent Contractor and Sole Proprietorship Mandated Reporting Form (V-13-39) Request for Taxpayer Identification Number and Certification (W-9) Form
Invoice for Interpreters Form

REFERENCE

CCR, title 9, chapter 11, section 1810.410.
Interpreter List

HUMBOLDT COUNTY DEPARTMENT OF
HEALTH & HUMAN SERVICES - BEHAVIORAL HEALTH
Policy & Procedure

Policy Number	**0100.604**
Policy Title	**ACCESS TO INTERPRETERS AND CULTURALLY AND LINGUISTICALLY COMPETENT PROVIDERS**
Program	ADMINISTRATION
Affects	ALL
Effective date	3/27/1998
Revision dates	10/23/17, 11/15/21, 1/26/22, 07/31/25
Review dates	11/02/98,12/21/99, 01/03/ 01, 02/22/02, 09/20/04; 09/05/08, 12/11/10, 01/05/12, 03/20/12, 08/30/12, 04/29/13, 12/20/13,01/14/14, 10/23/17, 11/9/20
BH Director Approval date	

PURPOSE

Humboldt County Department of Health and Human Services - Behavioral Health (DHHS-BH) provides culturally and linguistically competent services.

DEFINITION(S)

None

POLICY

DHHS-BH will obtain and provide culturally and linguistically competent services to clients 24 hours a day, 7 days a week.

PROCEDURE

1. Linking clients to DHHS interpreters:
   DHHS-BH prohibits the expectation that families will provide interpreter services for their family members who are receiving or requesting services; although at the client's specific request and with appropriate releases, this may be facilitated.

2. All front office and direct service staff will be trained on the following steps to provide appropriate interpreter services to clients:
   2.1. Identify language spoken. If in doubt, use Language Line services for language identification assistance or when face to face with a client, use Language Identification Card or Interpreting Services Available poster.
   2.2. Offer the client free interpreter service.
   2.3. If the client declines to use a local interpreter, staff will contact Language Line Services.
   2.4. If steps 2.2. and 2.3. fail to meet client's needs, or client declines those services, ask client if he or she prefers to have family or other support provide the interpreter services.
   2.5. Minor Children should not be used as interpreters.
   2.6. Document steps 2.1. through 2.4. in client's chart.

3. Appropriate translated materials will be distributed or posted at all points where clients access the Behavioral Health system.

4. Linking clients to culturally competent Behavioral Health service providers:
   DHHS-BH will maintain a current list of Behavioral Health approved/contracted providers. The list will contain the names, clinic addresses, telephone numbers, cultural and linguistic skills and specialty populations served by each provider. This list will be updated periodically and posted on the DHHS bulletin board and furnished to contract providers. The front office staff will make this list available to clients upon request and inform them in a language that they understand that they have the right to free language assistance services.

5. When a client requests a specific provider from the Behavioral Health Community Interpreter List, this information will be forwarded to the Access staff. The Access staff will make every effort to link the client with the provider of his/her choice.

FORM(s)/ATTACHMENTS

Interpreting Services Available Poster
Behavioral Health Community Interpreter List
Language Identification Card
Provider Directory
Working with Interpreters training

REFERENCE

CCR, title 9, chapter 11, section 1810.410.
Title VI, Civil Rights Act 1964 (U.S. Code 42, section 2000d; CFR, title 45, Part 80)

HUMBOLDT COUNTY DEPARTMENT OF
HEALTH & HUMAN SERVICES - BEHAVIORAL HEALTH
Policy & Procedure

Policy Number	**0100.605**
Policy Title	**OBTAINING INTERPRETATION, TRANSLATION AND TELEPHONE SERVICES FOR CLIENTS WITH PHYSICAL IMPAIRMENTS OR LIMITED ENGLISH PROFICIENCY**
Program	ADMINISTRATION
Affects	ALL
Effective date	03/27/1998
Revision dates	02/14/22
Review dates	11/02/98,12/21/99, 01/03/01, 02/22/02, 09/20/04, 9/05/08, 12/11/10, 04/29/13,12/20/13,01/14/14, 06/02/14, 12/18/17, 7/10/19, 9/29/22, 07/25/25
BH Director Approval date	

PURPOSE

Humboldt County Department of Health and Human Services Behavioral Health obtains translation, interpretative and telephone services.

DEFINITION(S)

Interpreter: A person who translates orally from one language to another.

Translator: A linguist professional who translates written communication from one language to another.

POLICY

Department of Health and Human Services (DHHS) - Behavioral Health shall provide qualified translation, interpretative, and telephone services whenever clients need language line, or services that assist clients with hearing, speech or visual impairments or limited English proficiency.

PROCEDURE

1. For assistance with the selection of interpreter or translator, see policy and procedure 0100.603 Selection of Interpreters.
2. For assistance for clients with speech impairments, see policy and procedure 0100.606 Speech-to-Speech Relay Service (STS).
3. For assistance for clients with hearing impairments, see policy and procedure 0100.607 Text Telephone (TTY) Use and 0100.306 Services to Clients with Hearing Impairments.

4. For assistance with accessing foreign language interpretation and translation, see policy and procedure 0100.604 Access to Interpreters and Culturally and Linguistically Competent Providers and 0100.608 AT&T Language Line Use.

5. For assistance for clients with visual impairments, see policy and procedure 0100.609 Serving Clients with Vision Impairments.

FORM(s)/ATTACHMENTS

0100.603 Selection of Interpreters.
0100.604 Access to Interpreters and Culturally and Linguistically Competent Providers.
0100.606 Speech-to-Speech Relay Service (STS)
0100.607 Text Telephone (TTY) Use
0100.608 AT&T Language Line Use
0100.609 Serving Clients with Vision Impairments
0100.306 Services to Clients with Hearing Impairments

REFERENCE

CCR, title 9, chapter 11, section 1810.410.

HUMBOLDT COUNTY DEPARTMENT OF
HEALTH & HUMAN SERVICES - BEHAVIORAL HEALTH
Policy & Procedure

Policy Number	**0100.606**
Policy Title	**SPEECH-TO-SPEECH RELAY SERVICE (STS)**
Program	ADMINISTRATION
Affects	ALL
Effective date	03/27/1998
Revision dates	
Review dates	11/2/98,12/21/99, 01/03/01, 02/22/02, 09/20/04, 09/05/08, 12/11/10, 04/29/13, 12/20/13, 01/14/14, 9/20/19, 11/22/2022
BH Director Approval date	11/30/2022

PURPOSE

Humboldt County Department of Health and Human Services – Behavioral Health (DHHS-BH) provides Speech-to-Speech Relay Services to clients with hearing and speech impairment.

DEFINITION(S)

California Speech-to-Speech Relay Service (STS): a part of the California Relay Service (CRS), a program of the California Public Utilities Commission (CPUC). It is a service that allows persons with hearing and speech disabilities to access the telephone system to place and receive telephone calls. STS enables persons with a speech disability to make telephone calls using their own voice (or an assistive voice device) rather than a text telephone (TTY). Trained operators function as human voicers for STS users who have trouble being understood on the telephone.

POLICY

DHHS-BH obtains translation, interpretative, and telephone services whenever clients are in need of language line, or services that assist clients with hearing, vision, or speech impairments.

PROCEDURE

Please refer to policy number 0100.604 Access to Interpreters and Culturally and Linguistically Competent Providers and policy number 0100.605 Obtaining Interpretation, Translation, And Telephone Services For Clients With Physical Impairments Or Limited English Proficiency.

1. If Staff member wishes to call a client with a speech impairment:
   A special phone is not needed for STS. To get connected directly to a specially trained STS Communications Assistant dial the designated STS toll free California Speech-to-Speech Number **866-988-4288** and ask the Communications Assistant to call the person with a speech impairment. The Communications Assistant will repeat the client's spoken words, making the words clear to the other party.

2. If Staff wishes to call a Spanish speaking client with a speech impairment, dial **866-288-4151**.

3. Persons with speech impairments may also place STS calls. They need to call the relay center at the same number above 866-988-4288 (or 866-288-4151 if Spanish speaking) and indicate they wish to make an STS call to Behavioral Health.

4. There are many options to personalize phone calls through STS that will make calls easier. You may call Customer service for California STS at 866-288-1909 to ask for options to customize your calls or create a personal profile. (Spanish Customer service number is 866-288-4151).

FORM(s)/ATTACHMENTS

Policy 0100.604 Access to Interpreters and Culturally and Linguistically Competent Providers
Policy 0100.605 Obtaining Interpretation, Translation, And Telephone Services For Clients With Physical Impairments Or Limited English Proficiency

REFERENCE

http://ddtp.cpuc.ca.gov/homepage.aspx
CCR, title 9, chapter 11, section 1810.410.

HUMBOLDT COUNTY DEPARTMENT OF
HEALTH & HUMAN SERVICES - BEHAVIORAL HEALTH
Policy & Procedure

Policy Number	**0100.607**
Policy Title	**TEXT TELEPHONE (TTY) USE**
Program	ADMINISTRATION
Affects	ALL
Effective date	3/27/1998
Revision dates	12/23/19, 8/8/23
Review dates	11/02/98,12/21/99, 01/03/01, 2/22/02, 09/20/04, 09/05/08, 12/11/10, 04/29/13, 12/20/13, 01/14/14, 1/4/18, 7/10/19
BH Director Approval date	08/14/2023

PURPOSE

In order to properly serve the population of Humboldt County who are deaf, hard of hearing, or speech-impaired, the Department of Health and Human Services - Behavioral Health (DHHS-BH) provides a text telephone line.

DEFINITION(S)

Text Telephone (TTY): a small telecommunications device with a keyboard for typing and a screen for reading conversation. A TTY is often used by people who are deaf, hard of hearing, or speech-impaired.

California Relay Service (CRS): provides specially-trained operators to relay telephone conversations back and forth between people who are deaf, hard of hearing, or speech-impaired and all those they wish to communicate with by telephone.

POLICY

Department of Health and Human Services-Behavioral Health provides a TTY line for use with callers who are deaf, hearing-impaired, or speech impaired.

PROCEDURE

1. **If a BH staff member wishes to call a client with a hearing impairment at his/her residence, from a standard telephone to TTY:**
   1.1. Dial a voice relay operator: **1-800-735 2922 (English) or** 1-800-855-3000 (Spanish).
   1.2. Give the relay operator the area code and TTY number you wish to call.
   1.3. The operator will voice what the TTY user says to you and type to the other party what you say.
   1.4. The conversation can go back and forth as long as necessary.
   1.5. You will need to talk slower than usual because everything you say is being typed.
   1.6. There are no charges for using the relay service. Usual charges for long distance calls will apply.

2. **If a client with a hearing impairment wishes to call BH, from TTY to standard telephone:**

2.1. The client will dial a TTY relay operator: **1-800-735-2929 (English)** or 1-800-855-3000 (Spanish)
2.2. The client will give the relay operator the area code and voice phone number they wish to call.
2.3. The operator will type what the DHHS-BH staff person voices to the client, and voice to the DHHS-BH staff person what the client types on their TTY.
2.4. The conversation can go back and forth as long as necessary.
2.5. There are no charges for using CRS. The usual charges for long distance calls will apply.

3. **When meeting with a client with a hearing impairment in person:**
   3.1. If possible, determine the client's preferred method of communication prior to the appointment. If the communication method cannot be predetermined, use handwritten notes or type back and forth into a Word document to ask the client how they prefer to communicate. Offer the following alternatives:
      3.1.1. Written communication, handwritten or typed.
      3.1.2. ASL Interpreter (refer to the Behavioral Health Community Interpreter list for instructions and contact information for ASL interpreters).
      3.1.3. Client's choice of interpreter (e.g., adult friend or family member over age 18).

4. When assisting a client with a hearing impairment who wishes to place a TTY call from a DHHS-BH site to another location:
   4.1. The TTY phone is stored at 730 Harris Street, Quality Improvement Office, in a marked box.
   4.2. Set up the TTY machine by plugging the cord into the TTY machine and then into the telephone wall outlet.
   4.3. Connect to the TTY voice relay operator:
      4.3.1. If calling within the state of California, dial: **711, 1-800-735 2922 (English) or** 1-800-855-3000 (Spanish).
      4.3.2. If calling long distance outside of California, dial **711**.
      4.3.3. This connects to the California Relay Service operator.
      4.3.4. Give the relay operator the phone number so that the relay operator can place the call to the other party.
      4.3.5. NOTE: At the end of each statement, the client should say "Go ahead" to indicate they are done communicating. There is a key on the TTY phone to use "GA" (go ahead) if preferred.
      4.3.6. There will be a printout on the TTY phone of the conversation. The conversation will also be imprinted on the front of the keyboard.

FORM(s)/ATTACHMENTS

Behavioral Health Community Interpreter list

REFERENCE

http://ddtp.cpuc.ca.gov/
CCR, title 9, chapter 11, section 1810.410

HUMBOLDT COUNTY DEPARTMENT OF
HEALTH & HUMAN SERVICES - BEHAVIORAL HEALTH
Policy & Procedure

Policy Number	**0100.608**
Policy Title	**ACCESS TO INTERPRETER SERVICES - LANGUAGE LINE USE**
Program	ADMINISTRATION
Affects	ALL
Effective date	03/27/1998
Revision dates	7/27/15, 1/4/18
Review dates	11/02/98,12/21/99, 01/03/ 01, 02/22/02, 09/20/04, 09/05/08,12/11/10, 04/29/13, 12/20/13, 01/14/14, 7/10/19, 11/9/20, 12/08/22
BH Director Approval date	12/08/022

PURPOSE

Humboldt County Department of Health and Human Services-Behavioral Health provides access to language interpretive services over the telephone.

DEFINITION(S)

POLICY

Department of Health and Human Services (DHHS) - Behavioral Health obtains interpretation, translation, and telephone services whenever clients are in need of language line, or services that assist clients with hearing, vision, or speech impairments

PROCEDURE

Please refer to Policy and Procedures 0100.604 Access to Interpreters and Culturally and Linguistically Competent Providers and 0100.605 Obtaining Interpretation, Translation, and Telephone Services for Clients with Physical Impairments or Limited English Proficiency.

1. When receiving a call from a client with limited English proficiency:
   1.1. Use the CONF button to place the client on hold.
   1.2. To access Language Line Services, dial **1-800-874-9426** or **1-866-874-3972.**
   1.3. Enter on your telephone keypad your 6-digit Client ID: 501181.
   1.4. Press 1 for Spanish.
   1.5. Press 2 for all other languages (Speak the name of the language at the prompt). You may press 0 or stay on the line for assistance with language identification.
   1.6. Give Information
      1.6.1. MH Access Code: 1170424
      1.6.2. Your first and last name
   1.7. An Interpreter will be connected to the call.
   1.8. Brief the Interpreter. Summarize what you wish to accomplish and give any special instructions.

1.9. Add client with limited English proficiency to the line:

1.9.1. by pushing the CONF button **once** when using AT&T Voice Dynamic Network Application (VDNA) Polycom system, OR

1.9.2. by pushing the CONF button **twice** when using Nitsuko / NEC phone system.

2. When placing a call to a client with limited English proficiency:

2.1. To access Language Line Services, dial **1-800-874-9426** or **1-866-874-3972.**

2.2. Follow steps 1.3. to 1.7. above. Request the language your client speaks. When the interpreter is connected, put the interpreter on hold by using the **CONF** button.

2.3. Call the client with limited English proficiency.

2.4. Conference in the interpreter

2.4.1. by pushing the CONF button **once** when using AT&T Voice Dynamic Network Application (VDNA) Polycom system, OR

2.4.2. By pushing the CONF button **twice** when using Nitsuko / NEC phone system.

2.5. If you need assistance when placing a call to a client with limited English proficiency, you may press 0 to transfer to a representative.

FORM(s)/ATTACHMENTS

Language Line Use FAQs

REFERENCE

BH Language Line Training
California Code of Regulations, title 9, chapter 11, section 1810.410
0100.604 Access to Interpreters and Culturally and Linguistically Competent Providers
0100.605 Obtaining Interpretation, Translation, and Telephone Services for Clients With Physical Impairments or Limited English Proficiency

HUMBOLDT COUNTY DEPARTMENT OF
HEALTH & HUMAN SERVICES - BEHAVIORAL HEALTH
Policy & Procedure

Policy Number	**0100.617**
Policy Title	**TRANSLATION OF WRITTEN MATERIALS**
Program	ADMINISTRATION
Affects	ALL
Effective date	06/27/16
Revision dates	09/18/2023
Review dates	09/23/2019
BH Director Approval date	01/11/2024

PURPOSE

The Department of Health and Human Services – Behavioral Health (DHHS-BH) provides translated clinical and non-clinical documents for the purpose of information and education to clients with Limited English Proficiency and their family members.

DEFINITION(S)

Limited English Proficiency (LEP) – A legal term referring to a level of English proficiency that is insufficient to ensure equal access to medical services without a health care interpreter.

Interpretation – Is the act of verbal communication, which is a process of accurate transposition of spoken words from one language to another.

Translation – Is the act of translating a written expression, of the meaning of a word, speech, book, etc. in another language.

Threshold Language – A language identified as the primary language, as indicated on the Medi-Cal Eligibility Data System (MEDS), of 3,000 beneficiaries or five percent of the beneficiary population, whichever is lower, in an identified geographic area, per Title 9, CCR Section 1810.410 (a)(3). Humboldt County's only Threshold Language is Spanish.

POLICY

DHHS-BH provides interpretation (verbal) and translation (written) services to clients with Limited English Proficiency (LEP) and their family members. DHHS – BH has a mechanism for ensuring accuracy of translated materials in terms of both language and culture.

PROCEDURE

1. Requests for translation of clinical documents that contain personal health information (PHI):
   1.1. Senior Program Manager (SRPM) or designee approves the request for translation of a clinical document.

1.2. SRPM or designee forwards the document(s) to be translated to the Quality Improvement Coordinator (QIC) or designee.
1.3. QIC or designee contacts Language Line Solutions to request a quotation of the cost, and arranges for translation services through Language Line Solutions.
1.4. QIC or designee sends the translated clinical documents back to the SRPM or designee who will arrange for treating staff to give the document to the client.
1.5. SRPM or designee forwards the translated document to Medical Records for inclusion in the client's health record.

2. Requests for written translation of non-clinical documents in threshold languages will be given priority, (such as forms, flyers, surveys, program brochures, educational materials):
   2.1. SRPM or designee approves the request for translation of a non-clinical document.
   2.2. SRPM or designee fills out the Public Health Translation Request Tracker found in the DHHS Forms section of the DHHS Bulletin Board.
   2.3. The Public Health (PH) Interpreter/Translator will respond and provide availability and turn-around time for the translation services.
   2.4. If a reasonable turn-around time can be expected, PH Interpreter/Translator translates the document.
   2.5. A second review to assure accuracy of translated materials in terms of both language and culture is required.
   2.6. If a reasonable turn-around time for a second review through PH can be expected, the PH Interpreter/Translator may arrange for a second review. Alternatively, the SRPM or designee may arrange for the second review through a community interpreter, or qualified bi-lingual staff.
   2.7. If the PH Interpreter/Translator is unavailable, SRPM or designee contacts a qualified, contracted Community Interpreter/Translator.
   2.8. After the Community Interpreter/Translator has provided the translation, the SRPM or designee arranges for a second review through either the PH Interpreter/Translator, another contracted Community Interpreter/Translator or DHHS-BH bi-lingual staff.
   2.9. If neither the PH Interpreter/Translator nor contracted Community Interpreters/Translators are available, the SRPM or designee requests that QIC or designee contacts Language Line Solutions to request a quotation of the cost and arranges for translation services through Language Line Solutions as appropriate.
   2.10. SRPM or designee sends translated document to QIC or designee for tracking purposes.
   2.11. Program staff or Quality Improvement staff makes the translated document available on the DHHS Bulletinboard as appropriate or arranges with print shop to obtain hard copies for distribution to programs.
   2.12. Clinical staff may review the translated version of a document with clients to assess the level of understanding as indicated. If clients consistently identify wording that reflects a more regional or colloquial form of expression, clinical staff informs the QIC to explain and request changes.

FORM(s)/ATTACHMENTS

None

REFERENCE

MHSUDS Information Notice No.: 15-042 Annual Review Protocol For Consolidated Specialty Mental Health Services And Other Funded Services Fiscal Year 2015-2016
CFR, title 42, section 438.10(d)(i),(ii)
CCR, title 9, chapter 11, sections 1810.110(a) and 1810.410(e)(4)
CFR, title 42, section 438.10(d)(2)
MHP Contract, Exhibit A, Attachment I

HUMBOLDT COUNTY DEPARTMENT OF
HEALTH & HUMAN SERVICES - BEHAVIORAL HEALTH
Policy & Procedure

Policy Number	**0100.150**
Policy Title	**RACIAL AND CULTURAL EQUITY IN BEHAVIORAL HEALTH**
Program	ADMINISTRATION
Affects	ALL
Effective date	08/16/2021
Revision dates	01/25/2024
Review dates	12/14/2023
BH Director Approval date	01/26/24

PURPOSE

To provide the foundation for the Department of Health and Human Services – Behavioral Health (DHHS-BH) to advance racial and cultural equity by dismantling systemic and structural racism and inequality.

DEFINITION(S)

Racial Equity: A reality in which a person is no more or less likely to experience society's benefits or burdens because of the color of their skin.

Racism: The marginalization and/or oppression of people of color based on a socially constructed racial hierarchy that privileges white people.

Structural racism: A system in which public policies, institutional practices, cultural representations, and other norms work in various, often reinforcing ways to perpetuate racial group inequity.

Systemic (institutional) racism: Policies and practices within and across institutions that, intentionally or not, produce outcomes that chronically favor, or disadvantage a racial group.

Cultural Equity: A reality in which a person is no more or less likely to experience society's benefits or burdens because of their race, ethnicity, age, disability, sexual orientation, gender, gender identity, socioeconomic status, geography, citizenship status, or religion.

Structural inequality: Systems of power that grant privilege and access unequally so that inequity and injustice result.

California Department of Health Care Services (DHCS): The Department that oversees the work of Mental Health Plans in the State of California, including the Cultural Competence Plan.

POLICY

It is the policy of DHHS-BH to work to advance racial and cultural equity by dismantling systemic (institutional) and structural racism and structural inequality. BH acknowledges that systems that are failing racial groups are failing all groups, and that dismantling racism in all its forms will result in improvements for everyone.

This policy will be implemented through the procedures outlined below

PROCEDURE

1. All BH policies, procedures and forms will be developed and reviewed as outlined in Policy and Procedure 0100.151 with a conscious consideration of how they advance, or hinder, racial, and cultural equity.

2. All BH budgets will be developed and reviewed as outlined in Policy and Procedure 0100.152 with a conscious consideration of how they advance, or hinder, racial and cultural equity.

3. All BH documents and communications such as Handbooks, Strategic Plans, Requests for Proposals, and website content will be developed and reviewed with conscious consideration of how they advance, or hinder, racial and cultural equity.

4. BH will work with the DHHS – Employee Services to strategize recruitment of qualified Black, Indigenous, People of Color (BIPOC) and other culturally diverse individuals (such as members of the LGBTQ+ community, people with a disability, etc.) for positions in BH.

5. BH will not discriminate or otherwise use cultural categories to choose or eliminate candidates for staff positions unless the position is one that is specifically intended to work with a cultural group or community and that group or community would benefit from having a staff person reflective of, or with their, lived experience.

6. BH will develop and implement the use of interview question(s) that will help to assess an interviewee's attitudes, beliefs and behaviors in order to select qualified applicants whose values align with racial and cultural equity.

7. The onboarding process for all BH staff will include training on racial and cultural equity as developed and required by DHHS and the County of Humboldt.

8. BH staff will participate in a minimum of one annual training focused on racial and/or cultural equity. Additional racial equity and/or cultural equity trainings may also be assigned throughout the year.

9. BH will hire and/or assign a staff member to serve in the role of "Ethnic Services Manager" (ESM). ESM is the title established by the DHCS to describe specific duties of individuals focused on racial and cultural responsiveness in County Behavioral Health.
   - 9.1 To the extent that resources allow, the ESM's duties will be consistent with the *Framework for Advancing Cultural, Linguistic, Racial & Ethnic Behavioral Health Equity* as developed by the California Behavioral Health Directors Association (CBHDA).
   - 9.2 The ESM will be an active member of the Cultural Competence, Equity & Social Justice Committee (CCESJC) of CBHDA.
   - 9.3 The ESM will report to the BH Director and in their role, work to ensure the branch actively works to fulfill the intent of this policy, dismantle systemic and structural racism, and advance racial and cultural equity.

10. BH will support and maintain a Cultural Responsiveness Committee (CRC), whose purpose is to strengthen BH's ability to provide client, family and community-driven, culturally and linguistically responsive services to Humboldt County's diverse population.
    - 10.1 The CRC will be comprised of employees from programs within BH as well as clients, family members and other community partners.
    - 10.2 The CRC will meet monthly and be facilitated by the ESM and Quality Improvement Program Manager (QI-PM)
    - 10.3 The CRC will monitor the implementation of the Cultural Competence Plan through a dedicated agenda item at CRC meetings.
    - 10.4 CRC members will share relevant information about CRC activities with their managers, supervisors and other staff in their programs, and will bring relevant information from their programs to the CRC to ensure a communication loop.

11. BH will develop, update, and maintain a Cultural Competence Plan (CCP) consistent with the criteria established by DHCS.
    - 11.1 The ESM and QI-PM have the primary responsibility for updating and completing the CCP each year.
    - 11.2 The ESM and QI-PM ensure that the CCP is reviewed by the CRC and BH Administration before submission to DHCS.
    - 11.3 The implementation of the CCP is monitored by the CRC.

12. BH will be an active member of the DHHS Racial Equity Steering Committee (Committee) and will participate in implementing strategies and activities that are developed by the Committee.
    12.1 The ESM is the assigned staff member to participate in the Committee on behalf of BH. The BH Director may assign other BH staff members in addition to, or instead of, the ESM to participate in the Committee.
    12.2 The ESM will share the progress and activities of the Committee at BH Managers meetings and at CRC meetings and will take information from BH Managers and CRC members back to the Committee to ensure a communication loop.
    12.3 BH Managers will share relevant information about Committee activities with supervisors in their programs. Supervisors are expected to share this information with their staff.
    12.4 CRC members will share relevant information about Committee activities with other staff in their programs.

13. As resources allow, BH will participate in other Humboldt County-sponsored committees, groups, programs, or activities relating to racial and/or cultural equity if such committees, groups, programs or activities are developed.

FORM(s)/ATTACHMENTS

NONE

REFERENCE

Annual Cultural Competence Plan
Behavioral Health Strategic Plan
Policy 0100.151, Racial and Cultural Equity Document Review in Behavioral Health
Policy 0100.152, Racial and Cultural Equity Budget Review in Behavioral Health

HUMBOLDT COUNTY DEPARTMENT OF
HEALTH & HUMAN SERVICES - BEHAVIORAL HEALTH
Policy & Procedure

Policy Number	**0100.151**
Policy Title	**RACIAL AND CULTURAL EQUITY WRITTEN MATERIAL REVIEW IN BEHAVIORAL HEALTH**
Program	ADMINISTRATION
Affects	ALL
Effective date	08/16/2021
Revision dates	05/16/2022
Review dates	
BH Director Approval date	08/04/2022

PURPOSE

To ensure that all Behavioral Health written materials will be developed and reviewed with a conscious consideration to advance racial and cultural equity and dismantle systemic (institutional) and structural racism and structural inequality.

DEFINITION(S)

Racial Equity: A reality in which a person is no more or less likely to experience society's benefits or burdens because of the color of their skin.

Cultural Equity: A reality in which a person is no more or less likely to experience society's benefits or burdens because of their race, ethnicity, age, disability, sexual orientation, gender, gender identity, socioeconomic status, geography, citizenship status, or religion.

Structural inequality: Systems of power that grant privilege and access unequally so that inequity and injustice result.

Structural racism: A system in which public policies, institutional practices, cultural representations, and other norms work in various, often reinforcing ways to perpetuate racial group inequity.

Systemic (institutional) racism: Policies and practices within and across institutions that, intentionally or not, produce outcomes that chronically favor, or disadvantage a racial group.

Policy: a plan, course of action or guiding principle adopted by an organization, intended to influence, and determine decisions, actions, and other matters.

Procedure: a set of actions which is the official or accepted way of doing something.

Written material: For the purposes of this policy, written material includes policies, procedures, forms, brochures, and informing materials that are in written form

POLICY

All Behavioral Health (BH) written materials will be developed and reviewed with a conscious consideration to advance racial and cultural equity and dismantle systemic (institutional) and structural racism and structural inequality.

PROCEDURE

1. BH r written materials shall be developed and reviewed using the BH Racial and Cultural Equity Review Tool for Written Materials (Review Tool).
2. It is the responsibility of the program developing the written materials to develop and review the materials referencing and following the guidance included in the Review Tool.
3. The materials will then go to the Ethnic Services Manager who will review or identify the appropriate individual or group to review using the Review Tool.
4. If written materials are found to need modification after the review with Review Tool, they will be returned to the program with recommendations for changes to be made. If the program needs additional technical assistance (TA) to make appropriate changes, they will initiate consultation with the DHHS Racial Equity Steering Committee, Cultural Responsive Committee or other group that may be developed within DHHS or the County, to identify appropriate resources for TA. The revised materials will then go back for review as specified in 3 above.
5. After the materials have been reviewed and approved as outlined above, they will proceed to the Policy and Procedure Review Committee following the procedures set forth in Policy 0100.100, Control and Organization of Policy Manuals.

FORM(s)/ATTACHMENTS

BH Racial and Cultural Equity Review Tool for Written Materials

REFERENCE

Policy 0100.100 Control and Organization of Policy Manuals

HUMBOLDT COUNTY DEPARTMENT OF
HEALTH & HUMAN SERVICES - BEHAVIORAL HEALTH
Policy & Procedure

Policy Number	**0100.152**
Policy Title	**RACIAL AND CULTURAL EQUITY BUDGET REVIEW IN BEHAVIORAL HEALTH**
Program	ADMINISTRATION
Affects	ALL
Effective date	08/16/2021
Revision dates	
Review dates	12/14/2023
BH Director Approval date	01/10/2024

PURPOSE

To ensure that the Department of Health and Human Services – Behavioral Health (DHHS-BH) budgets are developed and reviewed with a conscious consideration to advance racial and cultural equity and dismantle systemic (institutional) and structural racism and structural inequality.

DEFINITION(S)

Budget: An estimate of income and expenditure for a set period of time, usually one year.

Racial Equity: A reality in which a person is no more or less likely to experience society's benefits or burdens just because of the color of their skin.

Cultural Equity: A reality in which a person is no more or less likely to experience society's benefits or burdens because of their race, ethnicity, age, disability, sexual orientation, gender, gender identity, socioeconomic status, geography, citizenship status, or religion.

POLICY

All DHHS-BH budgets will be developed and reviewed with a conscious consideration to advance racial and cultural equity and dismantle systemic (institutional) and structural racism and structural inequality

PROCEDURE

1. DHHS-BH budgets shall be developed and reviewed using the BH Budget Planning Questionnaire (Budget Questionnaire). The Budget Questionnaire is distributed by DHHS Finance every year.

2. It is the responsibility of the program developing the budget to use the Budget Questionnaire, which includes specific questions regarding the impact of proposed budgets on racial and cultural communities, whether the program is adequately staffed to be culturally responsive in serving members of the community, and suggestions for services, activities or outreach that could be provided to better support racial and cultural equity.

3. The Budget Questionnaire is developed with staff, supervisor, and manager input. When it is completed it will be submitted to the Deputy Director of the Program, who will then compile and submit to the BH Director. The information in the Budget Questionnaire is reviewed and submitted to BH fiscal with a copy to the Financial Services Deputy Director. The Budget Questionnaire informs internal branch budget decisions including staffing, resource allocation, programming, and service provision, among other things.

FORM(s)/ATTACHMENTS

BH Budget Planning Questionnaire

REFERENCE

Policy 0100.150 Racial and Cultural Equity in Behavioral Health

HUMBOLDT COUNTY DEPARTMENT OF
HEALTH & HUMAN SERVICES - BEHAVIORAL HEALTH
Policy & Procedure

Policy Number	**0704.460**
Policy Title	**CLIENT PROBLEM RESOLUTION PROCESS**
Program	PERFORMANCE MANAGEMENT UNIT - QUALITY IMPROVEMENT
Affects	ALL BHP AND DMC-ODS PROGRAMS
Effective date	08/07/2006
Revision dates	6/17/19, 6/8/20, 7/13/2020, 11/16/20, 9/13/2021, 12/21/2023, 08/07/25
Review dates	03/12/10, 07/21/10, 03/01/11, 04/08/12, 19/27/13, 1/30/14, 9/13/17

PURPOSE

Humboldt County Department of Health and Human Services - Behavioral Health (DHHS-BH) assures that individuals receive thoughtful and timely response and resolution to requests for problem resolution, including Grievances, Appeals, Requests for Change of Provider, and Requests for Second Opinion.

Clients, or Providers acting on their behalf, shall not be subject to any cost penalty or discrimination for initiating a request, Grievance, or Appeal.

DEFINITION(S)

Grievance: An expression of dissatisfaction about any matter other than an Adverse Benefit Determination. A complaint is the same as a formal grievance. A complaint shall be considered a grievance unless it meets the definition of an “adverse benefit determination” (see below). Grievances may include, but are not limited to, the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a provider or employee, failure to respect the beneficiary’s rights regardless of whether remedial action is requested, and the beneficiary’s right to dispute an extension of time proposed by the Plan to make an authorization decision. There is no distinction between an informal and formal grievance.

Discrimination Grievance: A concern of discrimination based on sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation.

Appeal: A request for review of an Adverse Benefit Determination.

Adverse Benefit Determination: An “Adverse Benefit Determination” occurs when the DHHS-BH, while acting as the MHP for the County, takes any of the following actions:

1. The denial or limited authorization of requested services, including determinations based on the type or level of service, medical necessity, appropriateness, setting, or effectiveness of a covered benefit (1045 – Denial, 1045 – Delivery System);
2. The reduction, suspension, or termination of a previously authorized service (1045 – Modification, 1045 – Termination);
3. The denial, in whole or in part, of payment for a service (1045 – Payment Denial);
4. The failure to provide services in a timely manner (1045 – Timely Access, 1045 – Authorization Delay);
5. The failure to act within the required timeframes for standard resolution of grievances and appeals (1045 – Failure to Timely Resolve Grievances and Appeals); or
6. The denial of a beneficiary’s request to dispute financial liability (1045 – Financial Liability).

Request for Change of Provider: A request by a client to change treatment provider, whether physician, clinician, or Case Manager, within DHSS-BH or a contract provider. Responses will be sent to clients within fifteen (15) working days.

Request for Second Opinion: A request by a client for review of a decision regarding medical necessity criteria or type or level of service [a Notice of Adverse Benefit Determination (NOABD) situation], or review of diagnosis or treatment regimen. Responses will be sent to clients within fifteen (15) working days.

Trans-inclusive health care: Also known as TGI (transgender, gender diverse, or intersex) care, is defined as comprehensive health care that aligns with established standards of care for individuals who identify as transgender, gender diverse, or intersex. This approach to care emphasizes the importance of honoring each person's bodily autonomy, avoiding assumptions about gender identity, and embracing gender fluidity and nontraditional gender presentations. TGI care requires providers to treat all individuals with compassion, respect, and understanding, ensuring that behavioral health services are affirming, inclusive, and responsive to the unique needs and experiences of TGI individuals.

POLICY

During the process of responding to and resolving clients' requests, their rights to confidentiality shall be respected by all staff involved. The Quality Improvement Coordinator (QIC) or designee will coordinate, facilitate, log and track all requests for problem resolution. The QIC or designee is the assigned staff member responsible for responding to clients' questions regarding the status of their requests for problem resolution. Trended data from the problem resolution process shall be utilized in the Quality Improvement program to improve quality of care.

Through this policy, DHHS-BH shall ensure compliance with all TGI-related grievance monitoring and training reporting requirements as specified in BHIN 25-019. This includes tracking grievances related to failure to provide trans-inclusive care and reporting such data to DHCS on a quarterly basis.

PROCEDURE

All Requests for Problem Resolution will be logged, tracked and reported by the QIC or designee to the Quality Improvement Committee on a quarterly basis. The QIC or designee shall be responsible for all reports to the State about the Problem Resolution process.

1. Clients may authorize another person to act on their behalf in the Grievance and Appeal process, and they may also request that a staff member assist them. The Quality Improvement Coordinator or designee will assign a staff member in those cases.

2. Grievances or Appeals may be made verbally or in writing by a client, family member, or other client representative, to the Quality Improvement Coordinator or designee, a staff member, or the Patients' Rights Advocate.

   2.1. If the problem involves an Adverse Benefit Determination, the Problem Resolution request shall be treated as an Appeal (see Policy No. 0704.500).

3. Problem Resolution Forms and self-addressed envelopes will be available at all Provider sites so that the clients may obtain them without having to make a verbal request. Information about the problem resolution process, including the availability of fair hearings, is included in the beneficiary handbook and offered to all new clients at intake (see form 1196–Informing Materials Packet–Client Acknowledgement) and is present at all provider sites.

4. Resolution of problems may be reached through discussion between the client or client representative and any staff member. Every effort will be made to resolve problems at this level.

5. **Grievance**

   5.1. Clients may present Grievances either orally or in writing. Clients are encouraged to utilize, but not required to use, the Client Problem Resolution Form. If clients do not wish to use the Form, they may call the QIC or designee directly at (707) 268-2955, option 2, or any DHHS-BH staff may complete the Form for them. If necessary, a Release of Information Form (ROI) will be obtained from the client by the QIC or designee. The client may submit other written materials with the Grievance and may also request to review their own records.

5.2. Grievances and Appeals are documented and tracked by the Quality Improvement Unit in the BH Client Concern Database. The QIC or designee will enter the Problem Resolution request into the BH Client Concern Database within one (1) working day of receipt.

5.2.1. The Log information will include at a minimum:

- 5.2.1.1. The date and time of receipt of the grievance or appeal;
- 5.2.1.2. The name of the member filing the grievance or appeal;
- 5.2.1.3. The name of the representative recording the grievance or appeal;
- 5.2.1.4. A description of the complaint or problem;
- 5.2.1.5. A description of the action taken by the BHP or provider to investigate and resolve the grievance or appeal;
- 5.2.1.6. The proposed and final resolution by the BHP or provider;
- 5.2.1.7. The name of the BHP provider or staff responsible for resolving the grievance or appeal; and
- 5.2.1.8. The date of notification to the member of the resolution.
- 5.2.1.9. The date of each review or review meeting (if applicable),
- 5.2.1.10. The resolution information at each level of the problem (if applicable); and the date of resolution at each level of the problem (if applicable).

5.2.2. The Log shall document resolution of the problem within thirty (30) calendar days of its receipt, as well as the date the decision was sent to the client, or the reason why the problem could not be resolved.

5.2.3. The Quality Improvement Unit will issue a reminder letter one (1) week prior to due date to managers or supervisors who have Grievances or appeals that have not been resolved. If any Grievances or Standard Appeals are still outstanding within one week of the due date, Quality Improvement will notify Behavioral Health Administration (Director or Deputy Director) who will follow up with the responsible manager or supervisor to ensure resolution within the timeframe.

5.3. The QIC or designee will write a letter to the client acknowledging the receipt of the Grievance and explaining the Grievance process, within five (5) calendar days of receipt by the QIC or designee. The notification letter which is sent to the client is copied and kept with the original Grievance or Appeal form, and the date of the notification is noted in the Database.

5.3.1. The acknowledgement shall include the date of receipt, as well as the name, telephone number, and address of the MHP representative who the beneficiary may contact about the grievance.

5.4. If the Client Problem Resolution Form has not been completed, the QIC or designee will complete the Form. The Form (and any other documentation the client has submitted) will be sent to the appropriate Manager or Supervisor (Director, Deputy Director, Medical Director, Director of Nurses, Sr. Program Manager, Supervising Clinician) within one (1) working day of receipt by the QIC or designee. If the appropriate Manager or Supervisor was involved in the subject that is being grieved, another Manager will be designated to investigate the Grievance.

5.5. Upon receipt of the Form from the QIC or designee, the Manager or designee will investigate the problem in conjunction with other staff as necessary (only staff who is not involved in the issue being grieved) and will initiate and hold a discussion with the client and/or representative to resolve the problem.

5.5.1. The Grievance must be investigated and resolved within thirty (30) calendar days, unless the client requests more time, or there are other circumstances justifying a reason to delay. DHHS-BH may extend the timeframe for processing a grievance by up to fourteen (14) calendar days if the beneficiary requests an extension, or if DHHS-BH determines that there is a need for additional information and the delay is in the beneficiary's interest. If the timeframe is extended not at the request of the beneficiary, DHHS-BH will make reasonable efforts to give the beneficiary prompt oral notice of the delay and give the beneficiary written notice of the extension and the reasons for the extension within two (2) calendar days of the decision to extend the timeframe. This written notice of extension shall inform the beneficiary of the right to file a grievance if they disagree with DHHS-BH's decision. This notice is not a Notice of Adverse Benefit Determination. DHHS-BH may extend the timeframe for an additional fourteen (14) calendar days if the beneficiary requests the extension or DHHS-BH demonstrates a need for additional information and how the delay is in the beneficiary's best interest.

5.5.2. QIC or designee is responsible for sending Notice of Adverse Benefit Determination 1045 – Failure to Timely Resolve Grievances and Appeals NOABD when MHP fails to act within the timeframe for disposition for Grievances, see Policy Number 0704.500.

5.6. The Manager or designee who is responsible for the investigation will notify the client in writing of the resolution using the QI-115 Notice of Grievance Resolution form, which shall contain a summary of the grievance filed by the member, steps taken to resolve the grievance (e.g., investigation, speaking with provider), a clear and concise explanation of how the grievance was resolved, including if it was resolved in favor of the member, and the reasons for the decision. The following attachments will be included with all QI-115 Notice of Grievance Resolution forms: QI-109 Nondiscrimination, QI-110 Language Assistance, and QI-112 NAR Your Rights. If grievance is regarding staff, then Manager or Supervisor investigating the grievance must notify the staff grieved about of the disposition using the QI-105 Letter to Provider. The Manager will also send the documentation of the resolution to the QIC or designee (original of the Problem Resolution Form, copy of the QI-115 Notice of Grievance Resolution sent to member, and copy of the QI-105 Letter to Provider (if applicable).

5.7. The Manager may notify clients who do not have a permanent mailing address either in person or by telephone with written documentation of the discussion.

5.8. For clients who have been working with billing (Claims Data Management) and are not satisfied:

5.8.1. Billing will refer the client to the Managed Care Line.

5.8.2. QI will collect information about the client from the Electronic Health Record and billing. This process may take one to two days.

5.8.3. QI will contact Claims Data Management to determine what has already been done to assist the client. If a rate adjustment might be warranted the matter will be discussed with the QIC or designee or PMU Manager.

5.8.4. The QIC will notify the client by telephone of the status of their inquiry. If the client is still not satisfied, the client may file a Grievance.

5.8.5. The Grievance will be managed in the usual manner and will be tracked in a Finance Grievance Log binder separate from other grievances.

5.9. **<u>Grievances Related to Trans-Inclusive Care</u>**

5.9.1. Grievances involving failure to provide trans-inclusive care (as defined in W&I Code §14197.09) shall be:

5.9.1.1. Logged as TGI-related in the Client Concern Database.

5.9.1.2. Investigated and resolved following all standard grievance procedures.

5.9.1.3. Tracked separately and reported to DHCS quarterly.

5.9.1.4. If the grievance is resolved in the member's favor, the individual(s) named must complete a refresher of the DHHS-BH-approved trans-inclusive health care cultural competency training within 45 calendar days and before any further direct contact with members.

5.9.2. The QIC or designee shall report the following elements to DHCS quarterly:

5.9.2.1. Total number of trans-inclusive care grievances received

5.9.2.2. Total number resolved in favor of the member

5.9.2.3. Dates of receipt and resolution

5.9.2.4. Name, position, and affiliation of individual(s) involved

5.9.2.5. Refresher training completion dates

5.9.2.6. Any corrective actions taken to prevent recurrence

5.9.3. The QIC or designee will ensure all documentation of Discrimination Grievances is sent to DHCS Office of Civil Rights within ten (10) calendar days of mailing the grievance resolution. For grievances involving denial of trans-inclusive care, the QIC or designee shall additionally follow the BHIN 25-019 reporting instructions and timelines, ensuring submission of quarterly reports to QAPIS@dhcs.ca.gov.

6. **Discrimination Grievance**

6.1. Clients may present Discrimination Grievances either orally or in writing. Clients are encouraged to utilize, but not required to use, the Client Problem Resolution Form. If clients do not wish to use the Form, they may call the QIC or designee directly at (707)268-2955, option 2, or staff may complete the Form for them. If necessary, a Release of Information Form (ROI) will be obtained from the client by the QIC or designee. The client may submit other written materials with the Grievance and may also request to review their own records.

6.2. QIC or designee will monitor incoming grievances for discrimination content - concern of discrimination based on sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation.

6.3. Discrimination Grievances will be assigned to Discrimination Grievance Coordinator/QIC who is responsible for ensuring compliance with federal and state nondiscrimination requirements and investigating Discrimination Grievances related to any action that would be prohibited by, or out of compliance with, federal or state nondiscrimination law.

6.4. Discrimination Grievances are documented and tracked by the Quality Improvement Unit on the Client Concern Database. The QIC or designee will enter the Problem Resolution request into the Client Concern Database within one (1) working day of receipt. The Database information will include the name of the client, the date of receipt, the nature of the problem, the time period allowed for resolution, the staff member responsible, the date of each review or review meeting (if applicable), resolution information at each level of the problem (if applicable), the date of resolution at each level of the problem (if applicable), and the date required documentation was sent to the DHCS Office of Civil Rights. The Log shall document resolution of the problem within thirty (30) calendar days of its receipt, as well as the date the decision was sent to the client, or the reason why the problem could not be resolved.

6.5. If the Client Problem Resolution Form has not been completed, the QIC or designee will complete the Form. The Form (and any other documentation the client has submitted) will be sent to the Discrimination Grievance Coordinator within one (1) working day of receipt by the QIC or designee.

6.6. The QIC or designee will write a letter to the client acknowledging the receipt of the Discrimination Grievance and explaining the Discrimination Grievance process, within five (5) calendar days of receipt by the QIC or designee. The notification letter which is sent to the client is kept with the original Discrimination Grievance form, and the date of the notification in noted on the Database.

6.6.1. The acknowledgement shall include the date of receipt, as well as the name, telephone number, and address of the Discrimination Grievance Coordinator who the beneficiary may contact about the grievance.

6.7. The Quality Improvement Unit will issue a reminder letter to the Discrimination Grievance Coordinator one (1) week prior to due date. QIC or designee will enter this date in the Client Concern Database.

6.8. Upon receipt of the Client Concern form from the QIC or designee, the Discrimination Grievance Coordinator will investigate the problem in conjunction with other staff as necessary (only staff who is not involved in the issue being grieved) and will initiate and hold a discussion with the client and/or representative to resolve the problem.

6.9. The Discrimination Grievance must be investigated and resolved within thirty (30) calendar days, unless the client requests more time, or there are other circumstances justifying a reason to delay.

6.9.1.1. DHHS-BH may extend the timeframe for processing a Discrimination grievance by up to fourteen (14) calendar days if the beneficiary requests an extension, or if DHHS-BH determines that there is a need for additional information and the delay is in the beneficiary's interest. If the timeframe is extended not at the request of the beneficiary, DHHS-BH will make reasonable efforts to give the beneficiary prompt oral notice of the delay and give the beneficiary written notice of the extension and the reasons for the extension within two (2) calendar days of the decision to extend the timeframe. This written notice of extension shall inform the beneficiary of the right to file a grievance if they disagree with DHHS-BH's decision. This notice is not a Notice of Adverse Benefit

Determination. DHHS-BH may extend the timeframe for an additional fourteen (14) calendar days if the beneficiary requests the extension or DHHS-BH demonstrates a need for additional information and how the delay is in the beneficiary's best interest.

6.9.1.2. QIC or designee is responsible for sending Notice of Adverse Benefit Determination 1045 – NOABD Failure to Timely Resolve Grievance/Appeal when MHP fails to act within the timeframe for disposition for Grievances, see Policy Number 0704.500.

6.9.1.3. The Discrimination Grievance Coordinator who is responsible for the investigation and will notify the client in writing of the resolution using the QI-115 Notice of Grievance Resolution form, which shall contain a summary of the grievance filed by the member, steps taken to resolve the grievance (e.g., investigation, speaking with provider), a clear and concise explanation of how the grievance was resolved, including if it was resolved in favor of the member, and the reasons for the decision. The following attachments will be included with all QI-115 Notice of Grievance Resolution forms: QI-109 Nondiscrimination, QI-110 Language Assistance, and QI-112 NAR Your Rights.

6.9.1.4. If grievance is regarding staff, then person investigating the grievance must notify the staff grieved about of the disposition using the QI-105 Letter to Provider. The Discrimination Grievance Coordinator will also send the documentation of the resolution to the QIC or designee (original of the Problem Resolution Form, copy of the QI-115 NGR mailed to client with attachments, and copy of the QI-105 Letter to Provider (if applicable).

6.10. If a grievance is decided in the member's favor, the applicable individual(s) must complete the trans-inclusive health care cultural competency training within 45 days from the grievance resolution and before having direct contact with members

6.11. The QIC or designee will ensure Discrimination Grievance documentation are sent to DHCS Office of Civil Rights within ten (10) calendar days of mailing a Discrimination Grievance resolution letter to beneficiary.

6.11.1. The following will be included:

6.11.1.1. The original complaint.
6.11.1.2. The provider's or other accused party's response to the complaint.
6.11.1.3. Contact information for the personnel primarily responsible for investigating and responding to the complaint on behalf of the MHP.
6.11.1.4. Contact information for the beneficiary filing the complaint, and for the provider or other accused party that is the subject of the complaint.
6.11.1.5. All correspondence with the beneficiary regarding the complaint, including, but not limited to, the Discrimination Grievance acknowledgment letter and resolution letter sent to the beneficiary.
6.11.1.6. The results of the MHPs investigation, copies of any corrective action taken, and any other information that is relevant to the allegation(s) of discrimination.
6.11.1.7. QIC or designee will enter the date the required documentation was sent to the DHCS Office of Civil Rights in the Client Concerns Database.

7. **Appeal**

7.1. For appeals or expedited appeals of adverse benefit determinations, see Policy No. 0704.500 Notice of Adverse Benefit Determination for details on the Appeal and Expedited Appeal Process.

7.2. For grievances that are "appealed" because the client is not satisfied with the resolution of the grievance, this is treated as a second grievance and follows the same general process as detailed in section 5. The only difference is that the resolution of this secondary grievance is completed by a person other than the one who resolved the original grievance. These are also usually escalated to a higher level of management/administration.

7.3. For appeals involving trans-inclusive care determinations, all resolution and follow-up training requirements outlined in BHIN 25-019 shall apply if the case is decided in favor of the beneficiary.

8. **Requests for Culture-Specific Provider**

8.1. Upon receipt of the request for access to services with the beneficiary's preference for a culture-specific Provider, and after determining that (A) it is a non-emergency request, and (B) client meets medical necessity.

8.2. The beneficiary will be given an alphabetical list of up to five (5) possible providers and asked to choose one.

8.3. The Access staff will then contact Provider and arrange for authorization or referral.

8.4. The beneficiary will be notified accordingly.

9. **Requests for Change of Provider and Second Opinion**

9.1. **Request for Change of Provider**

9.1.1. Upon notification of a Request for Change of Provider, the involved clinical or support staff member will request the individual to complete the Request for Change of Provider Form, with assistance from staff as necessary.

9.1.2. The Form will be forwarded to the QIC or designee. Upon the receipt of the Form, the QIC or designee will log the request and forward the Form within one working day to the appropriate Manager for resolution.

9.1.3. If the Change of Provider Request includes an expression of dissatisfaction, the Change of Provider Request will be logged as a Change of Provider Request with Grievance. If the Change of Provider Request does not include an expression of dissatisfaction, the Change of Provider Request will be logged as a Change of Provider Request.

9.1.4. The Manager or designee will investigate the request and make a determination in conjunction with other staff as necessary.

9.1.5. After the determination is made, the client and the provider(s) will be notified of the decision by the Manager or designee within fifteen working days of the initial receipt. A copy of the Form with the disposition will be forwarded to the QIC. A letter will be sent to the client to confirm approval of Change of Provider Request and a copy of the letter will be sent to QI.

9.1.5.1. If the Change of Provider Request includes an expression of dissatisfaction, the resolution letter will additionally address the complaints made by the consumer using the QI-115 Notice of Grievance Resolution.

9.2. **Request for Second Opinion**

9.2.1. DHSS-BH will provide for a Second Opinion from a qualified care professional within Mental Health Plan (MHP) network or will arrange for the beneficiary to obtain a second opinion outside the Mental Health Plan Network at no cost to the beneficiary.

9.2.2. The client will fill out the Request for Second Opinion Form with assistance from the staff as necessary. The Form will be forwarded to the QIC or designee. Upon receipt, the QIC or designee will log the request and forward the Form to the appropriate Manager.

9.2.3. The Manager or designee will assign a licensed behavioral health professional with the same level of professional licensure as the person who made the initial decision to perform a second assessment, using the Second Opinion Review Form. The assigned staff will have no prior involvement with their current course of treatment. If medication issues are involved in the disagreement, the Medical Director or designee will be involved as well. This assessment may be done as a face-to-face, telephone interview, and/or review of records.

9.2.4. The Manager or designee will forward the completed Second Opinion Form to the QIC or designee. If the second opinion assessment agrees with the initial decision, the client (and provider as appropriate) will be notified of the decision in writing by the QIC or designee within fifteen working days of the date of the second assessment. The client will be referred to the Grievance or Appeal process if a dispute remains.

9.2.5. If the Second Opinion assessment does not agree with the initial determination (which may mean that medical necessity was found) the client (and provider as appropriate) will be notified in writing by the QIC or designee within fifteen working days of the change of decision. Assigned clinical staff will then authorize the change in services as necessary.

FORM(s)/ATTACHMENTS

QI-25 Client Problem Resolution Guide
QI-27 Request for Second Opinion Cover
QI-28 Request for Second Opinion Form
QI-29 Request for Change of Service Provider Cover
QI-30 Request for Change of Service Provider Form
QI-31 Client Problem Resolution Guide (Spanish version)
QI-32 Client Problem Resolution Request Form (Spanish version)
QI-33 Request for Second Opinion Cover (Spanish version)
QI-34 Request for Second Opinion Form (Spanish version)
QI-35 Request for Change of Service Provider Cover (Spanish version)
QI-36 Request for Change of Service Provider Form (Spanish version)
QI-57a Client Problem Resolution Request Form-Client
QI-57b Client Problem Resolution Request Form-Staff
QI-109 Nondiscrimination
QI-110 Language Assistance
QI-112 NAR Your Rights
QI-105 Letter to Provider
QI-115 Notice of Grievance Resolution
1045 NOABD Failure to Timely Resolve Grievances and Appeals
DHCS TGI Quarterly Grievance Report Template

REFERENCE

Behavioral Health Information Notice No: 25-014
CEC Section 1157
CWIC Section 4070
CCR Title 9, Div. 1, Chapter 11, Subchapter 1, Art. 4, Section 1810.405 (e)
CCR Title 9, Div. 1, Chapter 11, Subchapter 5, Art. 1, Sections 1850.205 through 1850.208
CCR Title 9, Div. 1, Chapter 11, Subchapter 5, Art. 2, Sections 1850.215
CCR Title 22, Div. 3, Subdivision 1, Chapter 3, Art. 1.3, Section 51014.2
CCR Title 28, Div. 1, Chapter 2, Art. 8, Section 1300.70
42 CFR Sections 438.206 (b & 438.228
42 CFR Sections 438.400 through 438.424*
CFR title 42 Section 438.408(e)(1),(2) * (as modified by the waiver renewal request of August 2002 and CMS letter, August 22, 2003.)