Member Outreach & Education Campaign for Non-Specialty Mental Health Services (Calendar Year 2025)

Introduction

The following is Partnership HealthPlan of California's Member Outreach and Education Campaign for CY 2025 in compliance with the requirements of Senate Bill 1019 and All Plan Letter (APL) 24-012.

Partnership contracts with Carelon Behavioral Health to administer the non-specialty mental health benefit on behalf of the plan. Carelon manages the provider network and processes claims. The non-specialty mental health provider network is comprised of over 4,000 individual providers at more than 1,800 provider sites.

Methodology & Background

Pursuant to the requirements of SB1019 and All Plan Letter 24-012, Partnership engaged in the following activities, in order to solicit input and feedback to inform our Member Outreach and Education Plan.

Mental Health Utilization Assessment

Partnership completed a comprehensive Mental Health Utilization Assessment that identified utilization rates for various demographic groups of Partnership's members. Results from this assessment identified several lower utilizing groups, which informs our Member Outreach and Education Plan. This Assessment is attached to this document (*see* **Exhibit I**).

Stakeholder Input (Surveys, Interviews & Focus Groups)

Quality Improvement & Health Equity Committee (QIHEC)

On August 20, 2024, Partnership staff presented to the QIHEC committee results from the 2023 Mental Health Utilization Assessment, presenting demographic utilization data and highlighting disparities. Subsequently, QIHEC members were surveyed soliciting their feedback on potential outreach strategies for specific lower utilizing groups.

Consumer Advisory Committee (CAC)

On September 12, 2024, Partnership staff presented to Consumer Advisory Committee (CAC) members results from the 2023 Mental Health Utilization Assessment, presenting demographic utilization data and highlighting disparities. Furthermore, CAC members were given surveys to complete soliciting their feedback on potential outreach strategies and to garner their own experience obtaining mental health services, if applicable.

Phone Surveys

Pursuant to the results of the utilization assessment, several groups were identified to connect with, in order to inform our Outreach and Education Plan. Therefore, Partnership's Population Health team

conducted surveys soliciting feedback on members' knowledge of the mental health benefits, perceived barriers and suggested forms of communication.

The Partnership HealthPlan of California Population Health team conducted an outreach campaign using telephonic surveys in addition to an online platform (Google Forms) among four groups of focus, each with a sample size 200 of randomly selected participants from the ages of 21-64 years old. The groups included Hispanics and African Americans in Solano County, all members in Modoc County, and Native Americans (as required by DHCS). This was due to low utilization rates among these demographics groups identified in the Mental Health Utilization Assessment in Exhibit I.

PCP Engagement

Partnership engaged SPH Analytics to conduct a physician/specialist study via a multi-mode survey approach, allowing respondents to complete via mail or web. Courtesy telephone calls were made to encourage participation. This information was useful in identifying barriers in collaboration between medical and mental health providers which can be construed as barriers to referrals.

Member Outreach & Education Plan

Developed with Stakeholder & Tribal Partner Engagement

Results and Feedback

Quality Improvement & Health Equity Committee (QIHEC) Survey:

Partnership's Quality Improvement and Health Equity Committee (QIHEC) which is co-chaired by the Chief Medical Officer (CMO) or medical director designee, and Partnership's Health Equity Officer, meets at least quarterly. This committee directs Quality Improvement and Health Equity Transformation Program (QIHETP), which outlines the systematic and continuous activities to monitor, evaluate, and improve upon the Health Equity and health care services delivered to members, including non-specialty mental health services.

The survey responses highlight several obstacles to accessing mental health care, including:

1. Stigma surrounding mental health.
2. Limited access to services.
3. Lack of culturally representative service providers.

Hispanic Members:

- Lowest utilization rates for mental health services.
- Barriers include a lack of bicultural and bilingual services.
- Recommended outreach methods:
    - Provide educational information at primary care provider (PCP) sites.

- Utilize texting campaigns for communication.

Rural Areas (e.g., Modoc County):

- Recommendation to increase access to culturally appropriate telehealth services.

African American Members:

- Lower utilization rates due to a lack of culturally representative providers.
- Suggested outreach methods:
  - Mail educational information to homes.
  - Provide information at PCP sites.
  - Conduct phone outreach.
  - Use texting campaigns.

Key Takeaways:

- Emphasis on culturally sensitive outreach.
- Importance of addressing language and cultural barriers in service provision.

Consumer Advisory Committee (CAC) Survey:

The Consumer Advisory Committee (CAC) provides Partnership members with a forum to discuss common issues of interest and importance, while creating a supportive and informative environment. Partnership's CAC is primarily composed of members, advocates, and stakeholders. Partnership values the input received through the CAC and considers the feedback during annual reviews and policy/procedural updates that affect quality and Health Equity. To better understand the barriers and opportunities of non-specialty mental health services, we conducted a targeted survey. Responses were collected through written surveys that allowed us to capture a view of the needs and experiences of our members. The responses highlight the following:

- **Awareness of Mental Health Benefits:**
  - All members are aware of mental health benefits available through Partnership.
  - Most members are aware of Partnership's collaboration with Carelon for mental health services.
  - Only a small percentage have used Carelon's services.
- **Barriers to Accessing Services:**
  - Wait times for appointments.
  - Lack of specific providers.
  - Challenges with obtaining prescriptions and scheduling appointments.
- **Recommendations for Improvement:**
  - Enhance the accuracy and availability of provider information.
    - Regularly update provider details.
    - Create an online list of service locations that accept Partnership.

  - Increase access to qualified psychologists with diverse training and backgrounds.
  - Improve service delivery by:
    - Ensuring prescription accuracy.
    - Reducing appointment rescheduling.
    - Shortening wait times.
- **Member Experiences:**
  - Some respondents already use the services.
  - Others are unsure about changes needed, indicating varied experiences with current mental health service access.

Phone Survey:

Our Population Health Team conducted a comprehensive survey targeting four specific groups: African Americans and Hispanics in Solano County, residents of Modoc County, and Tribal members. The approach included phone surveys which supported more personalized conversations, encouraging detailed responses. Additionally, we deployed Google Forms to accommodate respondents who preferred a self-paced, digital method for sharing their experiences and insights. This mixed-method approach ensured that participants had multiple avenues to engage with the survey based on their individual preferences and access to technology. Partnership conducted outreach to 200 individuals from each of the target populations. The results of this initiative include:

- **Awareness of Mental Health Services:**
  - Respondents across all groups demonstrated varying levels of awareness about available mental health services.
  - African American and Hispanic respondents in Solano County showed a moderate level of awareness, with many expressing lack of clarity about specific services offered.
  - Residents of Modoc County and Tribal members reported lower awareness levels, often citing limited outreach in their areas.
- **Barriers to Accessing Services:**
  - Transportation challenges to in-person services.
  - Difficulties navigating the healthcare system.
  - Wait times for appointments.
  - Distrust of external healthcare providers.
- **Recommendations for Improvement:**
  - Develop targeted outreach campaigns to address stigma and build trust.
  - Provide transportation assistance for in-person appointments.
  - Simplify the process for accessing mental health services.
  - Reduce wait times by increasing the availability of mental health professionals.
  - Establish consistent, transparent communication about available services.
- **Member Experiences:**
  - **Positive:**

  - Most respondents expressed satisfaction, noting no significant problems or issues.
  - Many described their experiences as good, excellent, or great, with phrases like "really good" and "amazing" being common.
- **Neutral:**
  - Some respondents mentioned limited or no interaction with services, indicating they have not needed to access care.
- **Challenges:**
  - A few respondents highlighted challenges, such as long wait times for services or appointments.

This campaign helped identify gaps in awareness and preferred communication channels, guiding future outreach efforts.

Tribal Engagement:

Partnership's Senior Behavioral Health Director engaged directly with Tribal stakeholders through several key initiatives. We began by visiting Tribal Health provider in Sonoma County, Sonoma County Indian Health Project on September 5, 2024, to discuss challenges and opportunities for improving health care access. Additional topics included opportunities that the Sonoma County Indian Health Behavioral Health team can potentially capture reimbursements under CalAIM for some of their outreach work with their behavioral health clients.

This was followed by the Tribal Convening in October 2024, which brought together Tribal leaders from nearly all of our Tribal Health Centers, community members, and health care stakeholders to collaborate on culturally responsive strategies. Additionally, we conducted a survey of Tribal members to capture valuable insights into their experiences and needs regarding health care access and service delivery. We worked closely with our Tribal Liaison to develop the outreach and education plan through a series of meaningful discussions aimed at fostering a culturally appropriate and respectful approach to engaging with Tribal communities. Our Tribal Liaison's expertise provided guidance in understanding the nuances of Tribal sovereignty, historical trauma, and community-driven practices, ensuring that our engagement methods align with the expectations and preferences of the communities we serve. Partnership's Tribal Liaison provided valuable reference materials on Tribal outreach and engagement that guides some of the efforts herein. These materials are included in Exhibit 3 for reference.

In 2025, Partnership plans to navigate a phased Tribal outreach and engagement strategy to align efforts with the 2016 Tribal Behavioral Health Agenda (TBHA). The year will begin with preparation and initial outreach, focusing on building relationships with Tribal leaders and providers to map existing behavioral health initiatives. Communication materials will be developed to reflect cultural values and health priorities, with initial outreach emails and letters sent to Tribes and Tribal Health Directors requesting formal discussions.

Direct engagement will follow in the second quarter, including virtual or in-person consultations with Tribal representatives to assess behavioral health initiatives, explore alignment with the TBHA, and highlight opportunities for leveraging federal grants.

In the third quarter, follow-up communication will ensure sustained engagement, summarizing outcomes and providing guidance for further collaboration. As part of our ongoing collaborative action plans Partnership will be hosting a Tribal Behavioral Health Roundtable to maintain open dialogue and consideration of alternative specialties recognized by tribes, such as natural healers to allow healing through mind and body connection. In addition, the forum will provide space to share updates, discuss trends, and explore ongoing opportunities.

The year will conclude with an evaluation of outreach efforts, analyzing outcomes and gathering feedback to refine future strategies. A comprehensive report will summarize the year's activities, lessons learned, and recommendations for 2026, ensuring continued progress in addressing behavioral health disparities.

County Behavioral Health Engagement:

In addition, Partnership collaborated with County Mental Health Partners to gather input on strategies for effectively reaching and educating members about Non-Specialty Mental Health Services (NSMHS) available in their counties. During the Quarterly Mental Health Directors meeting, discussions were targeted to identify tailored outreach approaches and received valuable feedback.

- Key suggestions included leveraging social media platforms to raise awareness,
- Participating in community health and event fairs to engage directly with residents,
- Building connections with local community health agencies for broader outreach,
- Using branded giveaways (swag) to enhance engagement and visibility.
- Providing the Non-Specialty Mental Health Provider Directory to each respective county MHP to have with their Access Teams and Display in their waiting rooms.

These insights inform our outreach and education efforts, ensuring they are aligned with community needs and preferences, and effectively promote access to NSMHS in all service areas.

Primary Care Engagement:

SPH conducted surveys on behalf of Partnership to measure the perception of service availability and collaboration within the primary care network:

- 50% of providers agreed that they routinely receive reports after my Partnership patients have accessed Mental Health Care and Services
- 66% of providers agreed that once a referral has been issued to Beacon, they routinely receive confirmation that their patient's mental health referral is being addressed.

This information was included to address potential barriers or bias in referring members to non-specialty mental health services.

Alignment with Population Needs Assessment

Health Education, Cultural & Linguistic Gap Analysis

Partnership maintains a Health Education unit responsible for creating and providing health education materials at an appropriate reading and comprehension level for members. The Health Education unit creates some materials to meet the needs of various member-outreach activities carried out by the organization. Other health education materials are more readily available on the Member Portal though the Healthy Living Tool. There are additional external health education materials available for both member and provider access on Partnership's external website:

- Members: https://www.partnershiphp.org/Members/Medi-Cal/Pages/Health%20Education/Health-Education---Members.aspx
- Providers: https://www.partnershiphp.org/Providers/HealthServices/Pages/Health%20Education/HealthEducationProviders.aspx

Printed copies of materials are available to both members and providers. Educational materials created by the Health Education Team are reviewed and updated no less than every 5 years and are translated into all Partnership threshold languages (Spanish, Russian, and Tagalog); other languages are available upon request. The Health Education unit reviews educational materials on the external website on an annual basis. This established process has been effective in providing materials to members, both directly and through providers.

The Health Education team is also responsible for the Cultural & Linguistic program, including evaluation of member grievances for issues arising from discrimination, and performance of audits for delegates mandated to carry out various Cultural and Linguistic responsibilities. They also review and recommend staff and provider training to promote awareness of diversity, equity, and inclusion to serve our members better.

Source: Population Needs Assessment 2024 pg. 56

Diversity, Equity, and Inclusion Training

Partnership Staff Training

Partnership is committed to ensuring both staff and members feel included and have equal opportunities for their mental, social, and physical wellbeing. One of the ways Partnership addresses inclusions is through an annual Health Equity Week for staff. Historically in alignment with the Martin Luther King Jr. holiday (the third week of January), a project team designs emails, videos, and interactive activities to raise staff awareness of the diversity of

Partnership's employees and members, and how to respectfully interact with others. Due to competing priorities, below are the results of Health Equity Week 2023.

Table 19: LMS Completion Report for Health Equity Week 2023 Activities

LMS Activity	Total Completions
A Tale of Two Zip Codes	236
Partnership's Health Equity Journey: The Past	168
Partnership's Health Equity Journey: The Present	159
Partnership's Health Equity Journey: The Future	174
What is NCQA Health Equity Accreditation	189

Source: LMS Training Report; Partnership Human Resource Department, 2023

Partnership also offers virtual and recorded training sessions for all staff to remind them of the legal rights of our diverse team and to educate them on how best to include others in office activities. There are at least 2 mandatory educational sessions per year. As additional training opportunities arise, they are made available to staff based on interest or assignment. Human Resources tracks staff participation through the Learning Management System (LMS). As of December 31, 2023, there were 1,013 Partnership employees. In 2023, Partnership employees completed the following trainings:

Total Completion	Partnership Training Sessions	Staff Assignment
1,110	Diversity, Equity, and Inclusion Training for Employees	Assigned to all staff in January 2023
284	Cultural & Linguistics Program Overview and Staff Training (eCourse)	Assigned to new hires and temps only
283	Affordable Care Act – Section 155	Pushed to new hires and temps only
224	Improving Health Outcomes for People Living in The Crisis of Poverty	Assigned to those who did not complete the live training in Dec 2022
240	Tale of Two Zip Codes	Optional training for all Partnership staff
194	What is NCQA Health Equity Accreditation?	Optional training for all Partnership staff
172	Partnership's Health Equity Journey: The Past	Optional training for all Partnership staff

167	Partnership's Health Equity Journey: The Present	Optional training for all Partnership staff
179	Partnership's Health Equity Journey: The Future	Optional training for all Partnership staff

To promote awareness and understanding of diversity, equity, and inclusion, Partnership will continue to identify and mandate high-quality staff training(s) on an annual basis. Some staff may seek further training opportunities to gain better insight into their peers and Partnership's population.

Provider Training

Partnership actively reviews and offers training to contracted providers to improve member experience and reduce unintended bias, discrimination, and health disparities. In 2023, Partnership hosted a 3-part training series for providers on Healthy Equity. Session 1 took place on June 13, 2023, and covered Implicit Bias. Session 2 occurred on July 18 and covered the definition of health equity and strategies to improve organizational practices. Session 3 took place on August 15 and presented toolkits to support health equity. The internal work committee agreed that if this work were to continue, the Health Equity officer and staff should have ownership.

Partnership's Director of Health Equity has been tasked with developing a training program in 2024 to align with DHCS's APL 23-025 Diversity, Equity, and Inclusion Training Program Requirements. In 2024, Partnership will identify the training material to offer providers. Partnership will begin offering providers at least 1 training opportunity per year on equity, cultural competency, bias, diversity, and inclusion to align with NCQA and DHCS quality standards by 2026.

Source: Population Needs Assessment 2024 pg. 59-61

Health Education, Culture & Linguistics

Partnership has an ongoing concern that its members lack knowledge around their benefits and how to use them. While managed care plans have several departments dedicated to member support, Partnership recognized an opportunity to support efforts to increase member awareness of Partnership benefits, including development of videos, written materials, and the distribution of educational materials at community outreach efforts. To further promote access,

Partnership is set to follow the strategies timeline in 2025 (show on Exhibit 2) in collaborating with community groups and plans to offer educational sessions to members, particularly non-English-speaking ones, about available benefits like vision, mental health services, and preventative care services.

Partnership also offers robust Community Resource pages on our external website (see Appendix B). These pages are a collection of local resources that are meant to supplement member needs. Each of Partnership's counties has a dedicated county page. Community Resource pages for Partnership's new expansion counties went live in December 2023. Partnership members also have the option to contact Partnership's Population Health Department to learn how to access local community resources. Population Health staff also routinely provide community resources to members during their various outbound call campaigns. Population Health staff track the resources provided to members, and conduct follow up calls to ensure the resource(s) met the needs of the member.

Member grievance data provides insight into member engagement with the health plan, their experience of culturally and linguistically appropriate care, and reported rates of discrimination. Members who want to report grievances with their care must know how to report a grievance using the appropriate channels and feel some assurance that their concerns will be taken seriously. Therefore, Partnership uses reported grievances as a proxy for trust in the agencies against whom the grievance is filed. While a general lack of trust in government and institutions may be the root cause for some distrust, Partnership works to overcome this through demonstrating responsiveness to member needs, as reflected in interactions with our members. This effort is ongoing and, while there are sufficient resources allocated, there are likely more opportunities to educate members on their rights and how to exercise them.

Finally, in alignment with DHCS and NCQA objectives, Partnership will continue its own organizational culture of diversity, equity and inclusion by offering regular staff and provider training. The goal of these training courses is to engage staff and providers in topics relating to equity (e.g., race, ethnicity and gender) and the barriers members experience that prevent them from being healthy. Partnership's Director of Health Equity has also been tasked with developing a mandatory Diversity, Equity, and Inclusion training for all Partnership staff, network providers, and delegates.

Source: Population Needs Assessment 2024 pg. 73

Primary Language

English continues to be the primary language spoken by Partnership's members. Based on Partnership's December 2023 enrollment data, 77.9% of members identify as English speaking and 22.1% identify as limited English proficiency (LEP). Partnership has 3 threshold languages

– Spanish, Russian, and Tagalog. Members identifying as Spanish speaking total 19.6%. Russian and Tagalog speakers account for 0.7% of LEP members, while 1.8% of the population speaks a language other than the 3 threshold languages.

Source: Population Needs Assessment 2024 pg. 18

Alignment with Utilization Assessment

For 2025, Partnership aims to implement several targeted outreach strategies to enhance awareness of non-specialty mental health services (NSMHS) for our members. This multi-faceted approach leverages social media to broadly inform members of the available services, aiming to reduce mental health stigma and drive engagement.

A key component of this initiative includes a text messaging campaign tailored to African American and Hispanic members in Solano County, and all members in Modoc County (low utilizers). These tailored messages will aim to bridge gaps in service awareness and accessibility within these populations.

In recognition of Mental Health Awareness Month in May, Partnership will hold a Community Health Event focused on mental health resources, support, and education. Partnership will also participate in a perinatal town hall for all members, providing a forum for discussing maternal mental health care during and after pregnancy. This is an important targeted outreach effort for a vulnerable member population with potential mental health needs.

Additionally, as Partnership's role becomes more prominent in NSMHS member facing activities a notification campaign will ensure referral pathways go uninterrupted. Finally, development of PCP Education flyers, which will serve as a key resource for primary care providers, equipping them with essential information to guide patients toward mental health resources.

Through these strategies, Partnership aims to improve mental health service accessibility, provide culturally relevant outreach, and empower both members and healthcare providers with the knowledge and resources needed for mental wellness.

Alignment with National Culturally and Linguistically Appropriate Services Standards

The outreach and member engagement activities involved in this plan will employ the cultural and linguistic requirements set forth in policy, MCND 9002, Cultural & Linguistic Program Description, and attachments to the policy.

Partnership is dedicated to providing culturally and linguistically appropriate health care services to its diverse member population, ensuring equitable access and health equity for all. Partnership offers

free language assistance services to members with limited English proficiency (LEP) and other communication needs, including interpretation services in over 200 languages such as Spanish, Tagalog, and Russian, as well as American Sign Language (ASL). Written translations of vital materials, such as Member Handbooks, Notices of Action, and Grievance Letters, are made available in threshold languages and accessible formats, including Braille, large print, and audio. These services ensure that members receive timely and effective care without language barriers.

Members are informed about the availability of language assistance services through non-discrimination notices and taglines included with all major correspondence. These notices are provided in up to 18 languages and are designed for accessibility, written to promote understanding. Partnership further ensures the competence of language assistance providers by employing qualification standards, requiring interpreters and translators to demonstrate proficiency in English and target languages, adhere to ethical principles, and use specialized medical terminology. This ensures members receive accurate and culturally sensitive support, avoiding reliance on untrained individuals or minors as interpreters.

All member-facing materials, including preventive health reminders and benefit information, are provided in easy-to-understand formats and translated into the most commonly used languages in the service area. Partnership routinely evaluates the linguistic needs of its population through annual assessments and adjusts materials and services to reflect any changes in language prevalence or regulatory requirements. This approach ensures that all materials meet the cultural and linguistic needs of members while also adhering to state and federal guidelines.

Partnership actively collaborates with community advisory committees, such as the Consumer Advisory Committee (CAC) to design, implement, and evaluate policies and practices that address cultural and linguistic appropriateness. These committees, composed of diverse community members, provide critical feedback on health education, accessibility, and outreach programs. Their input shapes the development of initiatives that address health equity and cultural competence, ensuring that services align with the unique needs of members.

To promote continuous improvement, Partnership offers training programs for staff, providers, and subcontractors on cultural competency, implicit bias, and health equity. In addition, Partnership tracks C&L trainings. These training programs emphasize sensitivity to cultural differences, effective communication with LEP members, and awareness of structural and institutional inequities affecting member health. Staff and provider training records are regularly reviewed to ensure compliance, and opportunities for improvement in diversity, equity, and inclusion are identified and addressed within the organization.

Best practices in Stigma Reduction

Pursuant to the article *Best Practices: Strategic Stigma Change* by Patrick W. Corrigan, PsyD.

[1], there are four components to ensure effective results in stigma reduction. These components include the following:

- Education: Provide education to combat myths or misunderstandings
- Targeted: Focus on specific groups for the highest impact and keep it local
- Credible: People hear it best from others who are most like them
- Continuous: The message needs to be repeated and in multiple ways for it to land

Best practices for reducing stigma in outreach and education materials focus on using inclusive, non-judgmental language, and normalizing mental health as part of overall health. Education addresses myths and misunderstandings about mental health through accurate, accessible information, empowering individuals with knowledge to challenge stigma. A targeted approach focuses on specific groups most affected by stigma, tailoring efforts to local contexts for greater relevance and impact. Ensuring credibility is critical, as people are more receptive to messages delivered by individuals who share similar experiences or backgrounds. Finally, continuity reinforces the message through repeated and varied communication methods, ensuring it resonates over time.

Multiple points of contact for member access

The Outreach and Education Plan highlights the multiple points of contact available for members to access information about their mental health benefits, ensuring they are informed and supported in utilizing these services. This includes a text messaging campaign specifically designed to notify members about Non-Specialty Mental Health Services (NSMHS) benefits, offering direct and timely communication. Additionally, information is shared through the Partnership website, providing an accessible platform for members to learn about their mental health options. Partnership will be enhancing the website further to include resource pages for mental health services in 2025 and making it more engaging and user-friendly to encourage members to retrieve information easily and navigate their mental health benefits.

Qualitative Assessment Summary of Findings (Across All Categories)

Developed with Stakeholder & Tribal Partner Engagement	• Wait times for appointments. • Lack of specific providers. • Transportation challenges in-person services. • Difficulties navigating the healthcare system.

[1]American Psychiatric Association. (2011). [*Best Practices: Strategic Stigma Change*]. *Psychiatric Services, 62*(8), 824. https://doi.org/10.1176/ps.62.8.pss6208_0824

Alignment with Population Needs Assessment/NCQA Population Assessment	• Partnership offers virtual and recorded training sessions for all staff on Diversity, Equity, and Inclusion. • Partnership offers and reviews training to contracted providers to improve member experience and reduce unintended bias, discrimination, and health disparities. • Partnership has an ongoing concern that its members lack knowledge around their benefits and how to use them.
Alignment with Utilization Assessment	• African Americans and Hispanics in Solano County, Modoc County and Tribal members are low utilizers of NSMHS.
Alignment with National Culturally & Linguistically Appropriate Services Standards	• Partnership provides free interpretation in over 200 languages and in accessible written translations. • Advisory committees like CAC guide culturally and linguistically appropriate policies and practices. • Partnership trains staff and providers in diversity, equity, and inclusion with regular reviews.
Best Practices in Stigma Reduction	• Limited understanding of mental health and available services contributes to stigma. • There are four components to ensure effective results in stigma reduction.
Multiple Points of Contact for Member Access	• Creating accessible avenues for members to obtain information on NSMHS benefits.
Primary Care Provider Outreach and Education	• Annual staff and provider training on NSMHS. • Informed decisions and feedback with the Quality Improvement and Health Equity Committee.

Education Plan

In 2025, Partnership plans to explore strategies to improve mental health access and address barriers. Efforts include leveraging social media and text message campaigns, hosting community health events and town halls, and engaging in further discussions with Tribal providers and leaders. Partnership is also initiating a member notification campaign, enhancements to the Partnership website, and the use of PCP education flyers to support provider awareness. These approaches aim to reduce disparities and potentially sustain or enhance mental health utilization rates. (Strategies Timeline shown in Exhibit 2)

1. Developed with Stakeholder & Tribal Partner Engagement

- Townhalls and Roundtable: Provide a platform for dialogue with focus population partners and community stakeholders to address concerns and co-develop culturally sensitive solutions.
- Outreach Events: Foster direct engagement with stakeholders, ensuring feedback shapes strategies to meet unique community needs.

2. Alignment with PNA/NCQA Assessment
   - Member Notification Campaign for Carelon De-Delegation: Notifies members that Carelon's services will now be managed in-house and directly delegated to Partnership, ensuring seamless communication about this transition and maintaining continuity of care.
   - PCP Education Flyers: Support PNA goals by enhancing provider understanding of member needs and improving service coordination.

3. Alignment with Utilization Assessment
   - Text Message Campaign: Directly addresses underutilization trends identified through utilization assessments by promoting awareness of available services and reducing barriers to engagement in focus populations.
   - Outreach Events: Target low-utilization areas to improve access and increase awareness about mental health and other essential services.

4. Alignment with National Culturally & Linguistically Appropriate Services (CLAS) Standards
   - PCP Education Flyers: Provide providers with culturally relevant educational materials to ensure care aligns with CLAS Standards.
   - Text Message Campaign: Delivered in multiple languages to improve accessibility for members with limited English proficiency, meeting CLAS requirements for linguistic inclusivity.

5. Best Practices in Stigma Reduction
   - Outreach Events: Facilitate face-to-face interaction to normalize mental health discussions, reducing stigma around seeking care.
   - Townhalls: Create a safe space for sharing experiences and fostering community support, addressing stigma at the community level.

6. Multiple Points of Contact for Member Access
   - Text Message Campaign: Provides immediate, accessible communication directly to members, improving access to timely information.
   - Website Enhancement: Improving digital platform to provide clear, comprehensive, and accessible information about non-specialty mental health services.

7. Primary Care Provider Outreach and Education

- PCP Education Flyers: Educate providers on upcoming changes on an annual basis, such as the Carelon de-delegation, and equip them with tools to better support member engagement and referrals.
- Outreach Events: Engage providers in discussions to improve alignment on member needs and facilitate coordinated care strategies.

Measurement of Effectiveness

Partnership's 2024 mental health utilization assessment highlights strong performance in providing access to non-specialty mental health services with utilization rates exceeding 9% when combined with specialty mental health services. This places Partnership on the higher end of Medi-Cal mental health utilization rates statewide, however opportunities for improvement remain, particularly for specific subgroups such as members with disabilities, individuals identified through Sexual Orientation and Gender Identity (SOGI) data, and other underutilizing populations.

Members with disability aid codes demonstrated significantly higher utilization rates with nearly 13% accessing mental health services, compared to the overall membership rate. While this is a positive outcome it is essential to continue monitoring and tailoring services for this subgroup to sustain and build on this engagement. In contrast, data limitations regarding SOGI have hindered a comprehensive analysis of mental health utilization by sexual orientation and gender identity. However, it is the intent for Partnership and the state to improve data collection to accurately reflect and address the identity of members.

Overall, 79% of mental health services utilized by members were delivered through the non-specialty mental health system, meeting the needs of those with mild to moderate impairments. Federally Qualified Health Centers (FQHCs) and Tribal FQHCs have played a critical role in achieving this outcome by offering low-barrier, integrated care models that make mental health services more accessible. Despite this success, the current utilization rate of 9% still falls short of the anticipated prevalence of mental health conditions among the membership.

Measuring the Effectiveness of the 2025 Outreach & Education Plan

To measure the effectiveness of this Outreach and Education Campaign for 2025, Partnership will track utilization rates of the campaign’s targeted groups. Specifically, utilization rates of the following groups will be tracked: Spanish-speaking members, Hispanic and African American members, and Native American members. Additionally, monitoring the utilization rates of Modoc County members will be a trackable measure. The hope for outcome would be to see increases in utilization rates for these members. However, given that the campaign is to occur over the course of the 2025 calendar year, it may take more than twelve months to see meaningful changes in utilization rates or trends.

(Exhibit I)

Partnership HealthPlan of California's Annual Mental Health Utilization Assessment

September 2024

Introduction

The following is Partnership's mental health annual utilization assessment in compliance with the requirements of Senate Bill 1019 and All Plan Letter (APL) 24-012. The utilization data reviewed has been culled from calendar year 2023 claims and encounter information.

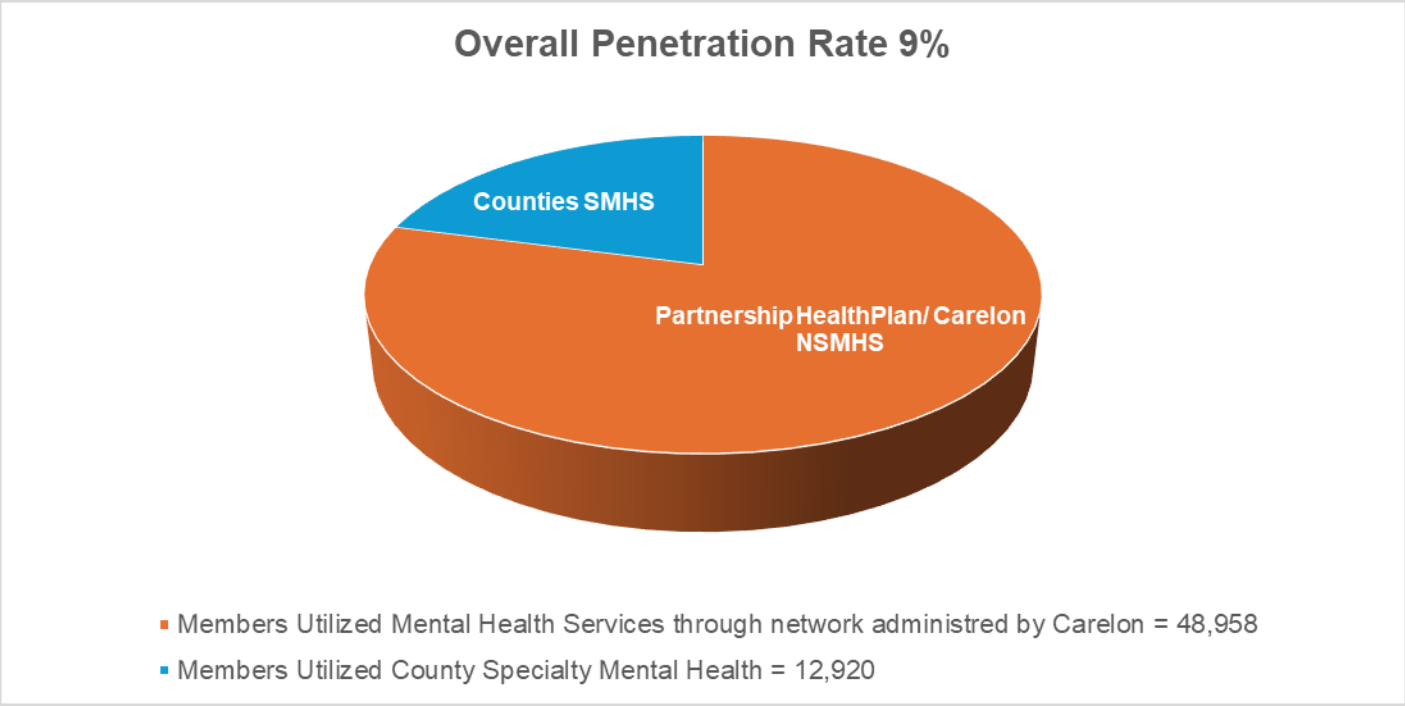
Partnership contracts with Carelon Behavioral Health to administer the non-specialty mental health benefit on behalf of the plan. Carelon manages the provider network and processes claims. The non-specialty mental health provider network is comprised of over 4,000 individual providers at more than 1,800 provider sites.

Also noteworthy, Partnership has a robust network on Federally Qualified Health Centers (FQHCs) and Tribal FQHCs. These health centers provide primary care to nearly 90% of the membership. Many of these FQHCs also provide integrated behavioral health services. This low-barrier, integrated model appears to serve Partnership's members quite well. This is evidenced, in part, by the fact that eight of the top ten non-specialty mental health providers by number of members served in the network are FQHCs.

Overall Mental Health Utilization

During calendar year 2023, Partnership had on average 680,000 members throughout the year in the fourteen counties where it was operating. Over 61,000 members (9%) received mental health services in either the specialty mental health system (SMHS) operated by the respective counties or in the non-specialty mental health system (NSMHS) administered by Partnership and its delegate, Carelon Behavioral Health. The majority of the utilizers obtained services in the non-specialty mental health system (79%), compared to the specialty mental health system (21%). This trend is longstanding and expected given that the majority of the mental health needs of members fall into the mild to moderate range of impairment and, therefore, can be served in the non-specialty mental health system of care.

Traditional mental health providers are not the only purveyors of mental health. Primary care providers address mental health needs of members with a significant frequency. Members seek out mental health interventions through primary care. In 2023, about 15.3% of primary care visits included a mental health diagnosis indicating that some aspect of a members' mental health was addressed during the visit. This is significant in that primary care providers address some of the mental health needs that patients present.



Demographics

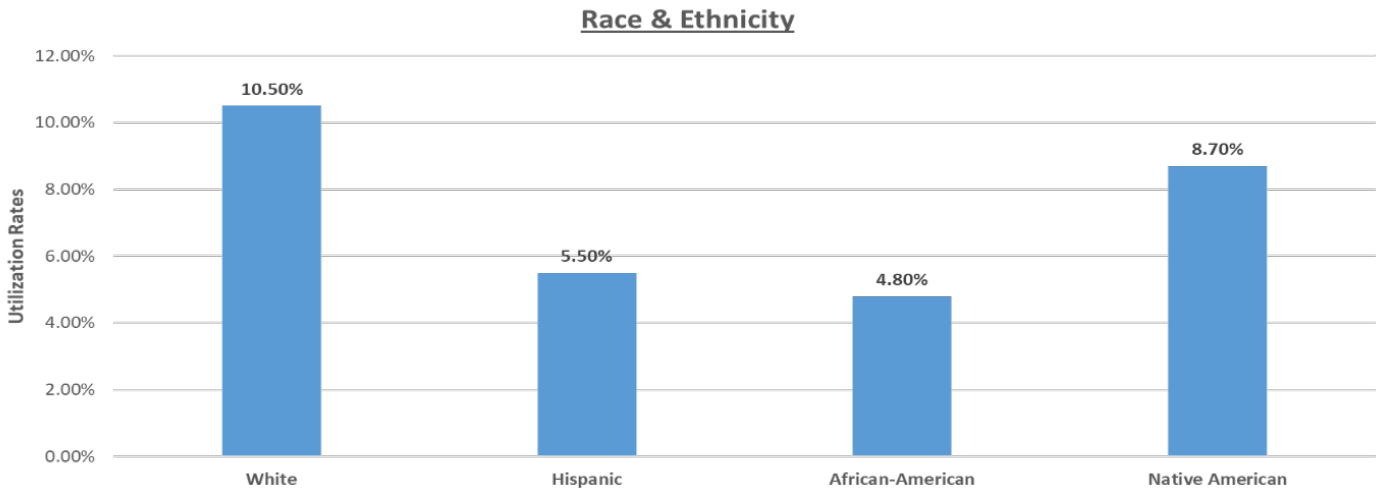
Membership demographic data is obtained from the eligibility files provided by the state of California. Partnership members in the fourteen counties being served in 2023 are comprised of the following demographics:

37%	White
33%	Hispanic
5%	African American
2%	Native American

Nearly 20% of Partnership membership have identified as “other” or “unknown.” Given the substantive numbers who have identified as such it would be noteworthy to do further inquiry including comparing these numbers to other managed care plan numbers to identify if this is a consistent experience across plans or not. However, Partnership’s membership is represented predominantly by White and Hispanic members. Other populations tend to be represented more regionally.

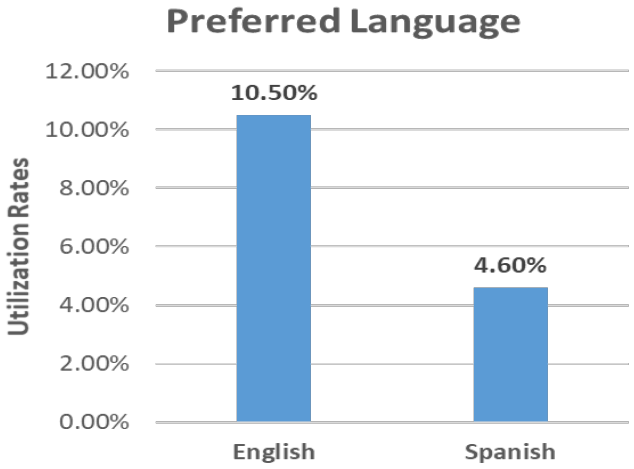
As part of this non-specialty mental health utilization assessment, Partnership analyzed the utilization rate by race and ethnicity. White members had the highest utilization rate for mental health services (10.5%). Whereas African American members had the lowest utilization rate (4.8%) of our identified racial/ethnic groups. Hispanic members, the second largest identified ethnic group amongst Partnership membership, utilization rate of mental health services was nearly half (5.5%) of White

members. Native American members had a utilization rate that was nearly twice that of African American members, higher than Hispanic members, but lower than White members. These discrepancies bear further inquiry and analysis. Some discussion of possible causes of these discrepancies are covered in a later section of this assessment.

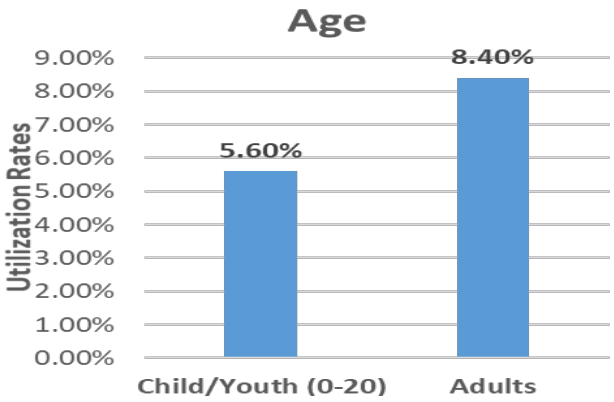


Preferred Language & Age

In 2023, 78% of Partnership's membership identified English as their preferred language; whereas 19% of members identified Spanish as their preferred language. Additionally, over 1% of members identified "Other" as a preferred language. Partnership reviewed the non-specialty mental health utilization rate by member's preferred language. There is a substantive difference in utilization rates by preferred language. Members whose preferred language was English had a utilization rate (10.5%) that was nearly twice the rate of members who identified Spanish as their preferred language (4.6%). Further inquiry is necessary to better identify reasons for this disparity in utilization.



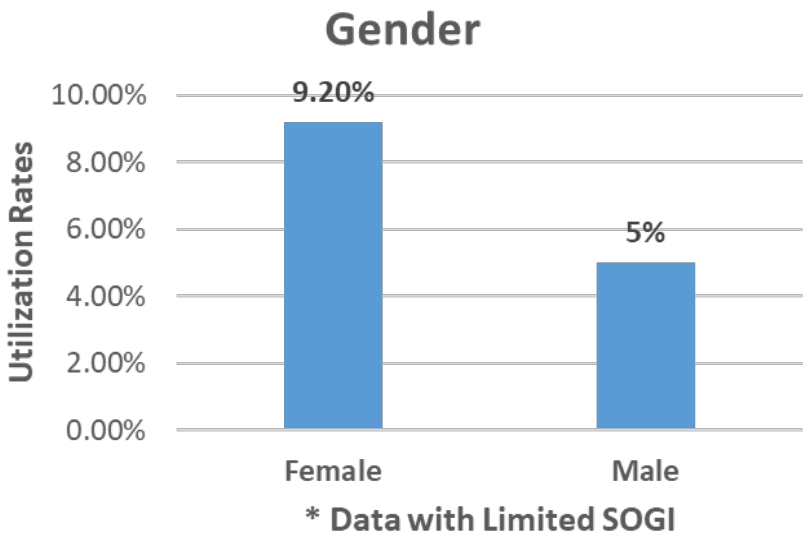
Partnership membership included 240,000 members, or 36%, who were 20 years old or younger. Analyzing the utilization rate of mental health services by age, children and youth had a slightly lower utilization rate (5.6%) than the adult membership utilization (8.4%).



Sexual Orientation & Gender Identity

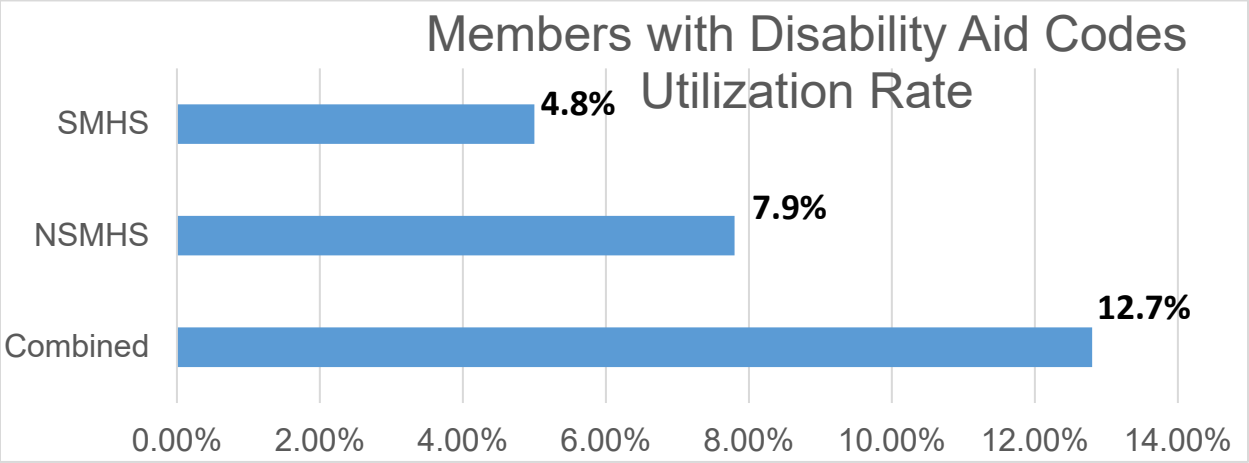
Due to data limitations, Partnership did not have a mechanism to track complete data that collected membership gender identity and sexual orientation. Therefore, Partnership is limited in its ability to analyze utilization rates based upon sexual orientation or gender identity other than what has been indicated on the membership eligibility files provided by the state of California. It is the intent of both the state and Partnership, that moving forward systems will be enhanced to more accurately reflect the identity of members.

Given these limitations, Partnership did analyze the utilization rates by the gender indicated on the membership files. Partnership's membership has slightly more female members (53%) than male members (47%). However, the graph below indicates a meaningful difference in utilization rates. Females tended to utilize non-specialty mental health services at a substantially higher rate than male members.



Members with a Disability

Utilization rates for the members with a disability membership aid code are significantly higher than that of the overall utilization for the entire membership. The total utilization of mental health services for those members who obtained services in both systems of care (specialty mental health and non-specialty mental health) was nearly 13%. The division between the two systems of care is relatively consistent with overall utilization patterns with Partnership's membership with the majority of members receiving care in the non-specialty mental health system.



Geography

Partnership covered members in fourteen counties during 2023 (beginning in 2024, 24 counties). These counties are quite diverse; from more urban areas to rural and some of the most remote areas of California in the far north. This diverse geography also demonstrates diverse utilization of mental health services. The county with the highest utilization is Shasta County at nearly 12%. A possible explanation for this high utilization rate is perhaps explained by the fact that the county enjoys robust FQHCs with strong integrated behavioral health. Additionally, one of the largest contracted non-specialty mental health providers, North American Mental Health Services, also has a large clinic in-county.

Modoc County has the lowest utilization of non-specialty mental health services amongst Partnership counties. It is unclear as to the reasons for this low utilization rate compared to other Partnership counties. Possible contributors may include a paucity of in person providers within the county, cultural factors and even unknown factors. However, Modoc County could be a potential target for a member outreach and education campaign, pending input from stakeholders.

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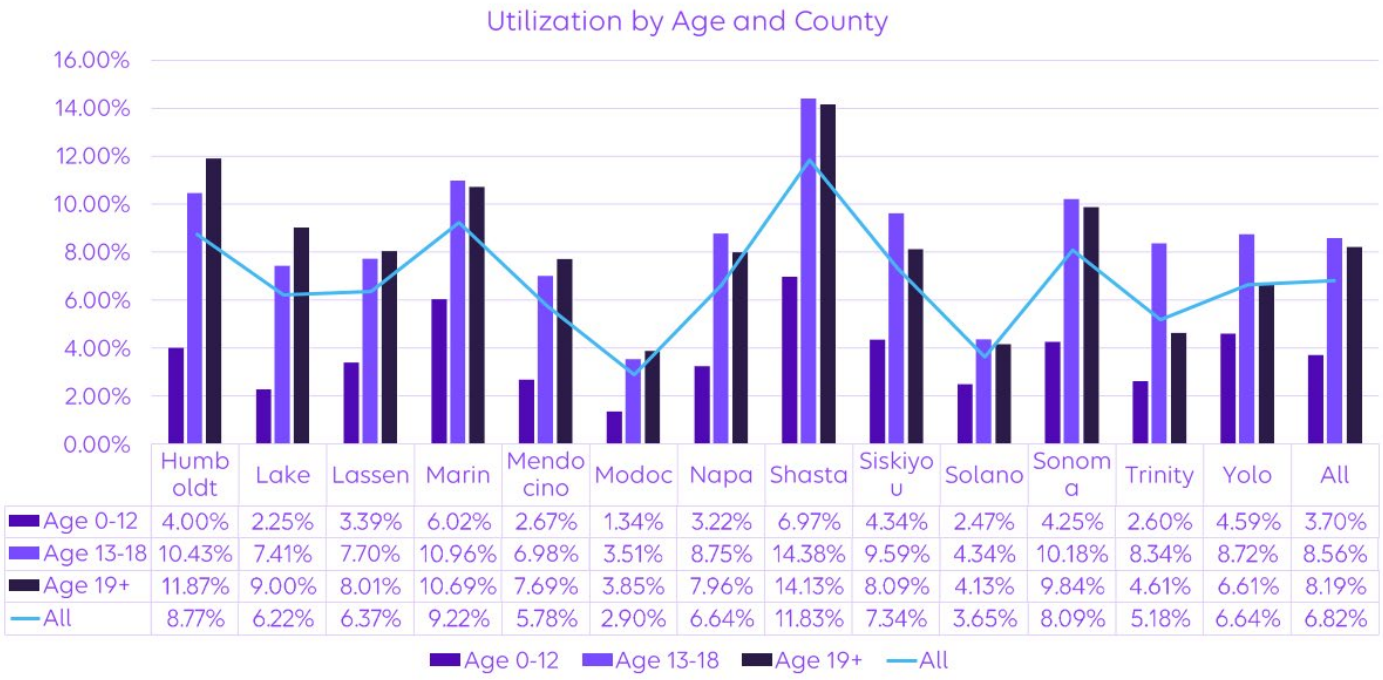

	Humboldt	Lake	Lassen	Marin	Mendocino	Modoc	Napa	Shasta	Siskiyou	Solano	Sonoma	Trinity	Yolo	All
Age 0-12	4.00%	2.25%	3.39%	6.02%	2.67%	1.34%	3.22%	6.97%	4.34%	2.47%	4.25%	2.60%	4.59%	3.70%
Age 13-18	10.43%	7.41%	7.70%	10.96%	6.98%	3.51%	8.75%	14.38%	9.59%	4.34%	10.18%	8.34%	8.72%	8.56%
Age 19+	11.87%	9.00%	8.01%	10.69%	7.69%	3.85%	7.96%	14.13%	8.09%	4.13%	9.84%	4.61%	6.61%	8.19%
All	8.77%	6.22%	6.37%	9.22%	5.78%	2.90%	6.64%	11.83%	7.34%	3.65%	8.09%	5.18%	6.64%	6.82%

Data represents 12 months claims paid 1/1/2023-12/31/2023 23

Summary

Partnership's utilization rate for non-mental health services is over 7%. Moreover, the utilization rate is over 9% when combined with members who receive services through the specialty mental health system. Although this rate is perhaps on the higher end of Medi-Cal members' utilization rate statewide, it still doesn't equate to the anticipated need based upon expected prevalence rates of mental illness. There is unmet need. Furthermore, through this utilization assessment, Partnership was able to identify significant discrepancies in utilization between certain racial and ethnic groups, and by preferred language. Another noted utilization discrepancy is by geography. It would behoove Partnership to be mindful of these discrepancies while creating the membership outreach and education campaign. Directly soliciting feedback and input from these lower utilizing groups will be important to better understand and identify barriers and challenges to obtaining mental health services.

Moving forward it will be important to track and evaluate some of the significant changes occurring and incorporate these changes in the annual utilization assessment in the future. These changes include improvements to SOGI data and tracking, and the potential impact of the new school-based Multi-Payer Fee Schedule. Hopefully, there will be increased understanding of utilization patterns for members based upon sexual orientation and gender identity. Additionally, it is anticipated with the

new Fee Schedule that there will increased utilization by school-age youth members moving forward. Lastly, with annual outreach and education campaigns, the hoped for result would be to see increased utilization overall, particularly amongst those groups who have been lower utilizers historically.

(Exhibit 2)

Partnership HealthPlan of California's NSMHS Outreach and Education Plan Strategies Timeline

November 2024

Strategies	Target Population	Timeframe
Social Media	**Focused**	**235 days (~ 8 months)**
Department Content Creation	**AA (Solano), Hispanic (Solano), Modoc (All), & Tribal (All)**	30 days
Department brainstorm on development of member content with Health Education & Communications team		1/1/2025 - 1/29/2025
Department submit materials to Communications to start formal approval process for member facing material		1/30/2025
Communications Review		5 days
Communications Staff member Assigned to the project		1/31/2025-2/07/2025
Review Design/Layout, Text Review, and PHC Branding		1/31/2025-2/07/2025
Health Education Review		5 days
C&L, Sixth-grade reading level, Medical/Clinical Review, Readability & Suitability, Visual Requirements		2/10/2025-2/14/2025
Communications Secondary Review		5 days
After review send content to department owner for approval		2/17/2025-2/21/2025
Once approved, Communications will send to DHCS		2/17/2025-2/21/2025
Member Informing (DHCS)		60 days
RAC submits to DHCS for review and approval		2/24/2025-4/25/2025
DHCS review (60 days)		2/24/2025-4/25/2025
Translations		5 days
Materials sent for translations, Communications finalizes translated versions of materials		4/28/2025-5/2/2025
Finishing		90 days
Communications works with department owner regarding appropriate distribution		5/2/2025-7/24/2025

Member Outreach & Education Campaign for Non-Specialty Mental Health Services (Calendar Year 2025)

Text Message Campaign	Focused	235 days (~ 8 months)
Department Content Creation	**AA (Solano), Hispanic (Solano), Modoc (All)**	30 days
Department brainstorm on development of member content with Health Education & Communications team		1/1/2025 - 1/29/2025
Department submit materials to Communications to start formal approval process for member facing material		1/30/2025
Communications Review		5 days
Communications Staff member Assigned to the project		1/31/2025-2/07/2025
Review Design/Layout, Text Review, and PHC Branding		1/31/2025-2/07/2025
Health Education Review		5 days
C&L, Sixth-grade reading level, Medical/Clinical Review, Readability & Suitability, Visual Requirements		2/10/2025-2/14/2025
Communications Secondary Review		5 days
After review send content to department owner for approval		2/17/2025-2/21/2025
Once approved, Communications will send to DHCS		2/17/2025-2/21/2025
Member Informing (DHCS)		60 days
RAC submits to DHCS for review and approval		2/24/2025-4/25/2025
DHCS review		2/24/2025-4/25/2025
Translations		5 days
Materials sent for translations, Communications finalizes translated versions of materials		4/28/2025-5/2/2025
Finishing		90 days
Communications works with department owner regarding appropriate distribution		5/2/2025-7/24/2025

Community Health Events/Fairs/Townhall	Focused	135 days
Perinatal Town Hall	**Pregnant Members (Perinatal Town Hall) & All Members (Community Event)**	3/15/2025
Conduct Site Visit		5/15/2025

Member Outreach & Education Campaign for Non-Specialty Mental Health Services (Calendar Year 2025)

Roundtable with Tribal Providers and Leadership	Focused	302 days
Roundtable Set Up	Tribal Members	302 days
Initial Outreach to Tribal Leaders		3/31/2025
Direct Engagment with Tribal Representatives		6/30/2025
Host Tribal Behavorial Health Roundtable		10/30/2025
Member Facing Notification Campaign	**All**	**235 days (~ 8 months)**
Department Content Creation	**All Members**	30 days
Department brainstorm on development of member content with Health Education & Communications team - For all Members		1/1/2025 - 1/29/2025
Department submit materials to Communications to start formal approval process for member facing material		1/30/2025
Communications Review		5 days
Communications Staff member Assigned to the project		1/31/2025-2/07/2025
Review Design/Layout, Text Review, and PHC Branding		1/31/2025-2/07/2025
Health Education Review		5 days
C&L, Sixth-grade reading level, Medical/Clinical Review, Readability & Suitability, Visual Requirements		2/10/2025-2/14/2025
Communications Secondary Review		5 days
After review send content to department owner for approval		2/17/2025-2/21/2025
Once approved, Communications will send to DHCS		2/17/2025-2/21/2025
Member Informing (DHCS)		60 days
RAC submits to DHCS for review and approval		2/24/2025-4/25/2025
DHCS review (60 days)		2/24/2025-4/25/2025
Translations		5 days
Materials sent for translations, Communications finalizes translated versions of materials		4/28/2025-5/2/2025
Finishing		90 days
Communications works with department owner regarding appropriate distribution		5/2/2025-7/24/2025

Member Outreach & Education Campaign for Non-Specialty Mental Health Services (Calendar Year 2025)

PCP Education Flyer	Focused	145 days (~5 months)
Department Content Creation	**Primary Care Providers (PCPs) in Solano, Modoc, and Tribal Health Providers**	30 days
Department brainstorm on development of member content with Health Education & Communications team		1/1/2025 - 1/29/2025
Department submit materials to Communications to start formal approval process for member facing material		1/30/2025
Communications Review		5 days
Communications Staff member Assigned to the project		1/31/2025-2/07/2025
Review Design/Layout, Text Review, and PHC Branding		1/31/2025-2/07/2025
Health Education Review		5 days
C&L, Sixth-grade reading level, Medical/Clinical Review, Readability & Suitability, Visual Requirements		2/10/2025-2/14/2025
Communications Secondary Review		5 days
After review send content to department owner for approval		2/17/2025-2/21/2025
Once approved, Communications will send to Health Educator for formal survey review (APL 18-016), including focus group review		2/17/2025-2/21/2025
Health Education Review		60 days
Alignment between content and focus group needs		2/24/2025-4/18/2025
Health Education works with Communications on feedback		2/24/2025-4/18/2025
Senior Health Educator completes DHCS checklist		2/24/2025-4/18/2025
Translations		5 days
Materials sent for translations, Communications finalizes translated versions of materials		4/21/2025-4/25/2025
Finishing		5 days
Communications works with department owner regarding appropriate distribution		4/28/2025-5/2/2025
Website		**365 days**
Enhance Website Messaging of NSMHS services	**All Members**	365 days
Enhance current messaging on how to access NSMHS services		12/31/2025

(Exhibit 3)

Tribal Outreach and Engagement Reference Materials

As provided by Partnership's Tribal Liaison

Title: Tribal outreach and education strategy:

EXECUTIVE SUMMARY

An effective outreach and education strategy for Tribal communities is essential for cultivating robust relationships and fostering mutual understanding between organizations and these communities. This strategy emphasizes respectful engagement, culturally informed communication, and collaborative partnerships that honor Tribal sovereignty and traditions. Key components include active listening, transparent dialogue, and customized educational programs that address the unique needs and priorities of each community. By prioritizing relationship-building and inclusivity, organizations can enhance their effectiveness in achieving shared objectives and creating sustainable, long-term impacts within Tribal communities.

TRIBAL BEHAVIORAL HEALTH AGENDA (TBHA)

The **Tribal Behavioral Health Agenda (TBHA)**, established in 2016, serves as a comprehensive framework developed collaboratively by tribal leaders, the federal government, and health organizations. It aims to address the distinctive mental and behavioral health challenges encountered by American Indian and Alaska Native (AI/AN) communities. The primary objective of the TBHA is to enhance behavioral health outcomes for tribal populations through a culturally relevant, community-based approach that tackles mental health issues, substance abuse, and the impacts of historical trauma.

Key Components of the TBHA:

- **Focus on Historical and Intergenerational Trauma**:
  The TBHA acknowledges that historical and intergenerational trauma—arising from colonization, forced removal, and cultural suppression—has played a significant role in the mental and behavioral health challenges faced by tribal communities. This recognition is crucial for developing healing strategies that address these entrenched issues.
- **Strengthening Tribal Behavioral Health Capacity**:
  The agenda is designed to enhance the capacity of Tribes to tackle behavioral health issues within their communities, fostering self-determination. It upholds tribal sovereignty by empowering Tribes to develop and implement their own mental health initiatives, rooted in their distinct cultural and traditional knowledge.
- **Prioritizing Suicide Prevention**:
  Suicide rates among AI/AN populations are among the highest in the United States. The TBHA places a strong emphasis on suicide prevention by advocating for enhanced resources, awareness campaigns, and culturally sensitive interventions to tackle this public health crisis.
- **Addressing Substance Abuse and Addiction**:

The TBHA emphasizes the urgent necessity of addressing substance abuse, specifically focusing on the effects of alcohol, opioids, and methamphetamine usage. It advocates for integrated care models that harmonize mental health services, addiction treatment, and traditional healing practices.

- **Cultural and Traditional Practices**:
  A key aspect of the TBHA is the focus on integrating traditional healing practices with Western behavioral health care. This integration includes the incorporation of tribal ceremonies, spiritual practices, and community-based healing traditions, all of which contribute to a holistic approach to wellness.
- **Building Collaborative Partnerships**:
  The agenda promotes collaboration among Tribes, federal agencies, and non-governmental organizations to develop sustainable, long-term solutions. Federal partners, including the Indian Health Service (IHS) and the Substance Abuse and Mental Health Services Administration (SAMHSA), are encouraged to engage closely with Tribes to ensure that resources and programs align with tribal priorities.
- **Addressing Trauma, Violence, and Adversity**:
  The TBHA recognizes the connection between trauma, including domestic violence and child abuse, and behavioral health disorders. It advocates for the development of trauma-informed care models that prioritize healing and recovery.
- **Data and Evaluation**:
  To enhance effectiveness, the TBHA advocates for the collection of culturally relevant data regarding AI/AN behavioral health issues. This data serves to monitor progress, evaluate outcomes, and guide future behavioral health initiatives.

TBHA VISION AND GOALS:

Vision:

The TBHA envisions healthy AI/AN individuals, families, and communities, free from the detrimental effects of mental health challenges, substance abuse, and the consequences of historical trauma.

Goals:

1. Advocate for behavioral health policies and programs that align with tribal priorities.
2. Enhance access to culturally competent and integrated care services.
3. Build tribal capacity for behavioral health services through targeted funding, training, and leadership development.
4. Address behavioral health disparities and improve outcomes through community-driven interventions.

The TBHA is a call to action for integrating traditional healing with behavioral health services, ensuring Tribes have the tools, resources, and autonomy to address the behavioral health needs of their communities in culturally appropriate ways.

This approach is grounded in the principles of the 2016 Tribal Behavioral Health Agenda (TBHA) and acknowledges the ongoing efforts by Tribal Leaders to address the behavioral health needs of their people. By building on the foundation already established through Tribal initiatives and federal demonstration grants, this strategy ensure that we continue to strengthen partnerships, respect sovereignty, and support the integration of culturally relevant behavioral health practices.

OUTREACH AND ENGAGEMENT STRATEGY

This strategy aims to engage Tribes and Tribal Health Programs in Partnership regions. Aligning outreach efforts with the 2016 Tribal Behavioral Health Agenda (TBHA). The strategy will consider the work already completed by the Tribes, leverage federal demonstration grants, and focus on culturally relevant, community-driven approaches. Given the short timeframe, this strategy is designed to prioritize efficiency and impactful engagement.

Preparation and Initial Outreach

Data Collection and Research:

- Identify Key Tribal Contacts: Compile a comprehensive contact list of Tribal leaders, health directors, and behavioral health program managers for the Tribes and Tribal Health Programs.
    - Action Item: List Key Tribal Contacts
- Map Existing Initiatives: Review the work already done by these Tribes in the area of behavioral health, particularly efforts supported by demonstration grants from SAMHSA, IHS, or other federal agencies. Focus on areas related to suicide prevention, substance abuse treatment, and traditional healing.
    - Action Item: Key Initiatives in Behavioral Health
- Federal Grant Alignment: Identify ongoing or available demonstration grants related to behavioral health and match them to Tribal efforts, noting where additional funding or technical assistance can support outreach.
    - Action Item: List out Federal/State Grants in the last Year or Two

Outreach Teams and Staff Self Care:

- The importance of engaging Tribal Leadership (Councils, Health Directors, and Elders) early and often in the planning and execution of prevention and health. Principles of Government-to-Government relationships and community driven approaches.
- Conflict Resolution and mediation skills. There are differing perspectives within tribal community between tribal members and external partners and fostering collaboration and finding culturally appropriate solutions.
- Ensure all outreach staff receive comprehensive training on American Indians culture, traditions, and potential barriers to accessing healthcare.
- Training on the nuances of Tribal Sovereignty and Governance. Knowing the distinctions between federally recognized tribes and non-recognized tribes, understanding how historical policies continue to impact Tribal health and wellness.

- Suicide prevention and substance use disorder interventions must be rooted in the cultural traditions and values of each tribe. One size does not fit all. Training should cover integration of traditional healing practices, ceremonies, and the role of elders in wellness.
- Training in culturally sensitive communication techniques that are respectful of Tribal customs, language, and traditions. This includes understanding different communication styles, such as indirect communication or the role of storytelling to convey meaning.
- Understanding historical trauma and the concept of historical trauma, which refers to the cumulative emotional and psychological wounds carried across generations as a result of colonization, force assimilation, and system violence against AI/AN.
- Mental Health First Aid tailored to tribal communities ensures they are prepared to provide immediate support during crises including suicide ideation and acute substance use episodes.

Managing Vicarious Trauma:

- Addressing issues such as suicide, substance use, and trauma can significantly impact outreach staff. It is crucial for them to receive training in self-care practices, stress management, and to recognize signs of vicarious trauma in themselves. This training is essential for maintaining their mental health while effectively supporting tribal communities.

Best Practices in Workforce Development and Tribes

- Sustainable programs achieve peak performance when tribal members are included. Educating and training them is essential for creating effective solutions to address healthcare disparities.
- When addressing workforce development Bridge programs must be considered and designed. Designed to support tribal members in gaining the necessary skills and knowledge to contribute to the healthcare system. These programs can take various forms, such as internships, mentorships, or certificate courses.
- Developing pathways at the high school level is essential for workforce development in tribal communities. By providing students with relevant education and training in specific career fields, pathways can help bridge the gap between education and employment. This not only benefits individual students but also contributes to economic growth within tribal communities.

Ethical Considerations and Confidentiality

- Ethical Engagement: Emphasize ethical standards in working with tribal communities, particularly around issues of privacy, consent, and community ownership of data. All work should respect the community's wishes and rights.
- Confidentiality and Engagement: Given the stigma associate with mental illness and substance use issues, staff must be trained to handle personal and sensitive information with the highest level of confidentiality. Missteps can undermine trust and harm relationships with the community.

Craft Tailored Communication Materials:

- Develop a standard outreach template that introduces the initiative, acknowledges each Tribe's prior work, and outlines the importance of aligning with the TBHA. Ensure the message emphasizes the mutual goal of improving behavioral health outcomes through collaborative partnerships and culturally relevant care.
- Create customized engagement material for Tribes already receiving demonstration grants, emphasizing ways to enhance current efforts with additional support and resources.

Initiate Engagement:

- Send initial emails to Tribes and Tribal Health Directors, requesting formal engagement meetings or phone calls to discuss alignment with the TBHA. Ensure messaging respects Tribal sovereignty and allows for each Tribe's unique priorities to guide the discussion.

Direct Engagement and Collaborative Efforts

Schedule and Hold In Person or Virtual Meetings

- Organize virtual meetings or consultations with representatives from each Tribe and Tribal Health Program. Focus discussions on:
    - Assessing current behavioral health efforts: Learn about existing initiatives, challenges, and successes.
    - Exploring alignment with the TBHA: Discuss how their work fits into the TBHA framework, particularly in areas such as trauma-informed care, suicide prevention, and substance abuse treatment.
    - Leveraging Demonstration Grants: Highlight how federal grants can support or enhance current efforts and provide technical assistance where necessary.
    - Gathering Tribal Input: Ensure Tribes have the opportunity to provide input on their behavioral health priorities and how future initiatives can be shaped by their traditional practices and knowledge.

Community Forums and Meetings

- Host regular meetings on tribal lands to present information about the Medicaid demonstration project, gather feedback, and address concerns.

Community Health Fairs and Events

- Participate in tribal health fairs, powwows, and community gatherings to provide information and conduct screenings.

Collaborate with Tribal Health Programs

- Engage with the Tribes and Tribal Health Programs, emphasizing integration of behavioral health with primary care, public health services, and traditional healing practices.
- Behavioral Health Leadership Teams: Encourage the establishment of Tribal Behavioral Health Leadership Teams that bring together community members, elders, and health professionals to guide behavioral health efforts.

Provide Resources and Tools

- Offer resources such as toolkits on traditional healing integration, trauma-informed care models, and substance abuse prevention strategies. Ensure these resources reflect the cultural values and healing practices important to each Tribe.
- Share success stories and best practices from Tribes that have effectively used federal demonstration grants to improve behavioral health outcomes.

Follow-Up and Next Steps

Conduct Follow-Up Communication:

- Send follow-up emails to Tribes and health programs with summaries of the consultation meetings, highlighting key areas of alignment with the TBHA and offering further support where needed.
- Provide guidance on the next steps for Tribes interested in pursuing additional federal grants, technical assistance, or collaboration opportunities with other Tribes or health programs.

Convene a Behavioral Health Roundtable:

- Organize a virtual Tribal Behavioral Health Roundtable at the end of Week 3, bringing together representatives from the Tribes and Tribal Health Programs. Use this platform to share updates on the engagement process, discuss emerging trends, and explore collaborative opportunities. Emphasize how ongoing alignment with the TBHA can strengthen Tribal behavioral health outcomes.

Track Progress and Outcomes:

- Establish a system for tracking the progress of each Tribe's engagement and alignment with the TBHA. Collect data on ongoing behavioral health initiatives, funding opportunities pursued, and any additional support requested by Tribes.
- Prepare a final report summarizing the outreach strategy, engagement activities, and next steps for continuous collaboration with Tribal governments and health programs.

Conclusion

This outreach and engagement strategy is designed to be comprehensive and respectful of Tribal sovereignty, while aligning with the goals of the 2016 Tribal Behavioral Health Agenda. By fostering meaningful consultation, leveraging existing grants, and supporting Tribal leadership, this strategy will drive improvements in behavioral health outcomes across California Tribes and Tribal Health Programs within a tight timeframe.

LEGAL FRAMEWORK

Numerous federal laws and policies establish a legal framework that empowers Tribes to govern and manage their healthcare services, safeguarding their rights to self-determination and sovereignty. Significant laws influencing Tribal healthcare include:

Indian Self-Determination and Education Assistance Act (ISDEAA) – 1975

This landmark legislation empowers Tribes to manage and administer federal programs for their members, including healthcare services. Under the Indian Self-Determination and Education Assistance Act (ISDEAA), Tribes may enter into 638 contracts or compacts with the federal government, thereby assuming control of healthcare programs previously overseen by the Indian Health Service (IHS). This approach enables Tribes to design, operate, and deliver healthcare tailored to their unique community needs.

Indian Health Care Improvement Act (IHCIA) – 1976

The Indian Health Care Improvement Act (IHCIA) serves as the foundation of healthcare services for American Indian and Alaska Native populations. It reinforces the federal government's responsibility to provide healthcare to Native communities, enabling Tribes to secure funding, develop healthcare infrastructure, and establish programs tailored to Tribal health needs. The 2010 Affordable Care Act (ACA) permanently reauthorized the IHCIA, ensuring ongoing federal support.

Affordable Care Act (ACA) – 2010

In addition to reauthorizing the IHCIA, the ACA enhanced healthcare access for Tribes by improving Medicaid and Medicare provisions. It empowered Tribes to establish insurance marketplaces and secure funding to enhance health services. Furthermore, Tribal members are exempt from specific ACA penalties, and the legislation facilitates direct reimbursement to Tribes for Medicaid-eligible services.

Tribal Law and Order Act (TLOA) – 2010

While primarily centered on criminal justice, the TLOA strengthens the role of Tribes in overseeing their communities' safety and well-being, directly influencing behavioral health and substance abuse treatment services. It empowers Tribes to have a more significant voice in addressing public safety concerns that impact mental health outcomes, particularly regarding drug and alcohol abuse.

Medicaid and Children's Health Insurance Program (CHIP)

Under these programs, Tribes have the ability to directly administer healthcare services to eligible members and receive reimbursement for those services. Recent expansions in California enable Tribes to contract with state Medicaid (Medi-Cal) to provide health services, manage long-term care, and coordinate behavioral health services for American Indian and Alaska Native (AI/AN) populations.

Patient Protection and Affordable Care Act (P.L. 111-148)

This law enhances the capacity of Tribes to manage their own health programs, improving access to private insurance via marketplaces and expanding Medicaid, which is especially vital for underserved AI/AN communities.

Executive Order 13175 (Consultation and Coordination with Indian Tribal Governments) – 2000

This order requires federal agencies to engage in consultation with Tribes when formulating policies and regulations that affect them, including healthcare services. It guarantees that Tribes have a significant role in influencing healthcare policies that impact their communities.

Public Law 93-638 (Self-Determination)

Grants tribes the authority to contract for the management and delivery of health services that were previously administered by IHS, thereby promoting tribal governance and enhancing autonomy in healthcare administration.

Tribal Behavioral Health Agenda (TBHA) – 2016

Developed through collaboration between Tribes and federal agencies, the TBHA emphasizes the mental and behavioral health challenges confronting Native communities. It promotes tribal self-determination in tackling issues related to mental health, suicide, and substance abuse, offering a framework for Tribes to oversee these essential services.

These laws collectively affirm the right of Tribes to govern, design, and operate their healthcare systems, allowing for the integration of traditional healing practices and culturally appropriate care within federal, state, and tribal framework.