

OFFICE OF CULTURAL & LINGUISTIC COMPETENCE

2015-2016

STRATEGIC PLAN



TABLE OF CONTENTS

Introduction.....	2
Population Assessment.....	3
Summary.....	6
Plan Evaluation and Reporting.....	7
Action Plan.....	8
<i>Focus area- Community Engagement.....</i>	<i>8</i>
<i>Focus area- Language Access.....</i>	<i>10</i>
<i>Focus Area – Provider Resources.....</i>	<i>12</i>
<i>Focus Area- Workforce Diversity and Inclusion.....</i>	<i>13</i>
<i>Focus Area Training and Technical Assistance.....</i>	<i>14</i>
<i>Focus Area- Refugee Healing Partnership (Refugee Mental Health Initiative).....</i>	<i>16</i>
<i>Additional Goals.....</i>	<i>18</i>
References	20

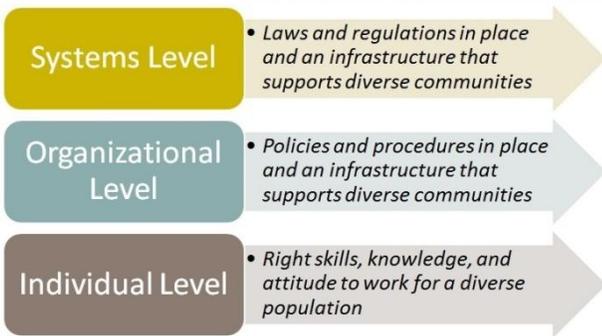
Pursuing equity in recovery, self determination, and wellness

Introduction

The DBHDS Office of Cultural & Linguistic Competence (OCLC) leads efforts to improve services to diverse and underserved Virginians while striving to eliminate the disparities within the state’s mental health, intellectual disability and substance-use disorder system.

Health disparity populations include a wide range of communities where there is evidence of systematic social or economic discrimination and exclusion that has adversely impacted health based on factors such as

Levels of Cultural and Linguistic Competence



race/ethnicity, socioeconomic status, gender, age, sexual orientation and geographic location (Office of Minority Health, 2011). These populations also referred to as *health priority populations*, include racial/ethnic minorities, sexual minorities, the poor, and rural populations, for example.

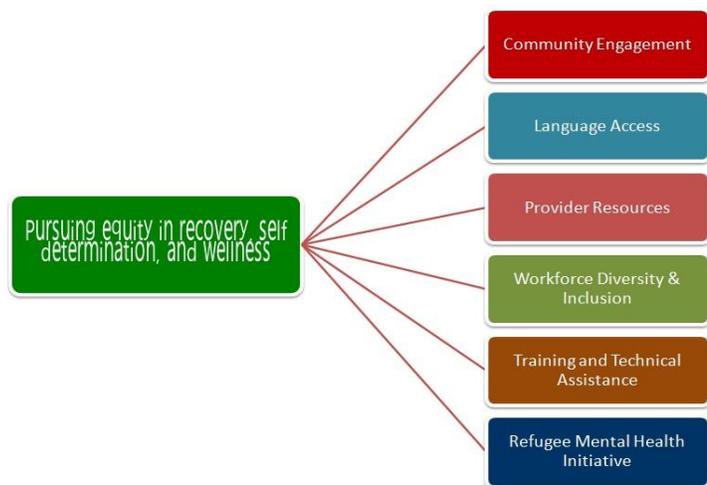
Understanding culture’s influence is central to effective services. It influences our health beliefs, practices, attitudes towards care, and trust in the system and individual providers. Cultural differences affect how information and services are received, understood, and provided. Barriers to quality care occur when cultural differences are not addressed which results in low or no care for many health priority populations. As such,

addressing cultural differences becomes imperative and high-performing healthcare organizations recognize cultural competency as an organizational strategy.

Cultural and linguistic competence is achieved through policies, learning processes, and structures by which organizations and individuals develop and support the attitudes, behaviors, practices, and systems that are needed for effective cross-cultural interactions (National Quality Forum, 2009).

The Office of Cultural & Linguistic Competence (OCLC) leads state efforts to provide exceptional services to all communities in the Commonwealth with a goal of eliminating the disparities in care within the mental health, intellectual disability and substance-use disorder system.

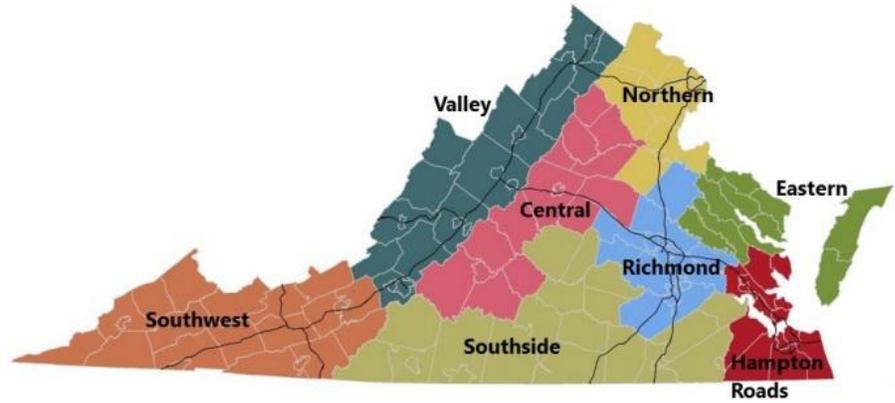
To effectively leverage limited resources, the OCLC has six focus areas for 2015-2016. Goals and activities will be developed within these six focus areas.



Population Assessment

General Demographics

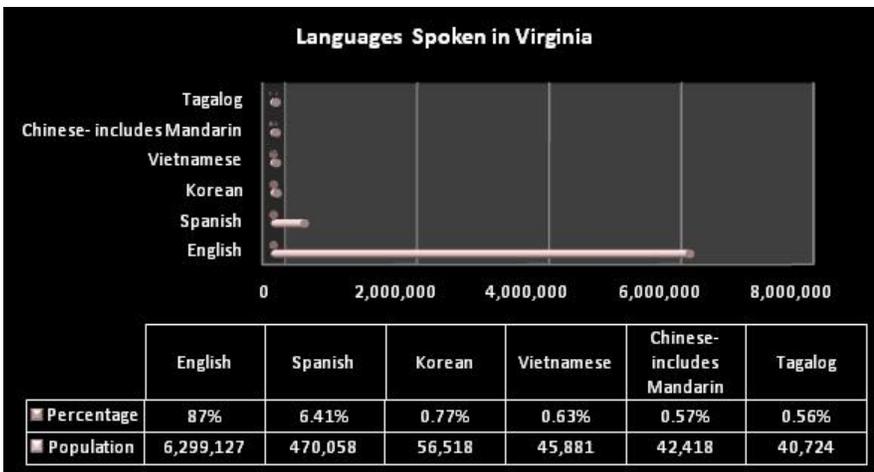
Virginia's population grows through both births and migration. Migration may involve people moving across states as well as people moving from other countries. Until 1970, only 1 in 100 Virginians was born outside of the United States; by 2012, 1 in every 9 Virginians is foreign-born (Weldon Cooper Center, 2014). Below are some key facts regarding Virginia's changing demographics.



- More than 1.5 million Virginia residents reported themselves to be Black or African American, accounting for nearly 20 percent of the total population. This ethnicity remains the largest minority group in Virginia.
- Just over 630,000 residents or 7.9 percent of the Virginia population reported themselves to be Hispanic. This is a 92 percent increase since 2000. Half of this population is made up of individuals under age 19.
- Almost 440,000 Virginia residents or 5.5 percent of the Virginia population are Asian. This is a 69 percent increase since 2000.
- The Virginia Department of Deaf and Hard of Hearing estimates that 1,360,000 Virginians are likely to have hearing impairments, and over 168,000 are likely to be deaf or have significant trouble hearing.
- The average age of the population continues to increase and is estimated by 2030, nearly one in every five Virginians is projected to be 65 years or older.
- Virginia is becoming more diverse, with racial and ethnic minorities now representing more than 35 percent of the population.
- Population growth continues to be concentrated in larger metropolitan areas.

Languages Spoken

Throughout the Commonwealth, over 100 languages are spoken in the home (Cai, 2012). In total, 14.13% (1,036,442) of Virginia's population age 5 and older spoke another language other than English. The most



common foreign language spoken other than Spanish is Korean. The most common Indo-Aryan language is Urdu and the most commonly encountered African language is Amharic (U.S. Census Bureau, 2010). The Virginia Department of Education reports 218 languages spoken in the schools systems statewide, with 66,530 being Spanish speakers. They report 97,000 students are limited English proficient (Virginia Department of Education, 2014).

Demographics in the DBHDS System

Total unduplicated number of individuals receiving any valid CSB services in each	Total
Alaskan	66
American Indian	385
Black/African American	64,406
White	125,560
Other	9,952
Asian	2,834
Native Hawaiian or Other Pacific Islander	189
American Indian or Alaska Native and White	289
Asian and White	517
Black or African American and White	4,407
American Indian or Alaska Native and Black or African American	180
Other Multi-Race	2,849
Unknown	3,487
Not Collected	7,298

Of the 222,419 unduplicated individuals in FY14 who received CSB services, 13,140 identified themselves as having a Hispanic origin, 5.9 percent of the total. Virginia's Hispanic population is continuing to grow meanwhile meeting its needs will be important in future service development (DBHDS, 2014).

Total unduplicated number of individuals receiving any valid CSB services in each Hispanic origin category

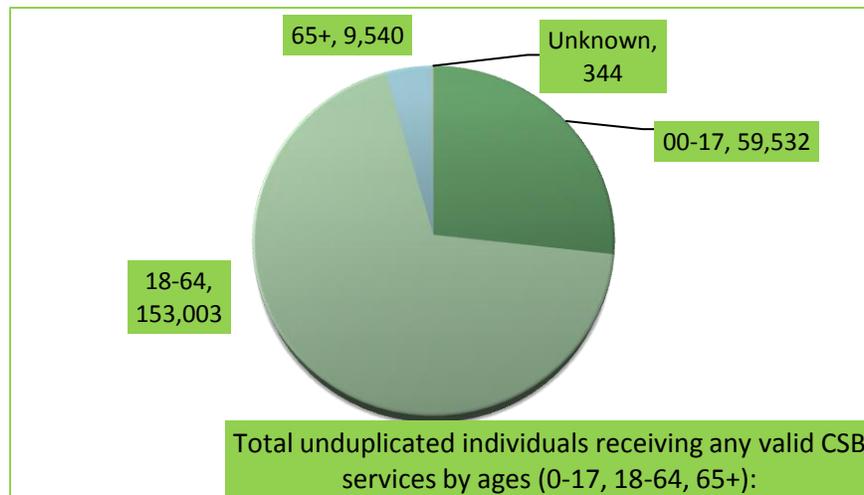
Ethnicity	Total
Puerto Rican	1,634
Mexican	1,559
Cuban	272
Other Hispanic	6,669
Not of Hispanic Origin	188,054
Hispanic - Specific origin not specified	3,006
Unknown	7,569
Not Collected	13,656

DBHDS Fiscal Year 2013 Annual Report 2013

Total unduplicated number of individuals receiving any valid CSB services in each gender category

Gender	Total
Female	101,425
Male	120,846
Unknown	44
Not Collected	104

DBHDS Fiscal Year 2013 Annual Report 2013



DBHDS Fiscal Year 2013 Annual Report 2013

Population Density- Urban and Rural Areas

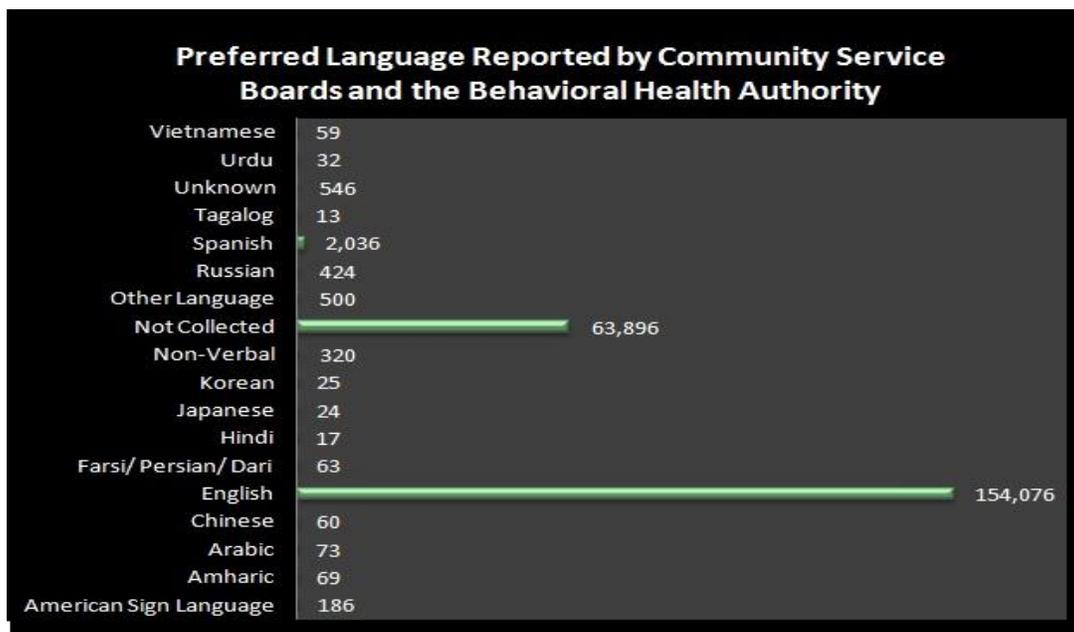
The following table lists Community Service Boards as being located in an urban area or a rural area. The number before the name identifies where the CSB ranks with regard to its population density. The figure in parentheses identifies where a locality ranks with regard to population in comparison to other localities in the state. Populations are the 2014 estimates from the Weldon Cooper Center for Public Service at the University of Virginia. This information is published in the DBHDS 2015 Overview of Community Services in Virginia.

Rank	CSB	Density	Rank	CSB	Density
Urban Community Services Boards (17): 200 or More People per Square Mile					
1	Alexandria (21)	10,146	14	Henrico Area (6)	548
2	Arlington (15)	8,853	11	Loudoun County (4)	696
16	Blue Ridge (10)	218	3	Norfolk (12)	4,580
12	Chesapeake (13)	692	5	Portsmouth (32)	2,925
10	Chesterfield (7)	775	9	Prince William County (2)	1,413
13	Colonial (20)	608	15	Rappahannock Area (5)	249
6	Fairfax-Falls Church (1)	2,866	4	Richmond (16)	3,552
7	Hampton-Newport News (8)	2,680	8	Virginia Beach (3)	1,819
17	Hanover County (30)	217			
Rural Community Services Boards (23): Less Than 200 People per Square Mile					
36	Alleghany Highlands (39)	49	35	Mount Rogers (27)	55
39	Crossroads (29)	38	21	New River Valley (17)	125
34	Cumberland Mountain (31)	65	19	Northwestern (14)	140
25	Danville-Pittsylvania (28)	105	27	Piedmont (23)	91
37	Dickenson County (40)	47	33	Planning District One (33)	67
28	District 19 (18)	90	29	Rappahannock-Rapidan (19)	87
31	Eastern Shore (37)	70	24	Region Ten (11)	115

26	Goochland-Powhatan (36)	92	40	Rockbridge Area (38)	36
18	Harrisonburg-Rockingham (25)	151	38	Southside (34)	43
20	Highlands (35)	126	30	Valley (26)	87
22	Horizon (9)	122	23	Western Tidewater (22)	116
32	Middle Peninsula-Northern Neck (24)	70	<i>DBHDS 2015 Overview of Community Services in Virginia</i>		

Languages Spoken in the DBHDS System

The following table lists preferred languages of individuals receiving services. This information is collected by Community Service Boards and reported to the state through the Community Consumer Submission (CCS).



Summary

Virginia’s population is increasing, but growth is highly uneven across communities with major metropolitan areas gaining in numbers and rural areas decreasing in size. Future populations, even in suburban and rural areas are becoming increasingly diverse, bilingual or speakers of other languages. This will continue to have an impact on the BHDS system in regards to how services are provided, where services are provided, in what languages they are provided, and more.

Currently, the OCLC does not have an efficient measure to evaluate how demographics may impact access to care, service delivery, quality of care, and outcomes in Virginia’s system, but is a well-researched and supported that they hold significant impacts to the overall state healthcare system. In the demographics above, information can be gleaned about who the system serves in the Commonwealth and where gaps in service may occur. Though it does not give an entire picture, it is part of a much larger complex puzzle.

What is known is that demographics and disparities are inextricably connected. Racial/Ethnic disparities are found across a wide range of healthcare settings, disease areas, and clinical services, even when various

confounders (SES, insurance) are controlled for (IOM, 2002). Risk factors for health disparities in rural areas include geographic isolation, lower socio-economic status, higher rates of health risk behaviors, and limited job opportunities. Higher rates of chronic illness and poor overall health are found in rural communities when compared to urban populations. And whether or not an individual has insurance coverage is strongly related to better health outcomes. Substantial disparities are observed among all demographic and socioeconomic groups who are uninsured (CDC, 2011).

These are the key issues that the biennial plan aims to address, which will then be reviewed by the Commissioner and her Statewide Cultural and Linguistic Competence Steering Committee to ensure it is aligned with the overall mission and goals of the Department.

Plan Evaluation and Reporting

The Director of the OCLC shall provide a quarterly progress reports to the Statewide Cultural and Linguistic Competency Steering Committee (CLC SC) and a yearly progress report to the Commissioner of the Department. A biennial report will be published and will include an evaluation of the outcomes and a narrative of the accomplishments and challenges in the implementation of the plan.

Action Plan

Focus area- Community Engagement

Genuine community engagement is a cornerstone of cultural and linguistic competence in addition to effective and efficient outcomes for service delivery. Support from all members of the community is important to provide programs, services, and supports that meet the needs of everyone in the community.

OCLC aspires to support providers by designing programs and resources that help to connect these developments to communities across the Commonwealth and highlight existing work from which others can learn.

Goal	Objectives	Timeframe	Implementation Action Steps
Increase the number of activities and opportunities for diverse communities to contribute to the discussions, programs, policy development, and awareness	Implement the 2015 & 2016 National Minority Mental Health Awareness Month Media Contests	Q2-Q3 2015 Q2-Q3 2016	2015- Feb / 2016-Feb <ul style="list-style-type: none"> Identify theme for the year Develop a communications plan for marketing Identify dates for beginning, end, recognition event, etc 2015-March/2016-March <ul style="list-style-type: none"> Create flyers to market the contest Identify selection committee Review selection process and refine if needed Follow communication plan as outlined moving forward. 2015- July/ 2016-July <ul style="list-style-type: none"> Plan events and market contest. Make personal contacts to invite people to create entries. Receive and judge entries 2015-Aug/2016-Aug <ul style="list-style-type: none"> Host recognition event
	Organize regional community events to promote awareness regarding equity and/or	Two planning regions in 2015	<ul style="list-style-type: none"> Partner with CLC SC Community Engagement Subcommittee and committee members from various regions to coordinate and host events targeting diverse communities in 2014. Committee will narrow the focus of the forums on the regional need.

	<p>language access in behavioral health and developmental services</p>	<p>Three planning regions in 2016</p> <p>Report is shared with providers in Q4 2016</p>	<p>Possible topics:</p> <ul style="list-style-type: none"> - Title IV Language Access - Self Advocacy - Stigma - Disproportionality - Culturally sensitive evaluations and assessments <ul style="list-style-type: none"> • Committee will partner with key stakeholders to market and implement event • OCLC supports interpreters • Information is gathered related to key issues of concern for participants • Results are compiled and shared with regional providers to build awareness of needs and concerns of communities in their areas.
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Focus area- Language Access

The proper assessment of an individual’s communication needs, preferences, and skill is critical for making a determination of appropriate diagnosis, service delivery, and treatment approach. It is expected that the behavioral health and developmental disability services system provide equal opportunity for all individuals receiving services and their authorized representatives to make informed care decisions, and equal access to services. This expectation is outlined by a number of federal and state policies.

These policies include DBHDS facility policy DI209, §51.5-40 of the Code of Virginia, Title VI of the Civil Rights Act of 1964, Americans with Disabilities Act (ADA) of 1990, Joint Commission Standards, National Standards for Culturally and Linguistically Appropriate Services (CLAS), Center for Medicaid and Medicare (CMS) policies, and other federal and state regulations.

Goal	Objectives	Timeframe	Implementation Action Steps
Increase the number of organizations that provide high quality language services in the BHDS system by 2016.	Support the development of language access plans in 6 state operations	three to be complete in 2015 Three plans to be complete in 2016	<ul style="list-style-type: none"> Identify five facilities that have a readiness for developing a plan. Build awareness of DI 209 and the requirements within. Meet with executive teams in each facility to offer technical assistance and templates. Identify champions in facilities that can carry the work forward. Draft plan with champions and seek input from cross discipline workgroup Finalize plan and create an operational plan. Develop a training and orientation process. Evaluate plan in 12 months.
	Complete Central Office language access plan (LAP) and engage Central Office in language access awareness and staff’s impact on language access system wide	Q2 2015-Q4 2015	<ul style="list-style-type: none"> Request the support of a cross division workgroup to assist in the review of a draft LAP Utilize this workgroup as resources in their practice areas. Offer informational sessions on language access and implementation in CO. Create resource guide for implementation in impacted offices.
		Q1 2016-Q3-2016	<ul style="list-style-type: none"> Audit, review, and revise plan with input from original workgroup
	Develop mechanism (process) for annual review and publication	Q1 2015-Q2 2015	<ul style="list-style-type: none"> Work with data analysts in Central Office to identify best methods for collection and distribution of information. Include facility demographic report in data warehouse as a method

<p>of preferred language data element in the Community Consumer Submission 3 (CCS3) statewide services database</p>	<p>for easy access to necessary data.</p>	<ul style="list-style-type: none"> • Develop draft publication and seek feedback from stakeholders, especially data management teams across the state. • Develop schedule for regular publication of information.
<p>Implement full Qualified Bilingual Staff (QBS) program in 3 organizations</p>	<p>Q4 2016</p>	<ul style="list-style-type: none"> • Work with organizations that are beginning to implement and provide resources such as training, policy, protocol, badges, etc. • Pilot one facility first to establish best practices • Highlight work in marketing material • Publish resource guide for additional implementations
<p>Provide six (QBS) Training Programs in five areas of the state in an effort to leverage the bilingual resources existing in organizations.</p>	<p>Three by Q4 2015</p>	<ul style="list-style-type: none"> • Hold 3 trainings in state facilities • Hold 3 in the community • Identify organizations that would like to send all bilingual staff
	<p>Three by Q4 2016.</p>	<ul style="list-style-type: none"> • Continue to fund the language proficiency test as a part of the training

Focus Area – Provider Resources

Organizations in our systems have tremendous workloads. While their primary role is to provide services and treatment to individuals in their communities, they are also working continuously on policies and procedures for community services; responding to federal and state audits and inquiries;; ensuring compliance with regulations from accreditation and licensing entities; and interfacing with justice, educational, and health systems.

Developing tools, templates, guidance documents and FAQs around culturally and linguistically competent practices can help busy organizations understand complex information and implement measures that make an immediate difference.

Goal	Objectives	Timeframe	Implementation Steps
Increase opportunities for providers to enhance their ability to provide culturally informed/adapted and linguistically appropriate services	Provide multiple pathways for opportunities for providers to network and learn about CLAS and multicultural approaches to services	Q2 2015	<ul style="list-style-type: none"> • Provide bimonthly one page info sheets on the latest research and program updates • Continue to market and populate the CLC Google group • Determine the feasibility of creating a sustainable weblog • Create specialized network (s) for providers of subpopulations who want to connect with others to enhance knowledge and resources. This is in partnership with community-based private providers
		Q3 2015	If weblog is determined feasible, work with CLCSC community engagement committee to create a protocol and schedule for posting.
	Identify and promote promising practices being implemented around the Commonwealth	Q1 2016	<ul style="list-style-type: none"> • Use nomination process to build awareness around promising practicing. • Create survey monkey form for providers to submit nomination for best practices or culturally and linguistically adapted programs • Create process to review nominations and assure their accuracy • Begin including these findings in the bimonthly one-pager.
	Create opportunities for providers to understand issues present in rural areas of the Commonwealth	Q4 2015	<ul style="list-style-type: none"> • Literature review of issues and prioritize topics of most importance. • Carry out inquiry of rural based organizations in the system to understand what critical issues they face.
		Q1 2016	Create FAQ sheets that highlight issues and identify solutions for the biggest challenges in rural areas for our service system
		Q2 2016	Build webpage to support information related to this topic and market material through multiple channels.

Focus Area- Workforce Diversity and Inclusion

Racial and ethnic minority groups are significantly underrepresented among health professionals in the United States. Research has shown that patient engagement is often enhanced when the workforce is reflective of the communities served. Workforce diversity planning can dramatically improve an organizations ability to recruit and retain cultural and linguistically competent staff. These are employees who are often in high demand.

	Objectives	Timeframe	Implementation
Goal Increase the number of organizations who develop diversity and inclusion initiatives designed to increase the cultural and linguistic competences of system providers	DBHDS HR Regional Managers will be aware of and utilize D&I material developed by OCLC	Q1 2016	<ul style="list-style-type: none"> Present material in Regional HR managers meetings, VACSB HR subcommittee meetings and events Offer individual TA Identify resources for HR staff
		Q2 2016	<ul style="list-style-type: none"> Follow up with Regional Managers and Facility Directors to encourage further implementation.
		Q3 2016	<ul style="list-style-type: none"> Identify facilities that are utilizing D&I interventions in their recruitment, retention, and performance planning and create report for executive team.
	Five organizations will include questions related to evaluating cross cultural skill sets in their interview process.	Q1-Q4 2016	<ul style="list-style-type: none"> Develop webinar series on D&I in BHDS system Market webinars via VACSB HR Subcommittee Identify qualified partners Provide individual follow up technical assistance
	Ten performance measures will be identified and disseminated for use in evaluating D&I in a BHDS organization.	Q1-Q4 2016	<ul style="list-style-type: none"> Develop webinar series on D&I in BHDS system Market webinars via VACSB HR Subcommittee Identify qualified partners Provide individual follow up technical assistance

Focus Area Training and Technical Assistance

Organizations have a "culture" of policies, procedures, programs, and processes & incorporate certain values, beliefs, assumptions, and customs. They often echo the mainstream culture in the sense of time orientation, values, and expectations around behavior. Organizational cultures may not lend itself to cultural competence, and that is where skill building becomes essential.

Culturally competent organizations use knowledge about different communities to transform standards, policies, and practices into high quality services for everyone. Cultural competence training should be a small piece of a larger developmental initiative that allows individuals and organizations to develop awareness, knowledge, and skills over an extended period of time.

Goal	Objectives	Timeframe	Implementation
Increase the number of system organizations who are begin or advance organizational cultural competence planning.	Provide data driven evidence that establishing a systematic focus on culturally and linguistically appropriate services helps to meet organizational goals and missions.	Q1	<ul style="list-style-type: none"> CLC SC policy committee will finalize recommendations on the utilization of the CLC ROI white paper Plan for white paper dissemination will be developed. CLC SC members will champion white paper recommendations in their organizations. OCLC will provide statewide marketing regarding white paper.
	Provide consistent and strategic educational opportunities for organizations to understand and utilize the CLAS standards to enhance their cultural and linguistic competence.	Ongoing	<ul style="list-style-type: none"> OCLC to promote CLAS Academy Catalog to providers and facilities Follow-up with CLC Facilitators to encourage their commitment to training Highlight one training in bimonthly news flyer
		Q2 2016	Identify methods to train leaders and middle management on CLC and CLC planning.
		Q3 2015	<ul style="list-style-type: none"> Plan & host the CLAS Winter Forum. A two-day event provides professional development for individuals and organizations supporting behavioral health and developmental disability services. Utilizing frameworks from intercultural communication and Bennett's Developmental Model of Intercultural Sensitivity; Certified Cultural &

		Linguistic Competence Workshop facilitators from around the state will deliver interactive sessions based on curriculum developed by the Language and Culture at Virginia Tech and the Office of Cultural and Linguistic Competence.
Expand the number of CLC trainers available to organizations in the state.	Q2 2015	<ul style="list-style-type: none"> Identify funding source Plan and host the 2nd CLC Facilitator TOT to 15 training and development staff in the system
	Q4 2016	CLC facilitators will do at least 10 trainings before the end of Q4 2016.
	Q4 2015	Enroll at least 15 qualified speakers in the CLAS Academy Speakers Bureau to expand the pool of training and consultation resources that can be tapped to provide expertise across the Commonwealth.
Provide opportunities to expand awareness in the ID/DD area regarding topics in cultural and linguistic competence, disparities, community engagement, and culturally adapted practices.	Q3 2015 & Q3 2016	Continue to support the Annual Building Bridges Conference. Continue partnership with Henrico Area Mental Health and Developmental Services, VCU’s Partnership for People with Disabilities, The Virginia Board for People with Disabilities, DBHDS Office of Developmental Disabilities, and the Office of Cultural and Linguistic Competence, and the CLC SC. Planning and funding will be done through this partnership.
Provide opportunities for senior leadership to network with national experts and policymakers in the language access services field as a mechanism to promote high quality language services in the BHDS system.	Q3 2015 & Q3 2016	Continue to support the Annual Northern Virginia Language Access Leadership Conference. Continue the partnership with Fairfax County Community Services Board, Alexandria DCHS, and Arlington County Mayor’s Office to plan and host this annual event.

Focus Area- Refugee Healing Partnership (Refugee Mental Health Initiative)

Researchers have shown that the most common mental health diagnoses associated with refugee populations include post-traumatic stress disorder (PTSD), major depression, generalized anxiety, panic attacks, and adjustment disorder. The incidence of diagnoses varies within various populations and their experiences. A range of studies has shown rates of PTSD and major depression in settled refugees to range from 10-40% and 5-15%, respectively. Children and adolescents often have higher levels of these disorders with various investigations revealing rates of PTSD from 50-90% and major depression from 6-40%. Risk factors for the development of mental health problems include the number of traumas, delayed asylum application process, detention, and the loss of culture and support systems (Refugee Technical Assistance Center: Mental Health; UNHCR, 2014; World Health Organization; Keller, A., and Stewart, A., 2011).

The Refugee Healing Partnership is a collaborative effort of the Virginia Department of Behavioral Health and Developmental Services – Office of Cultural and Linguistic Competence and the Virginia Department of Health – Newcomer Health Program focused on addressing refugee risk factors and strengthening mental health partnerships in communities where refugees resettle. The partnership designs and disseminates programs and activities that:

- Promote positive mental health and cultural adjustment in the refugee community
- Create linkages between provider communities and the refugee communities
- Provide opportunities for trauma-informed education at the community level and culture-informed education at the provider level

	Objectives	Timeframe	Implementation
Goal Increase the number of refugees who receive the appropriate level of mental health supports	Provide opportunities for refugees to self advocate by implementing the Feeling Good ESL module in ESL classrooms in 10 classrooms around the state.	Q2 2015-Q4 2017	<ul style="list-style-type: none"> • Develop and disseminate information regarding beliefs around western behavioral health and wellness • Disseminate and have implemented the “Feeling Good!” Refugee Mental Health ESL Module to 5 ESL programs. • Refugee Mental Health Analyst will market module to ESL classes across the state.
	Expand suicide prevention training to multilingual and multicultural communities in the Commonwealth	Q2 2015-Q4 2017	<ul style="list-style-type: none"> • Develop the Multicultural Mental Health First Aid Training Collaborative. • Facilitators are identified and committed to a long term relationship with the collaborative • Provide QPR Facilitator Training to a minimum of 5 refugee leaders and advocates • Seven facilitators for youth training to be trained in February & March 2015.

		<ul style="list-style-type: none"> • Seven facilitators for adult training to be trained in the summer of 2015 • Two trainings for youth and two trainings for adults will be offered in 2015 • Four training for youth and four training for adults will be offered in 2016. • Trainings are offered in languages other than English
Trauma Informed Pyschoeducational Curricula dissemination	Q1 2015-Q3 2015	<ul style="list-style-type: none"> • Identify community readiness for intervention • Work with refugee community, refugee mental health council, and local providers to build support. • Provide intervention and report on results. • Revise curricula as needed. • Contracted to VCU School of Social Work
Develop a professional development qualification designed for refugee leaders with nationally recognized interventions and best practices, which, combined with their bicultural and bilingual skills, provide an excellent candidate pool for a diverse and culturally competent entry-level workforce.	Q1 2015-Q3 2015	<ul style="list-style-type: none"> • Create a qualification process for Cultural Navigator for Refugee Wellness as a way to recognize this unique set of skills that are not always reflected in school transcripts or resumes. • Contracted to VCU School of Social Work
Strengthen the network for providers that are committed to providing behavioral health services to refugees.	Ongoing Q2 2015 and Q2 2016	<ul style="list-style-type: none"> • Continue to staff regional councils across the state. • Convene the 2nd Annual Refugee Mental Health Council Statewide Summit as a way to provide training, build enthusiasm, and collect information.
Offer interpreter funds to providers who are unable to offer language services for behavioral health services.	Until Q3 2015	<ul style="list-style-type: none"> • Establish protocol for distributing interpreter funding • Disseminate protocol • Follow up with utilizers of interpreter funding to build awareness of language access laws

Additional Goals

GOAL - POLICY	Objectives	Timeframe	Implementation
Impact the level of accountability for the provision of culturally and linguistically appropriate services through policy	Promote agenda that articulates policy priorities that impact accountability	Q2 2015-Q4 2015	<ul style="list-style-type: none"> Utilize CLC SC Policy Committee to conduct a study of current policies that have CLC requirements Study will result in a list of policies that can be targeted for revision or enforcement. Develop recommendation or policy platform to use as a guide for further action.
	Advocate for the development of state DHRM guidance on testing for language proficiency and compensation for bilingual skill set.	Q3 2015-Q2 2016	<ul style="list-style-type: none"> Explore the feasibility of policy change Interview HR staff in-house and at DHRM. Request a compensation study. Identify best practices and collect job descriptions and roles. If feasible, approach HHR-HR Committee, DHRM, and Secretary Rodrigues for support. Draft proposed guidance. Seek guidance and revise. If approved, shepherd changes through job roles and train on new guidance.
GOAL- Ensure that current system planning includes CLAS frameworks as a part of the decision making process	Objectives	Timeframe	Implementation
	Encourage the inclusion of disparities and cultural competence considerations into agency priorities such as Transformation Teams, Waiver Redesign, etc.	On-going	<ul style="list-style-type: none"> Seek input from Commissioner Ferguson Create workgroup to identify next steps

GOAL – Understand the key equity issues related to behavioral health, substance use, and developmental disabilities in Virginia’s diverse communities	Objectives	Timeframe	Implementation
	Carry out a research study of disparities in the BHDS system to better understand and assess where resources should be targeted.	Q42015- Q42016	<ul style="list-style-type: none"> • Develop statement of need for a research study related to the goal • Seek leadership approval • Identify funding source • Identify research entity • Carry out study • Create recommendations and publish report

GOAL – Sustain and Bolster the Statewide Cultural & Linguistic Competence Steering Committee	Objectives	Timeframe	Implementation
	All members are engaged to their maximum ability	Ongoing	<ul style="list-style-type: none"> • Identify ways to check in with members and ensure that they are feeling connected and empowered. • Add responsibility to monitor and motivate members to the Chair and Vice Chair. • Collect information about committee member’s skill sets and interests as a way to ensure they become involved in the most personally satisfying activities.

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