Stanislaus County
Behavioral Health and Recovery Services

FY 24-25 Behavioral Health Equity Plan

Annual Update

Fiscal Year
2024-2025

Table of Contents[1]

[1]

Executive Summary

This Cultural Competence Plan (CCP), which Stanislaus County Behavioral Health and Recovery Services (BHRS) refers to internally as the Behavioral Health Equity Plan, outlines our strategic approach to advancing health equity and eliminating behavioral health disparities across the systems of care. This plan, submitted in compliance with California Code of Regulations, Title 9, Section 1810.410, and Department of Health Care Services (DHCS) Cultural Competence Plan requirements, documents BHRS's systemwide commitment to culturally and linguistically appropriate services and outlines strategies to identify and reduce behavioral health disparities among Medi-Cal beneficiaries and other underserved populations. This plan highlights strategies implemented during Fiscal Year 2024-2025 and establishes forward-looking goals for FY 2025-2026.

Key priorities identified in FY 2024–2025 included:

- Reducing access and penetration disparities for Latino/Hispanic, Asian/Pacific Islander, older adults, children under age 5, and limited English proficient populations
- Strengthening language access services, including interpreter services and translated materials
- Maintaining a culturally competent workforce through required training and workforce development
- Ensuring meaningful community and consumer participation through the Behavioral Health Equity Committee (BHEC)

This document fulfills the State-mandated CCP requirement for county behavioral health systems. Given the integrated nature of mental health and substance use disorder services at Stanislaus County BHRS, this plan addresses cultural competence across the entire behavioral health continuum. The document is organized primarily according to the State's CCP Requirements Criteria while integrating relevant National CLAS Standards and the County's internal strategic goals and objectives.

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Criterion 1: Commitment to Cultural Competence

ORGANIZATIONAL COMMITTMENT

Stanislaus County Behavioral Health and Recovery Services (BHRS) is committed to ensuring that all individuals have equitable access to high-quality, culturally and linguistically appropriate behavioral health services. Cultural competence and health equity are foundational principles embedded in BHRS's mission, policies, and system operations and align with federal CLAS Standards, state requirements, and county priorities.

BHRS leadership affirms that cultural competence is not a standalone initiative but an integrated component of service planning, delivery, and evaluation. Equity considerations are incorporated into program development, contracting, quality improvement, workforce development, and community engagement activities.

MISSION AND VISSION

BHRS operates from a foundational commitment to cultural competence and health equity that permeates every level of the organization. BHRS' mission is to provide and manage effective prevention and behavioral health services that promote the community's capacity to achieve wellness, resilience, and recovery outcomes.

Our vision is to continue to be a leader in behavioral health and to be recognized for excellence in the community, state, and nation. Excellence is defined not merely by clinical outcomes, but by the system's ability to provide welcoming, compassionate recovery services that are effective, equitable, and responsive to individuals' cultural health beliefs and practices, preferred languages, health literacy, and communication needs.

ORGANIZATIONAL VALUES

BHRS's organizational values explicitly support cultural competence and guide daily operations, decision-making, and service delivery. These values are not merely aspirational statements: they are operationalized through workforce training and development, program design, quality improvement processes, community partnership structures, and accountability mechanisms that ensure cultural competence remains central to all BHRS activities.

Member Focus: Members and their families drive the development of services. Respect for cultural competence is fundamental to quality care, ensuring that services are designed with (not for) the communities served.

Excellence: BHRS is committed to continuous improvement to provide the highest quality services that exceed member and community expectations. Excellence requires cultural responsiveness and the elimination of disparities in access, quality, and outcomes.

Respect: BHRS holds the fundamental belief that respect for all individuals, and their cultures is non-negotiable. This value guides all interactions with members, families, staff, and community partners.

Strategic and Integrating Behavioral Health Equity: The County demonstrates commitment to innovative, flexible, and socially responsible efforts to overcome systemic challenges and advance health equity across all populations served.

Leadership Values: BHRS leaders are committed to empowering others to make decisions, providing clear information, setting strategic direction, acknowledging progress, and providing support when needed. Leadership at all levels is accountable for advancing cultural competence.

Encourage Initiative and Innovation: BHRS actively solicits ideas from staff, members, and community partners, celebrates contributions, and explores ways to implement innovative approaches that improve cultural responsiveness and service quality.

Individuals Working Together to Achieve Results: BHRS fosters teamwork, encourages diversity, and supports cooperation, partnership, collaboration, shared responsibilities, and joint decision-making with peers, consumers, families, and community members. Achieving health equity requires collective action across all stakeholders.

These values foster the organizational culture essential for meaningful cultural competence – one that transcends compliance to embody cultural humility, community partnership, and genuine transformation in the conception, delivery, and continuous improvement of behavioral health services.

LEADERSHIP OVERSIGHT AND ACCOUNTABILITY

BHRS has designated the Behavioral Health Equity Manager (BHEM) as the individual responsible for implementation and oversight of the Cultural Competence Plan. The BHEM promotes and monitors quality and equitable care as it relates to diverse racial, ethnic, and cultural populations served by both county-operated and contracted behavioral health programs and collaborates across divisions to ensure systemwide alignment.

Responsibilities of the BHEM include:

- Oversight of implementation of the National CLAS Standards
- Coordination and facilitation of the Behavioral Health Equity Committee (BHEC)
- Monitoring compliance with cultural and linguistic requirements
- Coordination of cultural competence and interpreter-related training
- Oversight of nondiscrimination, grievance, and complaint processes
- Advising leadership on identified disparities and equity strategies

The Behavioral Health Equity Manager will meet on a quarterly basis with the Behavioral Health Director and/or the BHRS Executive Leadership Team to provide structured updates on progress toward implementation of the Behavioral Health Equity Plan. These quarterly meetings will include, at a minimum, updates on recommendations from the Behavioral Health Equity Committee, findings from ongoing monitoring of access, utilization, and outcome disparities, and progress related to staff training, workforce development, and other strategies and actions identified in this Plan. The Director and Executive Leadership Team will use these discussions to support and guide BHRS divisions and systems of care in addressing identified gaps, barriers, and implementation challenges, ensuring a coordinated, department-wide focus on advancing behavioral health equity.

Outcomes, decisions, and key action items resulting from these quarterly meetings will be documented and incorporated into ongoing Behavioral Health Equity Plan updates and reporting.

INTEGRATION INTO OPERATIONS

BHRS demonstrates a commitment to recognizing, valuing, and including racial, ethnic, cultural, and linguistic diversity within its system. Policies and procedures related to access, language services, nondiscrimination, and member rights support the operationalization of cultural competence across the system. Additionally, cultural competence is integrated into BHRS operations through the following mechanisms:

- Inclusion of cultural and linguistic expectations in provider contracts
    - Cultural and linguistic competence expectations are embedded in provider contracts, including requirements for language access, staff training, and nondiscrimination. Compliance is reviewed through contract monitoring activities with corrective action plans required when deficiencies are identified.
- Review of access, utilization, and outcome data through an equity lens
    - Access, penetration, utilization, and outcome data are routinely reviewed by race/ethnicity, age, language, and other demographic factors to identify disparities. These analyses inform program planning, resource allocation, and quality improvement priorities.
- Incorporation of equity considerations into quality improvement activities
    - Cultural competence and equity considerations are incorporated into Quality Improvement Committee (QIC) reviews, including analysis of grievances, complaints, service timeliness, and member experience data. Identified issues inform performance improvement activities.
- Workforce development
    - BHRS is focused on expanding the behavioral health workforce to reflect and connect with California's diverse population, a vital step in enhancing cultural competence and equity within the system. Equity principles are integrated into workforce recruitment, onboarding, supervision, and ongoing training requirements. Examples include required annual cultural competence training of eight (8) hours and targeted recruitment for bilingual positions.
- Engagement of members, families, and community members in planning and evaluation
    - Individuals with lived experience, family members, and community stakeholders participate in planning and evaluation activities through the Behavioral Health Equity Committee (BHEC) and other advisory bodies. Input is used to shape outreach strategies, service design, and policy updates.

      Additional information about practices and activities that demonstrate community outreach, engagement, and involvement efforts with identified racial, ethnic, cultural, linguistic, and other diverse communities experiencing mental health disparities can be found in the most recent MHSA Annual Update, available here.

Criterion 2: Updated Assessment of Service Needs

I. General Population

OVERVIEW OF STANISLAUS DEMOGRAPHICS

Stanislaus County was established in 1854 and encompasses approximately 1,521 square miles. The County is nestled within 90 minutes of the San Francisco Bay Area, the Silicon Valley, Sacramento, the Sierra Nevada Mountains, and California's Central Coast. Please note, data sources referenced in this assessment reflect the most current information available at the time of analysis; reporting years vary by source due to differing data collection and publication cycles

Based on the 2024 American Community Survey census population estimates, Stanislaus County has approximately 556,972 residents. Approximately 29% of the population is under 19, and 14% are aged 65 or older, highlighting the importance of both youth-focused and older adult behavioral health strategies.

The racial and ethnic composition of Stanislaus County reflects significant diversity:

- Approximately 52% of residents identify as Hispanic/Latino
- Approximately 34% identify as non-Hispanic White
- Approximately 7% identify as Asian/Pacific Islander
- Approximately 2% identify as Black/African American
- The remaining population identifies as multiracial or other racial/ethnic groups

Stanislaus County reflects a region rich in cultural, ethnic and inclusive diversity with a strong sense of community. It is a global hub for agribusiness, boasting rich soils and progressive farming practices. The area is internationally recognized for its agricultural innovation, with almonds, milk, poultry, cattle, nurseries, and walnuts among the top-producing crops. This diversity underscores the need for culturally and linguistically responsive behavioral health services.

GROWTH

The Stanislaus County population is expected to reach 645,069 by 2040. Dealing with the impacts of growth will be an ongoing challenge for the area. Water, farmland preservation, air quality, job availability, a trained workforce, affordable housing, transportation, and school capacity are all issues tied to population growth.

POPULATION BY CITY

There are nine incorporated cities within Stanislaus County: Ceres, Hughson, Modesto, Newman, Oakdale, Patterson, Riverbank, Turlock, and Waterford. There are 12 unincorporated communities within the County: Crows Landing, Denair, Empire, Eugene, Grayson, Hickman, Keyes, Knights Ferry, La Grange, Salida, Valley Home, and Westley. Additionally, there are two Census Designated Places (CDPs): Monterey Park Tract and Riverdale Park Tract.

When comparing population growth from January 1, 2024, to January 1, 2025, Patterson experienced the fastest city growth at 3.6%, followed by Riverbank at 3.2%, Hughson at 2.3%, Newman at 1.1%, Turlock at 0.3%, Oakdale at 0.3%, Waterford at 0.1%, and Modesto at 0.03%. Ceres experienced a population decline of -0.4%.[2]

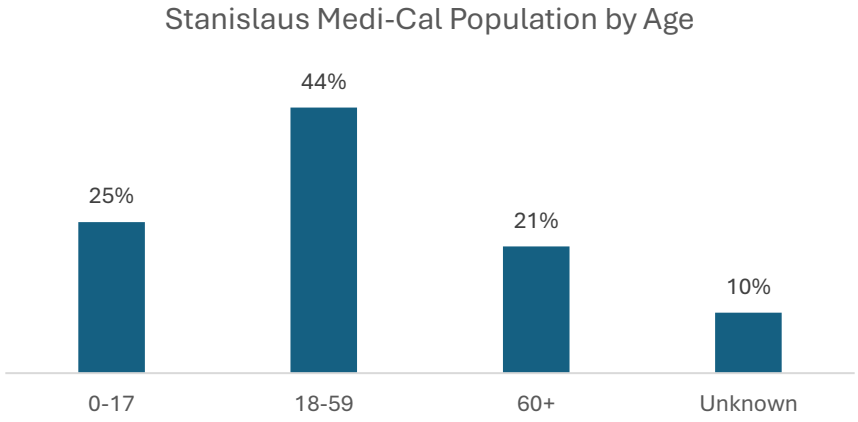
Additional details can be found in the most recent MHSA Annual Update, available here.

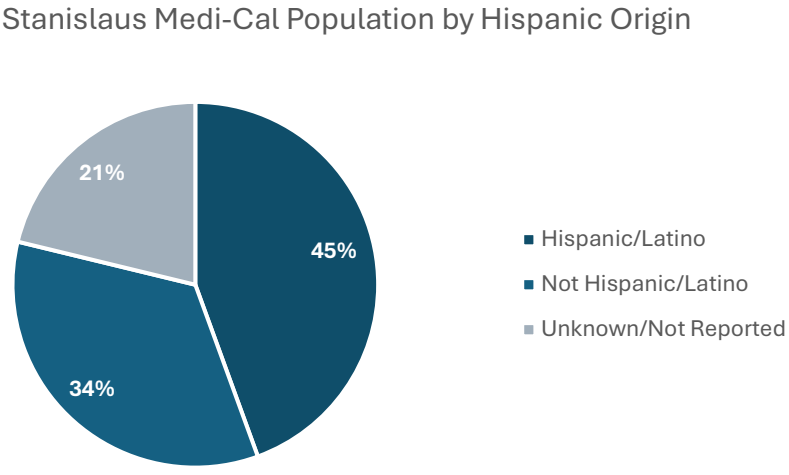
[2] California Department of Finance, Demographic Research Unit. *Tables of January 2025 City Population Ranked by Percent Change 2024 to 2025*. Released May 1, 2025. Available at: https://dof.ca.gov/forecasting/demographics/estimates/

II. Medi-Cal Population Service Needs

Medi-Cal eligibility can be established through multiple pathways. The most common qualification criteria include household income at or below 138% of the federal poverty level or the presence of specific disabilities. Comprehensive eligibility information is available here. Based on Stanislaus County's 2023 Medicaid coverage rate of 27.9%[3] and the estimated census population of 550,842,[4] approximately 153,685 individuals are enrolled in Medi-Cal in Stanislaus County as of the end of FY 24-25 (June 30, 2025).

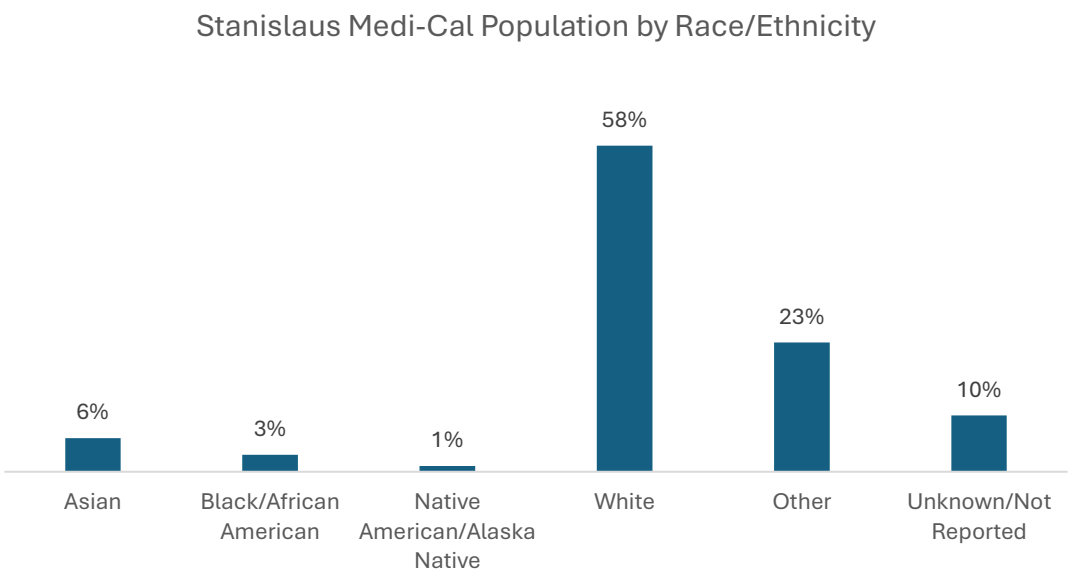
COUNTY'S MEDI-CAL POPULATION BY DEMOGRAPHICS

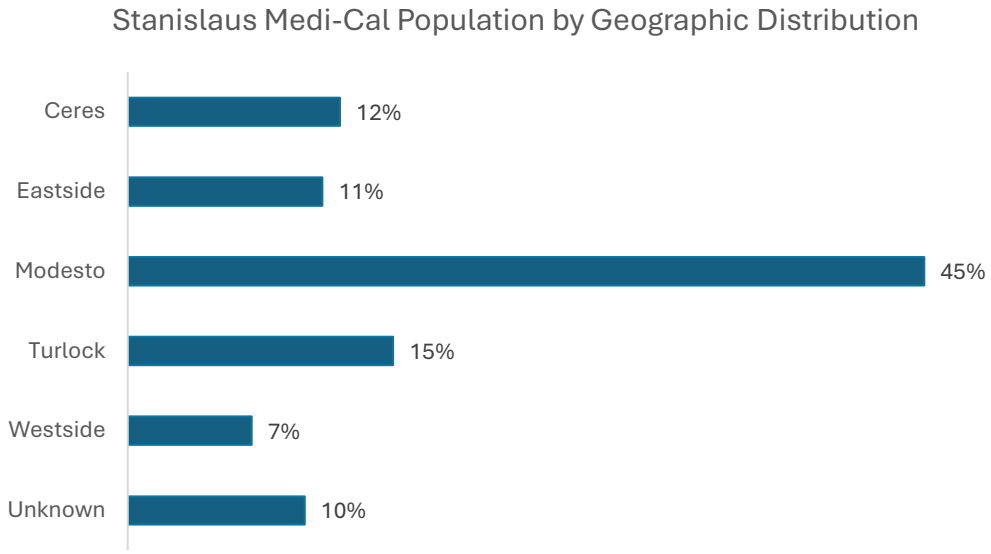




[3] Georgetown University Center for Children and Families.

[4] FY24-25 MHS 1627-Stanislaus County Mental Health Service Utilization Report. This population estimate (550,842) differs from the 2024 ACS estimate (556,972) cited earlier due to variations in data collection methodologies and timeframes. The MHS 1627 figure is used here for consistency with official DHCS mental health service reporting.





COUNTY'S MEDI-CAL POPULATION DISPARITY ANALYSIS

The following analysis is based on penetration rate data from the California Mental Health Services Authority (CalMHSA) Data Explainer Series, the most recent publicly available data. This data reveals differences in access to behavioral health services across racial, ethnic, age, and gender groups in Stanislaus County. While the county demonstrates strengths in DMC-ODS penetration rates, other indicators show opportunities for targeted improvement.

Specialty Mental Health Services (SMHS) Disparities

Race: Asian or Pacific Islander populations exhibit the lowest SMHS penetration rates for both adults (1.3%) and youth (0.7%), which are significantly lower than county averages of 2.4% and 2.6%, respectively.

Hispanic populations also fall below county averages for both adults (1.4%) and youth (1.0%), representing a notable disparity given the county's demographic composition. Alaskan Native or American Indian youth (1.0%) similarly show rates below the county average, though the adult population (6.5%) demonstrates rates well above average.

Black/African American populations show rates above county averages for both adults (4.0%) and youth (4.0%). White populations consistently access SMHS above county averages for adults (3.6%) and children (4.3%).

Age: Older adults aged 65+ have the lowest MHS penetration rate (1.1%), less than half the county average.

Children under age 5 show lower MHS rates (0-2 years: 0.4%; 3-5 years: 1.2%), while youth ages 12-17 demonstrate the highest rate (4.1%).

Gender: For SMHS, adult males (2.8%) access services at higher rates than adult females (2.1%). Among youth, females (2.6%) meet the county average while males (2.5%) fall slightly below.

Table 2.1. Penetration Rates for Specialty Mental Health Services (Adults)

ADULTS FY2021								
Race/Ethnicity	County Rate	Comparison to County Overall Rate of 2.4%	Age	County Rate	Comparison to County Overall Rate of 2.4%	Sex	County Rate	Comparison to County Overall Rate of 2.4%
Alaskan Native or American Indian	6.5%	Above	21-44	2.6%	Above	Male	2.8%	Above
Asian or Pacific Islander	1.3%	Below	45-64	2.6%	Above	Female	2.1%	Below
Black	4.0%	Above	65+	1.1%	Below			
Hispanic	1.4%	Below						
White	3.6%	Above						
Other*	2.2%	Below						

Table 2.2 Penetration Rates for Specialty Mental Health Services (Children and Youth)

CHILDREN/YOUTH (<21)								
Race/Ethnicity	County Rate	Comparison to County Overall Rate of 2.6%	Age	County Rate	Comparison to County Overall Rate of 2.6%	Sex	County Rate	Comparison to County Overall Rate of 2.6%
Alaskan Native or American Indian	1.0%	Below	0-2	0.4%	Below	Male	2.5%	Below
Asian or Pacific Islander	0.7%	Below	3-5	1.2%	Below	Female	2.6%	Equal
Black	4.0%	Above	6-11	2.7%	Above			
Hispanic	1.0%	Below	12-17	4.1%	Above			
White	4.3%	Above	18-20	2.6%	Equal			
Other	1.5%	Above						

DMC-ODS Disparities

Hispanic populations (0.8%) and Asian or Pacific Islander populations (0.3%) exhibit DMC-ODS penetration rates lower than the county average of 1.4%. White populations have penetration rates nearly double the county average (2.6%) and Alaskan Native/American Indian populations have highest rates (3.6%). Black/African American (1.6%) and "Other" (1.5%) populations show rates slightly above the county average.

Table 2. 5. Penetration Rates for DMC-ODS

ADULTS & YOUTH CY 2022*								
Race/Ethnicity	County Rate	Comparison to County Overall Rate of 1.4%	Age	County Rate	Comparison to County Overall Rate of 1.4%	Sex	County Rate	Comparison to County Overall Rate of 1.4%
Alaskan Native or American Indian	3.6%	Above	21-32	--	--	Male	--	--
Asian or Pacific Islander	0.3%	Below	33-44	--	--	Female	--	--
Black	1.6%	Above	45-56	--	--			
Hispanic	0.8%	Below	57-68	--	--			
White	2.6%	Above	69+	--	--			
Other	1.5%	Above						

Community and Stakeholder Input

In addition to data analysis, BHRS incorporates community and stakeholder input through consumer perception surveys, community forums, provider feedback, and the Behavioral Health Equity Committee. This qualitative information provides context for utilization patterns and helps identify cultural, linguistic, and structural barriers to care.

Summary of Service Needs

The assessment of service needs indicates a continued need to:

- Improve access and engagement for Latino/Hispanic, African American, and Asian/Pacific Islander communities
- Expand culturally and linguistically responsive services
- Strengthen early childhood and older adult behavioral health services
- Address barriers faced by individuals with limited English proficiency

Findings from this assessment directly inform the priority populations, strategies, and monitoring activities described in Criterion 3.

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

I. Target Populations

Based on the assessment of service needs, penetration and utilization data, and community input described in Criterion 2, BHRS prioritized the following for focused disparity reduction efforts:

- Underserved Racial and Ethnic Communities: Specifically, Latino/Hispanic (the largest underserved group), African American, and Asian/Pacific Islander populations.
- Children, Youth, and Transition Age Youth (TAY): Particularly those at risk of school failure, juvenile justice involvement, or early onset of severe mental illness.
- Older Adults: Individuals at risk of isolation, depression, and suicide.
- LGBTQ+ Individuals: Focused on reducing stigma and addressing unique mental health risks.

II. Disparity Reduction Strategies

BHEC Framework and Projected Outcomes

The Behavioral Health Equity Committee (BHEC), described further in Criterion 4, developed an equity framework to guide BHRS's efforts to reduce behavioral health disparities during Fiscal Year 2024–2025. The framework was informed by service utilization data, community and stakeholder input, and the lived experience of members and families.

BHEC's framework focuses on addressing cultural, linguistic, geographic, and systemic barriers to care through coordinated strategies implemented in partnership with community-based organizations, providers, and individuals with lived experience. Strategies are organized around key principles that promote services that are **equitable, understandable, respectful, and accessible**.

Recommendations for Equitable Services

BHRS is implementing the following priority strategies to reduce identified disparities:

- **Data Review and Disparity Reduction:** Ongoing review of ASAM, LOCUS, and CANS data to identify and address disparities in access and movement across levels of care, with particular attention to underserved populations.
- **System Development and Training:** Continued collaboration between the Behavioral Health Equity Manager and Workforce Development and Training to provide education and training on equity and culturally responsive practices for staff, providers, and community partners.
- **Language Access and Threshold Language:** Expansion of translated vital documents beyond informed consent forms in Spanish, the County's threshold language, with interpretation services available as needed. Throughout FY 2025-2026 BHRS plans to prioritize the availability of member-facing documents in Spanish.
- **Expanded Hours of Operation:** BHRS programs have extended evening and weekend hours to reduce access barriers, ensuring staffing capacity to meet cultural and linguistic needs.
- **Quality Improvement Integration:** All strategies are monitored through Quality Improvement Committees (QICs) across Adult, Children's, SUD, and Crisis systems of care to support consistent, high-quality, and culturally responsive services.

Recommendations for Understandable Services

Member feedback throughout FY 24-25 indicates that understandable services are characterized by clear access pathways, respectful communication, plain-language explanations, and sufficient time spent discussing assessment and treatment.

BHRS plans to address these needs by exploring standardization of referral and transfer workflows within the SmartCare EHR, promoting warm handoffs, clearly displaying member language preferences, and utilizing peer support to assist members during transitions.

Recommendations for Respectful Services

BHRS is strengthening respectful services by assessing program environments for cultural representation and accessibility, expanding multilingual marketing materials, and enhancing recruitment materials that reflect the County's commitment to a diverse and representative workforce. Development and pilot testing of Spanish treatment plan summaries within the EHR are underway, with full implementation planned following validation.

BHRS will work toward establishing targets for providing services directly in members' preferred languages. This work will be supported by exploration of EHR tracking of provider language fluency and language services delivered. The department's Quality Improvement Committees, in collaboration with the Behavioral Health Equity Manager, will utilize the data collected through the EHR's new tracking fields to establish a realistic yet ambitious target percentage for direct-language services, scheduled for formal announcement and implementation by early 2027.

Recommendations for Accessible Services

BHRS has streamlined access by merging the Access Team and the Behavioral Health Crisis and Support Line in September 2024, creating a single, coordinated entry point. Outreach efforts continue to inform underserved populations of available services across BHRS, managed care plans, private insurance, and community providers.

BHRS maintains accurate referral and community resource information through monthly verification processes and offers extensive cultural competence training aligned with CLAS Standards. Bilingual resource cards with QR codes provide easy access to service information.

BHRS collaborates with diverse Prevention and Community Collaboratives to gather feedback, provide education, and strengthen treatment capacity across SMI, SED, and SUD services. These collaborations include Assyrian, faith-based, Latino, NAACP, Southeast Asian, LGBTQIA+/2S, and other community groups.

BHRS leadership also continues to advance partnerships with Native American communities through training, policy alignment, and engagement with Indian Health Care Providers and tribal organizations, consistent with BHIN guidance.

III. Monitoring, Outcomes, and Lessons Learned

BHRS monitors progress through annual Mental Health and Substance Use Disorder Treatment Perception Surveys administered in English and Spanish. Results demonstrate strong performance in cultural competence, access, quality, and member participation, while identifying opportunities to strengthen engagement and outcome measurement.

Key successes include expanded language access, increased bilingual staffing, strengthened community partnerships, and enhanced community participation in planning and advisory processes. Lessons learned underscore the importance of sustained community engagement, workforce capacity development, and continuous refinement of equity strategies based on data and community feedback.

Criterion 4: Member/Family Member/Community Committee: Integration of the Committee Within the County Behavioral Health System

I. BHRS's Behavioral Health Equity Committee (BHEC)

The BHEC serves as Stanislaus BHRS's primary advisory body for cultural competence, health equity, and community engagement in behavioral health services. The committee exemplifies the BHRS's commitment to centering diverse community voices in system planning, policy development, and service delivery. BHRS ensures that partners, including community-based organizations, consumers, and family members with lived experience, are integral members of the Behavioral Health Equity Committee. The committee's membership structure is designed to represent the full spectrum of stakeholders invested in behavioral health equity.

COMMITTEE STRUCTURE

The restructured BHEC roster includes one representative from each of the following stakeholder categories:

- BHRS Systems of Care
- BHRS Community-Based Organization Treatment Providers
- BHRS Collaborative Partners
- Consumers with Lived Experience

There are 35 total BHEC members, of whom 4 have lived experience receiving behavioral health services. For these members, there is no term limit for the length of time in the committee.

Member Recruitment and Selection: BHEC annually assesses whether the current roster reflects the evolving diverse community profile of Stanislaus County. The committee proactively adds representatives from recent partnerships established through Prevention and Early Intervention Community Collaborative (PEICC) projects to ensure emerging community voices are included.

Frequency and Structure of Meetings: The BHEC meets monthly on the 2nd Monday of each month from 11:00 am to 12:00 pm in person at Stanislaus County Behavioral Health and Recovery Services, 1130 12th Street, Modesto, CA 95350.[5] Meetings are currently held in person to review cultural competence initiatives, assess progress on disparity reduction efforts, and provide guidance on behavioral health equity strategies. The committee is exploring virtual meeting options to enhance accessibility and participation.

Meeting Format and Engagement: Meeting attendance is tracked to monitor participation and ensure consistent community engagement. Members are actively encouraged to participate in discussions and are empowered to provide feedback and make recommendations on all matters before the committee. Guest speakers frequently present specific topics related to cultural competence,

[5] Committee meetings are only open to current members.

emerging best practices, and community needs, enriching the committee's knowledge base and informing recommendations.

Some recurring agenda topics are ADA compliance, CLAS standards, BHSA info, FURS, My Teen unhoused behavioral health, any new updated BHIN or Policy is covered, IHCPs, Outreach program (SUD), Cultural Competence trainings.

Committee Functions and Role

The BHEC serves multiple critical functions within the Stanislaus County behavioral health system:

Oversight and Accountability: The BHEC is responsible for overseeing BHRS's cultural competence initiatives and ensuring adherence to state requirements for Cultural Competence Plans. The committee monitors the Department's progress in implementing California's Culturally and Linguistically Appropriate Services (CLAS) Standards and holds leadership accountable for advancing health equity goals.

Cultural Competence Plan Development and Monitoring: The committee plays a central role in developing, reviewing, and updating the Stanislaus County BHRS's Cultural Competence Plan annually. BHEC members provide feedback on plan content, ensure community perspectives are integrated, and monitor implementation of plan recommendations throughout the fiscal year.

Empowerment of Members, Families, and Communities: A core function of the BHEC is to empower members, family members, and communities representing all cultures, ensuring their perspectives actively influence system change. The committee creates space for individuals with lived experience to share their insights, concerns, and recommendations, ensuring that these voices inform policy and program decisions.

Disparity Identification and Reduction: The BHEC reviews data on service penetration rates, utilization patterns, and outcomes across racial, ethnic, cultural, and linguistic populations to identify disparities. The committee developed the Behavioral Health Equity Framework (Equitable, Understandable, Respectful, Accessible themes) to guide the County's disparity-reduction strategies. (For detailed information on the BHEC Equity Framework and recommendations, see Criterion 3, Section III.A.)

Provider Performance and Quality Monitoring: The committee reviews providers' performance on cultural competency and helps identify and prioritize areas for improvement in care delivery. This includes assessing whether services are responsive to diverse cultural health beliefs, practices, preferred languages, and communication needs.

Workforce Development Guidance: The committee provides input on strategies to expand the behavioral health workforce to reflect California's diverse population, including recruitment, retention, and training priorities. (For information on workforce development initiatives, see Criterion 5.)

Decision-Making Authority and Influence

Members and all committee members are empowered to provide feedback and make recommendations on all aspects of behavioral health service delivery, policy development, and system planning. The committee's recommendations inform the BHRS leadership's decisions and guide the implementation of cultural competence and equity initiatives.

Authority and Accountability of Behavioral Health Equity Committee (BHEC) Recommendations:

The formal authority and accountability mechanisms for Behavioral Health Equity Committee (BHEC) recommendations typically align with an advisory and quality improvement function, requiring a structured organizational response, though not usually a direct vote for implementation.

Recommendations are Advisory: BHEC primarily serves to advise BHRS policies and initiatives, often through quality improvement or equity governance structure (like the QICs). They do not typically have direct operational authority to mandate implementation.

BHRS Leadership Response: Recommendations generally require a formal response or acknowledgment from BHRS Senior Leadership (e.g., the Director's Office or Quality Improvement leadership) to demonstrate buy-in and commitment.

Integrated into Quality Systems: Recommendations are typically tracked within the BHRS's Quality Improvement System (QICs) or a dedicated tracking tool (e.g., an action plan log). This ensures integration with ongoing operational and regulatory work.

Implementation Responsibility: Responsibility is often assigned to a specific BHRS manager or department (e.g., the Behavioral Health Equity Manager, Program Director, or Quality Management) who is tasked with developing the implementation plan and reporting progress.

Reporting and Documentation & Reporting Back to BHEC: Leadership or the assigned implementation owner reports back to BHEC to provide status updates on progress, barriers, and results of the implemented recommendations.

Written Response Process: A formal written response process is usually required, where BHRS leadership documents whether a recommendation is accepted, rejected, or modified, providing a rationale for the decision. This ensures transparency and accountability to the committee and the community it represents.

Input from the BHEC is documented and incorporated into planning, quality improvement activities, and updates to the Cultural Competence Plan. The BHEC coordinates with other BHRS advisory and quality improvement bodies to ensure alignment across planning, implementation, and evaluation activities.

Criterion 5: Culturally Competent Training Activities

I. Annual Cultural Competence Training

Three-Year Training Plan

BHRS maintains a comprehensive three-year training plan that includes core cultural competence requirements and schedules for administrative and clerical staff, interns and master's-level students, contracted providers, clinical staff, and leadership personnel. The full training plan is available upon request.

Completion of Required Cultural Competence Training

BHRS requires all staff to complete a minimum of eight (8) hours of cultural competence training annually. During FY 2024–2025, the following staff completed the requirement:

BHRS Full-Time Staff	BHRS Part-Time Staff	Contracted Provider Staff	**Total**
584	87	266	**937**

II. Embedding Cultural Competence Across All Training Activities

BHRS integrates cultural competence principles across all training offerings, rather than limiting equity content to standalone cultural competence courses. This embedded approach ensures that cultural responsiveness is applied consistently across clinical, administrative, and operational functions.

Key strategies include:

- **Trainer Guidance:** Workforce Development and Training staff provide trainers with guidance and review tools to ensure integration of CLAS Standards and cultural considerations across all trainings, with consultation from the Behavioral Health Equity Manager as needed.
- **Clinical Training:** Trainings address cultural formulation, adaptation of evidence-based practices, and the influence of culture on symptom presentation and help-seeking behaviors.
- **Ethics and Compliance Training:** Legal and ethical trainings incorporate cultural considerations related to informed consent, confidentiality, mandated reporting, and telehealth.
- **Administrative Training:** Front-line staff receive training in culturally respectful communication, identification of language access needs, and creation of welcoming service environments.

- **Evaluation and Continuous Improvement:** Training evaluations assess integration of cultural competence concepts and inform ongoing curriculum refinement.
- **Community Partnership:** BHRS collaborates with Community Behavioral Health Collaboratives to ensure training content reflects community perspectives and lived experience.

This approach ensures cultural competence is a foundational component of professional development across the system.

III. Annual Training Report for FY 2024-2025

During FY 2024–2025, BHRS delivered a robust cultural competence training program. Training topics included multicultural awareness, LGBTQ+ cultural competency, interpreter services, trauma-informed care, community engagement, and legal and ethical considerations in culturally responsive service delivery.

BHRS also promoted free external trainings and webinars offered by organizations such as the California Institute for Behavioral Health Solutions (CIBHS), National Council for Mental Wellbeing, NAADAC, and Health Net to supplement internal training offerings.

FY 2024-2025 Cultural Competence Training Summary:

- *Total Trainings Offered:* 33
- *Total Training Hours:* 382.25
- *Total Continuing Education (CE) Hours:* 245.75
- *BHRS Staff Participants:* 1,135
- *Contractor Staff Participants:* 613
- *Total Participants:* 1,748

A detailed table of individual trainings, dates, hours, and attendance is maintained by BHRS and available upon request.

IV. CULTURAL Competence Training Informed by Lived Experience

BHRS incorporates presentations by members, family members, and individuals with lived experience into several cultural competence trainings to ensure staff receive direct education on the experiences of those accessing behavioral health services.

FY 24-25 Trainings with Lived Experience Presenters Included:

- LGBTQ+ 101
- Medi-Cal Peer Support Specialist Training
- Crisis Intervention Team (CIT) Training for Law Enforcement
- Building Bridges of Understanding and Inclusivity

Impact:

- 267 participants received training that included lived experience perspectives during FY 2024–2025.
- An additional 523 participants are expected to receive this training approach in FY 2025–2026 through planned trainings, including Trans-Inclusive Health Care and Veterans' Cultural Training.

These trainings fulfill Title 9 requirements that staff receive education about the personal experiences of members and family members, including experiences related to racial, ethnic, cultural, and linguistic communities and interactions with behavioral health systems.

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

I. Recruitment, Hiring, and Retention of Multicultural Workforce

MHSA Workforce Assessment

Details about the Stanislaus County BHRS workforce are available in the most recent MHSA Annual Update, which can be accessed here.

BHRS Workforce Capacity

Stanislaus County BHRS believes in and is committed to developing and sustaining a diverse, culturally responsive workforce that is representative of the population it serves. BHRS collects staff ethnicity and language data by function and compares workforce demographics to county population data to identify gaps and guide recruitment, retention, and workforce development efforts. The Behavioral Health Equity Committee (BHEC) reviews workforce ethnicity and language capacity annually and develops recommendations on strategies to strengthen workforce diversity policies and practices.

The following assessment summarizes FY 2024–2025 BHRS workforce ethnicity by function and compares overall workforce composition to Stanislaus County demographics.

WORKFORCE ETHNICITY ANALYSIS (FY 2024-2025)

Overall Workforce Composition: Stanislaus County BHRS employs 696 county staff.

- Hispanic/Latino: 272 staff (39.1% of workforce)
- White: 248 staff (35.6% of workforce)
- Asian/Pacific Islander: 69 staff (9.9% of workforce)
- Black/African American: 29 staff (4.2% of workforce)
- Native American/Alaska Native: 3 staff (0.4% of workforce)
- Other/Unknown: 75 staff (10.8% of workforce)

Administration and Management Diversity: BHRS administration and management positions include 102 staff members responsible for department leadership, program oversight, and strategic direction. The ethnic composition of leadership demonstrates notable diversity:

- Hispanic/Latino: 22 staff (21.6%)
- White: 43 staff (42.2%)
- Asian/Pacific Islander: 17 staff (16.7%)
- Black/African American: 5 staff (4.9%)

- Native American/Alaska Native: 1 staff (1.0%)
- Other/Unknown: 14 staff (13.7%)

Direct Services Staff Diversity: Direct services positions (including licensed clinicians, case managers, therapists, peer support specialists, and other member-facing roles) represent the largest segment of the BHRS workforce, with 444 employees. The ethnic composition includes:

- Hispanic/Latino: 186 staff (41.9%)
- White: 149 staff (33.6%)
- Asian/Pacific Islander: 39 staff (8.8%)
- Black/African American: 20 staff (4.5%)
- Native American/Alaska Native: 2 staff (0.5%)
- Other/Unknown: 48 staff (10.8%)

Support Services Staff Diversity: Support services positions (including administrative assistants, data analysts, quality improvement specialists, peer navigators, and other support roles) include 209 employees with the following ethnic composition:

- Hispanic/Latino: 94 staff (45.0%)
- White: 66 staff (31.6%)
- Asian/Pacific Islander: 24 staff (11.5%)
- Black/African American: 6 staff (2.9%)
- Other/Unknown: 19 staff (9.1%)

Table 6.1. Workforce-to-Population Comparison

Ethnic Group	County Population %	BHRS Workforce %	Gap Analysis
Hispanic/Latino	~46%	39.1%	-6.9 percentage points (underrepresented)
White (Non-Hispanic)	~37.5%*	35.6%	-1.9 percentage points (closely aligned)
Asian/Pacific Islander	5.6%	9.9%	+4.3 percentage points (overrepresented)
Black/African American	2.9%	4.2%	+1.3 percentage points (overrepresented)
Native American/Alaska Native	1.0%	0.4%	-0.6 percentage points (underrepresented)

*Estimate based on subtracting Hispanic White from total White population

Key Findings:

1. *Hispanic/Latino Representation Gap:* While BHRS has achieved 39.1% Hispanic/Latino workforce representation, this remains 6.9 percentage points below the county's Hispanic/Latino population. This represents a priority area for continued recruitment efforts.
2. *Asian/Pacific Islander Overrepresentation as Strength:* Asian/Pacific Islander staff comprise 9.9% of the workforce despite representing 5.6% of the county population. This overrepresentation indicates highly successful recruitment, retention, and advancement of Asian/Pacific Islander professionals, particularly in leadership roles (16.7% of administration/management). This success may offer lessons applicable to recruitment of other underrepresented communities.
3. *Black/African American Alignment:* Black/African American representation (4.2% of workforce vs. 2.9% of population) slightly exceeds population proportions, indicating effective recruitment and retention practices.
4. *Native American/Alaska Native Recruitment Need:* With only 3 staff members (0.4%), Native American/Alaska Native communities remain underrepresented compared to their 1.0% county population proportion. Given the small numbers, partnership with tribal organizations and culturally specific recruitment strategies are essential.

These findings inform BHRS workforce development strategies, MHSA WET planning priorities, and BHEC recommendations to strengthen recruitment, retention, and advancement practices to better reflect county demographics and support culturally responsive service delivery.

Criterion 7: Language Capacity

I. Increasing Bilingual Workforce Capacity

BHRS is committed to providing culturally and linguistically competent services and ensuring meaningful access for members with limited English proficiency (LEP). Consistent with DHCS requirements for threshold language, BHRS tracks staff language capacity in our threshold language to support service delivery in members' preferred languages whenever possible and to reduce reliance on interpreter services.

BHRS Policy and Procedure 90.1.106 (Language Assistance Services to Limited English-Speaking Members and Family Members) governs language access practices. Language assistance is available free of charge, 24 hours a day, 7 days a week, through bilingual staff, certified interpreters, and contracted interpretation services.

BHRS's MHSA Workforce Education and Training (WET) Plan includes strategies to recruit, train, and retain bilingual staff—particularly in Spanish, the County's threshold language.

Bilingual Staff Capacity (FY 2024-2025)

BHRS tracked language capacity for 689 staff members counted for language capacity (note: staff speaking multiple languages are counted in multiple categories).

- Spanish: 185 staff (26.9% of workforce)
- English: 689 staff (100% of workforce)
- Asian Languages: 34 staff total (4.9% or workforce)
    - Cambodian: 10 staff
    - Assyrian: 6 staff
    - Hindi: 5 staff
    - Filipino Dialect: 3 staff
    - Punjabi: 3 staff
    - Hmong: 1 staff
    - Laotian: 1 staff
    - Thai: 1 staff
    - Vietnamese: 1 staff
- Other Languages: Portuguese (2), Russian (1), Samoan (1), Swedish (1), American Sign Language (1)

Spanish Language Capacity by Function: Spanish is Stanislaus County's threshold language, with 174,131 Spanish speakers representing 34.0% of the county's population aged five and over (512,053 total). BHRS Spanish language capacity by function demonstrates strategic distribution:

- Administration/Management: 17 Spanish-speaking staff (16.7% of admin/management)
- Direct Services: 118 Spanish-speaking clinical staff (26.6% of direct services staff)
- Support Services: 54 Spanish-speaking support staff (25.8% of support services staff)

Key Finding - Robust Spanish Clinical Capacity: With 118 Spanish-speaking clinicians among 444 direct services staff (26.6%), BHRS has achieved substantial capacity to provide mental health and substance use disorder treatment in Spanish without interpretation. Given that Spanish speakers represent approximately 34% of the county population, the 26.6% Spanish-speaking clinical workforce approaches proportional representation, enabling most Spanish-preferring members to receive linguistically matched services.

Key Finding - First Point of Contact Language Access: The Spanish language capacity of support services (25.8%) ensures that Spanish-speaking members encounter bilingual staff from initial phone contact through intake, scheduling, and care coordination. This reduces barriers at critical access points, enhancing member comfort and engagement.

Asian Language Capacity: BHRS demonstrates multilingual capacity across diverse Asian language communities, with 34 staff speaking various Asian languages. Notable capacity exists in:

- Cambodian (10 staff): Represents considerable capacity to serve the Cambodian refugee and immigrant community
- Assyrian (6 staff): Addresses needs of Middle Eastern communities
- Hindi (5 staff): Serves South Asian populations
- Filipino Dialect (3 staff): Supports Filipino community members
- Punjabi (3 staff): Serves Punjabi-speaking South Asian populations

Key Finding - Micro-Language Community Access: While numbers for individual Asian languages are small (1-10 staff per language), this diversity of language capacity reflects BHRS's commitment to serving smaller linguistic communities. Even limited capacity in languages like Hmong, Laotian, Thai, and Vietnamese enables some members to access services in their preferred language, demonstrating cultural responsiveness to diverse Asian communities.

Language Access Gaps and Mitigation: Based on county language data from the 2024 American Community Survey, there are 7,313 speakers of languages categorized as “Other Languages” (1.4%% of population 5 years and over), BHRS recognizes that staff language capacity cannot meet all linguistic needs. To address gaps, the BHRS:

- Utilizes Multilingual Virtual Poll Worker iPad system providing interpretation in 250 languages and ASL
- Contracts with qualified interpreter services for threshold.
- Provides Community Interpreter Training to ensure culturally appropriate interpretation practices
- Prioritizes recruitment of multilingual staff in threshold language during hiring processes

Note on Contracted Provider Language Capacity: The language and ethnicity data presented reflect BHRS county staff only and do not include contracted provider staff. BHRS contracts require all providers to report demographic data, enabling a comprehensive understanding of the full workforce serving Stanislaus County members. BHRS monitors contracted provider language capacity and workforce demographics through monthly Quality Improvement Committee (QIC) meetings with each system of care (Adult System of Care, Children's System of Care, Crisis, Access and Medication Services (CAMS), and Substance Use Disorder services). The Behavioral Health Equity Manager participates in these meetings to review data and ensure a comprehensive understanding of the full bilingual workforce serving Stanislaus County BHRS members.

These findings inform BHRS's ongoing workforce development strategies, WET plan implementation priorities, and BHEC recommendations for strengthening recruitment, retention, and advancement practices.

II. Services for LEP Members Persons through Interpreter Services

Comprehensive Language Access System

BHRS maintains a multi-layered language access system combining bilingual staff capacity, contracted interpretation services, and technology-based solutions to ensure timely access for all LEP members. As detailed in Section I of this Criterion, BHRS employs substantial bilingual workforce capacity to serve the linguistic needs of Stanislaus County residents.

When bilingual staff are not available, BHRS uses contracted interpreter services to provide immediate language access, including phone and video interpretation, and ASL.

Interpreter Resources and Utilization

BHRS utilizes multiple interpretation options, including:

- Telephonic and/or video interpretation to ensure real-time access across programs
- Multilingual iPad interpretation technology to support access across many languages and ASL

Language Line Utilization

The following table shows interpretation encounters by language, demonstrating the breadth of linguistic needs beyond threshold language:

Table 7.1. Language Line Utilization FY 24-25

Language	# of Encounters Requiring Language Line Services
Spanish	536
Dari	44
Russian	35
Arabic	34

Farsi	24
Punjabi	19
French	19
Khmer	14
Pashto	13
Vietnamese	5
Haitian Creole	4
Hindi	4
Laotian	3
Urdu	1
Portuguese	1
Mam	1

BHRS reviews interpreter utilization trends to support needs assessment and inform targeted recruitment and outreach for emerging language communities.

Training and Quality Assurance

BHRS provides recurring training on CLAS Standards and effective use of interpreters, including an eight-hour interpreter training program for bilingually designated staff receiving bilingual pay differential. Training addresses legal requirements, appropriate interpreter use in behavioral health settings, and procedures for accessing language assistance resources.

III. Threshold Language Access at All Points of Contact

Posted Notices in Service Locations

BHRS ensures language assistance is available at all points of contact, including first contact, intake, service delivery, and ongoing care coordination. Notices informing members of free language assistance are posted in visible locations at service sites in English and Spanish, and language access information is available upon request.

IV. Services Provided to LEP Members Who Do Not Meet Threshold Language Criteria

Plan for Culturally and Linguistically Appropriate Services (CLAS)

This plan outlines the procedures to ensure meaningful access to services for members with Limited English Proficiency (LEP), specifically addressing those who do not meet the county's threshold

language criteria, while strictly adhering to Title VI of the Civil Rights Act of 1964 requirements regarding interpreter use.

A. Plan for Members Not Meeting Threshold Language Criteria

For languages not designated as "threshold" (i.e., languages spoken by fewer than a certain percentage/number of beneficiaries), BHRS ensures meaningful access to culturally and linguistically appropriate services (CLAS) through the following steps:

1. Immediate Identification: At intake or first contact, the member's preferred language is documented in the EHR (e.g., SmartCare) regardless of threshold status.
2. Provide Qualified Interpretation: BHRS utilizes immediate, on-demand language interpretation services (typically via phone/video) that cover hundreds of languages.
3. Provide Culturally Responsive Service: The member is linked to a provider using the "best fit" model. If a staff member fluent in the non-threshold language is available (and qualified), they are prioritized. If not, a qualified interpreter is used for all sessions.
4. Provide External Linkage/Referral: If the service need is complex and requires specialized, long-term care that is better provided outside BHRS (e.g., due to a rare language need or unique cultural requirement), the member is actively linked to culturally specific community-based organizations or providers through established Memorandums of Understanding (MOU) or referral networks.
5. Continuous Monitoring: Language service usage and member satisfaction for non-threshold language speakers are monitored via the EHR and reported to the Quality Improvement System (QIS) and BHEC to ensure standards are met and service access is not delayed.

B. Compliance with Title VI of the Civil Rights Act of 1964

BHRS policies and procedures comply with Title VI requirements for LEP access, including:

Prohibiting the expectation that family members provide interpreter services.

- Policy: BHRS policy prohibits staff from asking or expecting family members, friends, or companions to serve as primary interpreters. Practice: All staff must offer and utilize qualified, free interpreter services for all vital communications unless a valid, documented refusal is obtained.

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

- Policy: A member has the right to choose an adult family member or friend to interpret, but only after being fully informed of their right to free, qualified interpreter services and acknowledging the potential risks (confidentiality, competence, objectivity). Practice: This choice must be documented in the members' record (SmartCare/EHR) via documentation.

Minor children should not be used as interpreters.

- Policy: BHRS policy strictly prohibits the use of minor children (under 18) as interpreters in all circumstances, recognizing the risks to the minor's well-being, confidentiality, and the potential for inaccurate communication in complex clinical settings.

V. Translated Documents, Forms, Signage, and Member Informing Materials

Documents, forms, and other materials in Spanish are available at service locations and upon request (see Criterion 8.II).

Criterion 8: Adaptation of Services

I. Member Peer Support/Operated Recovery and Wellness Programs

Behavioral Health Wellness Center

The recovery and wellness programs offered through Stanislaus County BHRS are designed to accommodate racially, ethnically, culturally, and linguistically diverse members across all areas of the county. BHRS achieves cultural responsiveness by offering peer support services in multiple languages, including Spanish. This is achieved through the development of programming tailored to culture-specific communities, such as LGBTQ+ groups and gender-specific support. Additionally, services are extended to underserved geographic areas through community-based outreach, and ongoing training is provided to Peer Support Specialists on delivering services in culturally appropriate methods. The peer-driven nature of these programs ensures that individuals with lived experience provide culturally resonant support, reduce stigma, and honor the diverse strengths and recovery pathways of the communities they serve.

Target Population: The BHWC serves adults across the lifespan who have severe mental illness:

- Transition Age Youth (TAY) Adults: ages 18-25
- Adults: ages 26-59
- Older Adults: age 60+

Core Services: Peer support (individual and group), self-help groups, skill-building, and wellness activities. BHWC provides services onsite, in community locations (including BHRS housing sites, shelters, and community centers), and through select virtual groups via Zoom to improve accessibility.

Culturally and Linguistically Responsive Programming: The BHWC offers programming that accommodates racially, ethnically, culturally, and linguistically diverse differences, including:

- *Spanish Peer Support Group:* Provides peer support services in Spanish for Spanish-speaking members
- *LGBTQ+ Group:* Creates safe, affirming space for LGBTQ+ members to connect and support one another
- *Men's Group and Women's Group:* Gender-specific peer support recognizing different support needs and preferences
- *Co-occurring Group:* Addresses the intersection of mental health and substance use disorders
- *Cultural and seasonal events:* Honors diverse cultural traditions and celebrations

Comprehensive Activity Menu

The BHWC offers diverse activities addressing multiple dimensions of wellness and recovery:

Skill-Building Groups:

- Life Skills

- Self-Esteem
- Advanced Sewing and Beginner's Sewing
- Photography
- Art
- Music (Beginner's Music and Advanced Music)

Social Connection and Recreation:

- Café (social gathering space)
- Gamers Group
- Movie Group
- Anime Group
- Dungeons & Dragons
- Alano Club Socials
- Community Socials
- Flea Market Fridays

Wellness and Recovery Support:

- Coed Peer Support
- Introduction to Meditation
- Outdoor Activities
- Golfing
- Field Trips

Community-Based Services

BHWC provides services not only onsite but also in community locations, reducing barriers for members who may face transportation or other access challenges:

BHRS Housing Sites:

- Bennett Place
- Courtney Manor
- Garden Gate
- Kansas House
- Miller Point

Shelter Partnerships:

- Turlock Gospel Mission (Men's and Women's programs)
- Modesto Gospel Mission (outreach)

Community Centers:

- Patterson Naomi/HOST
- Patterson Hammond

Virtual Access: BHWC offers select groups via Zoom, ensuring accessibility for members who face transportation barriers, have physical disabilities, or prefer remote participation:

- Co-occurring Group (Zoom)
- Coed Peer Support (Zoom)
- Meditation (Zoom)

Staff also provide one-to-one peer support on an individual basis, tailored to each member's unique recovery goals and needs.

Utilization and Outcomes

BHWC tracks utilization and outcomes to assess engagement and service effectiveness. Participant demographics are monitored by race/ethnicity, age, gender, and language, with small cell sizes suppressed for privacy. BHWC also uses recovery environment and satisfaction measures (e.g., RERS and perception survey domains) to evaluate cultural responsiveness and recovery orientation. Detailed demographic, utilization, and outcome data are reviewed internally through BHRS quality improvement processes and are available upon request.

Areas for Continued Growth

BHRS identified opportunities to strengthen:

- Spanish-language engagement (despite Spanish groups, utilization remains limited)
- Functional recovery supports (e.g., employment, housing, education, independent living)
- TAY participation (TAY engagement remains lower than desired)

BHRS plans to address these areas through program refinement, outreach, and partnership development while sustaining existing strengths.

II. Responsiveness of Behavioral Health Services

Stanislaus County BHRS regularly reviews and updates its recovery and wellness services to ensure cultural responsiveness to the county's diverse communities. New programs, service enhancements, and modifications to existing offerings are designed to better accommodate racially, ethnically, culturally, and linguistically diverse populations. Members are informed of new services and program changes through multiple channels, including the website, printed newsletters (available in English and Spanish), postings on the Wellness Center Events and Activities Board, email communications, and staff announcements. The following images are the cover pages of the member handbook. The English PDF can be found here, and the Spanish PDF can be found here.

Stanislaus County
Behavioral Health
Member Handbook

Specialty Mental Health Services
and
Drug Medi-Cal Organized Delivery System

BHRS Mission

In partnership with our community, our mission is to provide and manage effective prevention and behavioral health services that promote the community's capacity to achieve wellness, resilience, and recovery outcomes.

BHRS Vision

Our Vision is to continue to be a leader in Behavioral Health and to be recognized for excellence in our community, state, and nation.

STANISLAUS COUNTY
BEHAVIORAL HEALTH AND RECOVERY SERVICES
1601 I St., Ste. 200, 2nd Fl., Modesto, CA 95354
24/7 Access Line Toll Free 1-888-376-6246
Available 24 Hours a Day, 7 Days a Week

Revised Date: December 18th, 2024[1]
Effective Date: January 1, 2025

[1] The handbook must be provided at the time the beneficiary first accesses services.

Paper format of this document is available without charge upon request, please call 1-800-376-6246. Request will be processed within five (5) business days.

Condado de Stanislaus

MANUAL PARA EL MIEMBRO

Servicios especializados de salud mental
Y
Sistema de Prestación Organizada de Drug Medi-Cal (DMC-ODS)

Visión de BHRS
Nuestra visión es continuar siendo un líder en salud conductual y ser conocidos por la excelencia en nuestra comunidad, estado y nación.

Misión de BHRS
En asociación con nuestra comunidad, nuestra misión es proporcionar y gestionar servicios efectivos de prevención y salud conductual que promueven la capacidad de la comunidad para lograr resultados de bienestar, resiliencia y recuperación

STANISLAUS COUNTY
BEHAVIORAL HEALTH AND RECOVERY SERVICES
1601 I St, Ste 200, 2nd Floor
Modesto, CA 95354

Línea De Acceso Gratuita
1-888-376-6246
(24 Horas Del Día, los 7 días de la semana)

Fecha de Actualización: Diciembre 18, 2024
Fecha de Vigor: January 1, 2025[1]

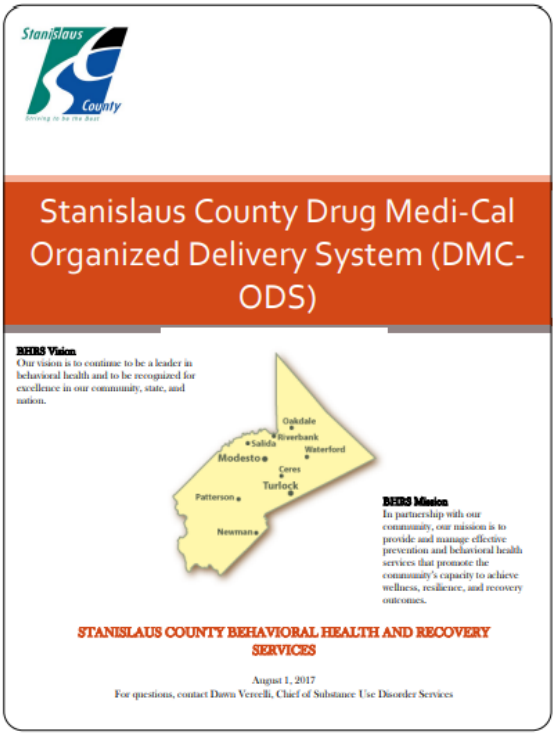
[1]El manual debe ofrecerse en el momento en que el miembro accede por primera vez a los servicios.

El formato en papel de este documento está disponible, bajo petición, sin cargo alguno. Por favor, llame a 1-800-376-6246 si quiere una copia de este documento. Su petición será procesada dentro de cinco (5) días laborables.

PROVEEDORES DE MEDI-CAL QUE OFRECEN SERVICIOS PARA TRASTORNOS DE SALUD MENTAL Y CONSUMO DE SUSTANCIAS

Stanislaus County Behavioral Health & Recovery Services (BHRS)
800 Scenic Drive
Modesto, CA 95350

Este documento se puede buscar
Para buscar use Ctrl+F (o Command+F en Mac)
Busque solo por nombre, apellido o nombre del programa



Stanislaus County Drug Medi-Cal Organized Delivery System (DMC-ODS)

BHRS Vision
Our vision is to continue to be a leader in behavioral health and to be recognized for excellence in our community, state, and nation.

Oakdale
Riverbank
Salida
Waterford
Modesto
Ceres
Turlock
Patterson
Newman

BHRS Mission
In partnership with our community, our mission is to provide and manage effective prevention and behavioral health services that promote the community's capacity to achieve wellness, resilience, and recovery outcomes.

STANISLAUS COUNTY BEHAVIORAL HEALTH AND RECOVERY SERVICES

August 1, 2017
For questions, contact Dawn Vercelli, Chief of Substance Use Disorder Services

III. Quality Assurance

Stanislaus County BHRS systematically analyzes member feedback data through a health equity lens. Mental Health Consumer Perception Survey and SUD Treatment Perception Survey results are disaggregated and compared across racial, ethnic, cultural, and linguistic subgroups to identify disparities in satisfaction, access, outcomes, and cultural sensitivity. These findings inform targeted program modifications and quality improvement initiatives.

The Behavioral Health Equity Manager serves as BHRS's designated Discrimination Grievance Coordinator, supporting compliance with federal and state nondiscrimination requirements (including ADA, Section 504, Section 1557, and California Government Code §11135). With support from the BHRS Risk Manager, the Coordinator investigates and processes discrimination grievances, trends member complaints by demographic characteristics to identify potential cultural and linguistic barriers and provides guidance to staff and contracted providers to strengthen nondiscrimination and equitable service delivery.