Emerald Bay, Lake Tahoe

El Dorado County

Mental Health Services Act (MHSA)

Outcomes

FY 2020-21 YEAR END RESULTS

Reported with the FY 2022-23 MHSA Annual Update

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Impact as a Result of the Public Health Emergency/Coronavirus Pandemic: Fiscal Year 2020/21 Outcomes

Beginning in March, 2020, California was faced with a new dilemma of how to continue to provide vital mental health services, in the face of the Public Health Emergency associated with the Coronavirus Pandemic. El Dorado County's Behavioral Health and our contracted service providers recognized the importance of continuing to provide services and did their best to adapt, and if necessary, transition to new and innovative service models.

It is also important to note that due to the various gathering and interaction restrictions as a result of the Public Health Emergency, some Outcome demographic data may represent "*contact* with individuals". Counties across the State agreed that while it is important to gather as much meaningful data as possible, during this unique time, it was crucial to have contact with individuals to assess their needs and resiliency. At times, that may have meant collecting the myriad of required data, was not practical.

Prevention and Early Intervention (PEI) Projects

Introduction

Prevention and Early Intervention (PEI) Projects are intended to prevent serious mental illness/emotional disturbance by promoting mental health, reducing mental health risk factors, and by intervening to address mental health problems before they occur, to the extent possible, or in the early stages of the illness.

This Outcome Measures Report accompanying the Fiscal Year 2022/23 MHSA Three-Year Program and Expenditure Plan provides outcome information for the PEI projects included in the Fiscal Year 2020/21 MHSA Annual Update.

Pursuant to Title 9 California Code of Regulations Section 3560.010(a)(1): "The first Annual PEI Report is due to the Mental Health Services and Oversight Accountability Commission on or before December 30, 2017 as part of an Annual Update or Three-Year Program and Expenditure Plan. Each Annual PEI Report thereafter is due as part of an Annual Update or Three-Year Program and Expenditure Plan within 30 calendar days of Board of Supervisors approval but no later than June 30 of the same fiscal year whichever occurs first. The Annual PEI Report is not due in years in which a Three-Year PEI Report is due."

Section 3560.010(a)(2): "The Annual PEI Report shall report on the required data for the fiscal year prior to the due date." Therefore, this Outcomes Report is due no later than June 30, 2022 and is to report the required data from fiscal year 2020/21 (i.e., July 1, 2020 through June 30, 2021).

Further, for each PEI Project, this PEI Report includes all the elements outlined in Section 3560.010(b).

This report reflects the responses as reported by the Project provider. In some cases, the reported data may not equal the number of unduplicated client counts.

Consistent with previous PEI Reports, there is a noticeable trend within many programs where the responses to the demographics questions are "Unknown or decline to state". It is not possible to specifically identify the reason for the increased rate of this response, however, it is believed that the number of potential responses to the many demographic questions may be too much information for individuals to review, so they elect to leave the questions blank.

Additionally, with the Public Health Emergency related to the Coronavirus Pandemic, some PEI service providers had to record number of "contacts" versus capturing all the required demographics.

Prevention Programs

MHSA Year-End Progress Report FY 2020/2021

Latino Outreach Project – South Lake Tahoe

Provider: South Lake Tahoe Family Resource Center

Project Goals

- Increased mental health service utilization by the Latino community.
- Decreased isolation that results from unmet mental health needs.
- Decreased peer and family problems that result from unmet health needs.
- Reduce stigma and discrimination.
- Integration of prevention programs already offered in the community is achieved.
- Reduction in suicide, incarcerations, and school failure or dropouts.

Numbers Served and Cost

Expenditures	FY 2018-19	FY 2019-20	FY 2020-21
MHSA Budget	$135,150	$135,150	$135,150
Total Expenditures	$125,702	$135,150	$135,150
Unduplicated Individuals Served	509	369	106
Cost per Participant	$247	$366	$1275
Age Group	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
0-15 (children/youth)	202	152	53
16-25 (transitional age youth)	74	31	32
26-59 (adult)	221	178	18
Ages 60+ (older adults)	12	8	3
Unknown or declined to state	0	0	3
Race	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
American Indian or Alaska Native	0	0	0
Asian	0	0	0
Black or African American	0	0	0
Native Hawaiian or Other Pacific Islander	0	0	0
White	32	0	0
Other	477	369	106
Multiracial	0	0	0
Unknown or declined to state	0	0	0

Ethnicity by Category	FY 2018-19	FY 2019-20	FY 2020-21
Hispanic or Latino	0	369	106
Caribbean	0	0	0
Central American	3	0	0
Mexican/Mexican-American/Chicano	491	0	0
Puerto Rican	0	0	0
South American	1	0	0
Other	14	0	0
Unknown or declined to state	0	0	0
African	0	0	0
Asian Indian/South Asian	0	0	0
Cambodian	0	0	0
Chinese	0	0	0
Eastern European	0	0	0
Filipino	0	0	0
Japanese	0	0	0
Korean	0	0	0
Middle Eastern	0	0	0
Vietnamese	0	0	0
Other	0	0	0
Multi-ethnic	0	0	0
Unknown or declined to state	0	0	0
Primary Language	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
Arabic	0	0	0
Armenian	0	0	0
Cambodian	0	0	0
Cantonese	0	0	0
English	62	62	6
Farsi	0	0	0
Hmong	0	0	0
Korean	0	0	0
Mandarin	0	0	0
Other Chinese	0	0	0
Russian	0	0	0
Spanish	447	369	106
Tagalog	0	0	0
Vietnamese	0	0	0
Unknown or declined to state	0	0	0

Sexual Orientation **Collection of this information from a minor younger than 12 years of age is not required.*	FY 2018-19	FY 2019-20	FY 2020-21
Gay or Lesbian	0	0	0

Heterosexual or Straight	126	369	106
Bisexual	0	0	0
Questioning or unsure of sexual orientation	0	0	0
Queer	0	0	0
Another sexual orientation	0	0	0
Declined to State	383	0	0
Gender ****Collection of this information from a minor younger than 12 years of age is not required.***	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
Male	213	129	33
Female	296	240	73
Declined to answer	0	0	0
Male	213	129	33
Female	296	240	73
Transgender	0	0	0
Genderqueer	0	0	0
Questioning / unsure of gender identity	0	0	0
Another gender identity	0	0	0
Declined to answer	0	0	0
Disability	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
Difficulty seeing	0	0	0
Difficulty hearing or having speech understood	0	0	0
Mental disability including but not limited to learning disability, developmental disability, dementia	3	0	0
Physical/mobility	3	0	0
Chronic health condition/chronic pain	3	0	0
Other (specify)	0	0	0
Declined to state	500	0	0

Veteran Status **Collection of this information from a minor younger than 12 years of age is not required.*	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
Yes	0	0	0
No	183	369	106
Unknown or declined to state	326	0	0
Region of Residence	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
West County	0	0	0
Placerville Area	0	0	0
North County	0	0	0
Mid County	0	0	0
South County	0	0	0
Tahoe Basin	448	369	106
Unknown or declined to state	61	0	0
Economic Status	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
Extremely low income	0	0	0
Very low income	285	0	0
Low income	218	369	106
Moderate income	6	0	0
High income	0	0	0
Health Insurance Status	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
Private	0	0	0
Medi-Cal	469	369	106
Medicare	0	0	0
Uninsured	40	0	0

Annual Report FY 2020/21

Please provide the following information for this reporting period:

1) **Briefly report on how implementation of the Latino Outreach project is progressing (e.g., whether implementation activities are proceeding on target and as described in the County's MHSA Plan), and any major accomplishments and challenges.**

   The Latino Outreach project is performing well for the South Lake Tahoe community & the Family Resource Center (FRC). We are serving new clients every month, as well as keeping the community informed with our Engagement and Outreach activities at numerous locations including schools in the LTUSD with our Cafecito's program(s). FY20-21 has been challenging due to the continuing COVID-19 pandemic and the closure of the LTUSD and LTCC. This has forced the FRC to reevaluate our operation. We have continued to use a virtual online model for our counseling services on a HIPAA compliant platform and we are conducting our Parenting classes over ZOOM. Our counselor has made great strides in providing therapy using a virtual model.

2) **Briefly report on how the Latino Outreach project has improved the overall mental health of the children, families, and communities by addressing the primary negative outcomes that are the focus of the Latino Outreach project (suicide, prolonged suffering, school failure or dropout, incarceration, unemployment, homelessness, and removal of children from their homes).**

The overall health of community is strengthened by the Latino Outreach by providing group and individual therapy as well as community participation in parent support groups that are focused on topics of mental health and family dynamics. This year, with the continuing COVID-19 pandemic, we continue to utilize an on-line secure platform to continue to provide counseling services and parenting classes for our clients.

Upon review of our program numbers for FY20-21 we notice a decrease in the total number of clients served. During the past year we have witnessed the need for more counseling sessions for a majority of counseling clients. We feel that given the extra stressors impacting families i.e. job loss, quarantine, isolationism, financial and food insecurities, increase in rents to name a few, clients are asking to utilize all sessions available as they feel their mental health issues are continuing to impact their daily lives. We know that the need for mental services is increasing and hope to continue to serve the community.

3) **Provide a brief narrative description of progress in providing services through the Latino Outreach project to unserved and underserved populations.**

By providing Outreach to schools in the Lake Tahoe Unified School District, as well as at Lake Tahoe Community College, the Family Resource Center informs the community of the Latino Outreach project and new clients continue to seek our services. The Foster & Kinship (FKCE) and English as a Second language (ESL) programs affords us the opportunity to provide information and services to a wider range of clients.

4) **Provide a brief narrative description of how the Latino Outreach services are provided in a culturally and linguistically competent manner, including activities to reduce racial/ethnic disparities.**

All staff at the FRC are bilingually, culturally and linguistically competent. All of our programming is in Spanish and provides opportunities to the community to further develop skills that empower them and their families to become self-sufficient. We meet individually with parents to assist them in overcoming their fears in communicating with their families, employers and schools.

5) **Provide a brief description of activities performed related to local and county-wide collaboration, outreach, access/linkages to medically necessary care, stigma reduction and discrimination reduction.**

The FRC Executive Director and/or designee participate in committees such as: South Lake Tahoe Behavioral Health Network, Barton Hospital's Community Health Advisory Committee, El Dorado County School Attendance Review Board (SARB) and the Lake Tahoe Collaborative. We participate in all community events to further disseminate information to the community.

6) **Provide the outcomes measures of the services provided and of customer satisfaction surveys. Outcome measures for the Latino Outreach project are:**

- **Measurement 1: Customer satisfaction surveys.**
  The survey indicates that longer duration counseling services are desired by some clients.

- **Measurement 2: Client outcome improvement measurements.**
  None stated

- **Measurement 3: Increased engagement in traditional mental health services.**
  Some clients will be referred to El Dorado County MHSA to seek other long-term services that the LEP does not provide. Others may be referred to local providers in the South Shore community.

7) **If known, the number of Clients referred to County Behavioral Health and the type of treatment to which Clients were referred.**

Three (03) clients were referred to county mental health for psychiatric services.

8) **If known, the number of individuals who followed through on the referral and engaged in treatment.**
Unknown.

9) **Provide total project expenditures and the type and dollar amount of leveraged resources and/or in-kind contributions.**

Total Project expenditures: $135.150.

10) **Provide any additional relevant information.**

The COVID-19 Pandemic has created a level of fear in our community that is difficult to overcome. The stress associated with COVID-19 is huge. So many of our families are not able to work and those that have begun to return to work are not being given enough hours to support themselves and families. Our clients are also in fear of contracting the virus at work, as most of our clients are working in service industry jobs and are being overrun by tourists in the workplace. The community is having difficulty paying rents that are past due and now they are concerned about being evicted from their place of residence. Food insecurity is a growing concern. We distribute food in coordination with the Food Bank of El Dorado and use donated and grant funds to purchase food cards to distribute to community members experiencing food insecurities.

The Family Resource Center (FRC) is in the process of petitioning the USCIS to approve our application of a qualified bilingual mental health therapist to work at the FRC. We currently have a waiting list of up to 8 weeks to see new clients. The mental health issues with our Latino population are increasing. The FRC is hopeful to have our candidate approved and seeing clients in 2022.

Latino Outreach Project – West Slope

Provider: New Morning Youth and Family Services

Project Goals

- Increased mental health service utilization by the Latino community.
- Decreased isolation that results from unmet mental health needs.
- Decreased peer and family problems that result from unmet health needs.
- Reduce stigma and discrimination.
- Integration of prevention programs already offered in the community is achieved.
- Reduction in suicide, incarcerations, and school failure or dropouts.

Numbers Served and Cost

Expenditures	FY 2018-19	FY 2019-20	FY 2020-21
MHSA Budget	$96,000	$96,000	$96,000
Total Expenditures	$88,579	$93,445	$96,000
Unduplicated Individuals Served	350*	433	351
Cost per Participant	$253	$216	$253

Age Group	FY 2018-19	FY 2019-20	FY 2020-21
0-15 (children/youth)	146	150	128
16-25 (transitional age youth)	45	66	65
26-59 (adult)	144	199	150
Ages 60+ (older adults)	15	18	8
Unknown or declined to state	0	0	0
Race	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
American Indian or Alaska Native	0	0	0
Asian	0	0	0
Black or African American	0	0	0
Native Hawaiian or Other Pacific Islander	0	0	0
White	344	421	351
Other	6	8	0
Multiracial	0	0	0
Unknown or declined to state	0	4	0

Ethnicity by Category	FY 2018-19	FY 2019-20	FY 2020-21
Hispanic or Latino	0	0	0
Caribbean	0	0	0
Central American	8	10	16
Mexican/Mexican-American/Chicano	328	422	329
Puerto Rican	0	0	0
South American	8	1	0
Other	6	0	6
Unknown or declined to state	0	0	0
Non-Hispanic or Non-Latino			
African	0	0	0
Asian Indian/South Asian	0	0	0
Cambodian	0	0	0
Chinese	0	0	0
Eastern European	0	0	0
Filipino	0	0	0
Japanese	0	0	0
Korean	0	0	0
Middle Eastern	0	0	0
Vietnamese	0	0	0
Other	0	0	0
Multi-ethnic	0	0	0
Unknown or declined to state	0	0	0
Primary Language	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
Arabic	0	0	0
Armenian	0	0	0
Cambodian	0	0	0
Cantonese	0	0	0
English	156	196	159
Farsi	0	0	0
Hmong	0	0	0
Korean	0	0	0
Mandarin	0	0	0
Other Chinese	0	0	0
Russian	0	0	0
Spanish	188	237	192
Tagalog	0	0	0
Vietnamese	0	0	0
Other language	6	0	0
Unknown or declined to state	0	0	0
Sexual Orientation **Collection of this information from a minor younger than 12 years of age is not required.*	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
Gay or Lesbian	0	0	0

Heterosexual or Straight	350	433	350
Bisexual	0	0	0
Questioning or unsure of sexual orientation	0	0	0
Queer	0	0	1
Another sexual orientation	0	0	0
Declined to State	0	0	0
Gender ***Collection of this information from a minor younger than 12 years of age is not required.***	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
Male	123	114	102
Female	227	319	249
Declined to answer	0	0	0
Male	123	114	102
Female	227	319	249
Transgender	0	0	0
Genderqueer	0	0	1
Questioning / unsure of gender identity	0	0	0
Another gender identity	0	0	0
Declined to answer	0	0	0
Disability	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
Difficulty seeing	0	0	1
Difficulty hearing or having speech understood	0	2	4
Mental disability including but not limited to learning disability, developmental disability, dementia	5	6	25
Physical/mobility	1	4	8
Chronic health condition/chronic pain	0	3	34
Other (specify)	0	0	2
Declined to state	344	1	0
Veteran Status ***Collection of this information from a minor younger than 12 years of age is not required.***	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
Yes	0	0	0
No	350	433	351
Unknown or declined to state	0	0	0

Region of Residence	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
West County	74	102	80
Placerville Area	175	221	209
North County	10	8	6
Mid County	89	102	56
South County	0	0	0
Tahoe Basin	0	0	0
Unknown or declined to state	2	0	0

Economic Status	FY 2018-19	FY 2019-20	FY 2020-21
Extremely low income	123	159	126
Very low income	96	134	161
Low income	125	135	63
Moderate income	6	5	1
High income	0	0	0
Health Insurance Status	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
Private	9	7	8
Medi-Cal	228	248	194
Medicare	4	7	9
Uninsured	109	171	140

Annual Report FY 2020/2021

Please provide the following information for this reporting period:

1) **Briefly report on how implementation of the Latino Outreach project is progressing (e.g., whether implementation activities are proceeding on target and as described in the County's MHSA Plan), and any major accomplishments and challenges.**

   Promotoras continue to provide a wide range of services that include advocacy, community outreach, interpretation, crisis support, home visitation, and linkage to other programs/resources (mental health services, domestic violence services, support for immigration status, referral and support for health services, referral to victims services, community Hubs, First 5 El Dorado, etc.).

   Since March 2020, these services and supports were provided through a tele-health modality. In some circumstances, when interpretive services are needed for special cases, *Promotoras* abide by social distancing and masks. During the last few months, with the increase of people receiving the vaccine, the *Promotoras* have been able to engage with their clients in person.

2) **Briefly report on how the Latino Outreach project has improved the overall mental health of the children, families, and communities by addressing the primary negative outcomes that are the focus of the Latino Outreach project (suicide, prolonged suffering, school failure or dropout, incarceration, unemployment, homelessness, and removal of children from their homes).**

   The *Promotoros* continue to advocate for the youth that are struggling in school and accompany parents to school meetings (SST and IEP) for interpretation and clarification. They assist in making referrals at schools for counseling services. In addition, Ruth provides services for the Wellness Centers located at each El Dorado Union High School District site. During the school closures due to COVID-19, the *Promotoras* continued to support parents struggling to help their children with their schoolwork at home. Ruth and Angie have been providing them with additional resources to assist families.

   Latino Outreach continues to address a variety of needs that effect each family member. During this period, Latinos were worried to any public assistance they received would be reported under the new "public charge" rule published under the Department of Homeland Security. This new rule wentinto effect in February 2020, but many Latinos had already declined services in advance. Even more concerning, due to the Coronavirus pandemic the Latino Population that do not have insurance are not

seeking medical assistance due to the cost and fear of being reported.

Latino Outreach continued to provide referrals for groceries and in some cases, they would deliver food to those clients who were unable to because they were sick with Covid-19. During this last quarter, the Latinx population employed in hospitality service and agricultural; returned to work.

3) **Provide a brief narrative description of progress in providing services through the Latino Outreach project to unserved and underserved populations.**

Latino Outreach continues to increase services to unserved/underserved populations, especially to engage Latino families' greater access to culturally competent medical and mental health services. Some of the Latinx community were facing homelessness in the pandemic we provided informationon the California rental moratorium slated to end July 31, 2021.

NMYFS continued to have families that were struggling due to the pandemic. Therefore, we referredand updated them to weekly and monthly sources for food. NMYFS reached out to El Dorado Food Bank and received $5,000 in Safeway gift cards to help 60 identified families purchase food. During the Christmas holiday season, New Morning provided 20 families with clothes, food, and toys.
Our *Promotoras* provided vaccination information on the mobile clinic dates through emails and texts messages. They emailed fliers to clients regarding the new Covid-19 guidelines starting June15, 2021.

4) **Provide a brief narrative description of how the Latino Outreach services are provided in a culturallyand linguistically competent manner, including activities to reduce racial/ethnic disparities.**

The *Promotoras* provide all their clients with respect; mindful that the Latino population has a mixture of diverse cultures, linguistics (Spanish dialects), nationalities, and spiritual beliefs. NMYFSprovides information through social media to reduce racial/ethnic disparities.

The *Promotoras* attended community events per Zoom hosted by non-profit organizations and county departments to increase cultural awareness and reduce racial/ethnic disparities. Over the year, they have attended at least thirty training provided by the National Hispanic and Latino MentalHealth Technology Transfer Center.

5) **Provide a brief description of activities performed related to local and county-wide collaboration, outreach, access/linkages to medically necessary care, stigma reduction and discrimination reduction.**

The *Promotoras* collaborate with county and non-profit organizations in outreach events to supportthe Latino population. This fourth quarter, we participated the 'drive-up' Kids Expo and provided goody bags to over 200 families (cars) which contained information (English and Spanish) about ourservices and vaccination information.

6) **Provide the outcomes measures of the services provided and of customer satisfaction surveys. Outcome measures for the Latino Outreach project are:**

- Measurement 1: Customer satisfaction surveys.
  95% of clients were satisfied with the assistance they received.

- Measurement 2: Client outcome improvement measurements.

85% of clients indicated that there were improvements.

- Measurement 3: Increased engagement in traditional mental health services.
  There are 4 to 6 clients a month that are referred to mental health services.

- Measurement 4: Number of Clients referred to County Behavioral Health, if known.
  8 to 10 clients a year are referred to County Behavioral Health.

- Measurement 5: Client self-report on the duration of untreated mental illness.
  Unknown

- Measurement 6: If known, the average interval between referral and participation intreatment.
  For mental health services, the interval is determined upon the client's 'level of care.' If the client requires prompt intervention, then 1-3 days. Likewise, a lower 'level of care' could be up to one month.

- Measurement 7: A description of the methods Contractor used to encourage Client access toservices and follow-through on referrals.

  The *Promotoras* prefer to accompany their clients to the resources because of language barriers and biases. If for any reason (COVID-19) they are not able to accompany their clients, the *Promotoras* contact the resource to obtain specific instructions that client will need to know when client arrivesat resource. Every client continues to receive follow-up and support until client has resolution.

7) Provide total project expenditures and the type and dollar amount of leveraged resources and/orin-kind contributions.

NMYFS continues to utilize community volunteers to provide additional educational services to Latino families. Furthermore, we provide counseling services in English or Spanish that are referredby Latino Outreach.

8) Provide any additional relevant information.
N/A

Senior Peer Counseling Project

Provider: EDCA Lifeskills

Project Goals

- Clients demonstrate an increased number of "Therapeutic Lifestyle Changes" over the course of their counseling.
- Clients identify the primary issue of focus (presenting problem) for counseling.
- Clients achieve improvements in their feelings of well-being as shown on the Outcome Rating Scale (ORS) measurement tool.
- Clients are informed about other relevant mental health and support services.
- New volunteer trainings will be provided based on need for both Senior Peer Counselors and Friendly Visitors.
- Through the use of TLCs, clients improve their mental health and self-sufficiency.
- Clients ameliorate their distress as described in their presenting problem.
- Clients' mental health and satisfaction with life is increased as evidenced by scores on the ORS measurement tool.
- Clients know of, and successfully access, other needed mental health services.

Numbers Served and Cost

Expenditures	FY 2018-19	FY 2019-20	FY 2020-21
MHSA Budget	$40,000	$48,000	$55,000
Total Expenditures	$34,493	$44,973	$39,515
Unduplicated Individuals Served	83 total / 45 new added in FY 18/19. Data in FY 18/19 is based upon the new clients only.	69	71
Cost per Participant	$416 (based on 83 total clients)	$652	$556
Age Group	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
0-15 (children/youth)	0	0	0
16-25 (transitional age youth)	0	0	0
26-59 (adult)	3	5	4
Ages 60+ (older adults)	42	64	67
Unknown or declined to state	0	0	0
Race	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
American Indian or Alaska Native	2	3	1
Asian	0	2	0
Black or African American	0	0	0
Native Hawaiian or Other Pacific Islander	0	0	0
White	43	63	70
Other	0	0	0
Multiracial	0	1	0
Unknown or declined to state	0	0	0

Ethnicity by Category	FY 2018-19	FY 2019-20	FY 2020-21
Hispanic or Latino	0	1	1
Caribbean	0	0	0
Central American	0	0	0
Mexican/Mexican-American/Chicano	0	0	0
Puerto Rican	0	0	0
South American	0	0	0
Other	0	0	0
Unknown or declined to state	0	0	0
Non-Hispanic or Non-Latino			
African	0	0	0
Asian Indian/South Asian	0	0	0
Cambodian	0	0	0
Chinese	0	0	0
Eastern European	43	62	1
Filipino	0	0	0
Japanese	0	0	0
Korean	0	1	0
Middle Eastern	0	0	0
Vietnamese	0	1	0
Other	2	1	0
Multi-ethnic	0	3	0
Unknown or declined to state	0	0	0

Primary Language	FY 2018-19	FY 2019-20	FY 2020-21
Arabic	0	0	0
Armenian	0	0	0
Cambodian	0	0	0
Cantonese	0	0	0
English	45	68	71
Farsi	0	0	0
Hmong	0	0	0
Korean	0	0	0
Mandarin	0	0	0
Other Chinese	0	0	0
Russian	0	0	0
Spanish	0	1	0
Tagalog	0	0	0
Vietnamese	0	0	0
Unknown or declined to state	0	0	0
Sexual Orientation ****Collection of this information from a minor younger than 12 years of age is not required.***	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
Gay or Lesbian	0	1	1
Heterosexual or Straight	45	67	70
Bisexual	0	1	0
Questioning or unsure of sexual orientation	0	0	0
Queer	0	0	0
Another sexual orientation	0	0	0
Declined to State	0	0	0
Gender ****Collection of this information from a minor younger than 12 years of age is not required.***	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
Assigned sex at birth:			
Male	8	14	20
Female	37	55	50
Declined to answer	0	0	0
Current gender identity:			
Male	8	14	20
Female	37	55	50
Transgender	0	0	0
Genderqueer	0	0	0
Questioning / unsure of gender identity	0	0	0
Another gender identity	0	0	0
Declined to answer	0	0	0

Disability	FY 2018-19	FY 2019-20	FY 2020-21
Difficulty seeing	3	5	6
Difficulty hearing or having speech understood	0	16	3
Mental disability including but not limited to learning disability, developmental disability, dementia	0	2	4
Physical/mobility	9	33	28
Chronic health condition/chronic pain	4	14	15
Other (specify)	0	0	0
Declined to state	0	0	1
Veteran Status ***Collection of this information from a minor younger than 12 years of age is not required.***	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
Yes	2	6	8
No	43	63	63
Unknown or declined to state	0	0	0
Region of Residence	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
West County	15	14	11
Placerville Area	18	34	44
North County	6	12	6
Mid County	5	8	8
South County	1	1	0
Tahoe Basin	0	0	2
Unknown or declined to state	0	0	0
Economic Status	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
Extremely low income	10	15	10
Very low income	14	19	22
Low income	4	12	13
Moderate income	17	12	11
High income	0	11	9 (6 no answer)
Health Insurance Status	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
Private	1	4	7
Medi-Cal	1	6	9
Medicare	43	61	57
Uninsured	0	2	1

Please provide the following information for this reporting period:

1) **Briefly report on how implementation of the Senior Peer Counseling project is progressing (e.g., whether implementation activities are proceeding on target and as described in the County's MHSA Plan), and any other major accomplishments and challenges.**

   We are proud to have been able to continually and successfully achieve all of our project goals listed at the beginning of this report. These goals continue to be the foundation of our program services and direct our weekly work with clients. One major accomplishment is that even amidst the pandemic, our program has run at full functioning and hasn't reduced the amount or frequency of services provided. All clients requesting services and completing an intake have been connected with an ongoing counselor within two weeks and no clients are unassigned. Our volunteers are stellar people who have a high level of ethics, compassion for older adults and their mental health, commitment to ongoing training and to providing the best possible services for our older adult community. The results from our Outcome Rating Scale and Therapeutic Lifestyle Hygiene reports show that clients achieve improvements in their feelings of well-being, resolve or come to terms with their presenting problems thereby ameliorating their distress, and that their mental health and life satisfaction is improved.

   Challenges have been in dealing with the Covid19 pandemic. We lost the ability to meet face to face with our clients and as a group, so we have worked extra hard at maintaining connection with our clients through weekly phone, online and outdoor sessions. The clinical supervisor has provided weekly group supervision meetings with the volunteers via Zoom, and individual supervision by phone. Another challenge is that we lost our designated office space to run the program and meet with clients in the Placerville Senior Center. We were moved in with another program to share office space and now have only 20 hours per week available to do in office work. We have had to adjust to doing a lot of work from home because of reduced access due to the pandemic and loss of office space. Another challenge has been that we have lost 6 of our volunteer peer counselors in this fiscal year. But even with that, we have been able to provide services to all who were a match for our program as volunteers worked harder during the pandemic to meet the need. Another attrition is that at the beginning of the fourth quarter our office administrator resigned. It has been very difficult finding someone to fill the position, which at fiscal year end is still vacant. The clinical supervisor is doing the work of that position to date.

2) **Briefly report on how the Senior Peer Counseling project has improved the overall mental health of the older adult population by addressing the primary negative outcomes that are the focus of the Senior Peer Counseling project (suicide and prolonged suffering). Please include other impacts, if any, resulting from the Senior Peer Counseling project on the other five negative outcomes addressed by PEI activities: (1) homelessness; (2) unemployment; (3) incarceration; (4) school failure or dropout; and (5) removal of children from their homes.**

At intake we gather date on the self-reported amount of suffering in the categories of Emotional, Mental and Relationship from the client. Data at intake shows that 43 % of our clients have been suffering in one or more of the aforementioned categories for 2 years or more. Further, 27% have been suffering for more than 1 year and 30% have been suffering for 1-32 weeks. This data represents prolonged suffering which can lead to hopelessness and suicide in older adults. Older adults are the demographic with the highest risk for suicide of all age groups in the United States. Senior Peer Counseling has improved the overall mental health of these older adults by providing regular and ongoing counseling sessions that are based on a solution focused self-help model that empowers the client to take action and make movement in their lives. Through this connection to a caring peer counselor who encourages and helps hold them accountable, depression, anxiety, grief and trauma are reduced

or resolved. Clients also are provided with connection to community resources, and referrals to appropriate medical services. Most clients are able to end counseling with their presenting issues resolved or accepted with a new peace. We gather a self-reported evaluation at the end of counseling services to ascertain this data and conclusions, which are mailed out at discharge. Of the final evaluations completed and returned, 72% reported they were either improved or much improved from their presenting problems. 27% reported they had stayed the same, but that their experience with their peer counselor was helpful and they had an improvement in their emotional well-being. This data shows a reduction in the primary negative outcomes of prolonged suffering and suicide that Senior Peer Counseling is tasked with ameliorating. We have had no suicides of clients in our program.

Of the other five negative outcomes, only homelessness and unemployment have been areas where we are seeing clients dealing with. Through improving mental health and self esteem and efficacy we have been able to encourage a small number of older adults to get back to work and stay engaged in stable employment. Potential homelessness has been mostly addressed through connecting older adults to their family members or community resources that help them to stay in their own homes.

One of the best ways of expressing how SPC has improved the overall mental health of the older adult population is to share with you some of the comments they themselves have written on our Data Outcome measurements this fiscal year. Here's a sampling of what they have said:

- "My counselor's openness and understanding made a difference in aiding improvement of my mental/emotional growth. The open setting of our meetings was positive as was the flexibility of meeting dates and times."

- "He was very helpful and kept me challenged. He helped me in areas that needed to be addressed and drove me to tackle them. He was a great sounding board to confirm I was on the right track."

- "I found it so easy to talk to my counselor. She listened carefully and made such insightful points for me to consider in my relationship with my daughter. We had much in common and she has had similar life experiences, and she receives excellent training and support from all volunteers in the program. This is a great program! Thank you so much!"

- "I appreciated the care with which a counselor was selected for me. She was very relatable, kind, considerate of my feelings and thoughtful in her responses, questions, posed and encouragement that I was moving through the process well. I felt she really listened and reflected back what I was saying. I was so grateful for the prompt attention to my request for help, even with a pandemic. I knew I needed help at the time, but didn't truly realize just how badly I needed it until I began meeting with my counselor and felt the comfort and safety of being able to truly share. I will be forever grateful to her and Senior Peer Counseling for taking the time to be there for people like me in need of some support during difficult and challenging times in one's life…thank you!"

- "I have been very happy with my counselor and would highly recommend your service to anyone needing personal help."

- "I enjoyed meeting with the counselor and talking to someone who was interested in me. I became more confident in relationships. I think the service is really helpful and important"

- "My counselor had a lot of helpful tools and suggestions for me to move forward"

- "I am very grateful and blessed to have this resource. I have recommended Senior Peer Counseling to friends and family. I will use it again if needed. Thank you to my counselor for his compassionate insights. I have used the coping strategies we discussed with great success."

- “My counselor was an angel in my life just at the right time. This is a great program. Thanks”

- “Very supportive, never judgmental. Did force me to change”

- “My counselor was very good at staying objective and helped me make some hard decisions for myself”

- “He was a good listener. He gave me some good resources I could use in helping me navigate through my situation at the time”

3) Provide a brief narrative description of progress in providing services through the Senior Peer Counseling project to unserved and underserved populations. Underserved is defined in California Code of Regulations 3200.300 as “clients of any age who have been diagnosed with a serious mental illness and/or serious emotional disturbance and are receiving some services but are not provided with the necessary opportunities to support their recovery, wellness, and/or resilience. These clients include, but are not limited to, those who are so poorly served that they are at risk of homelessness, institutionalization, incarceration, out-of-home placement, or other serious consequences.”

Although we are not directly working with clients who meet the definition or criteria in the California Code for “serious mental illness or emotional disturbance”, we do work with an underserved population which is older adults. The older adults in our population are more in the mild to moderate category of mental illness or emotional disturbance. Having said that, our population of older adults’ mental health is generally underserved in El Dorado County. This is due to lack of access or services provided by County Mental Health, lack of available private therapists who are covered by Medicare, lack of ability to pay for counseling out of pocket due to low and fixed incomes, and no community mental health clinic funded by grants for older adults. Another reason older adults are underserved is due to geographic isolation and lack of public or private transportation. Many of our older adults live rurally and many miles away from local cities where they can access services. Some of our older adults have lost the ability to drive due to physical limitations or results of aging. Public transportation is not available in many areas of our rural county as well, so access to services is impaired. A Senior Peer counselor may be able to prevent out of home placement in a facility with linking older adults to needed in home services and financial assistance programs.

4) Provide a brief narrative description of how the Senior Peer Counseling services are provided in a culturally and linguistically competent manner, including activities to reduce racial/ethnic disparities.

This year we have added a volunteer counselor who is fluent in Spanish and is from South America. He is able to help reduce stigma around mental health with the Hispanic community by being part of them. This is known to improve access within that culture. He has been able to provide a training to our volunteers on understanding and working with the Hispanic culture and family dynamics. We look forward to providing more outreach to the Latino/Latina community once the pandemic is over. Our population of older adults is not racially or ethnically diverse. At intake, we ask how someone identifies racially and ethnically and ask them to educate us on their particular culture, as it may affect the way we work with them and how they choose to be helped with mental health issues. Generally, our client population has been 99% racially White without ethnic diversity this past fiscal year.

Senior peer counselors attended a training provided by the National Coalition on Aging during the Older Adult Mental Health Awareness Symposium on “Inequities in Diverse Populations, (Native American, LatinX, African Americans and LGBTQ). We also watched a TED Talk on Agism and engaged in a robust discussion about reducing stigma and ethnic disparities in our program. Senior Peer Counselors are

regularly challenged to look at their own biases and assumptions that may impact and interfere with how we interact with each other and our clients.

5) **Provide a brief description of activities performed related to local and county-wide collaboration, outreach, access/linkages to medically necessary care, stigma reduction and discrimination reduction.**

Senior Peer Counseling collaborates with the Information and Assistance program at the Placerville Senior Center to receive referrals and provide services. We also collaborate with Adult Protective Services with making and receiving referrals from them. We have accessed the Meals On Wheels program to provide outreach about our services by giving one of our advertising rack cards to each meal that was delivered from the Placerville Center. We have done some outreach and collaboration with Marshall Medical In Home Nursing and made connections with their social workers for potential referrals. Outreach is also done through ads in the Mountain Democrat newspaper and several other local advertising magazines and publications. We regularly refer clients with moderate mental illness for medically necessary care to a licensed Medicare contracted psychologist or licensed clinical social worker, and to psychiatry. Referrals are regularly made to the client's primary care physician for physical or medication related issues being disclosed to the counselor.

Stigma reduction is greatly enhanced by the fact that our counselors are the clients' peers and similar in age and life experiences. Our services are modeled on a solution focused and self-help model rather than labeling the client with their problems and assigning a mental health diagnosis. We work with the client's strengths and building on them rather than categorizing them according to their problem set. These strategies build hope and reduce stigma.

6) **Provide the outcomes measures of the services provided. Outcome measures for the Senior Peer Counseling project are:**

- **Measurement 1: Contractor will have peer counselors complete a pre-and post-rating form with the client to measure Therapeutic Lifestyle Changes, primarily pro-health and pro-mental health activities and habits which have been shown to lead to positive physical, emotional and cognitive improvements in people of all ages. The categories to be measured are: Exercise, nutrition/diet, nature, relationships, recreation/enjoyable activities, relaxation/stress management, religious/spiritual involvement, contribution/services.**

This outcome tool we have titled "Lifestyle Hygiene" and it measures the therapeutic lifestyle habits of clients. This measure is given to clients at the beginning, every three months, and at the end of the counseling process. Results below show improvements in these pro-mental health areas, showing overall clients have become more interested in engaging with their communities and in attending to their own healthy self-care habits.

Data Results: N=25 Rating Scale: 0=Deficient, 5=Just Right, 10=Excessive

(Results are shown as pre and post number averages)

Exercise: from 3.5 to 4.2	Recreation/Enjoyable Activities: from 4.3 to 5.8
Nutrition and Diet: From 4.6 to 5.2	Relaxation/Stress Management: from 4.7 to 5.1
Nature: from 5.3 to 6.4	Religions/Spiritual Involvement: from 6.2 to 5.9
Relationships: from 4.7 to 5.3	Contributions/Volunteering: from 4.2 to 4.7
TV, Computer: from 5.5 to 6.1	Sleep: from 5.7 to 5.5

- **Measurement 2: Volunteers will record the clients' self-reported improvement in the presenting problem selected by each client at the start of the peer counseling.**

  This instrument measures the client's self-reported improvement in the presenting problem and goal chosen by them at the outset of counseling. We use it at the end of every session until goals as met and counseling ends. Data results show that overwhelmingly clients made improvements, found solutions to their problems and reached their preset counseling goals. This represents a huge increase in their self-efficacy, reduced suffering and improved mental health.

  Data Results: N=208 sessions
  Questions Asked:

  1. How well did you feel heard and understood? 0=not at all, 5=well understood
     Average score: 4.94 (score of 5= 195, score of 4=13, score of 3=0, score of 2=0, score of 1=0, score of 0=0)

  2. How helpful was our session today? 0=not helpful, 5=very helpful
     Average score: 4.92 (score of 5=191, score of 4=17, score of 3=0, score of 2=0, score of 1=0, score of 0=0)

  3. How do you feel after our session today? Better, Same, Worse
     Average score: Better (Better=97%, Same=3%, Worse=0%)

  4. Do you believe there has been improvement in your original problem/s? Yes/No
     Average Score: Yes (Yes= 99%, No=1%)

- **Measurement 3: Outcome Rating Scale (ORS) measurement tool, which measures the following four psychological categories: Individually (personal well-being), interpersonally (family, close relationships), socially (work, school, friendships), and overall (general sense of well-being)**

  This is an outcome tool that is given at the end of the client's counseling to measure four (4) realms of psychological health. The 4 realms are: Individual, Interpersonal, Social, and Overall Wellbeing. It also asks the client to rate how well the volunteer did as their counselor. The results, as stated below, prove that SPC is improving older adults' quality of life with statistical significance. It shows that not only are problems with mental health being prevented from becoming severe and disabling, but that there is an overall improvement at the end of the counseling experience.

  Data Results: N=18

  Counseling Experience: 0=least helpful, 10=very helpful
  Average Score: 8.94

  Individually (personal wellbeing): 0=worse, 5=the same, 10=better
  Average Score: 8.05

  Interpersonally (family, close relationships): 0=poor, 10=excellent
  Average Score: 8.05

  Socially (work, friends, groups, community): 0=not satisfied, 5=satisfied, 10=very satisfied

Average Score: 6.16 (the low score socially was noted by some as a result of the Covid19 pandemic)

Overall (General Sense of Well-Being): Gotten worse, Stayed the same, Improved
Average Response: Improved (13 were Improved, 5 Stayed the same)

7) Report on unduplicated numbers of individuals served, including demographic data.

See information provided in the table above.

8) Report on the reduction of prolonged suffering that may result from untreated mental illness by measuring a reduction in risk factors, indicators, and/or increased protective factors that may lead to improved mental, emotional, and relational-functioning.

Question 2 above reports on the reduction of prolonged suffering and the reduction of the risk factors of suicide. Other risk factors that contribute to these include social isolation, subjective feelings of loneliness, disconnection from family members and feelings of hopelessness. I'd like to address the increase of protective factors that may lead to improved mental, emotional and relational functioning here. Protective factors that Senior Peer Counseling work to build in clients include regularly connecting with others, exercise, nutrition and diet, interacting with nature, good relationships with family and friends, engaging in recreation and enjoyable activities, relaxation and stress management, spiritual and religious involvement, contribution and service/volunteering, and sleep. These protective factors are a target of the work done by the Senior Peer Counseling program. We call it "Lifestyle Hygiene" and we measure it at intake and again at discharge. In addition to addressing the clients chosen presenting problem and being client centered in that way, we work to build competencies and engagement in these aforementioned target areas throughout the counseling process. We know that the more engaged the client is with themselves and with their family and wider community, the better mental health outcomes are obtained. These outcomes are reflected in the answers to question 6 above. To summarize those findings, older adult who have participated in Senior Peer Counseling has improved awareness and actions taken toward self care, feel heard and understood, have resolved the presenting problem, have an improved sense of well being and feeling better about themselves and their lives, have increased engagement with friends and the greater social community, have connected with and availed themselves to community resources and programs and have experienced a reduction in stigma about seeking mental health services due to the relationship with their counselor.

9) If known, provide the number of Clients referred to County Behavioral Health and the type of treatment to which Clients were referred.

Unknown

10) If known, the number of individuals who followed through on the referral and engaged in treatment.

Unknown

11) If known, provide the average interval between mental health referral and participation in treatment.

Unknown

12) Provide the total project expenditures and the type and dollar amount of leveraged resources and/or in-kind contributions.

Clinical Supervision and Program Management: $33,060

Office Administrator	$ 6,296
Zoom Subscription	$ 150
Office Keys	$ 9
Total Expenditures:	$39,515

13) Provide any additional relevant information.

Senior Peer Counseling is ramping up to recruit new peer counselors and provide them with a 50 hour training on providing mental health counseling. This will help expand our capabilities in providing additional services to the older adult community in the next fiscal year.

The following trainings were attended by the Clinical Supervisor and the Senior Peer Counselors this fiscal year:
How we Heal Ourselves and Others: Communicating in Ways That Create Meaningful Change, Provided by the Institute on Brain Potential 8/6/20
The Habits of Stress Resilient People, Provided by The Institute on Brain Potential/Christian Waugh PhD 8/7/20
Older Adult Mental Health Awareness Symposium, Provided by the National Council on Aging 5/6/21
40th Annual Mental Health & Aging Conference 11/12/20
How to Successfully Engage Clients in Closing Services, Provided by Jayann Askin LMFT 10/29/20

Senior Link

Senior Link is a partner program to the "Partnership Between Senior Nutrition and Behavioral Health" Innovation project, which was approved by the Mental Health Services Oversight and Accountability Commission in January 2020. This project was delayed by the COVID-19 pandemic, therefore there is no data to report for the Senior Link project in FY 20/21.

Primary Intervention Project - Black Oak Mine Union School District

Provider: Black Oak Mine Union School District (BOMUSD)

Project Goals

- Provide services in a school-based setting to enhance access.
- Build protective factors by facilitating successful school adjustment.
- Target violance prevention as a function of skills training.
- To decrease school adjustment difficulties at an early age and build protective factors to foster youth resilience and mental health.

Numbers Served and Cost

Expenditures	FY 2018-19	FY 2019-20	FY 2020-21
MHSA Budget	$77,000	$77,000	$88,000
Total Expenditures	$73,278	$72,246	$79,630
Unduplicated Individuals Served	72	78	46
Cost per Participant	$1,018	$926	$1,731
Age Group	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
0-15 (children/youth)	72	78	46
16-25 (transitional age youth)	0	0	0
26-59 (adult)	0	0	0
Ages 60+ (older adults)	0	0	0
Unknown or declined to state	0	0	0
Race	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
American Indian or Alaska Native	5	2	3
Asian	2	0	0
Black or African American	4	1	3
Native Hawaiian or Other Pacific Islander	0	2	0
White	60	73	39
Other	1	0	0
Multiracial	0	0	1
Unknown or declined to state	0	0	0

Ethnicity by Category	FY 2018-19	FY 2019-20	FY 2020-21
Hispanic or Latino	0	4	3
Caribbean	0	0	0
Central American	0	0	0
Mexican/Mexican-American/Chicano	0	0	0
Puerto Rican	0	0	0
South American	0	0	0
Other	0	0	0
Unknown or declined to state	1	0	0
Non-Hispanic or Non-Latino		74	43
African	0	0	0
Asian Indian/South Asian	0	0	0
Cambodian	0	0	0
Chinese	0	0	0
Eastern European	0	0	0
Filipino	0	0	0
Japanese	0	0	0
Korean	0	0	0
Middle Eastern	0	0	0
Vietnamese	0	0	0
Other	0	0	0
Multi-ethnic	0	0	0
Unknown or declined to state	0	0	0
Primary Language	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
Arabic	0	0	0
Armenian	0	0	0
Cambodian	0	0	0
Cantonese	0	0	0
English	71	77	0
Farsi	0	0	0
Hmong	0	0	0
Korean	0	0	0
Mandarin	0	0	0
Other Chinese	0	0	0
Russian	0	0	0
Spanish	1	1	1
Tagalog	0	0	0
Vietnamese	0	0	0
Unknown or declined to state	0	0	0
Sexual Orientation **Collection of this information from a minor younger than 12 years of age is not required.*	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
Gay or Lesbian			

Heterosexual or Straight			
Bisexual			
Questioning or unsure of sexual orientation			
Queer			
Another sexual orientation			
Declined to State			
Gender **Collection of this information from a minor younger than 12 years of age is not required.*	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
Assigned sex at birth:			
Male	45	39	29
Female	27	39	17
Declined to answer	0	0	0
Current gender identity:			
Male			
Female			
Transgender			
Genderqueer			
Questioning / unsure of gender identity			
Another gender identity			
Declined to answer			
Disability	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
Difficulty seeing	0	0	0
Difficulty hearing or having speech understood	0	0	0
Mental disability including but not limited to learning disability, developmental disability, dementia	0	0	0
Physical/mobility	0	0	0
Chronic health condition/chronic pain	0	0	0
Other (specify)	0	0	0
Declined to state	72	78	46

Veteran Status *Collection of this information from a minor younger than 12 years of age is not required.*	FY 2018-19	FY 2019-20	FY 2020-21
Yes			
No			
Unknown or declined to state			
Region of Residence	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
West County	0	0	0
Placerville Area	0	0	0
North County	72	78	46
Mid County	0	0	0
South County	0	0	0
Tahoe Basin	0	0	0
Unknown or declined to state	0	0	0
Economic Status	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
Extremely low income	unknown	unknown	unknown
Very low income	unknown	unknown	unknown
Low income	unknown	unknown	unknown
Moderate income	unknown	unknown	unknown
High income	unknown	unknown	unknown
Health Insurance Status	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
Private	unknown	unknown	unknown
Medi-Cal	unknown	unknown	unknown
Medicare	unknown	unknown	unknown
Uninsured	unknown	unknown	unknown

Annual Report FY 2020-21

Please provide the following information for this reporting period:
Note: For many years, this program was known as the Primary Intervention Project (PIP) and only served children in Kindergarten through Third Grade. In FY 2020, this Project was adapted to the Primary Project model, and children in Transitional-Kindergarten through third grade became eligible.

1) **Briefly report on how implementation of Primary Project (PP) is progressing (e.g., whether implementation activities are proceeding on target and as described in the County's MHSA Plan), and any major accomplishments and challenges.**

A total of 4 part-time Aides served two elementary schools: American River Charter (one day per week), Georgetown School of Innovation (five days per week), and Northside STEAM School (two and-a-half days per week). We served a total of 46 students over two semesters.

Accomplishments: A major accomplishment for us this year was to actually serve students during a pandemic! We took on new safety measures such as removing from the playroom toys and supplies that were difficult to sanitize between clients, and vigilance with masking, hand sanitizing and physical distancing. We also hired and trained a new Aide mid-year. She is an asset to our program!

Challenges: Our foremost challenge during this period was Covid-19. Like other providers, we had to be responsive to the daily changes of school schedules, quarantines of individuals and classes, and safety protocols. Staffing was not stable. One Aide resigned, and another took a stress leave. A few clients left in-person school to be home schooled. And, because of the shortened school day, we could not see as many clients per workday. (In a normal, full day, we were able to see from 5-6 students)

2) **Briefly report on how PP has improved the overall mental health of the children, families, and communities by addressing the primary negative outcome that is the focus of PP (school failure or dropout). Please include other impacts, if any, resulting from PP on the other six negative outcomes addressed by PEI activities: (1) suicide; (2) incarceration; (3) unemployment; (4) prolonged suffering; (5) homelessness; (6) removal of children from their homes.**

More than any other school year, this one stands out to me as demonstrating the power that positive social interventions can have on the emotional health of children. In March of 2020 our schools closed to in-person learning. In October 2020, Black Oak Mine Unified re-opened its doors to students. I was asked to help on that first day assist the younger students coming off the bus find their teachers and classrooms. The joy I saw in their faces and bodies, truly struck me. They were with friends, classmates, and friendly adults after a long period of separation (and for some, isolation). They were *so happy* to be back to school!

Primary Project, being a school-based intervention, meets children exactly where they are.

3) **Provide a brief narrative description of progress in providing PP services to unserved and underserved populations.**

Increasing PP services to unserved and underserved populations is addressed in answers to Question 5, below.

4) **Provide a brief narrative description of how PP services are provided in a culturally and linguistically competent manner, including activities to reduce racial/ethnic disparities.**

The racial/ethnic demographics of BOMUSD is predominately White 87%, followed by Hispanic/Latino at 8%, and American Indian/Alaskan Native at 3%. All of the students served by PP have been English speaking. If a parent is not fluent in English we have staff on site who can translate for Spanish speaking parents.

5) **Provide a brief description of activities performed related to local and county-wide collaboration, outreach, access/linkages to medically necessary care, stigma reduction and discrimination reduction.**

For families on the Divide, access to services is a critical concern. The distance to the nearest mental health services makes the children here an underserved population on the whole. PP helps to alleviate this problem by identifying issues when students are still young and serving them before there is a need for more intense intervention. Since PP is offered on school campuses, during the school days, there is no transportation involved.

PIP also introduces parents to mental health interventions that are less stigmatized and easier to accept than therapeutic models. For a family, PP is often their first encounter with mental health services, and because it is such a positive experience for the child, it can make it easier to accept higher level interventions that may be necessary in the future.

6) **Identify whether PP participants were provided with further referrals for services at the conclusion of the PP semester, and if so, what type of referrals were made (e.g., mentoring programs, recreational programs, individual counseling, group counseling).**

   Unknown

7) **Provide the outcomes measures of the services provided. Outcome measures for the Primary Project are:**

- **Measurement 1: Administer Walker Assessment Scale (WAS) assessment tool to students at the time student is selected to enter the program and again when the student exits the program.**

2020-21 PP Walker Assessment Scale Scores (BOMUSD)

Identifying Number	WAS Start	WAS End	Difference
G1	57	70	13
G2	79	59	20
G3	49	72	23
G4	47	82	35
G5	73	77	4
G6	61	48	-13
G7	95	95	0
G8	67	85	18
G9	50	53	3
G10	42	67	25
G11	56	72	16
G12	56	63	7
G13	26	63	37
G14	62	75	13
G15	74	84	10
G16	62	57	-5
G17	80	84	4
G18	79	85	6
G19	58	82	24
G20	85	86	1
G21	85	91	6
G22	54	n/a	n/a
G23	55	82	27
G24	65	73	8
G25	61	59	-2
G26	54	n/a	n/a
G27	59	46	-13
G28	35	40	5
G29	95	94	-1

G30	55	50	-5
G31	86	93	7
N1	76	87	9
N2	72	89	17
N3	63	79	16
N4	64	60	-4
N5	61	62	1
N6 *	n/a	n/a	n/a
N7	50	63	13
N8	54	62	8
N9	27	65	38
N10	46	60	14
N11	74	68	-6
N12	56	58	2
N13	56	56	0
N14	54	65	11
N15	71	73	2

* Student moved to distance learning after 2 sessions.

- **Measurement 2: Completion of service delivery report to the County on a PP semester basis showing number of students served.**

  Completed in separate documents

- **Measurement 3: Completion of year-end progress report to the County showing annual number of students served and pre- and post- WAS scores, identifying program successes, challenges faced and post-PP participation outcomes for the children.**

8) Report on unduplicated numbers of individuals served, including demographic data.

Submitted in separate document

9) Report on the reduction of prolonged suffering that may result from untreated mental illness by measuring a reduction in risk factors, indicators, and/or increased protective factors that may lead to improved mental, emotional, and relational-functioning.

Primary Project is a prevention and early intervention model.
Increased protective factors:

- "… coping skills like compassion, self-regulation, self-confidence, the habit of active engagement, and the motivation to learn and be literate cannot be instructed. They can only be learned through self-directed experience (i.e. play)" -Susan J. Oliver, "Playing for Keeps"
- Early engagement and success in school. PIP students overwhelmingly are enthusiastic about coming to school.

- Positive relationships with trusted adults
- Express him/herself symbolically
- Succeed at new things
- Practice skills that may be perceived by the child as being too difficult
- Experience a calm and positive environment
- Recreate experiences and change outcomes
- Experiment and find strengths
- Try new behaviors and play other roles
- Learn things for themselves that can't be taught

10) If known, provide the number of Clients referred to County Behavioral Health and the type of treatment to which Clients were referred.

4 students were referred to school-based counseling.

11) If known, the number of individuals who followed through on the referral and engaged in treatment.

4

12) If known, provide the average interval between mental health referral and participation in treatment.

Unknown

13) Provide total PP expenditures and the type and dollar amount of leveraged resources and/or in-kind contributions.

Total expenditures: $79,630

In-kind contributions: Dedicated playrooms and office equipment at 2 school sites.

14) Provide any additional relevant information.

Most students did not start Primary Project until mid-October when in person instruction began in the District. 8 students started in August and September and had private transportation to the playrooms at the school sites.

Primary Intervention Project - SLT

Provider: Tahoe Youth and Family Services

Project Goals

- Provide services in a school-based setting to enhance access.
- Build protective factors by facilitating successful school adjustment.
- Target violance prevention as a function of skills training.
- To decrease school adjustment difficulties at an early age and build protective factors to foster youth resilience and mental health.

PIP 4th Quarter & Final Report – July 30, 2021

During this school year only three students were provided with PIP services. The demographics of these children were submitted last quarter and did not change. Of these three children, none were referred for counseling or to CPS. We have chosen to submit one report both for the 4th quarter and the Final.

The challenges faced during the school year for the Primary Intervention Program (PIP) are all due to the continuous effects of the pandemic. The biggest one trying to begin the program within the elementary schools when children were at home and schools were providing distanced learning. As children came back to in-person school, the challenges of scheduling and teachers finding time to let the PIP Worker take the students since they themselves had limited times and days with their classrooms was difficult.

However, being able to have the program going with at least two of the four elementary schools during such a rough period and transition for families, children, the school district, administrators, teachers, and individual organizations like Tahoe Youth and Family Services trying to provide services to their communities is a success in and of itself. Being able to do a little bit of outreach for the program by providing school administrators and staff with a presentation the PIP Worker created about PIP and what it does was also successful, and she believes will help continue to establish the program more within the elementary schools.

The PIP Worker received wonderful feedback from the teachers and administrators as well as the students. The PIP Worker had a moment with one child, a kindergartner, asking me if she “played” with other children. The PIP Worker told him she did and that she worked with two other children, one being from another school. He was shocked she did not have more and recommended she persuade teachers and parents to have them meet with her. He then proceeded to ask her more questions as to her methods of persuasion and if she was making sure that she told them that she played with them and that he even mentioned my time with him and what we did when we met. He made me feel that PIP was making a difference and that what he felt the program was providing for him, he thought so many other children should have available to them too. Coincidentally, the PIP Worker ran into this wonderful child while she was at a different job, and he recognized her. He immediately ran up to her and said hi. While this encounter may not particularly seem of much meaning, it meant a great deal to the PIP Worker because even though she was in a different setting that he and she were used to, with facemasks and while with his family, he knew it was her, he remembered her, and she my hoped remembered the positive experiences and took the initiative to come say hi.

Overall, the PIP Worker hopes PIP continues to be implemented in the elementary schools and that its success grows with each passing school year. It has been a great experience, and while a challenging one through a

pandemic, PIP continues to be a great resource for teachers and families that has positive and beneficial outcomes for everyone, including Tahoe Youth and Family Services.

PIP Evaluation:

Tahoe Youth & Family Services, TYFS for many years has had a contract with Duerr Evaluation to score the Walker-McConnell Scale with our P.I.P. program. However, when contacted this year, we ran into several challenges. First of all, we had too few students participating in the P.I.P. program due to the pandemic for them to feel comfortable scoring the students. The second challenge TYFS faced was the owner of Duerr Evaluation sold it to a new person and that individual is currently in the process of closing down the business. However, they did provide the scoring scale so I could hand count the data and come to some realistic conclusions.

With that said all students who started and completed the P.I.P. program improved. The overall percentage increase was 78% for student #1, 77% for student #2 and 80% for student #3.

In Subscale 1 – Teacher-preferred Social behaviors which measures social behaviors of students that are highly valued or preferred by teachers during non-instructional interactions with other students.

- Student #1 improved in this area by 63%.
- Student #2 improved in this area by 9%
- Student #3 improved in this area by 9%

In Subscale 2 – Peer preferred Social Behaviors measures social behaviors that are highly valued by peers in terms of peer dynamics and social relations in free play settings.

- Student # 1 improved in this area by 9%.
- Student #2 improved in this area by 58%.
- Student #3 improved in this area by 63%.

In Subscale 3 – Classroom Adjustment Behaviors measures adaptive social-behavioral competencies highly valued by teachers in classroom instructional contexts.

- Student #1 improved in this area by 6%.
- Student #2 improved in this area by 10%.
- Student #3 improved in this area by 8%.

All though our student numbers were low, it does feel good to know that the PIP program helped make a difference with these students in overall school success. TYFS will need to find another evaluator to contract with for this upcoming school year.

Please feel free to contact if you have any questions or concerns. Thank you.

Karen Carey Executive Director

Mirelle Zamudio PIP Worker

Numbers Served and Cost

Expenditures	FY 2018-19	FY 2019-20	FY 2020-21
MHSA Budget	$88,000	$88,000	$88,000
Total Expenditures	$28,940	$13,740	$5,804

Unduplicated Individuals Served	43	24	3
Cost per Participant	$673	$573	$1,935
Age Group	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
0-15 (children/youth)	43	24	3
16-25 (transitional age youth)	0	0	0
26-59 (adult)	0	0	0
Ages 60+ (older adults)	0	0	0
Unknown or declined to state	0	0	0
Race	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
American Indian or Alaska Native	2	0	0
Asian	0	0	0
Black or African American	0	0	0
Native Hawaiian or Other Pacific Islander	0	0	0
White	17	15	3
Other	0	0	0
Multiracial	0	0	0
Unknown or declined to state	24	9	0
Ethnicity by Category	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
Hispanic or Latino	0	0	0
Caribbean	0	0	0
Central American	0	0	0
Mexican/Mexican-American/Chicano	21	4	0
Puerto Rican	0	0	0
South American	0	0	0
Other	0	0	0
Unknown or declined to state	1	0	0
Non-Hispanic or Non-Latino			
Non-Hispanic or Non-Latino	0	0	0
African	2	0	0
Asian Indian/South Asian	0	0	0
Cambodian	0	0	0
Chinese	0	0	0
Eastern European	0	0	0
Filipino	0	1	0
Japanese	0	0	0
Korean	0	0	0
Middle Eastern	0	0	0

Vietnamese	0	0	0
Other	0	1	0
Multi-ethnic	0	0	0
Unknown or declined to state	19	18	3
Primary Language	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
Arabic	0	0	0
Armenian	0	0	0
Cambodian	0	0	0
Cantonese	0	0	0
English	31	15	3
Farsi	0	0	0
Hmong	0	0	0
Korean	0	0	0
Mandarin	0	0	0
Other Chinese	0	0	0
Russian	0	0	0
Spanish	0	1	0
Tagalog	0	0	0
Vietnamese	0	0	0
Unknown or declined to state	12	8	0

Sexual Orientation **Collection of this information from a minor younger than 12 years of age is not required.*	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
Gay or Lesbian	N/A	N/A	N/A
Heterosexual or Straight	N/A	N/A	N/A
Bisexual	N/A	N/A	N/A
Questioning or unsure of sexual orientation	N/A	N/A	N/A
Queer	N/A	N/A	N/A
Another sexual orientation	N/A	N/A	N/A
Declined to State	N/A	N/A	N/A
Gender **Collection of this information from a minor younger than 12 years of age is not required.*	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
Assigned sex at birth:			
Male	N/A	14	3
Female	N/A	10	0
Declined to answer	N/A	0	0

Current gender identity:			
Male	N/A	N/A	N/A
Female	N/A	N/A	N/A
Transgender	N/A	N/A	N/A
Genderqueer	N/A	N/A	N/A
Questioning / unsure of gender identity	N/A	N/A	N/A
Another gender identity	N/A	N/A	N/A
Declined to answer	N/A	N/A	N/A
Disability	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
Difficulty seeing	1	0	0
Difficulty hearing or having speech understood	1	0	1
Mental disability including but not limited to learning disability, developmental disability, dementia	0	0	0
Physical/mobility	0	0	0
Chronic health condition/chronic pain	0	0	0
Other (specify)	0	0	0
Declined to state	0	0	0
Veteran Status ****Collection of this information from a minor younger than 12 years of age is not required.***	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
Yes	1	N/A	N/A
No	0	N/A	N/A
Unknown or declined to state	42	N/A	N/A
Region of Residence	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
West County	0	0	0
Placerville Area	0	0	0
North County	0	0	0
Mid County	0	0	0
South County	0	0	0
Tahoe Basin	43	24	3
Unknown or declined to state	0	0	0
Economic Status	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
Extremely low income	2	1	N/A
Very low income	2	2	N/A
Low income	15	4	N/A
Moderate income	9	7	N/A
High income	0	1	N/A

Health Insurance Status	FY 2018-19	FY 2019-20	FY 2020-21
Private	10	4	N/A
Medi-Cal	12	7	N/A
Medicare	0	0	N/A
Uninsured	0	0	N/A

Wennem Wadati: A Native Path to Healing Project

Provider: Foothill Indian Education Alliance

Project Goals

- Increase awareness in the Native American community about the crisis line and available services.
- Improve the overall mental health care of Native American individuals, families and communities.
- Reduce the prevalence of alcoholism and other drug dependencies.
- Maximize positive behavioral health and resiliency in Native American individuals and families reducing suicide risk, prolonged suffering, and incarceration.
- Reduce school drop-out rates.
- Support culturally relevant mental health providers and their prevention efforts.

Numbers Served and Cost

Expenditures	FY 2018-19	FY 2019-20	FY 2020-21
MHSA Budget	$125,750	$125,750	$125,750
Total Expenditures	$87,639	$89,776	$104,552
Unduplicated Individuals Served	374	301	334
Cost per Participant	$234	$298	$313
Age Group	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
0-15 (children/youth)	242	88	79
16-25 (transitional age youth)	82	72	84
26-59 (adult)	28	28	51
Ages 60+ (older adults)	22	19	37
Unknown or declined to state	0	94	83
Race	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
American Indian or Alaska Native	346	301	334
Asian	0	0	0
Black or African American	0	0	0
Native Hawaiian or Other Pacific Islander	0	0	0
White	28	0	0
Other	0	0	0
Multiracial	0	0	0
Unknown or declined to state	0	0	0
Ethnicity by Category	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**

Hispanic or Latino	0	0	0
Caribbean	0	0	0
Central American	0	0	0
Mexican/Mexican-American/Chicano	0	0	0
Puerto Rican	0	0	0
South American	0	0	0
Other	0	0	0
Unknown or declined to state	0	0	0
Non-Hispanic or Non-Latino			
African	0	0	0
Asian Indian/South Asian	0	0	0
Cambodian	0	0	0
Chinese	0	0	0
Eastern European	0	0	0
Filipino	0	0	0
Japanese	0	0	0
Korean	0	0	0
Middle Eastern	0	0	0
Vietnamese	0	0	0
Other	346	0	0
Multi-ethnic	0	0	0
Unknown or declined to state	28	0	0

Primary Language	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
Arabic	0	0	0
Armenian	0	0	0
Cambodian	0	0	0
Cantonese	0	0	0
English	374	301	334
Farsi	0	0	0
Hmong	0	0	0
Korean	0	0	0
Mandarin	0	0	0
Other Chinese	0	0	0
Russian	0	0	0
Spanish	0	0	0
Tagalog	0	0	0
Vietnamese	0	0	0
Unknown or declined to state	0	0	0
Sexual Orientation ***Collection of this information from a minor younger than 12 years of age is not required.***	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
Gay or Lesbian	0	0	
Heterosexual or Straight	0	0	
Bisexual	0	0	
Questioning or unsure of sexual orientation	0	0	
Queer	0	0	
Another sexual orientation	0	0	
Declined to State	374	301	334
Gender ***Collection of this information from a minor younger than 12 years of age is not required.***	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
Assigned sex at birth:			
Male	0	104	
Female	0	197	
Declined to answer	374	0	334
Current gender identity:			
Male	0	104	
Female	0	197	
Transgender	0	0	
Genderqueer	0	0	
Questioning / unsure of gender identity	0	0	
Another gender identity	0	0	
Declined to answer	374	0	334
Disability	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**

Difficulty seeing	unknown	unknown	unknown
Difficulty hearing or having speech understood	unknown	unknown	unknown
Mental disability including but not limited to learning disability, developmental disability, dementia	unknown	unknown	unknown
Physical/mobility	unknown	unknown	unknown
Chronic health condition/chronic pain	unknown	unknown	unknown
Other (specify)	unknown	unknown	unknown
Declined to state	374	unknown	unknown
Veteran Status **Collection of this information from a minor younger than 12 years of age is not required.*	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
Yes	18	17	22
No	356	284	312
Unknown or declined to state	0	0	0
Region of Residence	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
West County	0	68	95
Placerville Area	0	129	166
North County	0	15	17
Mid County	0	17	34
South County	0	14	22
Tahoe Basin	0	0	0
Unknown or declined to state	374	58	0
Economic Status	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
Extremely low income	unknown	0	unknown
Very low income	unknown	44	unknown
Low income	unknown	145	unknown
Moderate income	unknown	105	unknown
High income	unknown	7	unknown
Health Insurance Status	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
Private	unknown	unknown	unknown
Medi-Cal	unknown	unknown	unknown
Medicare	unknown	unknown	unknown
Uninsured	unknown	unknown	unknown

Annual Report FY 20/21

Please provide the following information for this reporting period:

1) **Briefly report on how implementation of the Wennem Wadati: A Native Path to Healing project is progressing (e.g., whether implementation activities are proceeding on target and as described in the County's MHSA Plan), and any major accomplishments and challenges.**

   2020/21 was another challenging year for the Wennem Wadati program. With Covid still a part of our everyday lives and still causing havoc among our families, our Wennem Wadati program chose to focus on the issues that impacted our Native community most. Mental health was a major focus for our community. Due to Covid restrictions, we have not had in school talking circles for some time. Talking circles have been held at the Rancheria while also continuing to providing need mental services through our ongoing crisis line. The numbers served through our crisis line has continued to grow with many requiring numerous follow up. Our cultural classes have started again although in smaller numbers and with all the ongoing Covid protocols. These classes have been much appreciated by all participants as it gives them a time to become immersed again in cultural things as well as provides an opportunity to visit with friends they may not have seen since the Covid shut down. Native people are very social within their group and these classes have proved very beneficial for those attending.

2) **Briefly report on how the Wennem Wadati: A Native Path to Healing project has improved the overall mental health of the children, families, and communities by addressing the primary negative outcomes that are the focus of the Wennem Wadati: A Native Path to Healing project (suicide, incarcerations, prolonged suffering, homelessness, unemployment, school failure or dropout, and removal of children of their homes).**

   With many Covid restrictions in place in the early part of the 2020/21 program year, we spent quite a bit of time on phone calls to native families. Some were generated by our staff, but many were in response to calls from Native community members and their families. Reminding families regularly that there is a support system in place to provide mental health and cultural support services was an important part of our program. That information passes quickly through the Native community. Covid has certainly raised the level of anxiety among the community. Foothill Indian Education alliance provides a food disatr4ibution site for members of the Native community. Family members can collect food for others including native Elders. Our Crisis line provides a point of entry to available mental health services provided by our program as well as the Single Springs Rancheria behavioral health program. Our program refers members of our community to appropriate agencies for further assistance with housing, employment, school issues. Indian Education provides academic tutoring and liaison service for students struggling with school.

3) **Provide a brief narrative description of progress in providing services through the Wennem Wadati: A Native Path to Healing project to unserved and underserved populations.**

   It is difficult to measure progress while the Covid pandemic is still with us. We work hard to help our community keep their heads above water. With that in mind, as we begin to emerge from the Covid fog that hangs over us all, I believe we are in a good place to continue putting additional pieces in place to provide the needed safety and support for our community.

4) **Provide a brief narrative description of how the Wennem Wadati: A Native Path to Healing services are provided in a culturally and linguistically competent manner, including activities to reduce racial/ethnic disparities.**

   All of our services are and have always been delivered from a Native perspective. Talking circles, cultural gatherings, Native art classes and all other mental health and support services are provided in a way that

honor Native traditions and Native values that are understood by Natives all over the country. We do not have to deal with racial and ethnic disparities within our community.

5) Provide a brief description of activities performed related to local and county-wide collaboration, outreach, access/linkage to medically necessary care, stigma reduction and discrimination reduction.

Our program has always collaborated with Foothill Indian Education Alliance, Inc., The El Dorado/Amador Counties Indian Education Project, the Shingle Springs Rancheria (Behavioral Health, Medical, educational, and cultural departments) to provide services. In the event outside assistance is need we refer to County Behavioral Health and the MACT Health Board. We collaborate, and have for about 20 years, with the Food Bank of El Dorado County to provide supplemental food for needy Native Families. We also collaborate with Toys for Tots, the El Dorado County Office of Education and local school districts. We also receive donations of clothing and household good throughout the year that are distributed to the native community as needed.

6) Provide the outcome measures of the services provided and customer satisfaction surveys.

- **Measurement 1: Casey Life Skills Native American Assessment, or other assessment tool to be determined by contractor, to be given when a student joins the Talking Circles and when they end their participation.**

  The Casey Life Skills Assessment was not administered this year as Covid made it very difficult to do so. We expect to do so in the coming year as soon as we can begin doing face to face student talking circles again.

7) Report on unduplicated numbers of individuals served, including demographic data.

Our total numbers of unduplicated individuals served is 334. They participated from a number of areas around the county with the Placerville (166) and West County (95) being the largest groups.
Distance to travel is sometimes a factor for some participants although we have some that travel from Grizzly Flats and Somerset regularly to attend activities. This year we used Zoom and the telephone to reach out to people who could not participate due to Covid restrictions. We regularly reached out to Elders by phone to just talk and let them know they were not alone. Every Elder we spoke with reported that they looked forward to our calls.

8) Report on the reduction of prolonged suffering that may result from untreated mental illness by measuring a reduction in risk factors, indicators, and/or increased protective factors that may lead to improved mental, emotional, and relational-functioning.

Many American Indians families living in our community have experienced prolonged suffering as a result of untreated mental illness that was caused from past traumatic events from long ago. Traumas have been passed now from generation to generation by the way of learned behaviors, family stories, and "blood memory." Trauma have manifested into anxiety, depression, substance use, family violence, physical illness, etc. The presence or absence of protective and risk factors contribute to the mental health of our youth. Identifying protective and risk factors in our tribal youth have allowed us to plan prevention and intervention strategies to pursue a healthier community.

Our annual community assessments and walk-in assessments have identified the following risk factors:

- Poor social skills - Poor school functioning and low grades - Low self-esteem
- Shyness - Early substance use - Parental depression - Parent-child conflict
- Family conflict. - Parent with anxiety - Parental drug/alcohol use
- Family dysfunction - Poor parental supervision

The programs and events provided for our community are designed to increase the following protective factors:

- Academic achievement/intellectual development
- High self-esteem
- Good coping skills and problem-solving skills
- Engagement and connections with school, with peers, and culture
- Family provides structure, limits, rules, monitoring, and predictability
- Supportive relationships with family members
- Presence of mentors and support for development of skills and interests
- Opportunities for engagement within school and community
- Clear expectations for behavior
- Physical and psychological safety

9) If known, provide the number of Clients referred to County Behavioral Health and the type of treatment to which Clients were referred.

The American Indian clients that we have referred for mental health services were referred to The Shingle Springs Health and Wellness Center in Shingle Springs which is owned and operated by the Shingle Springs Band of Miwok Indians. If the clients are not eligible for services at SSHWC, they would be referred to County Behavioral Health. We would not have that information to share in this report.

10) If known, the average duration of untreated mental illness.

The average duration of untreated conditions is unknown.

11) If known, the number of individuals who followed through on the referral and engaged in treatment.

Because the referrals were made to SSHWC, we are unaware of the individuals who have followed through with their treatment.

12) If known, provide the average interval between mental health referral and participation in treatment.

Depending on whether the client will be a new client to the SSHWC or is an existing client, time can very on when a client can participate in treatment.

13) Provide total project expenditures and the type and dollar amount of leveraged resources and/or in-kind contributions.

Wennem Wadati’s budget for 2020/21 was $125,750.00.
Expenditures were $104,552.42.
Foothill Indian Education Alliance, Inc. provides a location for most of our services and also provides the use of office equipment and materials.

14) Provide any additional relevant information.

MHSA Year-End Progress Report FY 2020/2021

Children 0-5 and Their Families Project

Provider: Infant Parent Center

Project Goals

- Increased number of families within the target population who are accessing prevention/wellness/intervention services.
- Strengthened pipeline among area agencies to facilitate appropriate and seamless referrals between agencies in El Dorado County.
- Increased awareness of services available among families, health care providers, educators and others who may have access to target population.
- Emotional and physical stabilization of at-risk families (increasing trust).
- Improved infant/child wellness (physical and mental health).
- Improved coping/parenting abilities for young parents.
- Increase awareness and education of Domestic Violence and how it impacts families and young children.
- Enhancement of programs serving children 0-5.
- Decreased number of children removed from the home.
- Decreased incidence of prolonged suffering of children/families.
- Child abuse prevention.
- Suicide prevention.
- Increased cooperation and referrals between agencies.
- Reduced stigma of mental health/counseling interventions among target population.
- Improved trust of services as evidenced by an increase in self-referral by target group families.
- Decreased cost of 5150 and hospitalizations by providing services in outpatient setting.

Numbers Served and Cost

Expenditures	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
MHSA Budget	$250,000	$300,000	$300,000
Total Expenditures	$250,000	$300,000	$299,981
Unduplicated Individuals Served	11	215	237
Cost per Participant	$1,381	$1,395	$1,266
Age Group	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
0-15 (children/youth)	76	73	10
16-25 (transitional age youth)	16	17	2
26-59 (adult)	87	117	32
Ages 60+ (older adults)	1	0	0
Unknown or declined to state	1	3	0

Race	FY 2018-19	FY 2019-20	FY 2020-21
American Indian or Alaska Native	1	1	0
Asian	2	2	0
Black or African American	0	4	0
Native Hawaiian or Other Pacific Islander	3	1	0
White	145	186	40
Other	6	0	2
Multiracial	2	4	1
Unknown or declined to state	22	12	1
Ethnicity by Category	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
Hispanic or Latino	34	0	4
Caribbean	1	1	0
Central American	5	1	0
Mexican/Mexican-American/Chicano	25	41	4
Puerto Rican	0	1	0
South American	0	3	0
Other	3	0	0
Unknown or declined to state	33	0	0
Non-Hispanic or Non-Latino			
African	6	6	0
Asian Indian/South Asian	2	1	0
Cambodian	0	1	0
Chinese	0	0	0
European	97	127	38
Filipino	0	0	0
Japanese	0	0	0
Korean	0	0	0
Middle Eastern	0	1	0
Vietnamese	0	0	0
Other	9	6	0
Multi-ethnic	0	0	1
Unknown or declined to state	55	21	1

Primary Language	FY 2018-19	FY 2019-20	FY 2020-21
Arabic	0	0	0
Armenian	0	0	0
Cambodian	0	0	0
Cantonese	0	0	0
English	170	195	42
Farsi	0	0	0
Hmong	0	0	0
Korean	0	0	0
Mandarin	0	0	0
Other Chinese	0	0	0
Russian	0	0	0
Spanish	10	15	2
Tagalog	0	0	0
Vietnamese	0	0	0
Unknown or declined to state	1	0	0
Sexual Orientation **Collection of this information from a minor younger than 12 years of age is not required.*	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
Gay or Lesbian	0	0	0
Heterosexual or Straight	90	110	31
Bisexual	0	4	2
Questioning or unsure of sexual orientation	0	0	0
Queer	0	0	0
Another sexual orientation	0	0	0
Unknown or declined to state	91	22	1
Gender **Collection of this information from a minor younger than 12 years of age is not required.*	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
Assigned sex at birth:			
Male	45	12	9
Female	127	119	35
Unknown or declined to answer	9	6	0
Current gender identity:			
Male	45	12	9
Female	127	121	35
Transgender	0	0	0
Genderqueer	0	0	0
Questioning / unsure of gender identity	0	0	0
Another gender identity	0	0	0
Unknown or declined to answer	9	4	0
Disability	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**

Difficulty seeing	1	0	0
Difficulty hearing or having speech understood	0	8	0
Mental disability including but not limited to learning disability, developmental disability, dementia	9	7	4
Physical/mobility	0	0	0
Chronic health condition/chronic pain	3	1	0
Other (specify)	1	4	0
Declined to state	9	15	1
Veteran Status **Collection of this information from a minor younger than 12 years of age is not required.*	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
Yes	1	5	6
No	171	116	38
Unknown or declined to state	9	16	0
Region of Residence	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
West County	53	43	14
Placerville Area	58	77	18
North County	6	13	0
Mid County	16	21	9
South County	7	2	0
Tahoe Basin	28	29	3
Unknown or declined to state	13	19	0
Economic Status	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
Extremely low income	17	24	1
Very low income	2	28	3
Low income	81	84	22
Moderate income	46	64	16
High income	20	1	2
Health Insurance Status	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
Private	41	52	19
Medi-Cal	119	129	25
Medicare	0	0	0
Uninsured	1	7	0

Please provide the following information for this reporting period:

1) **Briefly report on how implementation of the Children 0-5 and Their Families project is progressing (e.g., whether implementation activities are proceeding on target and as described in the County's MHSA Plan), and any major accomplishments and challenges.**

The continued support from El Dorado County Mental Health Services Act (MHSA) program is greatly appreciated, especially this year. There is no question the complexity of isolation and barriers COVID-19 created for so many families and our community. The diversity MHSA funding provides not only allowed us to continue services, but also collaborate with easy linkage to other resources and providers which in turn decreased risks and magnified true prevention and early intervention missions.

Major accomplishments

- The Infant Parent Center (IPC) brought creativity to all areas of service this year. We found new ways to serve, collaborate and link families to break through barriers created by COVID-19 as well as connect with families in isolation with low to no support systems.
- Because of successful years of services and collaboration, Marshall Medical Center initiated new collaboration through the Pediatric and Family Medicine Programs. We were grateful to them for reaching out and immediately engaged with staff and met with doctors to begin collaboration and new referral systems. Consequently, we have received a significant number of new clients and higher numbers needing Perinatal Support Services and Family Therapy.
- IPC took advantage of the lockdown for education and increased certifications. Independent funding was provided for the Poly Vagal Institute and Registered Play Therapy trainings which build greater therapeutic services and thus more opportunities for client empowerment and sustainable wellness. All MHSA families are offered these specialized services as clinically appropriate.
- IPC has also engaged in further conversations for prevention and family maintenance with El Dorado County Child Welfare Program. We provided continued services and more collaboration with administration to streamline referrals and increase effective interdisciplinary collaboration among providers.
- IPC also joined the Child Abuse Prevention Council to help support prevention, education, identification, and service practices in El Dorado County. Our goal is to increase connection, collaboration and support this council to increase capacities for our families and community at large.

Challenges

As with others, the pandemic created many barriers and increased intensive stress and trauma. The Infant Parent Center has had to get creative on how to serve clients. We have provided telehealth as well as some home visitation and have gradually increased in-person visits with masks. IPC has taken increased measures to ensure compliance and safety for all clients; creating intentional space between sessions so there is ample time to clean and take precautions. These added measures created extended time for each client service consequently decreasing time availability. Therapists have given more time and amazing efforts to see as many families as possible while also maintaining safety and creating a comforting environment during such a treacherous time.

We had more discussions with schools, Public Health, Child Welfare, Marshall Medical and other providers this year. There are great concerns of unidentified needs and potential risks made unaware due to COVID-19 family isolation. IPC worked hard to connect to all referrals to lower risk but found we had many families not engage or

even respond to referrals made by providers. We are working hard through interdisciplinary collaboration to find more effective ways to engage families.

Many more of our perinatal families reported increased stress and intense trauma during labor and delivery resulting in significantly higher levels of Perinatal Mood and Anxiety Disorders and sadly even higher proportional rates of suicidality in new mothers. IPC was able to immediately offer services to these high-risk families while also providing easy linkage to additional resources.

2) Briefly report on how the Children 0-5 and Their Families project has improved the overall mental health of the children, families, and communities by addressing the primary negative outcomes that are the focus of the Children 0-5 and Their Families project (suicide, prolonged suffering, school failure or dropout, and removal of children from their homes). Please include other impacts, if any, resulting from the Children 0-5 and Their Families project on the other three negative outcomes addressed by PEI activities: (1) incarceration; (2) unemployment; and (3) homelessness.

The Infant Parent Center surpassed our normal duties in this unprecedented time. Our core mission to provide a safe and comforting environment held true even through telehealth and when able, home visits and eventually in person sessions again. By continuing our services without disruption, families were able to be contacted immediately after a call or electronic request. This gave families assurance to know they were not alone. They discovered they had options for grounding, healing and hope despite the lockdown, job loss and uncertain times.

Because of our consistent work over the last thirteen years, former families also felt comfortable calling us again to re-engage with services. We had a significant increase in returning families. Most families were calling due to the intensified stress of COVID-19 and the heavy impact on young parents who no longer could have loved ones help with childcare and home support. IPC was able to not only provide therapeutic services but also help families navigate medical support, housing, employment, food distribution and eventually transitioning back to school, work, and childcare programs.

Specific to the PEI Project areas of focus, IPC reports the following:

Please note that these numbers are reflective solely on new clients from this year.

Suicide: Fifteen (15) pregnant or postpartum women suffered with suicidality this year. This number is staggering compared to prior years. Our belief is the isolation for women, including during labor and delivery, created an intensified level of trauma and suffering thus resulting in such a significantly higher number. Thankfully, no women completed intent and only two (2) women were held under involuntary holds. Both women were provided additional medical and therapeutic support and are currently accessing IPC and additional services.

Prolonged Suffering: One hundred (100) families qualified under this criterion. The harsh reality is that most of our families were already enduring prolonged suffering. The pandemic has greatly exacerbated their hardships and trauma. It will be imperative as a community that we promote effective harm reduction for these families. We are still learning about the devastating effects of COVID-19 and will continue to learn more as research progresses. IPC is dedicated to not only supporting families but also engaging in further community discussions to create more opportunities and prevention from further suffering.

Risk of Removal: Twenty-eight (28) children were referred with potential risks of being taken into foster care. With such a huge increase in perinatal families this year and with COVID-19 isolation, we have much lower numbers. Collaborative meetings with Child Welfare Department also indicated lower numbers this year due to lack of connection and oversight in schools, day cares, etc. Sadly, we are preparing for a much higher rate next year due to the prolonged stressors of COVID-19 and instability in homes.

Incarceration to Mainstream: Only one (1) family was involved with the legal system this year. Again, this may be an outlier number to general statistics, and we will continue to support all families and collaborate with all partners available to help families move to sustainable wellness.

Homelessness/Unemployment: We only served four (4) families enduring homelessness this year. With the Nomadic Shelter closed and Hope House and Mother Teresa's inaccessible, we had difficulty getting connected to families we usually serve. We will continue to collaborate with these agencies and programs with hopes to serve more families next year.

School dropout/failure: IPC provided psychoeducation and experiential training for Early Head Start Teachers on a variety of topics such as the Autonomic Nervous System, Grief and Loss, Compassion/Empathy as well as Mindfulness and Resourcing. We have found over the years that supporting teachers directly results in great benefits to students and their families at home. We are excited as we expand our teacher support to new districts this coming year including new support in South Lake Tahoe.

3) Provide a brief narrative description of progress in providing services through the Children 0-5 and Their Families project to unserved and underserved populations.

Our Spanish speaking clinicians went above and beyond to serve Latino families and work collaboratively with other providers serving this population. Many of the Latino families we serve need increased services due to lack of resources and fear to access resources. Trust is monumental in serving these families who have suffered immigration trauma, increased terror of deportation without their children, fear of getting sick with COVID-19 and the lack of access to medical resources. They also endured long waits in the ER which further increased fear of exposure to COVID-19.

4) Provide a brief narrative description of how the Children 0-5 and Their Families services are provided in a culturally and linguistically competent manner, including activities to reduce racial/ethnic disparities.

The Infant Parent Center makes an intentional effort to humbly learn from each family. We honor all families and seek to fully understand their cultures, values, practices and definitions of life and safety. We continually seek new education and trainings to be as understanding and supportive as possible. We work diligently to create an environment where all clients feel welcome and comfortable to request, question and educate us with confidence that all staff will respond with benevolence.

5) Provide a brief description of activities performed related to local and countywide collaboration, outreach, and access/linkages to medically necessary care, stigma reduction and discrimination reduction.

COVID-19 has been a unique journey. We faced so many hardships, traumas, and barriers yet we also learned a great deal about our endurance, creativity and the amazing efforts of our families and community. There was never a doubt that all providers were working together to support families and minimize potential risks. This was a year that prevention/early intervention in El Dorado County truly shined. We are always grateful for our collaborative partners and for them knowing they can call us anytime. We worked extremely hard this year and are excited to collaborate on even greater levels next year for sustainable health changes in our community.

7) Provide the outcomes measures of the services provided and of customer satisfaction surveys. Outcome measures for the Children 0-5 and Their Families project are:

- **Measurement 1: Clinical assessment and progress will include, but are not limited to, Parent Stress Index, Beck's Depression Beck's Depression and Anxiety Scale, Post-Partum Depression Scale, Ages and Stages, and Marshak Interaction Method.**

- 237 were served this year (145 new families and 92 returning)
- 190 families engaged in services

- 145 families achieved treatment success in at least two areas of concern
- 45 new families are currently in services

It is important to note that due to COVID-19, IPC was not able to begin in person sessions and assessments until later in the year, therefore, assessment numbers are far lower this year than previous years.

Marschak Interaction Method (MIM) - IPC conducted thirty-three (33) MIM assessments during this period. Clients/caregivers displayed progress in one or more of the following areas:

- Increase in social-emotional development
- Decrease in trauma symptoms as evidenced by trust, reciprocity, and engagement
- Increased ability to nurture, set appropriate boundaries and emotional safety
- Increased attunement with infant/child needs, cues, and development
- Increase in caregivers' reflective capacity

Playroom/Observation and Evaluation - IPC provided nineteen (19) playroom observation and evaluations for children served. The Playroom Evaluation/Observation is a systematic assessment provided for every child and caregiver. The assessment provides client directed as well as therapist led activities for greater observation of the child's presenting needs as well as opportunities to observe indicators of other areas of need.

Perinatal Assessment - IPC administered fifteen (15) perinatal assessments during this period with client displaying progress in one or more of the following:

- Identify perinatal mood and anxiety disorders
- Increase protective factors
- Strengthen relationship with baby in utero
- Process ambivalence, grief, and loss
- Linking family to resources that can minimize risk factors and increase competency

Evidence Based Parent Education - We provide this program individually to support each caregiver's relationship with his/her child(ren). This evidence-based practice enhances awareness, attunement, connection, and consistent containment which are essential components for a secure attachment and optimal development for children. Many of our families receive parent support in addition to their therapeutic services. With new trainings this year, families are also receiving education on their regulation and how to support their child's regulation resulting in faster changes in the above areas as well as greater changes in behavior and attachment.

Additional Assessments - IPC provided an additional seventy-two (72) assessments. These include but are not limited to: The Parent Stress Index (27), Beck's Depression Anxiety and Depression Scales (13), and Edinburgh and Postpartum Depression Scale (32). Because IPC staff has additional specialized trainings and certifications, other instruments are also available and provided when clinically appropriate:

- **Measurement 2: Client satisfaction questionnaires, other provider questionnaires.**

Client Satisfaction Questionnaire (CSQ) - We received twenty-five (25) client satisfaction survey responses. Although most of the year was served through telehealth, we were able to electronically send CSQs to families providing a similar number of responses this year.

Collaborative Partner Survey - The Infant Parent Center received a significantly higher response from providers this year. Twenty (20) community partners responded with an overall average of excellent (see Appendix). We are

grateful that other providers took time to not only complete the survey but made sure other providers had access to provide their opinions as well.

- **Measurement 3: Tracking of referrals and engagement.**

Sixty-eight (68) clients were self-referred or referred by a family or friend. This represents an increase again from the previous year. We continue to see significant increases each year in self-referrals. IPC is excited to see the growth in community awareness of our agency as well as the confidence in referring friends and families to our services.

- **Measurement 4: Decreased incidents of Abusive Head Trauma (formerly known as "shaken Baby Syndrome).**

The Infant Parent Center worked successfully with seventeen (17) infants who were at risk of Abusive Head Trauma (formerly known as Shaken Baby Syndrome). We are happy to see such a reduction but also recognize COVID-19 isolation has skewed numbers dramatically this year. Nonetheless, we do hope to see continued decline with greater perinatal support. Because of the intense multigenerational trauma, we recognize the complexity of this risk and the sensitivity to caregivers' stress yet also the essential need of safety for the infants. IPC has had great success through collaboration with Public Health, Early Head Start and Child Protective Services to increase safety measures and effective services for families.

8) **If known, provide the number of Clients referred to County Behavioral Health and the type of treatment to which Clients were referred.**

IPC refers families to Behavioral Health in concordance with other community referrals. Those overall referrals were not tracked. However, three specific parents were referred. All three adults did not meet criteria for services. New discussions with a Behavioral Health Coordinator have started for more efficient referral processes. We are happy to use any methods to best serve families and look forward to closer collaboration.

9) **If known and if applicable, provide information on Client self-report on the duration of untreated mental illness.**

The discussion of untreated mental health has become a broad forum this past year. With more awareness and lowering the stigma of mental health issues, we are seeing a greater number of self-referrals and preventative work options. However, sadly we did have nineteen (19) women who did not respond to our calls. These women scored above clinical range on the Edinburgh Postpartum Screener indicating high mental health concerns. IPC reaches out multiple times with various options to respond. Our goal next year is to get more creative in engaging families.

In accordance, we have started discussions with Marshall Medical in Obstetrics and Pediatrics to begin screening fathers. Research tells us that men suffer silently with Perinatal Mood and Anxiety disorders far too often. It is unheard of to screen men for this common struggle and thus we find couples in great distress, increased substance abuse and increased domestic violence. The Infant Parent Center plans to begin screenings in El Dorado County and to increase awareness and normalize the perinatal needs of our fathers.

10) **If known, provide the average interval between mental health referral and participation in treatment.**

IPC does not track the time span between a referral we give to a family and the time it takes for them to receive the service. As previously stated, we are looking forward to working closer with Behavioral Health Coordinators to create a warm hand off to clinicians there.

11) If known, the number of individuals who followed through on the referral and engaged in treatment.

As noted above, IPC provides BHD as a steady referral resource. Specifically, three (3) referrals were provided to adults who did not meet criteria for services.

12) If known, provide a description of the methods Contractor used to encourage Client access to services and follow-through on referrals.

IPC strives to provide warm, non-judgmental support to caregivers needing additional services. Our continued positive relationship with other providers gains easy access to linkage and referrals with specific identified people or agencies that caregivers can contact. IPC continually provides interdisciplinary collaboration throughout the time we serve families, referring and linking families to services outside the area.

13) Provide total project expenditures and the type and dollar amount of leveraged resources and/or in-kind contributions.

IPC used all funds allocated minus $19.00 in conjunction with additional contracts. We are grateful for the county's continued financial and professional support.

Infant Parent Center Client Satisfaction Survey

Fiscal Year 2020/2021

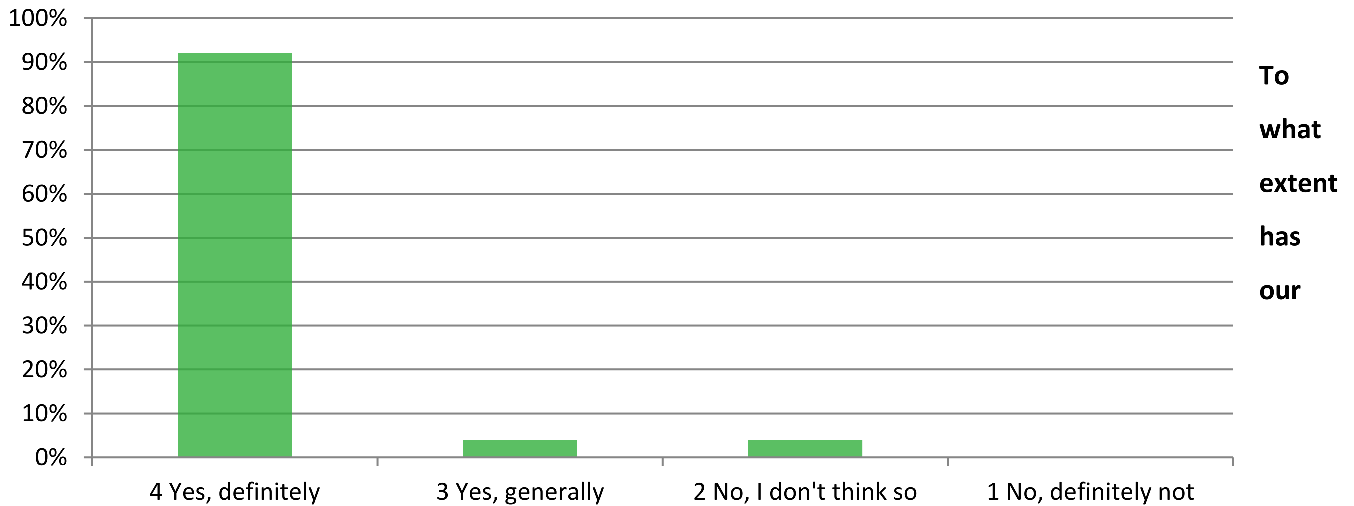
How would you rate the quality of service you received?

4 Excellent	92%	23
3 Good	4%	1
2 Fair	4%	1

1 Poor	0%	0

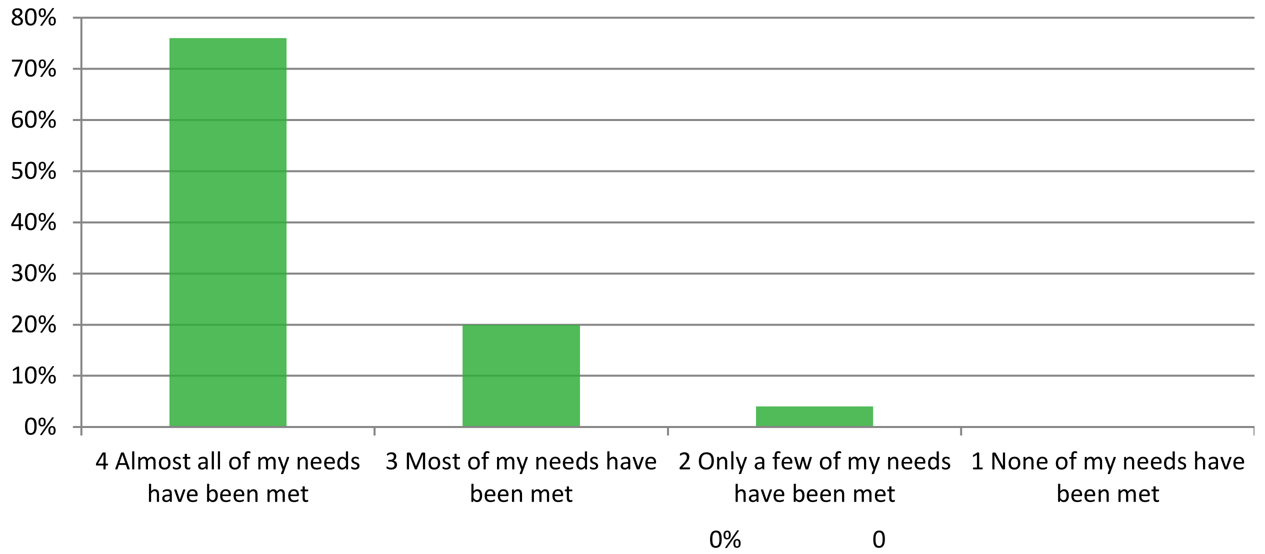
Did you get the kind of service you wanted?

4 Yes, definitely	92%	23
3 Yes, generally	4%	1
2 No, I don't think so	4%	1
1 No, definitely not	0%	0



To what extent has our program met your needs?

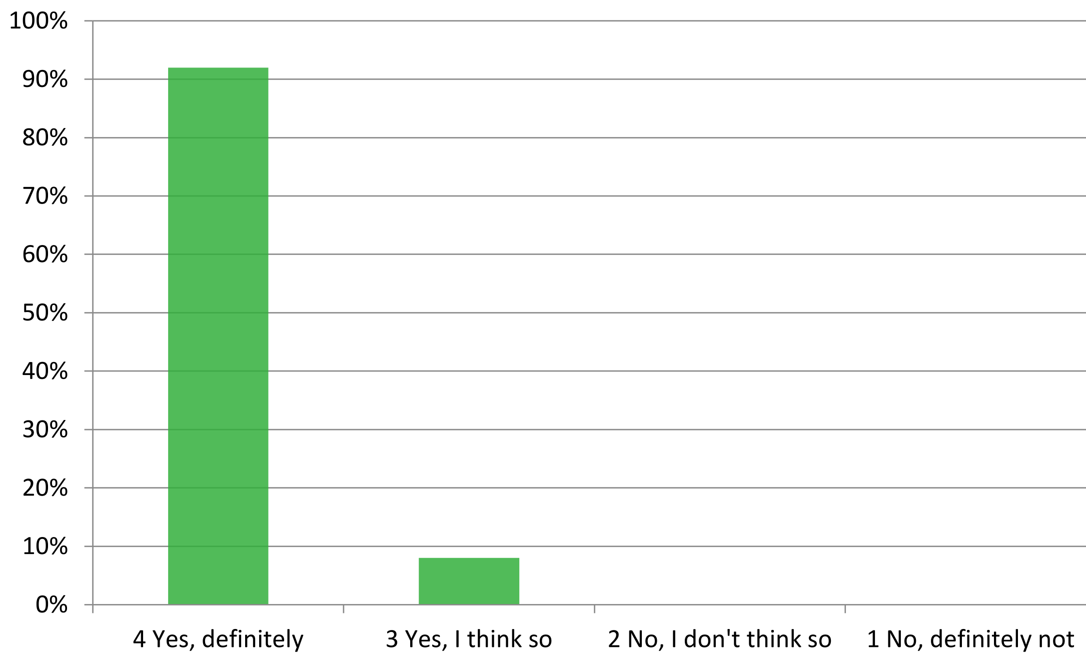
4 Almost all of my needs have been met	76%	19
3 Most of my needs have been met	20%	5
2 Only a few of my needs have been met	4%	1
1 None of my needs have been met		



	0%	0

If a friend needed similar help, would you recommend our program to him or her?

4 Yes, definitely	92%	23
3 Yes, I think so	4%	2
2 No, I don't think so	0%	0
1 No, definitely not	0%	0

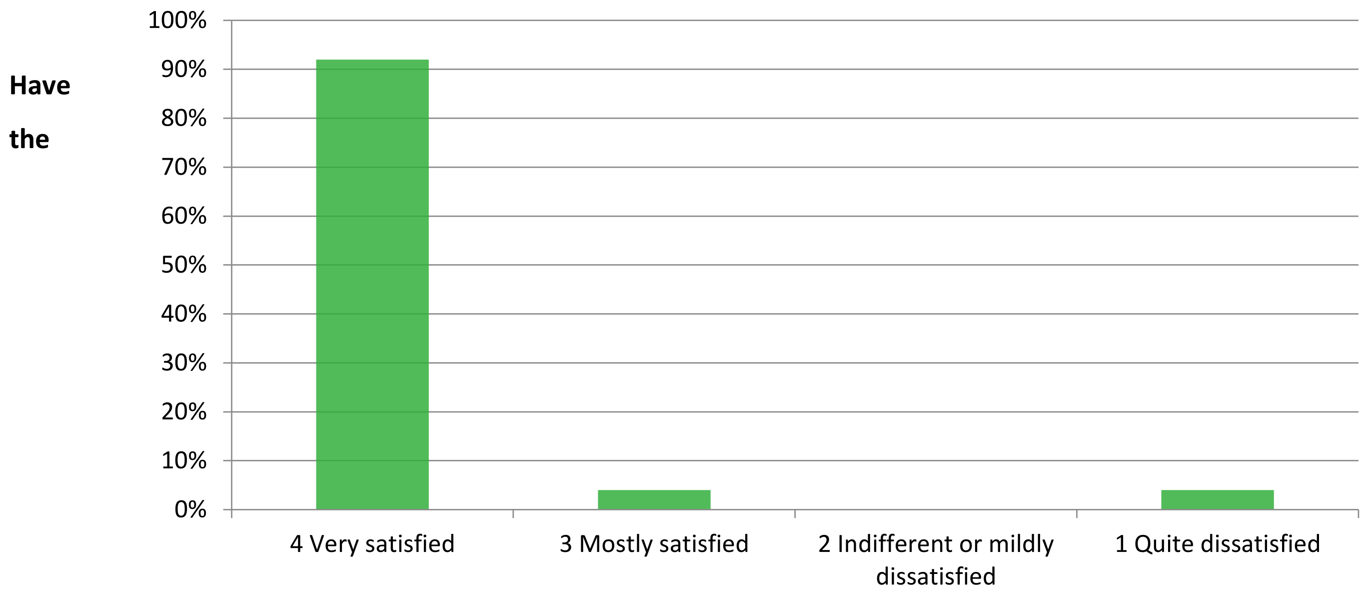


How satisfied are you with the amount of help you received?

4 Very satisfied	92%	23

3 Mostly satisfied	4%	1
2 Indifferent or mildly dissatisfied	0%	0
1 Quite dissatisfied	4%	1

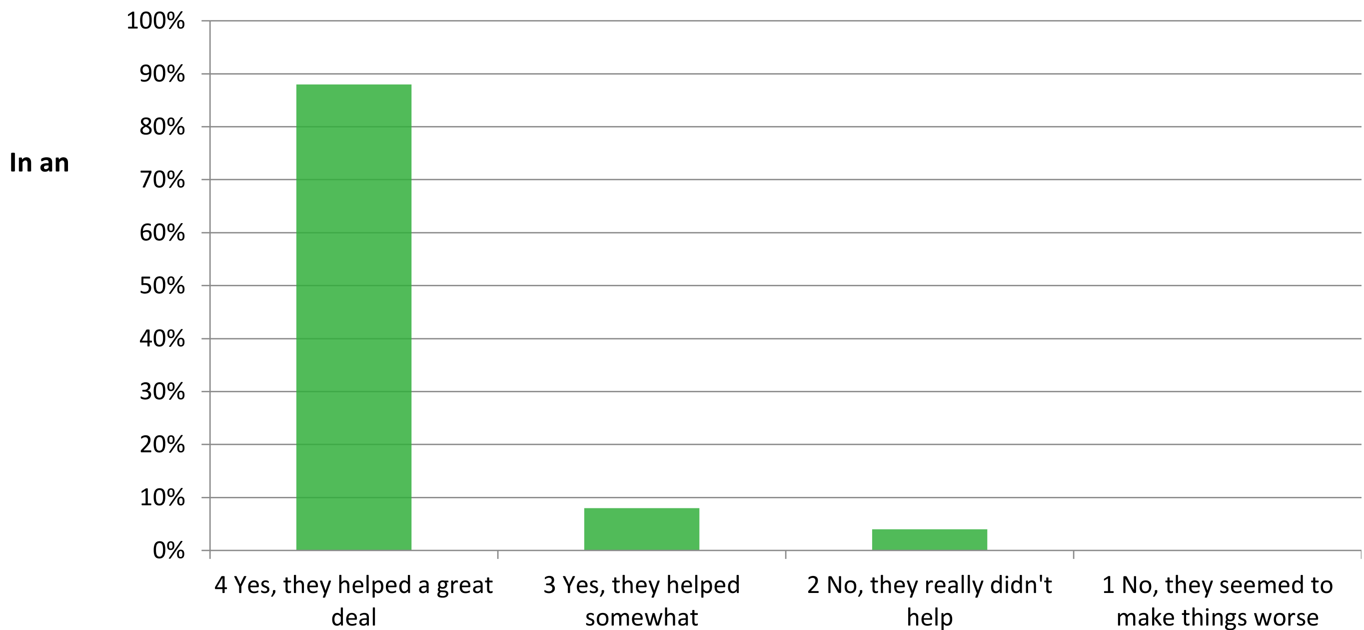
Have the



services you received helped you to deal more effectively with your problems?

4 Yes, they helped a great deal	88%	22
3 Yes, they helped somewhat	8%	2
2 No, they really didn't help	4%	1
1 No, they seemed to make things worse	0%	0

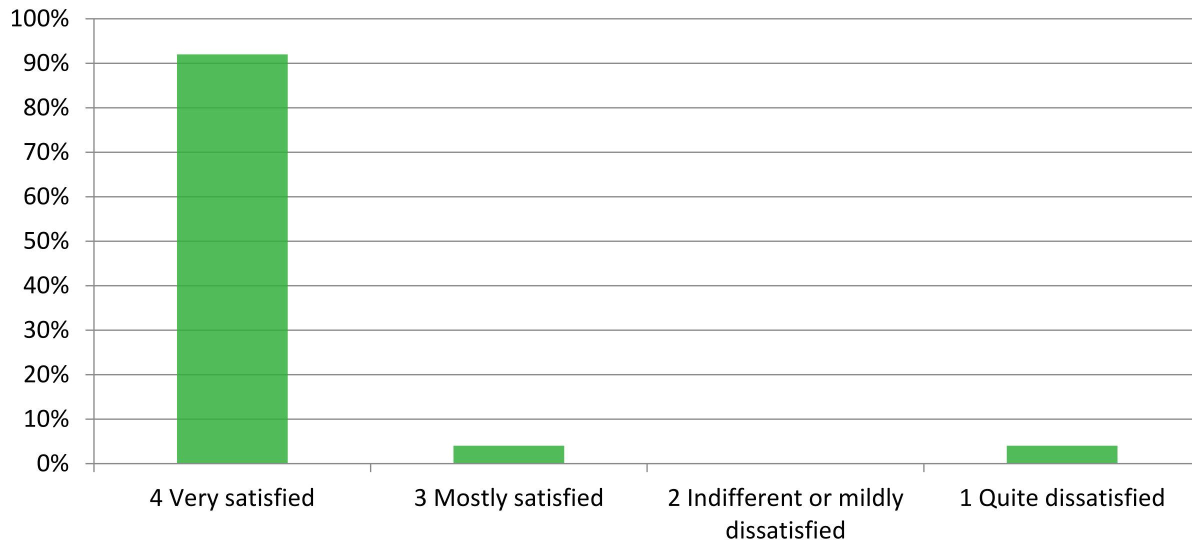
In an



overall general sense, how satisfied are you with the service you received?

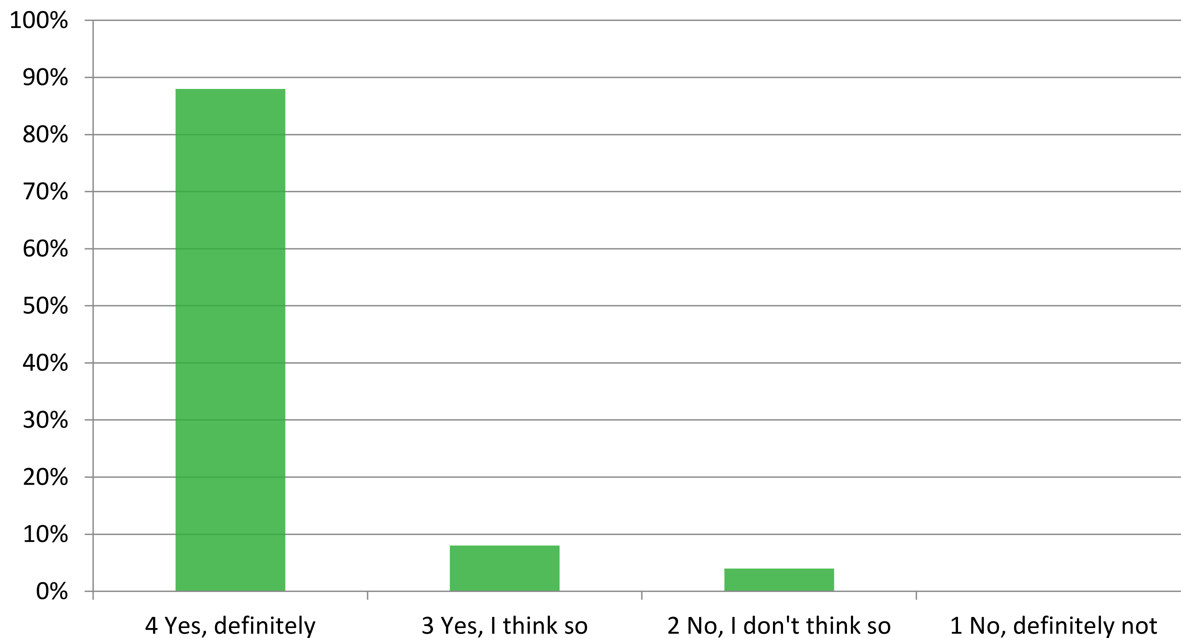
4 Very satisfied	92%	23

3 Mostly satisfied	4%	1
2 Indifferent or mildly dissatisfied	0%	0
1 Quite dissatisfied	4%	1



If you were to seek help again, would you come back to our program?

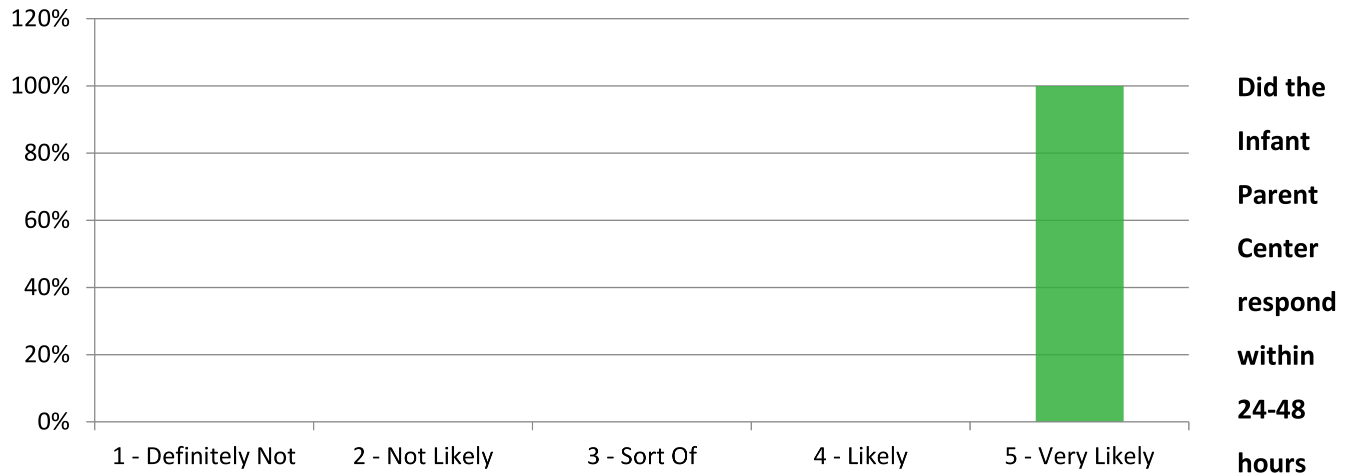
4 Yes, definitely	88%	22
3 Yes, I think so	8%	2
2 No, I don't think so	5%	1
1 No, definitely not	0%	0



How likely are you to recommend our agency to families or individuals in the future?

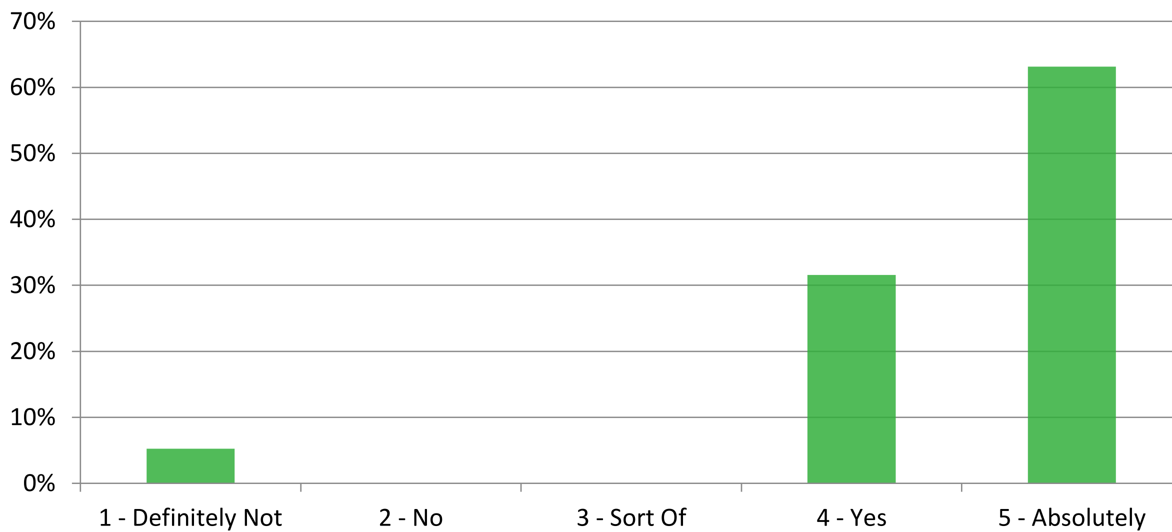
1 – Definitely Not	0%	0
2 - Not Likely	0%	0

3 - Sort Of	0%	0
4 - Likely	0%	0
5 - Very Likely	100%	20



Did the Infant Parent Center respond within 24-48 hours of your referral?

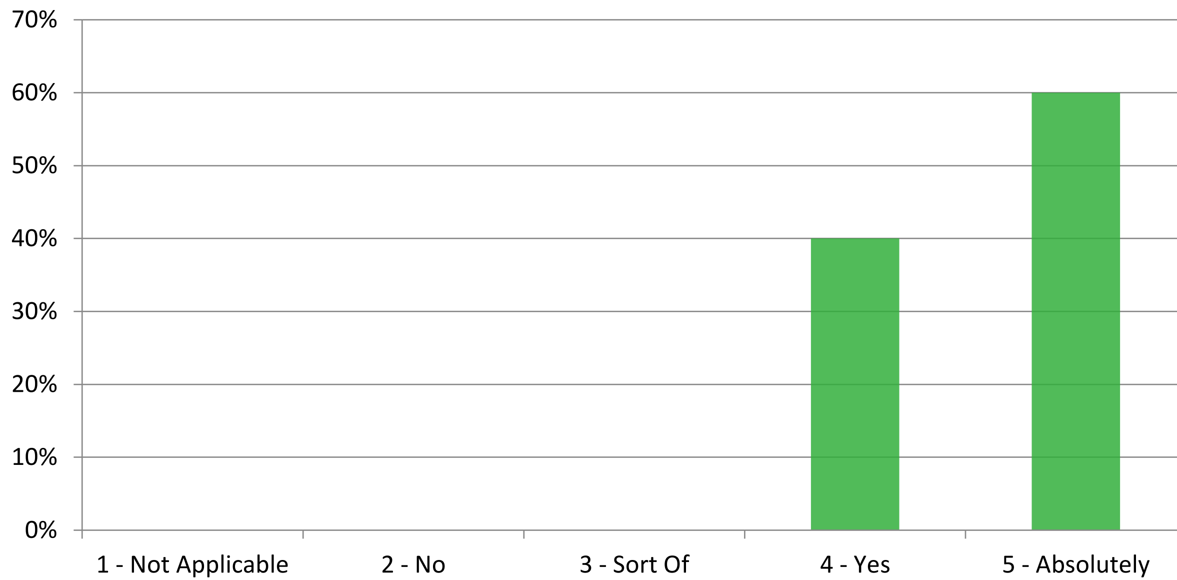
1 - Definitely Not	5%	1
2 - Not	0%	0
3 - Sort Of	0%	0
4 - Yes	32%	6
5 – Absolutely	63%	12



Have you heard positive feedback from families regarding services they received from IPC?

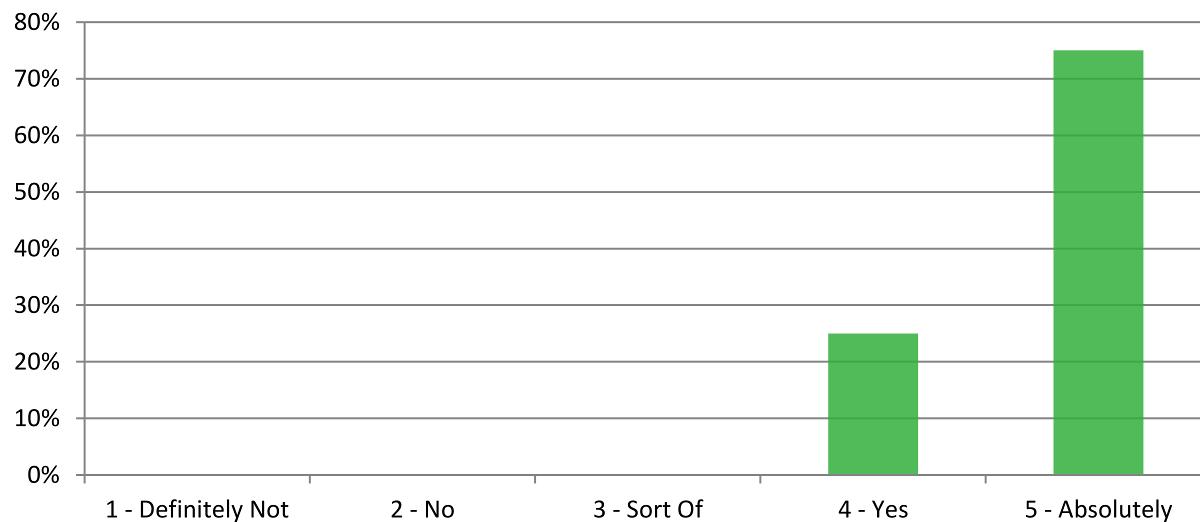
1 – Not Applicable	0%	0
2 - No	0%	0

3 - Sort Of	0%	0
4 - Yes	40%	8
5 – Absolutely	60%	12



Do you believe that family wellness improves after services with IPC?

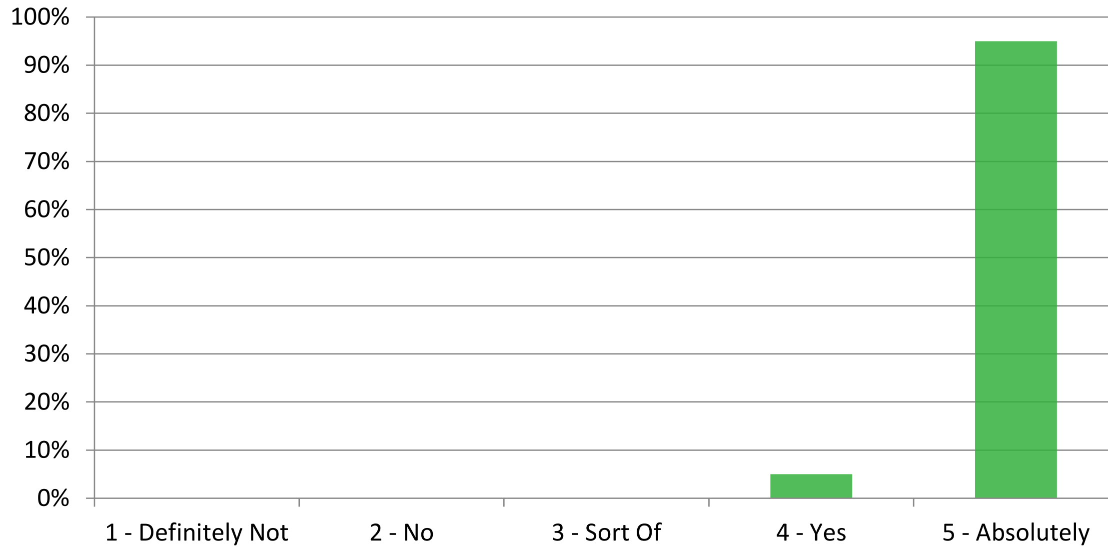
1 – Definitely Not	0%	0
2 – No	0%	0
3 – Sort Of	0%	0
4 – Yes	25%	5
5 – Absolutely	75%	15



Do you find the Infant Parent Center's services essential for the community?

1 – Definitely Not	0%	0
2 – No	0%	0

3 – Sort Of	0%	0
4 – Yes	5%	1
5 – Absolutely	95%	19



MHSA Year-End Progress Report FY 20-21

Prevention Wraparound Services: Juvenile Justice Project

Provider: Stanford Sierra Youth & Families

Project Goals

- Improve the array of services and supports available to children and families involved in thechild welfare and juvenile probation systems.
- Engage families through a more individualized casework approach that emphasizes family involvement.
- Increase child/youth safety without an over-reliance on out-of-home care.
- Improve permanency outcomes and timeliness.
- Improve child and family well-being.
- Prevent involvement in the juvenile justice system.

Numbers Served and Cost

Expenditures	FY 2019-20	FY 2020-21
MHSA Budget	$550,000	$550,000
Total Expenditures	$103,918 Invoicing began July 2019.	$242,585
Unduplicated Individuals Served		24
Cost per Participant	$	$10,108

Age Group	FY 2019-20	FY 2020-21
0-15 (children/youth)	2	13
16-25 (transitional age youth)	13	11
26-59 (adult)	0	0
Ages 60+ (older adults)	0	0
Unknown or declined to state	0	0
Race	**FY 2019-20**	**FY 2020-21**
American Indian or Alaska Native	0	1
Asian	0	0
Black or African American	0	2
Native Hawaiian or Other Pacific Islander	0	0
White	14	19
Other	0	1
Multiracial	1	1
Unknown or declined to state	0	0

Ethnicity by Category	FY 2019-20	FY 2020-21
Hispanic or Latino	0	0
Caribbean	0	0
Central American	0	0
Mexican/Mexican-American/Chicano	1	1
Puerto Rican	0	0
South American	0	0
Other	1	2
Unknown or declined to state	0	1
Non-Hispanic or Non-Latino		
African	0	2
Asian Indian/South Asian	0	0
Cambodian	0	0
Chinese	0	0
European	11	11
Filipino	0	0
Japanese	0	1
Korean	0	0
Middle Eastern	0	0
Vietnamese	0	0
Other	2	2
Multi-ethnic	0	0
Unknown or declined to state	1	4
Primary Language	**FY 2019-20**	**FY 2020-21**
Arabic	0	0
Armenian	0	0
Cambodian	0	0

Cantonese	0	0
English	14	23
Farsi	0	0
Hmong	0	0
Korean	0	0
Mandarin	0	0
Other Chinese	0	0
Russian	0	0
Spanish	0	1
Tagalog	0	0
Vietnamese	0	0
Unknown or declined to state	1	0
Sexual Orientation **Collection of this information from a minor younger than 12 years of age is not required.*	**FY 2019-20**	**FY 2020-21**
Gay or Lesbian	0	0
Heterosexual or Straight	13	18
Bisexual	1	2
Questioning or unsure of sexual orientation	0	0
Queer	0	0
Another sexual orientation	0	0
Unknown or declined to state	1	4
Gender **Collection of this information from a minor younger than 12 years of age is not required.*	**FY 2019-20**	**FY 2020-21**
Assigned sex at birth:		
Male	0	11
Female	0	13
Unknown or declined to answer	0	0
Current gender identity:		
Male	11	11
Female	3	12
Transgender	0	0
Genderqueer	0	1
Questioning / unsure of gender identity	0	0
Another gender identity	0	0
Unknown or declined to answer	1	0
Disability	**FY 2019-20**	**FY 2020-21**
Difficulty seeing	0	1
Difficulty hearing or having speech understood	0	0
Mental disability including but not limited to learning disability, developmental disability, dementia	0	3
Physical/mobility	0	0
Chronic health condition/chronic pain	0	0
Other (specify)	1	0

Declined to state	0	0
Veteran Status ****Collection of this information from a minor younger than 12 years of age is not required.***	**FY 2019-20**	**FY 2020-21**
Yes	0	0
No	0	24
Unknown or declined to state	0	0
Region of Residence	**FY 2019-20**	**FY 2020-21**
West County	2	6
Placerville Area	4	8
North County	1	3
Mid County	0	3
South County	0	0
Tahoe Basin	5	0
Unknown or declined to state	3	4
Economic Status	**FY 2019-20**	**FY 2020-21**
Extremely low income	2	5
Very low income	2	1
Low income	3	7
Moderate income	4	7
High income	4	3
Health Insurance Status	**FY 2019-20**	**FY 2020-21**
Private	7	14
Medi-Cal	7	10
Medicare	1	0
Uninsured	0	0

Annual Report FY 2020/21

Please provide the following information for this reporting period:

1) **Briefly report on how implementation of the Prevention Wraparound Services: Juvenile Service project is progressing (e.g., whether implementation activities are proceeding on target and as described in the County's MHSA Plan), and any major accomplishments and challenges.**

   General Implementation: The Prevention Wraparound program has been in implementation phase ofthe project since July 2019. Referrals continued in FY 20-21 to be from CPS and Probation. Due to COVID-19 both the CPS and Probation teams reported being low within their own referrals which resulted in low system-partner referrals for the Wraparound program. Our census became primarily filled with CPS youth, specifically focused on the emergency response CPS calls for families needing additional support to prevent CPS involvement. Utilizing this particular type of referral has resulted in an increase in referrals for the program and more families served. We continue to meet monthly with our system partners to discuss potential referrals and the progress families in service are seeing.

   Challenges: Hiring has been a challenge in the county due to resources available in regards to the scarcity of the hiring pool, socio-political stressors of the area and remoteness of locations served. Referrals and census have been low throughout this last year which could be due to COVID-19, restricted referral sources (limited

to CPS and Probation only), and need for better understanding of program fit from system partners as many referrals came and were already open to EPSDT services or qualified for EPSDT services. The linkage or qualifying criteria for EPSDT/SMHS services results in manyof our referrals closing out shortly after intake or initial engagement calls. We have been working diligently with CPS to determine a best process in identifying youth/family need and appropriateness

of referrals as well as how to best support with the linkage to EPSDT/SMHS which the new ACCESS addition as a referral partner should greatly assist. It's worth noting that around half of the dischargedreferrals this fiscal year were due to youth already being linked to SMHS at the time of referral or qualifying and being more suited to SMHS at time of intake.

Accomplishments: The addition of ACCESS joining as a referral/system partner for FY 21-22 is a large accomplishment. We are hopeful the additional referrals for low-moderate needs to serve youth andfamilies in preventing need for higher level of care or out-of-home placement. This addition will also support with more streamlined coordination and linkage to more appropriate services when youth are referred through CPS/Probation and are presenting with needs that meet criteria for Specialty Mental Health Services. Another accomplishment is that we've ended the fiscal year with having hireda full team, this has been a challenge for us historically and we are excited to have a complete dedicated team to the program.

Opportunities: If schools were able to refer this might increase the level of youth/families able to beserved in a preventative manner through meeting their global needs versus youth already experiencing system involvement.

2) **Briefly report on how the Prevention Wraparound Services: Juvenile Services has improved the overall mental health of the children, families and communities by addressing the negative outcomes that are the focus of the Prevention Wraparound Services project (suicide, incarcerations, prolonged suffering, homelessness, unemployment, school failure or dropout, and removal of children from their homes).**

The Prevention Wraparound team has continued to work with referring partners prior to referral to discuss the nature and appropriateness of the referral. During the intake and assessment process, our team assesses for mental health related needs utilizing tools such as the CANS-50; CSE-IT; CAFAS;PSC-35; CODA; and a comprehensive Core Assessment evaluating biopsychosocial history, risk assessment, and mental health history. Utilizing this information we are able to screen for higher mental health needs and potential negative outcomes (suicide, self-harm, prolonged suffering, school failure or dropout, incarceration, trauma, homelessness, or removal of children from their homes) and have referred to Specialty Mental Health Services when appropriate. Utilizing the High Fidelity Wraparound process we are able to create a comprehensive plan with the family, referral partner, and treatment team to address identified priority needs.

We have collaborated at our cross-systems monthly meeting to determine extensions for prospective discharge dates for youth needing additional time/support to complete recommended tasks. Lastly, we have remained open to ensure linkage for youth with alternative or higher level needs identified,supporting with that linkage and offering in-person support if needed.

3) **Provide a brief narrative description of progress in providing services through the Prevention Wraparound Services project to unserved and underserved populations. Underserved is defined in California Code of Regulations 3200.300 as "clients of any age who have been diagnosed with a serious mental illness and/or serious emotional disturbance and are receiving some services but are not provided with the necessary opportunities to support their recovery, wellness, and/or resilience. These clients include, but are not limited to, those who are so poorly served that they are at risk of homelessness, institutionalization, incarceration, out-of-home placement, or other serious consequences."**

Through the referrals received we have learned that the county in general has a shortage of resourcesand services available to youth and families. Specifically, we have found that often times our referralsqualify for higher level care though referring parties send the referral to this program as a means to get the youth/family in the door anywhere, with hopes that services will more appropriately link.
We have collaborated with our system partners both in training and creating agreements on how to best serve families from referral through linkage or treatment. Though this increases the youth/families opening and closing following linkage to more appropriate services it has ensured support and linkage in the process. It is worth noting that a significant number of referrals from our partners at CPS have been referred and already have open services through EPSDT/SMHS of which weare simply confirming and closing due to appropriate fit.

Additionally we also had received referrals for a couple of youth who had identified Specialty MentalHealth Services, but due to Medi-Cal ineligibility could not access the level of services offered by County Behavioral Health. For these youth we were able to obtain permission from MHSA to providethem services that they otherwise would not have access to. One of these youth came to us throughCPS with active daily suicidal ideation and while the youth did experience a hospitalization during services they are now taking medication consistently, managing symptoms appropriately and on-set to successfully complete the program.

With the services provided, the team has supported youth and families in identifying strengths, becoming medication compliant, and creating a plan to support with the transition to the new placement, thus minimizing out-of-home placement or hospitalization.

4) Provide a brief narrative description of the number of youth who have reduced the number, duration, and repetition of in-patient psychiatric hospital care admissions.

One of our youth referred had a history of hospitalization and did experience a 51/50 hospitalizationduring care though continued with Wraparound services and is now stable and set for positive closure.The youth mentioned would have otherwise qualified for SMHS at time of referral due to active suicidal ideation, however does not qualify for Medi-Cal. There were many (15) youth referred for services who either through the referral or assessment process frequent/recent hospitalizationdetermined a higher level of need for Specialty Mental Health services and they were linked for moreappropriate support.

5) Provide a brief narrative description of the number of youth who have had reduced contacts withlaw enforcement, the Juvenile Justice System and/or Child Welfare.

One youth was referred via probation and before opening was already in custody to complete a program at the Juvenile Treatment Center (JTC). Most of our referrals this year (33) were from CPS of which none resulted in removal of the home during their time served; many were referred out or relinked to their County provider for SMHS.

6) Provide a brief narrative description of the number of youth who maintain integration or have been reintegrated into a permanent family-based setting and in the community.

Of the youth who opened within the program, one closed due to running away between the intake appointment and subsequent assessment appointment. One youth also moved out of state to live with a natural support (adult-aged sibling) early into treatment/services. No youth were removed from their family-based setting during time in services.

7) **Provide a brief narrative description of how the Prevention Wraparound Services are provided in a culturally and linguistically competent manner, including activities to reduce racial/ethnic disparities.**

All staff hired for our Prevention Wraparound program receive cultural competence training and are prepared to support youth and families as appropriately indicated. During our assessment process, our team assesses any needs related to cultural accommodations, language needs, ADA or Indian Child Welfare Act (ICWA)-related accommodations. We have bilingual (Spanish speaking) staff who can provide services in Spanish, as well as the capacity to utilize interpreter services if needed. At thistime we have had no need for language accommodations. Additionally, at the time of assigning staffor adding additional team members, we utilize information known about the youth and family to bestmatch the needs and comfort of the family. A specific example of this match consideration could be applied with our adding of youth advocates and family partners to some of our family teams; the teammet and discussed the family dynamics and cultures in order to identify team members who'd best fitfamily culture and be able to best address the needs identified utilizing their lived-experience. Throughout services we continue to assess with any need for cultural or language accommodations.

8) **Provide a brief description of activities performed related to local and county-wide collaboration, outreach, access/linkage to medically necessary care, stigma reduction, and discrimination reduction.**

Our team has partnered with our referring partners of CPS and Probation to provide training and facilitate conversation around our services and create an open dialogue to best support with coordination of care. We have a monthly cross-systems meeting where we discuss the current census,the needs of the youth and families, any critical incidences or significant concerns, and plans for transition as clients near the end of services. We discuss each referral with the referring partner priorto calling caregivers to set up intake in order to gather pertinent information around needs and potential mental health concerns. In the event that a youth requires Specialty Mental Health Services,our team is able to support the referring partner and the caregiver in navigating the referral process;With ACCESSS joining as a referral partner we are hopeful this will be more streamlined and increase access to services for many youth/families. In regards to access/linkage to medically necessary care,we identify primary care physicians for each of our youth and complete a Child Health Questionnaire(CHQ) to identify any needed linkage/support medically, with this information we support youth andfamilies in accessing care within their county and plan.

9) **Provide the outcome measures of the customer satisfaction surveys.**

The program does not have a developed customer satisfaction survey and we are working toimplement the wraparound fidelity index (WFI). Currently we are utilizing the CANS scores to monitorand measure progress within the program.

10) **If known, provide the number of Clients referred to County Behavioral Health and the type of treatment to which Clients were referred.**

Fourteen youth were referred and linked to SMHS County Behavioral Health either due to alreadybeing open with a provider or qualifying for services due to acuity of mental health needs.

11) **If known and if applicable, provide information on Client self-report on the duration of untreated mental illness.**

One of our youth referred and receiving services ongoing has had a history of mental health servicesthat recommended treatment was not received for; that youth did not qualify for EPSDT/SMHS serviceon account of private insurance though has been participating well and is set to successfully completethe program. Many other youth either self-reported or caregiver(s) reported history of untreated or relapsed mental illness and did qualify for EPSDT/SMHS and were of the 15 closed to higher care and linked appropriately.

12) **If known, provide the average interval between mental health referral and participation in treatment.**

Information regarding mental health referral to date of open when youth are referred out is unknown.The average time between referral to prevention wraparound to intake averaged 16 days; this is witha couple of outliers including one 55 day referral to open due to communication around potentially referring to SMHS in lieu of Prevention Wraparound services. Once the initial intake assessment appointment occurs, depending on family needs support can begin immediately.

13) **If known, the number of individuals who followed through on the referral and engaged in treatment.**

Upon receiving referral, our clinician calls the referring partner (CPS Social Worker or Probation Officer) to discuss the referral and gather any pertinent information before contacting the caregiver.The clinician then calls the identified caregiver on the referral and provides information about the program and the roles within the team. At this time they explain the intake assessment and planningprocess in order to answer any questions the caregiver may have and they set up a time for intake. Our facilitator also provides a reminder call or text (depending on caregiver's preference) prior to theappointment. We have a streamlined intake and assessment process in order to be able to develop aplan for services with the family's voice and choice at the forefront by the second or third appointment, typically with the treatment plan signed and active services occurring by week three.

14) **If known, provide a description of the methods Contractor used to encourage Client access to services and follow-through on referrals.**

The opening clinician coordinates with the referring partner to explore any higher level needs or linkage prior to the intake appointment as well as any other concerns the referring partner finds pertinent. The opening clinician attempts to engage the listed caregiver within 24-48 hours from receipt of referral to

discuss the program and explore ways in which the program can support the youth and family. The opening clinician provides their next available 2-3 appointments and works with the caregiver to identify a time and place most convenient for the family to engage in the intakeprocess (home, community, the office, school, etc.). When experiencing difficulty in initially reachingthe listed caregiver or following any missed intake appointments, the clinician will then coordinate further with the referring system partner as a means of reaching the family and gaining buy-in. If thisis not possible and phone calls are not being returned a letter is sent as a means to reach the family in the event that phones are out of service.
Once services have started, our team utilizes the principles of Wraparound and with a team-based approach work to build rapport, learn about the family's unique family culture, identifies what's mostimportant to the family to work on for purpose of buy-in, and explore from a strength-based approachwhat's working or what could be improved throughout services in order to make progress toward theidentified objective.

15) Provide total project expenditures and the type and dollar amount of leveraged resources and/or in-kind contributions.

Information about expenditures can be accessed via the invoices, and a quarterly total can be provided when it becomes available.

16) Provide any additional relevant information.

No additional information provided.

MHSA Year-End Progress Report FY 2020/2021

Mental Health First Aid and Community Education Project

Provider: El Dorado County Health and Human Services Agency, Behavioral Health Division

Project Goals:

- Raise personal awareness about mental health, including increasing personal recognition of mental illness risk-factors.
- Community members us the knowledge gained in the training to assist those who may be having a mental health crisis until appropriate professional assistance is available. Opens dialogue regarding mental health, mental illness risk factors, resource referrals, and suicide prevention. Work towards stigma and discrimination reduction in our communities and networks.

Numbers Served and Cost

Expenditures	FY 2018-19	FY 2019-20	FY 2020-21
MHSA Budget	$120,000	$120,000	$113,000
Total Expenditures	$30,207	$29,907	$10,378
Unduplicated Individuals Served	274	119	29
Cost per Participant	$110	$251	$358
Number of Classes			
Youth	6	54	1
Adult	11	65	2
Veterans	0	0	0
Cost per Class	$1,777	$251	$3,459

Outcome Measures

- **Measurement 1: Class evaluation provided to attendees at the end of each session.**
- **Measurement 2: Evaluation survey provided to attendees six (6) months after taking the class, including information regarding application of material learned.**
  Outcome information is not currently available.

LGBTQIA Community Education Project

Provider: El Dorado County Health and Human Services Agency, Behavioral Health Division

Project Goals:

- Reduction of stigma and discrimination associated with being lesbian, gay, bisexual, transgender, or questioning.
- Education, in the form of presentations/discussions, to the general public regarding sexual orientation.

Numbers Served and Cost

Expenditures	FY 2018-19	FY 2019-20	FY 2020-21
MHSA Budget	$5,000	$10,000	$10,000
Total Expenditures	$82	$0	$0

Outcome Measures

- **Number of informing material distributed.**

- **Number of people reached through presentations.**

- Each Mind Matters regularly sends El Dorado County MHSA new LGBTQIA informing materials.

Statewide PEI Projects

Provider: CalMHSA

Project Goals:

- Reduce the stigma and discrimination associated with mental illness, prevent suicide, and improve student mental health.

Numbers Served and Cost

Expenditures	FY 2018-19	FY 2019-20	FY 2020-21
MHSA Budget	$55,000	$60,000	$60,000
Total Expenditures	$58,253	$60,000	$58,253

MHSA Year-End Progress Report FY 20/21

Parenting Classes Project

Provider: El Dorado County HHSA, Social Services Division/Child Welfare Services

Project Goals

- Improvement in the caregiver-child relationship.
- Reduction in problematic behaviors at home, in school, and in the community.
- Reduction in dollars spent on mental health services, special education, and criminal justiceinvolvement.

Numbers Served and Cost

Expenditures	FY 2019-20	FY 2020-21
MHSA Budget	$100,000	$100,000
Total Expenditures	$24,917* *See response toquestion #1 below	$ 45,710
Unduplicated Individuals Served	34	54
Cost per Participant	$733	$846
Age Group	**FY 2019-20**	**FY 2020-21**
0-15 (children/youth)	0	0
16-25 (transitional age youth)	3	3
26-59 (adult)	28	43
Ages 60+ (older adults)	1	0
Unknown or declined to state	2	8
Race	**FY 2019-20**	**FY 2020-21**
American Indian or Alaska Native	4	2
Asian	0	0
Black or African American	0	0
Native Hawaiian or Other Pacific Islander	1	0
White	15	40
Other	3	2
Multiracial	0	2
Unknown or declined to state	11	8
Ethnicity by Category	**FY 2019-20**	**FY 2020-21**
Hispanic or Latino	unknown	unknown
Caribbean	unknown	unknown
Central American	unknown	unknown
Mexican/Mexican-American/Chicano	unknown	1
Puerto Rican	unknown	2

South American	unknown	unknown
Other	unknown	6
Unknown or declined to state	2	0
Non-Hispanic or Non-Latino		
African	unknown	unknown
Asian Indian/South Asian	unknown	unknown
Cambodian	unknown	unknown
Chinese	unknown	unknown
Eastern European	1	2
Filipino	unknown	unknown
Japanese	unknown	unknown
Korean	unknown	unknown
Middle Eastern	unknown	unknown
Vietnamese	unknown	unknown
Other	unknown	22
Multi-ethnic	unknown	unknown
Unknown or declined to state	31	21
Primary Language	**FY 2019-20**	**FY 2020-21**
Arabic	0	0
Armenian	0	0
Cambodian	0	0
Cantonese	0	0
English	34	49
Farsi	0	0
Hmong	0	0
Korean	0	0
Mandarin	0	0
Other Chinese	0	0
Russian	0	0
Spanish	0	0
Tagalog	0	0
Vietnamese	0	0
Unknown or declined to state	0	5
Sexual Orientation ***Collection of this information from a minor younger than 12 years of age is not required.***	**FY 2019-20**	**FY 2020-21**
Gay or Lesbian	unknown	unknown
Heterosexual or Straight	4	28
Bisexual	unknown	1
Questioning or unsure of sexual orientation	unknown	unknown
Queer	unknown	unknown
Another sexual orientation	1	1
Declined to State	29	24

Gender **Collection of this information from a minor younger than 12 years of age is not required.*	**FY 2019-20**	**FY 2020-21**
Assigned sex at birth:		
Male	13	21
Female	14	27
Declined to answer	7	6
Current gender identity:		
Male	13	22
Female	14	27
Transgender	unknown	unknown
Genderqueer	unknown	unknown
Questioning / unsure of gender identity	unknown	unknown
Another gender identity	unknown	unknown
Declined to answer	7	5
Disability	**FY 2019-20**	**FY 2020-21**
Difficulty seeing	1	4
Difficulty hearing or having speech understood	0	3
Mental disability including but not limited to learningdisability, developmental disability, dementia	2	3
Physical/mobility	2	1
Chronic health condition/chronic pain	1	2
Other (specify)	1	2
Declined to state	5	43
Veteran Status **Collection of this information from a minor younger than 12 years of age is not required.*	**FY 2019-20**	**FY 2020-21**
Yes	1	0
No	29	41
Unknown or declined to state	4	13
Region of Residence	**FY 2019-20**	**FY 2020-21**
West County	8	6
Placerville Area	10	14
North County	4	4
Mid County	unknown	6
South County	unknown	1
Tahoe Basin	3	11
Unknown or declined to state	11	(includes out of county and state)
Economic Status	**FY 2019-20**	**FY 2020-21**
Extremely low income	unknown	6
Very low income	unknown	1
Low income	5	17
Moderate income	4	5

High income	unknown	0
Health Insurance Status	**FY 2019-20**	**FY 2020-21**
Private	6	2
Medi-Cal	19	33
Medicare	1	0
Uninsured	unknown	4

Annual Report FY 2020/21

Please provide the following information for this reporting period:

1) **Briefly report on how implementation of the Parenting Classes project is progressing (e.g., whether implementation activities are proceeding on target and as described in the County's MHSA Plan), and any major accomplishments and challenges.**

We began this fiscal year in a pandemic which altered the original delivery of services from an in person format to online conferencing. As we moved further into the year, we prepared packets for clients which could be picked up or mailed to participants as a way to deliver a high quality group while still maintaining social distancing and Agency safety protocols. As the year progressed, we identified additional participant needs that were not covered by the original Nurturing Parenting Group. We implemented appropriate changes to our curriculum and launched a Parent Engagement group to assist participants entering our system in understanding: 1) why they are involved in Child Protective Services (CPS), 2) CPS dynamics and the court process, 3) their responsibility for what has occurred and 4) how to receive support and advocate for themselves.

2) **Briefly report on how the Parenting Classes project has improved the overall mental health of the children, adults, older adults, families, and communities by addressing the primary negative outcomes that are the focus of the Parenting Classes project: (1) school failure or dropout and (2) removal of children from their homes. Please include other impacts, if any, resulting from the Parenting Classes project on the other five negative outcomes addressed by PEI activities: (1) suicide; (2) incarceration; (3) unemployment; (4) prolonged suffering; and (5) homelessness.**

More than half of the parents in our class had their children removed from their care due to safety issues while the other half maintained custody of their children while participating in a voluntary case with the Agency. The Parent Engagement Group is available for parents at the beginning of their case whether the case was voluntary or court ordered. This class format allows us to answer participants' initial questions regarding involvement with the Agency, including court interaction, substance abuse treatment, therapy referrals, etc. Additionally we begin to lay the groundwork to help them to understand harm and danger and why this is a cornerstone of their case plans as it drives services.

The Parent Engagement Group helps improve the mental health of participants by reducing their anxiety due to interactions with our Agency, providing them a venue to ask questions that may have not been answered by their social worker, providing them a space to work through what occurred or was brought to light during their investigation and helping them identify their own support network. Our Nurturing Parenting class assists parents to learn age appropriate developmental milestones, expectations, and consequences for their children as well as parentalbehaviors, parenting techniques and supervision necessary for keeping their children

safe.
Mastery of these skills assists parents to avoid CPS involvement and reduce re-entry into the CPS system. It cannot be underestimated the importance of community support and the positive impact on parents when their natural supports are identified. The parents in this group receive support from the facilitators in group and individually. Additionally, they receive support from each other; they share details of their situations in confidential space, free from judgement. In theory, this reduces their risk of suicide, incarceration, and prolonged suffering.

3) Provide a brief narrative description of progress in providing the Parenting Classes project servicesto unserved and underserved populations.

Parenting classes that address the specific needs of the families served by the Agency are difficult to find and often not available in a drop-in format. Additionally, due to the pandemic our community saw a decrease in the availability of community parenting classes. Prior to our classes, parents involved in CPS services often waited for class openings which created a barrier to services for families experiencing a high degree of stress, conflict and anxiety.

Our class design specifically addressed known barriers to service delivery and access for this particular participant population; social workers merely referred parents at the time of detention or when their case opened for voluntary services. The group facilitators then reached out to parents and coordinated their entry into the classes. Additionally, our model allowed facilitators to work with parents that missed classes to ensure they not only received the class materials and instruction but understood the application for their unique situation. Participants are not exited from a group due to their inability and/or failure to participant according to a set schedule. Furthermore, our groups are now available over the internet so any parent with a cell phone or computer access can participate, including parents residing in the SLT Basin.

Finally, due to the online format, we were able to accommodate several parents residing in different locales; in the past, these parents had to seek services from their community whichoften delayed and/or fragmented services.

4) Provide a brief narrative description of how the Parenting Classes services are provided in a culturally and linguistically competent manner, including activities to reduce racial/ethnicdisparities.

Our parenting program addresses the specific needs of each individual family. Therefore, facilitators identify parents' strengths and areas of concern as well as any cultural customs andbeliefs that must be considered in order to provide the most effective support and interventions. Additionally, translators are provided when needed though one facilitator is certified to translate for Spanish speaking parents.

5) Provide a brief description of activities performed related to local and county-wide collaboration, outreach, access/linkages to medically necessary care, stigma reduction and discrimination reduction.

The parenting group was started after a countywide collaboration between CPS, our local community HUBS and other local service providers. Our specific group works to reduce stigma often associated with CPS involvement by providing participants with dedicated space to take ownership over the circumstances leading to CPS intervention. In other community parenting groups, it can be hard for families to discuss the sensitive issues that led to CPS involvement further exacerbating feelings of isolation and shame. Participants in our classes express

appreciation for the freedom to share their story and experiences with others in similar situations.

Unfortunately, parents' real needs and concerns can be overlooked and unaddressed because they are reticent and/or struggle to honestly convey the myriad of complicating factors that are often at the heart of parents' struggles to effectively parent their children. Parents avoid topics of parental drug use, child abuse, neglect and domestic violence for fear of Agency involvement.Our parenting groups are unique in that we address these needs directly through close collaboration and communication with parents' service providers to ensure that the families areaddressing the more critical and relevant issues. As previously mentioned, we also work with the participants to help them identify and understand how and why they became involved with CPS.

6) Provide the outcomes measures of the services provided and of customer satisfaction surveys. Outcome measures for the Parenting Classes project are:

Identifying a customer satisfaction survey that effectively addresses participants' feedback in a way that is timely and respects privacy has proven challenging. Due to the pandemic, FY 20/21 class format occurred solely over Zoom thus satisfaction surveys were primarily sent to parents through email. Ethically, the decision not to tie the return of a survey to class graduation/completion enables parents to provide any type of feedback, both positive and negative, without fear it will negatively affect their case status. An unintended consequence of this has been that we only received three participant surveys. Because our return rate for the participant survey is so poor it effectively skewed any data we did collect.The Agency is actively exploring other options and are hopeful we can obtain more feedback in the comingmonths.

Measurement 2: Participant surveys.

The participant survey contains the questions listed below and asks parents to rate their answers using anumber scale from zero to five (0 – 5) with zero representing the least satisfaction and five the highest satisfaction. It also provides space for participants to give other feedback.

How did you like the group?
Was the class time convenient for you? If no, what would work better?
Was the room comfortable? If no, what would make it more
comfortable?
Was the location of the group convenient for you? If no, what would work better?
Did you think the facilitators did a good job?
What is one thing you liked about the group?
What is one thing that could make the group better?
Would you attend another group like this? Why or why not?
Please write your suggestions for the topics you would like to see covered in group below:

7) Unduplicated numbers of individuals served, including demographic data.

We served 37 new individuals this fiscal year. Three of these individuals are not represented in the demographics as they did not return their intake questions. We had an additional 17 participants whobegan services during the previous fiscal year yet continued and completed

them during this reportingperiod. We differentiate participants by denoting an * (participants who started the program during FY 20/21 versus ** (participants who began in the prior year yet completed the class during this period.

8) **The number of potential responders engaged. Potential responders include, but are not limited to, families, employers, primary health care providers, visiting nurses, school personnel, community service providers, peer providers, cultural brokers, law enforcement personnel, emergency medicalservice providers, people who provide services to individuals who are homeless, family law practitioners such as mediators, child protective services, leaders of faith-based organizations, and others in a position to identify early signs of potentially severe and disabling mental illness, provide support, and/or refer individuals who need treatment or other mental health services.**

Participants in our program have the benefit of working with facilitators who are also CPS social workers. They also have a CPS social worker responsible for overall case management. The latter is primarily responsible for engagement with other "responders" depending upon the family's needs. Through the life of a family's open case with CPS, a myriad of different responders are accessed , including but not limited to community therapists, behavioral health, social services aids, probation officers, law enforcement, attorneys, other community providers as well as family support members. An estimate for the potential number of responders engaged can range from a low of 60 but could beas high as 100 or more as we work with a minimum of two responders per client.

9) **The setting(s) in which the potential responders were engaged.**
Facilitators engage with potential responder's primarily through Child and Family Team meetings (CFT), phone calls and emails.

10) **The type(s) of potential responders engaged in each setting (e.g., nurses, principles, parents).**

During a CFT, there are required participants and the Agency identifies other individuals including thefamily's own support network as long as the parents want them in attendance. Facilitators use emailand the telephone to contact individual Social Workers, therapists, case aids, probation officers, lawyers, community service providers, drug treatment counselors, Alta Regional staff and any other community partner applicable to a specific case as long as we have the requisite releases informationsigned.

11) **If known, the number of individuals with serious mental illness referred to treatment and the kind of treatment the individual was referred to.** Self-reported -m3, suspected - 1, referred for treatmentthrough behavioral health – 4. It is safe to conjecture that all the participants in the CPS group experience some type of mental health issue, such as depression, anxiety, dysregulated emotions; yeta smaller number actually present with serious mental illness.

12) **If known, the number of individuals who followed through on the referral and engage in treatment.**
Unknown

a. **If known, the average duration of untreated mental illness.** Unknown

13) **If known, the interval between the referral and participation in treatment.** Unknown

14) **Provide total project expenditures and the type and dollar amount of leveraged resources and/orin-kind contributions.**

Total project expenditures for FY20/21 was $45,709.77. The breakdown by quarter is as follows:

Q1: $8,830.10

Q2: $9,190.72

Q3: $9,947.26

Q4: $17,741.69

T: $45,709.77

15) **Provide any additional relevant information.**

None

Community Education and Parenting Classes Project

Provider: Summitview Child and Family Services

Project Goals

- Improvement in the caregiver-child relationship.
- Reduction in problematic behaviors at home, in school, and in the community.
- Reduction in dollars spent on mental health services, special education, and criminal justice involvement.

Numbers Served and Cost

Expenditures	FY 2018-19	FY 2019-20	FY 2020-21
MHSA Budget	$19,500	$19,500	$19,500
Total Expenditures	$17,856	$15,725	$13,000
Unduplicated Individuals Served	150	105	59
Cost per Participant	$119	$149	$220
Age Group	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
0-15 (children/youth)	0	6	0
16-25 (transitional age youth)	7	8	2
26-59 (adult)	98	66	42
Ages 60+ (older adults)	16	12	14
Unknown or declined to state	29	13	1
Race	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
American Indian or Alaska Native	5	3	1
Asian	1	3	0
Black or African American	5	1	4
Native Hawaiian or Other Pacific Islander	1	2	1
White	102	79	51
Other	0	0	0
Multiracial	3	4	2
Unknown or declined to state	33	13	0

Ethnicity by Category	FY 2018-19	FY 2019-20	FY 2020-21
Hispanic or Latino	0	3	1
Caribbean	0	0	0
Central American	0	0	1
Mexican/Mexican-American/Chicano	10	1	1
Puerto Rican	0	1	0
South American	0	0	0
Other	0	0	0
Unknown or declined to state	0	0	0
Non-Hispanic or Non-Latino			
African	5	1	1
Asian Indian/South Asian	1	1	0
Cambodian	0	0	0
Chinese	0	0	0
Eastern European	1	0	0
Filipino	1	1	1
Japanese	1	0	0
Korean	0	1	0
Middle Eastern	0	0	0
Vietnamese	0	0	0
Other	0	5	0
Multi-ethnic	0	4	2
Unknown or declined to state	131	87	55
Primary Language	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
Arabic	0	0	0
Armenian	0	0	0
Cambodian	0	0	0
Cantonese	0	0	0
English	122	92	58
Farsi	0	0	0
Hmong	0	0	0
Korean	0	0	0
Mandarin	0	0	0
Other Chinese	0	0	0
Russian	0	0	0
Spanish	0	0	1
Tagalog	0	0	0
Vietnamese	0	0	0
Unknown or declined to state	28	13	0
Sexual Orientation **Collection of this information from a minor younger than 12 years of age is not required.*	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
Gay or Lesbian	10	0	1

Heterosexual or Straight	120	86	55
Bisexual	0	3	3
Questioning or unsure of sexual orientation	0	0	0
Queer	0	2	0
Another sexual orientation	0	0	0
Declined to State	20	14	0
Gender ****Collection of this information from a minor younger than 12 years of age is not required.***	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
Assigned sex at birth:			
Male	unknown	29	9
Female	unknown	61	50
Declined to answer	unknown	15	0
Current gender identity:			
Male	unknown	28	9
Female	unknown	61	50
Transgender	unknown	2	0
Genderqueer	unknown	0	0
Questioning / unsure of gender identity	unknown	1	0
Another gender identity	unknown	0	0
Declined to answer	unknown	13	0
Disability	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
Difficulty seeing	unknown	0	0
Difficulty hearing or having speech understood	unknown	2	0
Mental disability including but not limited to learning disability, developmental disability, dementia	unknown	5	10
Physical/mobility	unknown	0	5
Chronic health condition/chronic pain	unknown	2	5
Other (specify)	unknown	1	7
Declined to state	unknown	95	32

Veteran Status *Collection of this information from a minor younger than 12 years of age is not required.*	FY 2018-19	FY 2019-20	FY 2020-21
Yes	5	11	3
No	unknown	unknown	54
Unknown or declined to state	145	94	2
Region of Residence	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
West County	35	28	23
Placerville Area	36	41	20
North County	6	3	2
Mid County	7	6	2
South County	0	0	0
Tahoe Basin	0	1	1
Unknown or declined to state	66	26	11
Economic Status	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
Extremely low income	2	4	0
Very low income	4	4	6
Low income	25	11	9
Moderate income	73	61	40
High income	13	12	4
Health Insurance Status	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
Private	92	78	31
Medi-Cal	19	15	7
Medicare	11	5	8
Uninsured	3	1	0

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Implementation

- The Covid-19 pandemic interfered with presenting the Nurtured Heart Approach (NHA) day-long trainings during the 2020/21 fiscal year. Eventually the decision was made to provide training via Zoom instead of in-person given the restrictions on gatherings. The first training via Zoom was offered in the Spring of 2021.

- All those who attend the one-day training are offered 6 half-hour follow-up phone coaching sessions to support their use of the approach. Parents and caregivers (and their children) were under increased stress during this fiscal year given the pandemic and its attendant uncertainties, anxieties, and demands. An effort was made to reach out to previous training attendees who had not used their follow-up phone coaching sessions to support them in using the Nurtured Heart Approach. This produced an increase in parents and caregivers accepting help and support in using the approach via phone coaching.

Fiscal

- Total expenditures during the 2019-20 fiscal year were $13,000.
- There were no leveraged resources or in-kind contributions.
- Cost per participant was $220.

Underserved Populations

- There has been some success in reaching underserved populations in terms of socioeconomic status. Twenty-five percent of attendees who provided demographic information indicated that they are in low to very low income brackets. Health insurance status also suggested that we are reaching some people who are economically disadvantaged; 25% of respondents indicated that they have Medi-Cal or Medicare.

Cultural Competency

- The presenter Jennifer Lotery, Ph.D. (who is also the provider of follow-up Nurtured Heart Approach coaching sessions) is a Clinical Psychologist who was trained at UCLA, where she received specialty training in the areas of developmental and community psychology. (Community psychology training is focused on providing psychological tools and support in a culturally sensitive manner and empowering community members to be agents of positive change in improving mental health and the functioning of their families and communities). The presenter has worked with El Dorado County residents from various ethnic groups and socioeconomic backgrounds for over thirty years.

- The Nurtured Heart Approach materials and the examples which are given during the training are designed to be applicable to a variety of cultures and backgrounds. The videos shown of the approach in action feature people of various races and ethnicities.

- The follow-up phone coaching sessions provide the opportunity to individualize feedback and suggestions in a manner sensitive to the participant's cultural background.

Outreach Activities

- The availability of Nurtured Heart Approach trainings is communicated to a variety of agencies and organizations throughout El Dorado County including private practice therapists, mental health agencies, the head of Foster and Kinship Education, Community Hub leaders, and educators (teachers, counselors, and school administrators) who can share the information with students' parents.

- The training is publicized to a variety of individuals and organizations who provide parent support and education including Choices for Children and First 5.

- Data provided by participants in terms of how they heard about the Nurtured Heart Approach training during the 2019-20 fiscal year (the most recent year in which the data was collected) broke down as follows:

  Therapist or mental health agency: 33%
  Agencies providing parent help or education: 9%
  School personnel or school district: 7%
  Flyer: 9%
  Juvenile judicial system and/or CPS: 3%
  Substance abuse treatment agency: 2%
  "Email" 4%
  Friend or relative: 20%

"Work": 9%
Other: 4%

Linkage with other services

- Parents and caregivers who attend trainings are provided with information about services available in the county which provide support and/or parent education and/or counseling. Those parents who participate in follow-up phone coaching receive additional personalized help identifying resources as needed.

Stigma Reduction

- Regarding stigma reduction, the Nurtured Heart Approach effectively re-frames the qualities that often get children and teens diagnosed with mental illness as potentially effective, adaptive qualities when successfully channeled. For example, the stubbornness and resistance that gets diagnosed as Oppositional Defiant Disorder can reframed and developed as determination and persistence. The Nurtured Heart Approach helps bring out the positive aspects of young people and helps their parents see them as less mentally ill. In turn, young people see themselves as less disordered and feel less stigmatized and their behavior improves.

Outcomes

Participant Surveys:

- Participants rated the presentation materials on a scale of 1 to 10. The average score was 8.6
- Participants rated the presenter's delivery on a scale of 1 to 10. The average score was 8.7
- Participants were asked to answer Yes or No regarding whether the presentation met or exceeded their expectations and 93% of respondents answered Yes.
- Participants were asked to answer Yes or No regarding whether they would recommend the Nurtured Heart Approach to family or colleagues and 100% responded Yes.

Peer Partner Project

Provider: Stanford Sierra Youth & Families

Project Goals

- Engage youth and parents more fully in the child welfare case planning and services process.
- Provide informal supports to families by providing linkage to community resources that will support the efficacy of the family system.
- Empower families to make changes to address trauma and hardship, to keep families healthy, safe, and together.

Numbers Served and Cost

Expenditures	FY 2018-19	FY 2019-20	FY 2020-21
MHSA Budget	$$275,000	$275,000	$275,000
Total Expenditures	$28,712	$241,519	$262,347
Unduplicated Individuals Served	5	33	44
Cost per Participant	$5,742	$7,319	$14,204
Age Group	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
0-15 (children/youth)	5	4	3
16-25 (transitional age youth)	0	8	14
26-59 (adult)	0	22	32
Ages 60+ (older adults)	0	0	0
Unknown or declined to state	0	0	0
Race	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
American Indian or Alaska Native	0	1	2
Asian	0	0	0
Black or African American	0	0	0
Native Hawaiian or Other Pacific Islander	0	0	0
White	3	30	44
Other	1	2	2
Multiracial	1	1	1
Unknown or declined to state	0	0	0

Ethnicity by Category	FY 2018-19	FY 2019-20	FY 2020-21
Hispanic or Latino	0	0	0
Caribbean	0	0	0
Central American	0	0	0
Mexican/Mexican-American/Chicano	1	2	4
Puerto Rican	0	0	0
South American	0	0	0
Other	1	3	3
Unknown or declined to state	0	0	0
Non-Hispanic or Non-Latino			
African	0	0	0
Asian Indian/South Asian	0	0	0
Cambodian	0	0	0
Chinese	0	0	0
European	0	3	2
Filipino	0	0	0
Japanese	0	0	0
Korean	0	0	0
Middle Eastern	0	0	0
Vietnamese	0	0	0
Other	3	26	37
Multi-ethnic	0	0	2
Unknown or declined to state	0	0	1
Primary Language	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
Arabic	0	0	0
Armenian	0	0	0
Cambodian	0	0	0
Cantonese	0	0	0
English	5	34	47
Farsi	0	0	0
Hmong	0	0	0
Korean	0	0	0
Mandarin	0	0	0
Other Chinese	0	0	0
Russian	0	0	0
Spanish	0	0	0
Tagalog	0	0	0
Vietnamese	0	0	0

Unknown or declined to state	0	0	2

Sexual Orientation ***Collection of this information from a minor younger than 12 years of age is not required.**	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
Gay or Lesbian	0	0	0
Heterosexual or Straight	3	30	42
Bisexual	1	3	7
Questioning or unsure of sexual orientation	0	0	0
Queer	0	0	0
Another sexual orientation	0	0	0
Unknown or declined to state	1	1	0
Gender ***Collection of this information from a minor younger than 12 years of age is not required.**	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
Assigned sex at birth:			
Male	1	5	12
Female	4	29	37
Unknown or declined to answer	0	0	0
Current gender identity:			
Male	1	5	11
Female	3	28	36
Transgender	0	0	1
Genderqueer	1	1	1
Questioning / unsure of gender identity	0	0	0
Another gender identity	0	0	0
Unknown or declined to answer	0	0	0
Disability	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
Difficulty seeing	0	7	12
Difficulty hearing or having speech understood	0	0	0
Mental disability including but not limited to learning disability, developmental disability, dementia	1	5	10
Physical/mobility	0	1	2
Chronic health condition/chronic pain	0	6	6
Other (specify)	0	0	0
Declined to state	0	0	28
Veteran Status ***Collection of this information from a minor younger than 12 years of age is not required.**	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**

Yes	0	1	2
No	5	33	47
Unknown or declined to state	0	0	0
Region of Residence	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
West County	0	5	9
Placerville Area	3	12	18
North County	0	2	5
Mid County	0	3	3
South County	0	0	1
Tahoe Basin	1	2	1
Unknown or declined to state	1	8	12
Economic Status	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
Extremely low income	0	12	25
Very low income	0	12	8
Low income	0	3	8
Moderate income	5	7	8
High income	0	0	0
Health Insurance Status	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
Private	0	1	3
Medi-Cal	5	31	43
Medicare	0	0	1
Uninsured	0	2	2

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Please provide the following information for this reporting period:

1) **Briefly report on how implementation of the Peer Partner project is progressing (e.g., whether implementation activities are proceeding on target and as described in the County's MHSA Plan), and any major accomplishments and challenges.**

Stanford Sierra Youth and Families team consists of two Parent partners and is currently actively looking to hire a Youth Advocate to fill the vacant position. Services implemented by the Parent Partners focus on support to clients to achieve wellness, recovery and resilience by building protective factors and networks of natural supports. This is being achieved through a number of approaches and modalities such as Seeking Safety (evidenced based practice) being utilized through the Youth Advocate. The CANS is the tool being utilized to identify and reduce negative outcomes that result from untreated mental illness as well as identify areas of need to build protective factors for the parent whose child(ren) have been removed. The Transitional Readiness Scales helps the youth and parent identify the 7 key factors necessary for resilience and efficacy and supports the family in building a plan to address low scoring areas.
Parent Partners attended (CMHACY) California Mental Health Advocates for Children and Youth conference virtually. Due to Covid-19 pandemic. Engagement with families has continued to be on virtual platforms due

to COVID-19 pandemic. Except in extreme cases or crisis where in person has been deemed more effective or necessary. Team members follow and utilize State and Local recommended social distancing and wear recommended PPE. Parent partners have shifted to monthly support groups Via Telehealth method to support the Families of the community. Topics such as, Navigating the child welfare system, Effects of childhood trauma, Overcoming addiction, Building healthy lifestyle and reaching set goals. In order to continue to support our Youth and Families through these challenging times, the warm-line has remained available for parents/caregivers that would like to check in with someone to receive additional support.

2) **Briefly report on how the Peer Partner project has improved the overall mental health of the children, families and communities by addressing the negative outcomes that are the focus of the Peer Partner Project (suicide, incarcerations, prolonged suffering, homelessness, unemployment, school failure or dropout, and removal of children from their homes).**

Mom who has struggled with substance use and recently lost her two older children has managed to maintain sobriety, engage in all services, has demonstrated setting healthy boundaries and has navigated through her challenges effectively. Mom has been accepted into a medical assisting training program to complete her externship to start her medical career and is maintaining her maintenance with her youngest son. Mom has been able to work on building trust and communication with her social worker to promote success and progress with mom's case.

3) **Provide a brief narrative description of progress in providing services through the Peer Partner project to unserved and underserved populations. Underserved is defined in California Code of Regulations 3200.300 as "clients of any age who have been diagnosed with a serious mental illness and/or serious emotional disturbance and are receiving some services but are not provided with the necessary opportunities to support their recovery, wellness, and/or resilience. These clients include, but are not limited to, those who are so poorly served that they are at risk of homelessness, institutionalization, incarceration, out-of-home placement, or other serious consequences."**

The Peer Partner program is progressing in services to underserved and unserved populations by bridging communication with social workers, treatment staff and other community supports that can offer more resources and services. The Peer Partner program has also offered support groups, facilitated meetings with community partners and engaged with clients in treatment facilities and out of home placements.

4) **Provide a brief narrative description of how the Prevention Wraparound Services are provided in a culturally and linguistically competent manner, including activities to reduce racial/ethnic disparities.**

Peer Partners receive training in cultural responsiveness and address individual cultural needs with each youth and family. Peer Partners are also trained in recognizing implicit bias, community trauma, and encourage families to openly communicate their needs with other community providers and workers. Peer partners have access to interpreter services as needed. Peer Partners receive and attend Diversity equity inclusion training.

5) **Provide the number of potential responders engaged. "Potential responders" include, but are not limited to, families, employers, primary health care providers, visiting nurses, school personnel, community service providers, peer providers, cultural brokers, law enforcement personnel, community service providers, people wo provide services to individuals who are homeless, family law practitioners such as mediators, child protective services, and disabling mental illness, provide support, and /or refer individuals who need treatment or other mental health services.**

The Peer Partner program engaged a diverse range of over 200 potential responders.

6) **The setting(s) in which the potential responders were engaged. Setting providing opportunities to identify early signs of mental illness include, but are not limited to, family resource centers, senior centers, schools, cultural organizations, churches, faith-based organizations, primary health care, recreation centers, libraries, public transit facilities, support groups, law enforcement departments, residences, shelters, and clinics.**

   We engaged with potential responders in community settings, treatment facilities, child welfare office, Child and family team meeting, support groups, doctors' offices, Veterans administration, telehealth, family homes, treatment facilities, hospital settings.

7) **The types of responders engaged in each setting (e.g., nurses, principles, parents).**

   The types of responders are listed but not limited to youth and families, natural support, treatment staff, community service providers, social workers, law enforcement.

8) **If known, provide the number of Clients referred to County Behavioral Health and the type of treatment to which Clients were referred.**

   Unknown

9) **If known and if applicable, provide information on Client self-report on the duration of untreated mental illness.**

   Unknown

10) **If known, provide the average interval between mental health referral and participation in treatment.**

    Unknown

11) **If known, the number of individuals who followed through on the referral and engaged in treatment.**

    Unknown

12) **Provide the outcome measures of the services provided and of customer satisfaction surveys.**

    Parent Partner Outcomes: There were 29 clients who discharged from the Parent Partner program in 20-21 FY. Of those 29 discharges, 8 of those clients never engaged, and thus their outcomes will not be reported below in the measurements. Of the 21 parents who discharged and completed the program:

    Measurement 1 (6) clients were on the family reunification track, and (2) (100%) reunified with their youth.

    Measurement 2 (15) clients were on the family maintenance track, and (15) (100%) maintained their family unit.

    Measurement 3 (21) clients reduced child abuse and maltreatment risk factors**.**

    Youth Advocate Outcomes: N/A: There were 0 youth who discharged from Youth Advocacy in 2021 FY and thus, no data is available to report.

    Measurement 1 Report on the reduction in seven-day notices.
    Measurement 2 Report on the improvement in foster care placement stability.
    Measurement 3 Report on behavior as it relates to a decrease in maladaptive behavior.
    Measurement 4 Report on behavior as it relates to an increase in strengths.
    Measurement 5 Report on the number of discharges to permanency.

13) **Provide total project expenditures and the type and dollar amount of leveraged resources and/or in-kind contributions.**

N/A

14) Provide any additional relevant information.

The Peer Partner Program has seen much success with families this year despite challenges everyone is experiencing with the COVID-19 pandemic. The Peer Partners have been creating opportunities to connect with parents in support groups or in person with face masks. We are hopeful in hiring a new youth advocate for the Peer Partner Project and are working with our County Partners to identify an potential youth they have worked with.

Mentoring for Youth Project

Provider: Big Brothers Big Sisters of El Dorado County

Project Goals

- Determine if child or family has organically or environmentally induced mental illness concerns and develop a case plan for the child.
- Conduct parent workshops.
- Through skill building activities, mentors will develop coping mechanisms with the child.
- Through education and training, mentors normalize mental health conditions helping reduce stigma.
- Mentors reduce the effects of parental mental health issues affecting the child.
- Child will utilize skills learned to increase social and emotional development, increase academic performance, and increase socialization skills in school and public.

Numbers Served and Cost

Expenditures	FY 2018-19	FY 2019-20	FY 2020-21
MHSA Budget	$75,000	$75,000	$75,000
Total Expenditures	$75,000	$75,000	$66,165
Unduplicated Individuals Served	42	52	79
Cost per Participant	$1,786	$1,442	$838
Age Group	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
0-15 (children/youth)	42	52	63
16-25 (transitional age youth)	0	0	16
26-59 (adult)	0	0	0
Ages 60+ (older adults)	0	0	0
Unknown or declined to state	0	0	0
Race	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
American Indian or Alaska Native	0	3	2
Asian	0	0	0
Black or African American	3	5	7
Native Hawaiian or Other Pacific Islander	0	0	1
White	30	37	58
Other	0	0	3
Multiracial	0	0	0
Unknown or declined to state	0	0	0

Ethnicity by Category	FY 2018-19	FY 2019-20	FY 2020-21
Hispanic or Latino	9	7	7
Caribbean	0	0	0
Central American	0	0	0
Mexican/Mexican-American/Chicano	0	0	0
Puerto Rican	0	0	0
South American	0	0	0
Other	0	0	0
Unknown or declined to state	0	0	0
Non-Hispanic or Non-Latino			
African	0	0	0
Asian Indian/South Asian	0	0	0
Cambodian	0	0	0
Chinese	0	0	0
Eastern European	0	0	0
Filipino	0	0	0
Japanese	0	0	0
Korean	0	0	0
Middle Eastern	0	0	0
Vietnamese	0	0	0
Other	0	0	0
Multi-ethnic	0	0	0
Unknown or declined to state	0	0	0
Primary Language	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
Arabic	0	0	0
Armenian	0	0	0
Cambodian	0	0	0
Cantonese	0	0	0
English	42	52	77
Farsi	0	0	0
Hmong	0	0	0
Korean	0	0	0
Mandarin	0	0	0
Other Chinese	0	0	0
Russian	0	0	0
Spanish	0	0	2
Tagalog	0	0	0
Vietnamese	0	0	0
Unknown or declined to state	0	0	0
Sexual Orientation **Collection of this information from a minor younger than 12 years of age is not required.*	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
Gay or Lesbian	NA	NA	0

Heterosexual or Straight	NA	NA	0
Bisexual	NA	NA	0
Questioning or unsure of sexual orientation	NA	NA	0
Queer	NA	NA	0
Another sexual orientation	NA	NA	0
Declined to State	NA	NA	79
Gender **Collection of this information from a minor younger than 12 years of age is not required.*	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
Assigned sex at birth:			
Male	22	25	39
Female	20	27	40
Declined to answer	0	0	0
Current gender identity:			
Male	22	25	39
Female	20	27	40
Transgender	0	0	0
Genderqueer	0	0	0
Questioning / unsure of gender identity	0	0	0
Another gender identity	0	0	0
Declined to answer	0	0	0
Disability	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
Difficulty seeing	0	0	0
Difficulty hearing or having speech understood	0	0	1
Mental disability including but not limited to learning disability, developmental disability, dementia	0	0	45
Physical/mobility	0	0	0
Chronic health condition/chronic pain	0	0	0
Other (specify)	0	0	7
Unknown or declined to state	42	52	8
Veteran Status **Collection of this information from a minor younger than 12 years of age is not required.*	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
Yes	0	0	0
No	42	52	79
Unknown or declined to state	0	0	0

Region of Residence	FY 2018-19	FY 2019-20	FY 2020-21
West County	24	28	41
Placerville Area	13	20	23
North County	1	0	3
Mid County	2	2	8
South County	0	0	0
Tahoe Basin	2	2	4
Unknown or declined to state	0	0	0
Economic Status	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
Extremely low income	unknown	13	14
Very low income	unknown	20	26
Low income	unknown	10	24
Moderate income	unknown	7	13
High income	unknown	2	2
Health Insurance Status	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
Private	unknown	15	15
Medi-Cal	unknown	37	63
Medicare	unknown	0	0
Uninsured	unknown	0	0

Annual Report FY 2020/2021

Please provide the following information for this reporting period:

1) **Briefly report on how implementation of the Mentoring for Youth project is progressing (e.g., whether implementation activities are proceeding on target and as described in the County's MHSA Plan), and any major accomplishments and challenges.**

   The Mentoring for Youth project is progressing accordingly. This last quarter we have been able to serve the most children year to date with the funding through MHSA, in this FY 2020-2021 we ended the year serving 79 youth. This was an increase of 27 youth. While COVID is lessening, it was still a struggle for many of our matches and a huge problem for making new matches. Additionally, we continue to struggle in our most rural pockets of the county. We see a high need there for mentors but getting mentors out to those areas is difficult. We are hoping our school partnerships will be back up and running again this fall and allow us on campuses so we can match these most rural youth with mentors at their school sites. We are currently planning meetings with school partners to plan for when school opens in the fall.

2) **Briefly report on how the Mentoring for Youth project has improved the overall mental health of the children, adults, older adults, families, and communities by addressing the primary negative outcomes that are the focus of the Mentoring for Youth project (suicide, prolonged suffering, school failure or dropout, and removal of children from their homes). Please include other impacts, if any, resulting from the Mentoring for Youth project on the other four negative outcomes addressed by PEI activities: (1) incarceration; (2) unemployment; and (3) homelessness.**

   All children can benefit from time with a mentor, and the impact can be huge and range from suicide prevention, addiction reduction, bullying decrease, higher self-esteem and more. The power of a mentor benefits the child that is matched greatly. Children being served by the BBBS program experience single parent homes, parental or childhood mental health issues, physical issues, low economic status, homelessness, unemployment, parental/caregiver incarceration and sometimes children experience

multiple risk factors. All of the children served by Big Brothers Big Sisters gain consistency and stability from their Big. They know they can rely on them for their regular visits and can be a normal kid while they are with them. Overall, the mental health has improved with improved educational outcomes, peer relationships and adult relationships stronger. Bigs and parents become partners in the child's success and work together to make sure they are progressing in their educational outcomes, mental health, physical health and overall wellbeing. Additionally, the volunteers support the families with their needs, if the families are struggling in certain areas with food or housing security, the volunteers will help them in the right direction.

3) Provide a brief narrative description of progress in providing services through the Mentoring for Youth project to unserved and underserved populations.

BBBS continues to serve unserved or underserved populations in El Dorado County, by providing a volunteer Big Brother or Big Sister mentor to the children. This provides much needed social and emotional support to the youth. BBBS continues to work on ways we can serve outlying areas in the county that are more rural.

4) Provide a brief narrative description of how the Mentoring for Youth services are provided in a culturally and linguistically competent manner, including activities to reduce racial/ethnic disparities.

All of our volunteers are trained in pre-match trainings prior to their match, including ACEs, drug and alcohol, cultural competency and appropriate relationship development. Also, each match is individually case managed by a professional BBBS case manager, who will assist and coach when necessary to ensure individual needs are met and to reduce any possible disparities.

5) Provide a brief description of activities performed related to local and county-wide collaboration, outreach, access/linkages to medically necessary care, stigma reduction and discrimination reduction.

With COVID, some of our county-wide collaborations have either been put on hold or gone virtual, but we are excited that they are coming back. Big Brothers Big Sisters collaborates with several community and government agencies to adequately serve the children enrolled in programing. The majority of referrals received by BBBS come from the El Dorado County Office of Education and the local school districts. Our close relationship with local school districts allows BBBS to have ongoing access to the children in our program while they are at school, to monitor outcomes, match relationship building, collaboration for additional referrals and child safety. BBBS is involved in countywide resource meetings and collaboratives; Georgetown Ready by 5, Western Slope Community Strengthening Coalition funded by Ready by 5, ACE's collaborative, SARB, and the Early Education Planning Council. Additionally, BBBS is involved in: Kiwanis, Rotary, Tahoe Young Professionals and all local chambers.

6) Provide the outcomes measures of the services provided and of customer satisfaction surveys. Outcome measures for the Mentoring for Youth project are:

- **Child Intake: Contractor will assess child and family whenever possible, for program effectiveness.**

  Every child referral for BBBS services is assessed and placed in a program if the needs are adequate with BBBS services. Rarely, are children turned away, but at times given the circumstances they are unable to be served by BBBS. In these instances, the BBBS Enrollment Manager and/or Associate Director work at providing referrals for other services in county.

- **Volunteer Enrollment: Contractor will assess potential volunteers for acceptance into program.**

  Every volunteer is screened and trained prior to any involvement with a child. Child safety is our number one concern, and the volunteer in-person interview asks several questions to gage child safety.

Occasionally, a potential volunteer is turned away because we feel they are not a good fit for program participation.

- **Child Assessment: Contractor will use completed pre-match and annual behavior evaluations and monthly volunteer match support of all enrolled children.**

  100% of children matched with PEI funding have a pre-match and annual behavior evaluations completed. The initial evaluation is done during intake and written into the child's assessment. Annually, at the anniversary of the match, new behavior evaluations are completed. After the annual evaluations are done the child's case plan is updated with new goals individual for each child matched. Match support is done monthly for the first year of the match. This is done to make sure the match relationship is developing successfully, there are no child safety concerns and the child is progressing well towards their goals.

- **Contractor will administer Big Brothers Big Sisters pre-match and end-of-school-year surveys, such as the "Start Early" interactive survey to enrolled children.**

  The Youth Outcome Survey is given to children pre match and annually. This survey measures outcomes from 7 categories [social acceptance, scholastic competency, educational expectations, grades, risky behavior attitudes, parental trust and truancy]. 100% of youth completed a baseline YOS pre match.

  Highlights from this funding period 85.4 % reduced or had no change in their tendency towards risky behavior, 76%, had higher academic performance, 100% had no police or juvenile justice contact and 69% had higher emotional regulation.

- **Contractor will administer Big Brothers Big Sisters "Strength of Relationship" survey to volunteer mentors.**

  Strength of Relationship Surveys monitor the relationship between the Big and the Little. The highest score for a match relationship is 5- this meaning the relationship is strong, positive and worthwhile. Of the 3-month post-match surveys the average score was 4.75, of the annual surveys the average score was 4.72. This shows that, in the Little's perspective, the relationship between the Big and the is strong and they feel connected. The higher the score, the stronger the relationship is and lasts longer.

  Additionally, we have questions about feeling ignored, mad, bored, and disappointed. For these question, they all were at a 1. The Strength of Relationship is also given to the Bigs to measure their take on their match. They had similar ratings, at the 3 month with a 4.5 and annually at 4.2.

- **Contractor shall provide testimonials, as appropriate, from parents, mentors and children.**

  "I love my Little Sister! We go swimming, ride bikes, cook at my house together, go to the park…we have so much fun together!" -Big Sister

  "She is heaven sent, she is a wonderful person and I appreciate all the time and attentions she has given to my daughter." -Parent

  "I love our thoughtful conversations. Sometimes I get discouraged with school, but he encourages me and helps me stay on the right path." - Little Brother

"He has really grown up the last few years. I am proud of him, he has a job, he works hard, he's really growing into a good young man." - Big Brother

7) Unduplicated numbers of individuals served, including demographic data.

49 new matches were made- which equals 49 youth and 49 volunteers: 98 people. The remainder of the matches were matches that were carried over from previous years.

8) The number of potential responders reached by this program.

There is a total number of 79 matches supported through PED, which equates to 79 youth and 79 volunteers, total people: 158.

9) The setting(s) in which the potential responders were engaged. (Settings providing opportunities to identify early signs of mental illness include, but are not limited to, family resource centers, senior centers, schools, cultural organizations, churches, faith-based organizations, primary health care, recreation centers, libraries, public transit facilities, support groups, law enforcement departments, residences, shelters, and clinics.)

Our youth and families come from a variety of partnerships we have throughout the county. A good portion are through our school partners, but we also have referrals through CPS, and other community-based organizations. Some of our matches meet at the schools where the child attends, others meet out in the community itself. Each match is completely individual and meet the needs of the child. Case management, done by our professional case managers, are done either in person or on the phone.

10) The types of potential responders engaged in each setting (e.g., nurses, principles, parents).

Potential responders are mentors in our field. They are teachers, first responders, businesspeople, or retired. Big Brothers Big Sisters prides ourselves on pairing children with volunteers from wide backgrounds.

11) If known, the number of individuals with serious mental illness referred to treatment and the kind of treatment the individual was referred to.

Parents/guardians do not always disclose their mental illness or if their child suffers from a serious mental illness during intake. We do ask, but they choose not to divulge, and it is not required for us to know the parents' mental status for services for their child. Occasionally, children enrolled in our program will need treatment for mental treatment of some kind during our services. Of the children served with PEI there have been no known serious mental illnesses.

12) If known, the number of individuals who followed through on a referral and engaged in treatment.

N/A

13) Provide total project expenditures and the type and dollar amount of leveraged resources and/or in-kind contributions.

The total project expense of 2020/2021 was $66,165.33 with funding provided by PEI. The total expenses include staff salaries and mileage. We fell short based on our shortage on staff and the hardships of COVID. We are building staff and making more matches currently.

14) Provide any additional relevant information.

No additional information was provided.

MHSA Year-End Progress Report FY 2020/2021

Psychiatric Emergency Response Team (PERT) Project

Provider: El Dorado County Health and Human Services Agency/Behavioral Health Division and El Dorado County Sheriff's Office

Project Goals:

- Raise awareness about mental health issues and community services available.
- Improved community health and wellness through local services.
- Improve access to medically necessary care and treatment.

Numbers Served and Cost

Expenditures	FY 2018-19	FY 2019-20	FY 2020-21
MHSA Budget	$300,000	$375,000	$500,000
Total Expenditures	$379,135	$361,615	$290,949
Unduplicated Individuals Served (may be duplicated)	677	321	233
Cost per Participant	$560	$1,127	$1,249
Age Group	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
0-15 (children/youth)	54	36	25
16-25 (transitional age youth)	89	53	32
26-59 (adult)	394	169	104
Ages 60+ (older adults)	110	58	44
Unknown or declined to state	30	5	28
Race	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
American Indian or Alaska Native	18	2	3
Asian	5	11	4
Black or African American	19	27	2
Native Hawaiian or Other Pacific Islander	1	2	2
White	530	235	158
Other	0	15	5
Multiracial	12	0	0
Unknown or declined to state	37	29	61

Ethnicity by Category	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
Hispanic or Latino	0	50	101
Caribbean	0	0	0 unknown
Central American	0	2	0 unknown
Mexican/Mexican-American/Chicano	6	7	4
Puerto Rican	0	0	1
South American	0	0	0 unknown
Other	15	44	96
Unknown or declined to state	0	6	72
Non-Hispanic or Non-Latino			
African	unknown	4	1
Asian Indian/South Asian	unknown	1	1
Cambodian	unknown	0	unknown
Chinese	unknown	1	unknown
Eastern European	unknown	0	5
Filipino	unknown	1	unknown
Japanese	unknown	0	unknown
Korean	unknown	0	unknown
Middle Eastern	unknown	4	1
Vietnamese	unknown	3	unknown
Other	unknown	8	11
Multi-ethnic	8	1	112 European
Unknown or declined to state	31	72	97
Primary Language	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
Arabic	0	0	
Armenian	0	1	
Cambodian	0	0	
Cantonese	0	0	
English	647	313	198
Farsi	0	0	
Hmong	0	0	
Korean	0	0	
Mandarin	0	0	
Other Chinese	0	0	
Russian	0	0	
Spanish	3	1	1
Tagalog	0	0	
Vietnamese	0	0	
Unknown or declined to state	27	6	50
Sexual Orientation **Collection of this information from a minor younger than 12 years of age is not required.*	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
Gay or Lesbian	2	2	2

Heterosexual or Straight	580	234	77
Bisexual	6	2	2
Questioning or unsure of sexual orientation	0	0	unknown
Queer	0	1	unknown
Another sexual orientation	0	0	unknown
Declined to State	89	82	152
Gender ****Collection of this information from a minor younger than 12 years of age is not required.***	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
Assigned sex at birth:			318
Male	360	174	194
Female	310	146	124
Declined to answer	7	1	
Current gender identity:			
Male	319	170	97
Female	253	145	113
Transgender	3	3	
Genderqueer	6	0	
Questioning / unsure of gender identity	0	0	
Another gender identity	0	0	
Declined to answer	96	3	29
Disability	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
Difficulty seeing	1	1	
Difficulty hearing or having speech understood	4	2	1
Mental disability including but not limited to learning disability, developmental disability, dementia	27	24	19
Physical/mobility	16	8	5
Chronic health condition/chronic pain	38	7	7
Other (specify)	0	1	63-none
Unknown or declined to state	591	278	145
Veteran Status ****Collection of this information from a minor Younger than 12 years of age is not required.***	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
Yes	28	25	8
No	649	296	180
Unknown or declined to state	0	0	44

Region of Residence	FY 2018-19	FY 2019-20	FY 2020-21
Cameron park			18
Camino			4
Cool			5
Diamond springs			12
El Dorado			3
El Dorado Hills			23
Fairplay			1
Garden Valley			5
Georgetown			5
Grizzly Flatts			2
Lotus			1
Mt. Aukum			1
Placerville			32
Pleasant Valley			1
Pollock Pines			21
Shingle Springs			7
Somerset			4
Other			11
Economic Status	**FY 2018-19**	**FY 2019-20**	FY 2020-21
Extremely low income	61	18	14
Very low income	73	29	22
Low income	118	115	74
Moderate income	357	133	64
High income	68	26	6
Health Insurance Status	**FY 2018-19**	**FY 2019-20**	FY 2020-21
Private	215	99	52
Medi-Cal	201	98	55
Medicare	149	69	19
Uninsured	112	55	75

Note: For individuals in crisis, it may not be feasible to collect all data.

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Please provide the following information for this reporting period:

1) **If known, the number of referrals to treatment, including the kind of treatment to which the person was referred.** **23 declined referrals**

Referral	Number
Adult Protective Services	9
National Alliance on Mental Illness (NAMI)	8
Veterans Administration Services	8
Emergency Crisis Resources	40
Behavioral Health	52
Child Protective Services	4
Advocacy	0
Medical	12(does this mean Medi-Cal the insurance?)
Food/Clothing/Shelter	11
Family and Natural Supports	11
Public Guardian	11
Transportation	0
Financial Aid	1
Substance Use Disorder Services	10
Data not recorded	99

2) **If known, the number of persons who followed through on the referral and engagement in treatment, defined as the number of individuals who participated at least once in the program to which the person was referred.**

   63 people followed through with referrals

3) **The number of Welfare and Institutions Code 5150 holds written at the time of contact by PERT members.**

   -25 holds for 5150
   -166 encounters where clients were de-escalated and crisis response plan was formulated and referrals were made instead of holding 5150.

4) **If known, the average duration of untreated mental illness for individuals who have not previously received treatment.**

   Data insufficient to average. 10 years, 2 years, and "years" was only data gathered for 3 people

5) **If known, the average interval between the referral and engagement in treatment, as defined as participating in at least once in treatment to which referred.**

   Immediately – 51 responses
   On-going –
   1 Day – 4 responses

1 week – 2 responses
Rest unknown. Insufficient data

6) Report on implementation challenges, successes, lessons learned, and relevant examples.

Not available at this time

Veterans Outreach Project

Provider: Only Kindness

Project Goals

- Provide outreach and linkage to services for approximately 100 Veterans and their immediate family members annually.
- Provide a single point of entry for homeless Veterans to connect to and receive services.
- Assist Veterans with housing and reduce the number of homeless Veterans in El Dorado County.

Numbers Served and Cost

Expenditures	FY 2018-19	FY 2019-20	FY 2020-21
MHSA Budget	$261,601	$150,000	$150,000
Total Expenditures	$261,601	$150,000	$150,000
Unduplicated Individuals Served	126	157	79
Cost per Participant	$2,076	$955	$1,899
Age Group	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
0-15 (children/youth)	0	0	0
16-25 (transitional age youth)	2	2	2
26-59 (adult)	80	95	38
Ages 60+ (older adults)	44	60	39
Unknown or declined to state	0	0	0
Race	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
American Indian or Alaska Native	6	5	4
Asian	0	0	0
Black or African American	2	5	3
Native Hawaiian or Other Pacific Islander	0	0	0
White	107	137	70
Other	7	5	0
Multiracial	3	4	1
Unknown or declined to state	1	1	1

Ethnicity by Category	FY 2018-19	FY 2019-20	FY 2020-21
Hispanic or Latino	17	18	7
Caribbean	0	0	0
Central American	0	0	0
Mexican/Mexican-American/Chicano	9	9	3
Puerto Rican	0	1	0
South American	0	0	0
Other	8	1	4
Unknown or declined to state	0	7	0
Non-Hispanic or Non-Latino			
African	1	2	0
Asian Indian/South Asian	0	0	0
Cambodian	0	0	0
Chinese	0	0	0
Eastern European	0	0	0
Filipino	0	0	0
Japanese	0	0	0
Korean	0	0	0
Middle Eastern	0	0	0
Vietnamese	0	0	0
Other (Caucasian)	108	137	0
Multi-ethnic	0	0	0
Unknown or declined to state	0	0	0
Primary Language	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
Arabic	0	0	0
Armenian	0	0	0
Cambodian	0	0	0
Cantonese	0	0	0
English	117	154	79
Farsi	0	0	0
Hmong	0	0	0
Korean	0	0	0
Mandarin	0	0	0
Other Chinese	0	0	0
Russian	0	0	0
Spanish	0	0	0
Tagalog	0	0	0
Vietnamese	0	0	0
Unknown or declined to state	9	3	0
Sexual Orientation **Collection of this information from a minor younger than 12 years of age is not required.*	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
Gay or Lesbian	3	4	1

Heterosexual or straight	110	137	73
Bisexual	0	0	0
Questioning or unsure of sexual orientation	1	1	0
Queer	0	0	0
Another sexual orientation	0	1	1
Declined to State	12	14	4
Gender **Collection of this information from a minor younger than 12 years of age is not required.*	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
Gender assigned at birth:			
Male	113	131	67
Female	13	26	12
Declined to answer	0	0	0
Current gender identity:			
Male	111	126	65
Female	13	23	9
Transgender	1	2	1
Genderqueer	0	1	0
Questioning / unsure of gender identity	0	0	0
Another gender identity	0	0	0
Declined to answer	1	0	4
Disability	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
Difficulty seeing	12	26	19
Difficulty hearing or having speech understood	127	73	36
Mental disability including but not limited to learning disability, developmental disability, dementia	41	48	13
Physical/mobility	66	73	30
Chronic health condition/chronic pain	54	76	41
Other (specify)	5	13	11
Declined to state	0	0	0

Veteran Status *Collection of this information from a minor younger than 12 years of age is not required.*	FY 2018-19	FY 2019-20	FY 2020-21
Yes	124	155	78
No (Family Member)	2	2	1
Unknown or declined to state	0	0	0
Region of Residence	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
West County	12	13	7
Placerville Area	66	79	35
North County	3	16	5
Mid County	15	14	11
South County	2	5	4
Tahoe Basin	2	10	17
Unknown or declined to state	26	20	0
Economic Status	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
Extremely low income	78	104	49
Very low income	33	33	18
Low income	9	13	10
Moderate income	5	5	1
High income	2	2	1
Health Insurance Status	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
Private / Other	13	22	1
Medi-Cal	39	52	27
Medicare	14	18	13
Uninsured	16	19	5
VA	62	87	48

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Please provide the following information for this reporting period:

1) **Briefly report on how implementation of the Veterans Outreach project is progressing (e.g., whether implementation activities are proceeding on target and as described in the County's MHSA Plan), and any major accomplishments and challenges.**

   Implementation activities as described in El Dorado County's MHSA 3-year plan are very close to proceeding on target in spite of the Covid-19 crisis and its dramatic impact on outreach. VOP continues to reduce the negative consequences of untreated mental illness through connection to mental health supports or verification of such connection already in place and also by providing supportive services through times of crisis so that a Veteran's mental health remains stable. Our major accomplishments are: 1) the number of homeless Veterans who have been housed through this and other leveraged funding, 2) the collaborative success of the El Dorado County Coordinated Entry System in engaging and including homeless Veterans and connecting all Veteran service providers through a bi-weekly case management and triage work group so that we are all better able to provide services. El Dorado County is close to attaining functional non-homelessness for Veterans in our communities, per the El Dorado County Coordinated Entry System Leader. It can be extremely challenging to engage with Veterans whose mental health issues themselves inhibit the Veteran from linking to needed services. It remains difficult to assist Veterans with discharges typically not supported by

mainstream Veteran services and Veterans whose circumstances are barriers to housing and/or support, but these challenges are less of a barrier than historically.

2) **Briefly report on how the Veteran Outreach project has improved the overall mental health of veterans and their families, and how the Veteran Outreach project has addressed the negative outcomes that result from untreated mental illness (suicide, incarceration, unemployment, homelessness, prolonged suffering, school failure or dropout, and removal of children from home).**

Covid-19 forced us out of Veterans Treatment Court as service providers were not allowed into the Courthouse during the Shelter-In Place orders. This made engaging with Veterans in the Criminal Justice System more difficult. However, through increased participation in Veterans Coordinated Entry work group, VOP maintained connection to providers like VASH and probation who were in closer contact with Veterans in the Criminal Justice System, and VOP could step in to assist upon need. Successful completion of Veterans Treatment Court can reduce felonies to misdemeanors and minimize restitution requirements. This reduces the likelihood of further incarceration and positively influences a Veterans ability to acquire and sustain housing and employment. VOP continued to connect Veterans and/or their family members to needed mental health supports which minimizes prolonged suffering and suicidal ideation. Through outreach – even by phone or with personal protective measures in place - we were the trained-layman who recognized suicidal language, defied stigma and discrimination and connected with a hurting Veteran. By providing supportive services and assistance through a crisis, we can stabilize a Veteran with a mental health issue so that it is not exacerbated and we can prevent another Veteran from developing mental health issues.

3) **Provide a brief narrative description of progress in providing services through the Veterans Outreach project to unserved and underserved populations.**

Veterans were identified in the El Dorado County MHSA 3-Year Plan as an underserved group. The Veteran Outreach Project serves only Veterans and their family members with a focus on those who are homeless and/or in the criminal justice system.

4) **Provide a brief narrative description of how the Veterans Outreach services are provided in a culturally and linguistically competent manner, including activities to reduce racial/ethnic disparities.**

Intake for homeless Veterans is two-pronged as data must be included in the El Dorado County Coordinated Entry System in order for the Veteran to be placed on the County By Name List and be eligible to receive support from other service providers including VASH. Another set of data must also be collected for the Veteran Outreach Project. Intake for non-homeless Veterans involves only the data collection for the Veteran Outreach Project. Both intake processes identify any language and/or cultural barrier and ensures removal of the barrier by providing interpreters or culturally competent assistance.

5) **Provide a brief description of activities performed related to local and county-wide collaboration, outreach, access/linkages to medically necessary care, stigma reduction and discrimination reduction.**

The COVID-19 crisis negatively impacted the "walk-in" options of several Veteran service providers. El Dorado Veteran Resource (EDVR) office was closed for most of 2020 and 2021. Volunteers of American (VoA) is still doing much of their work by internet or phone although personal intakes are on the increase. Intake and assessment are ongoing through Only Kindness and can be accessed through our outreach phone line 530 344-1864 and/or via email at vets@onlykindness.net. A flyer with Available Mental Health Resources is provided to all Veterans encountered through outreach efforts and/or at intake. Other mental health information from resources such as Every Mind Matters and the Suicide Prevention Network (SPN) are handed out and made available. Through Veterans Treatment Court, Veteran participants are linked to all forms of physical and mental health as part of a mandated treatment program. We hold SPN trainings for our staff and volunteers when it is available to help reduce any stigma and discrimination that we may be unconsciously holding. As an active member of the El Dorado County Continuum of Care (EDOK), we remain informed and connected to all locale homeless service providers and through the COVID-19 crisis the EDOK has been very busy, holding many

web-based meetings to keep members informed about COVID-19 funding, Project Room Key and other unique assistance opportunities and services. EDOK and its member organizations are working on a Strategic Plan to address equity issues that are being identified through the improved collection of data and outcome reporting. Only Kindness VOP is a participant in these efforts.

6. **Provide the outcomes measures of the services provided and of customer satisfaction surveys. Outcome measures for the Veterans Outreach project are:**

- **Measurement 1: Unduplicated numbers of individuals served, including demographic data.**
  Please see pages 1 – 4 of this report for unduplicated numbers served and demographics. Note: the number served represents Veterans for whom we were able to complete full intakes and provide direct services to. Outreach is more difficult to quantify and has been negative impacted by the Covid-19 crisis and Shelter-In-Place Orders. We did do outreach in 2020 and 2021, but most large outreach events were cancelled.

- **Measurement 2: If known, the number of referrals to County Behavioral Health and the type treatment of treatment to which person was referred**
  Please note our contract specifies that Measurement 2 is: the number of referrals to treatment and the kind of treatment (not limited to County Behavioral Health Referrals only)

	MEASUREMENT 2
Referral Type (Kind of Treatment)	**Number Referrals Made to Treatment**
4 Paws 2 Freedom	0
Behavior Modification Classes (ie: DUI Wet and Reckless)	0
Community Based Substance Use Disorder Services (Tahoe Turning Point, Progress House, New Beginnings, Treehouse)	4
Community Based Support Groups	28
DV Services (The Center, LVF, Batterers programs, etc.)	0
EDC Mental Health	9
Hospital or Private Healthcare Providers	26
Mather Behavior Health/Mental Health/Alcohol Recovery	35
NAMI	0
Other	12
Private Counselor working with Veterans	24
Skilled Nursing Facilities	0
Soldiers Project	0 (closed program)
VA Based Residential Recovery Programs (Walters House, Martinez)	5
VA Medical Center	18
Veteran Centers (Citrus Heights, Reno, etc)	4
Veteran Resource Centers (SVRC, etc)	11
Windows to My Soul, Equine Therapy	11
Total	**187**

- **Measurement 3: If known, the number of persons who followed through on the referral and engaged in treatment, defined as the number of individuals who participated at least once in the Program to which the person was referred.**

Referral Type (Kind of Treatment)	Number of Referrals that Clients Followed Through With
4 Paws 2 Freedom	0
Behavior Modification Classes (ie: DUI Wet and Reckless)	0
Community Based Substance Use Disorder Services (Tahoe Turning Point, Progress House, New Beginnings, Treehouse)	4
Community Based Support Groups	5
DV Services (The Center, LVF, Batterers programs, etc.)	0
EDC Mental Health	3
Hospital or Private Healthcare Providers	10
Mather Behavior Health/Mental Health/Alcohol Recovery	5
NAMI	0
Other	5
Private Counselor working with Veterans	4
Skilled Nursing Facilities	0
Soldiers Project	0 (closed program)
VA Based Residential Recovery Programs (Walters House, Martinez)	1
VA Medical Center	3
Veteran Centers (Citrus Heights, Reno, etc)	2
Veteran Resource Centers (SVRC, etc)	0
Windows to My Soul, Equine Therapy	2
Total	**40**

- **Measurement 4: If known, the average duration of untreated mental illness for individuals who have not previously received treatment.**

Time between Start Date of Mental Illness and Date Entered into Project	
LessthanOneYear	6
OnetoTwoYears	2
ThreetoFiveYears	5
SixtoTenYears	9
MorethanTenYears	42

- **Measurement 5: If known, the average interval between the referral and engagement in treatment, defined as participating at least once in the treatment to which referred.**

Average Time (Years) between Start Date of Mental Illness and Date Entered into Project	
Average Time (Years)	49.23

- **Measurement 6: Implementation challenges, successes, lessons learned, and relevant examples.**

MEASUREMENT 6

Implementation challenges, successes, lessons learned and relevant examples		
Implementation challenges during the 2020.2021 Fiscal Year are all about the COVID-19 crisis, Shelter-In-Place orders and the resulting difficulty completing outreach as well as accessing other service providers. It is always a challenge to recruit skilled volunteers and appropriately-experienced professionals as well as getting some Veterans in need to acknowledge mental health needs.		
Lessons learned include how to leverage VOP funding and our role in the wider county, how to assist and best engage with El Dorado County's Coordinated Entry System to serve Veterans in need		
Our greatest successes center on how many homeless Veterans have been successfully housed in spite of Covid-19 and how we assisted Veterans in crisis which allowed them to stabilize and prevent or exacerbate mental health issues		
Service Category - Case Management	FY 20-21	Contract Period
Benefit Assistance	12	12
Budgeting Assistance	6	6
Document Processing or ID Assistance	7	7
Housing Placement Assistance	8	8
Housing Searches	11	11
Rental Application Assistance	1	1
Service Related Disability Application	1	1
Social Security Disability Application	1	1
Transportation to Health Provider	2	3
Total Services - Case Management	49	49
Service Category - Communication		
Assurance Wireless Phones	0	0
Minutes on Existing Phone Plans	1	1
Pre-Paid Cellular Phones	0	0
Total Services - Communication	1	1
Service Category - Emergency Needs Fulfillment		
Duffle Bags or Sea Bags	0	0
Hygiene Supplies for Emergency Needs	0	0
Pre-Paid Food Cards	4	4
Tents/Sleeping Bags/Tarps	0	0
Toiletries for Emergency Needs	0	0
Total Services - Emergency Needs Fulfillment	4	4
Service Category - Health Services		
Mental Health Assistance	14	14
Physical Health Assistance	3	3
Total Services - Health Services	17	17
Service Category - Household Needs Fulfillment		
Cleaning Supplies	0	0
Cooking Utensils	0	0
Hygiene Supplies	0	0

Pre-Paid Food Cards	0	0
Toiletries	0	0
Total Services - Household Needs Fulfillment	0	0
Service Category - Housing		
Campground Fees	0	0
Emergency Lodging	171	171
Mortgage Assistance	0	0
Rents	16	16
Security Deposits	4	4
Utility Deposits	0	0
Utility Payments	3	3
Total Services - Housing	194	194
Service Category - Transportation		
Auto Payments	0	0
Fuel	2	2
Insurance and/or Registration	1	1
Pre-Paid Fuel Cards	1	1
Public Transportation	2	2
Smog Certificates	0	0
Vehicle repairs and maintenance	9	9
Total Services - Transportation	15	15
Service Category - Other		
Other	12	12
Total Services Provided	275	275

Dearest Only Kindness, Jennifer & René,

Just a quick note to express my Gratitude for all the assistance over the past few years.

It's a great feeling to secure permanent housing and be off the streets, finally.

I couldnt have done this without your help, including assist for transportation to doctor appts.

Finally being settled in my own Space will allow me peace of mind to continue healing.

Best Wishes,

Richard Wilson

1/16/2021

Harvey E. Zuckerberg
2644 LAKE TAHOE BLVD #5
South Lake Tahoe, CA
96150

Dear V.O.P.,

I would not be alive today if it weren't for Catherine Seitzler, Rene Evans, and the V.O.P. My downward spiral, where I bottomed out led me to a homeless shelter for the first time in my life, at the ripe old age of 77. I had the fortune of getting the help I needed from Catherine Seitzler and thru Catherine I found Rene Evans.

Since March 1st, 2020 I have received assistance for housing thru the "Only Kindness" program and the V.O.P. Catherine and Rene found me at my lowest point and gave me hope.

I thank them and the V.O.P. for all of your help and support.

Sincerely
Harvey E Zuckerberg

(NO RELATION)

PROCLAMATION

of the Board of Supervisors of the County of El Dorado
In Recognition of
Aid to a Distressed Veteran

WHEREAS, EDC Veterans Affairs Commissioner Todd Smith, EDC Sheriff's Deputies Jill Jencks and Jeramy Buckman, EDC Sheriff's Sergeant Alex Sorey, American Legion Post 119 Service Officer David Zelinsky, Rene Evans of Only Kindness, Tim Whalen of the Military Family Support Group and Iisha Toombs LCSW, Sacramento Veterans Administration Medical Center, Mather, helped to save the life of a Placerville resident, a female U.S. Army combat medic veteran who was suffering from severe combat-related post-traumatic stress and related afflictions; and

WHEREAS, Deputy Jenks of the El Dorado Sheriff's Office was the first to engage, encouraging the veteran to seek medical attention at the Sacramento Veterans Administration Medical Center at Mather Field. When she realized the severity of the veteran's medical condition, Deputy Jenks called Commissioner Smith and asked for his assistance in convincing the veteran to seek care; and

WHEREAS, Commissioner Smith and Deputy Jenks put in place a plan to intercede and persuade the vet to accompany them to the VA Hospital. As the vet resisted care, Sergeant Sorey of the Sheriff's H.O.T. team made it possible for Commissioner Smith to transport the vet to Mather safely. Deputy Buckman took a day off from work and volunteered to accompany Smith and the vet; and

WHEREAS, Commissioner Smith and Deputy Buckman drove to the veteran's motel quarters and they comforted and observed her as Buckman transported them to Mather. Smith was able to connect with the veteran on the drive and communicate that she was not alone, that other vets cared about her welfare, and that there was hope for her future. As in these cases of combat-stressed veterans, it often takes another vet to be able to talk to and convince the stressed vet to accept care; and

WHEREAS, upon learning of the vet's life-threatening condition, Commissioner Smith called the motel where this homeless veteran was residing to assure that a room would be available for her upon her being discharged from the VA hospital. Smith then contacted American Legion Post Service Officer Zelinsky who engaged others in the effort to get the veteran follow-up care and housing. Tim Whalen of Military Family Support Group with help from Rene Evans of Only Kindness made sure that the veteran would not be out on the street after she returned from Mather with payment for her room provided by the EDC Veterans Affairs Commission; and

WHEREAS, following the veteran's recovery at Mather, Smith and Zelinsky sought to have the veteran undergo counseling and treatment for PTS-related addictions. They enlisted the help of LCSW Iisha Toombs of Sacramento VA Medical Center Mather who arranged for the veteran to be admitted directly from the hospital into recovery. Although the veteran refused, Ms. Toombs did not give up; she made it possible for the vet to enter a recovery program following the vet's return to Placerville. Ms. Toombs' tireless efforts were an example of compassionate professionalism.

NOW, THEREFORE, BE IT PROCLAIMED that the Board of Supervisors of the County of El Dorado does hereby recognize and commend the indefatigable care that was provided to the combat medic veteran, which reflects highly on all involved and the organizations they represent.

Passed by the Board of Supervisors of the County of El Dorado at a regular meeting of said Board, held this 16th day of March 2021.

Suicide Prevention and Stigma Reduction

Provider: Suicide Prevention Network

Project Goals

- Increase awareness of mental illness, programs, resources, and strategies.
- Increased linkage to mental health resources.
- Implement activities that are designed to attempt to reduce the number of attempted and completed suicides in El Dorado County.
- Change negative attitudes and perceptions about seeking mental health services.
- Increase access to mental health resources to support individuals and families.

Numbers Served and Cost

Regarding demographic data collection: Per the amended PEI regulations, effective July 1, 2018, the Contractor is only required to report on the number of contacts.

Expenditures	FY 2018-19	FY 2019-20	FY 2020-21
MHSA Budget	$40,000	$60,000	$70,000
Total Expenditures	$39,992	$49,672	$71,324
Unduplicated Individuals Served	733	unknown	1,310
Cost per Participant	$55	unknown	$54
Age Group	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
0-15 (children/youth)	342	Per PEI regulations, not required.	360
16-25 (transitional age youth)	304	Per PEI regulations, not required.	300
26-59 (adult)	54	Per PEI regulations, not required.	623
Ages 60+ (older adults)	33	Per PEI regulations, not required.	27
Unknown or declined to state	0	Per PEI regulations, not required.	0

Race	FY 2018-19	FY 2019-20	FY 2020-21
American Indian or Alaska Native	unknown	Per PEI regulations, not required.	23
Asian	8	Per PEI regulations, not required.	53
Black or African American	3	Per PEI regulations, not required.	36
Native Hawaiian or Other Pacific Islander	unknown	Per PEI regulations, not required.	2
White	363	Per PEI regulations, not required.	637
Other	18	Per PEI regulations, not required.	47
Multiracial	341	Per PEI regulations, not required.	512
Unknown or declined to state	unknown	Per PEI regulations, not required.	Unknown

Ethnicity by Category	FY 2018-19	FY 2019-20	FY 2020-21
Hispanic or Latino	unknown	Per PEI regulations, not required.	237
Caribbean	unknown	Per PEI regulations, not required.	Unknown
Central American	23	Per PEI regulations, not required.	Unknown
Mexican/Mexican-American/Chicano	299	Per PEI regulations, not required.	33
Puerto Rican	unknown	Per PEI regulations, not required.	4
South American	19	Per PEI regulations, not required.	Unknown
Other	unknown	Per PEI regulations, not required.	Unknown
Unknown or declined to state	unknown	Per PEI regulations, not required.	Unknown

Non-Hispanic or Non-Latino			
African	3	Per PEI regulations, not required.	36
Asian Indian/South Asian	8	Per PEI regulations, not required.	53
Cambodian	unknown	Per PEI regulations, not required.	Unknown
Chinese	unknown	Per PEI regulations, not required.	8
Eastern European	unknown	Per PEI regulations, not required.	Unknown
Filipino	unknown	Per PEI regulations, not required.	39
Japanese	unknown	Per PEI regulations, not required.	4
Korean	unknown	Per PEI regulations, not required.	2
Middle Eastern	unknown	Per PEI regulations, not required.	Unknown
Vietnamese	unknown	Per PEI regulations, not required.	48
Other	363	Per PEI regulations, not required.	103
Multi-ethnic	18	Per PEI regulations, not required.	743
Unknown or declined to state	unknown	Per PEI regulations, not required.	Unknown

Primary Language	FY 2018-19	FY 2019-20	FY 2020-21
Arabic	unknown	Per PEI regulations, not required.	Unknown
Armenian	unknown	Per PEI regulations, not required.	Unknown
Cambodian	unknown	Per PEI regulations, not required.	Unknown
Cantonese	unknown	Per PEI regulations, not required.	Unknown
English	384	Per PEI regulations, not required.	1,310
Farsi	unknown	Per PEI regulations, not required.	Unknown
Hmong	unknown	Per PEI regulations, not required.	Unknown
Korean	unknown	Per PEI regulations, not required.	Unknown
Mandarin	unknown	Per PEI regulations, not required.	Unknown
Other Chinese	unknown	Per PEI regulations, not required.	Unknown
Russian	unknown	Per PEI regulations, not required.	Unknown
Spanish	341	Per PEI regulations, not required.	Unknown
Tagalog	unknown	Per PEI regulations, not required.	Unknown
Vietnamese	unknown	Per PEI regulations, not required.	Unknown
Unknown or declined to state	unknown	Per PEI regulations, not required.	Unknown
Sexual Orientation **Collection of this information from a minor younger than 12 years of age is not required.*	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
Gay or Lesbian	unknown	Per PEI regulations, not required.	Unknown

Heterosexual or Straight	unknown	Per PEI regulations, not required.	Unknown
Bisexual	unknown	Per PEI regulations, not required.	Unknown
Questioning or unsure of sexual orientation	unknown	Per PEI regulations, not required.	Unknown
Queer	unknown	Per PEI regulations, not required.	Unknown
Another sexual orientation	unknown	Per PEI regulations, not required.	Unknown
Declined to State	unknown	Per PEI regulations, not required.	Unknown
Gender ****Collection of this information from a minor younger than 12 years of age is not required.***	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
Assigned sex at birth:			
Male	350	Per PEI regulations, not required.	Unknown
Female	383	Per PEI regulations, not required.	Unknown
Declined to answer	0	Per PEI regulations, not required.	Unknown
Current gender identity:			
Male	unknown	Per PEI regulations, not required.	455
Female	unknown	Per PEI regulations, not required.	796
Transgender	unknown	Per PEI regulations, not required.	12
Genderqueer	unknown	Per PEI regulations, not required.	Unknown
Questioning / unsure of gender identity	unknown	Per PEI regulations, not required.	Unknown
Another gender identity	unknown	Per PEI regulations, not required.	47

Declined to answer	unknown	Per PEI regulations, not required.	Unknown
Disability	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
Difficulty seeing	unknown	Per PEI regulations, not required.	Unknown
Difficulty hearing or having speech understood	unknown	Per PEI regulations, not required.	Unknown
Mental disability including but not limited to learning disability, developmental disability, dementia	unknown	Per PEI regulations, not required.	Unknown
Physical/mobility	unknown	Per PEI regulations, not required.	Unknown
Chronic health condition/chronic pain	unknown	Per PEI regulations, not required.	Unknown
Other (specify)	unknown	Per PEI regulations, not required.	Unknown
Declined to state	unknown	Per PEI regulations, not required.	Unknown
Veteran Status ***Collection of this information from a minor younger than 12 years of age is not required.***	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
Yes	11	Per PEI regulations, not required.	11
No	unknown	Per PEI regulations, not required.	Unknown
Unknown or declined to state	unknown	Per PEI regulations, not required.	Unkown

Region of Residence	FY 2018-19	FY 2019-20	FY 2020-21
West County	0		0
Placerville Area	0		300
North County	0		0
Mid County	0		0
South County	0		0
Tahoe Basin	733		1,010
Unknown or declined to state	0		0

Economic Status	FY 2018-19	FY 2019-20	FY 2020-21
Extremely low income	unknown	Per PEI regulations, not required.	Unknown
Very low income	unknown	Per PEI regulations, not required.	Unknown
Low income	unknown	Per PEI regulations, not required.	Unknown
Moderate income	unknown	Per PEI regulations, not required.	Unknown
High income	unknown	Per PEI regulations, not required.	Unknown

Health Insurance Status	FY 2018-19	FY 2019-20	FY 2020-21
Private	unknown	Per PEI regulations, not required.	Unknown
Medi-Cal	unknown	Per PEI regulations, not required.	Unknown
Medicare	unknown	Per PEI regulations, not required.	Unknown
Uninsured	unknown	Per PEI regulations, not required.	Unknown

Annual Report FY 2020/21

Please provide the following information for this reporting period:

1. **Briefly report on how implementation of the Suicide Prevention and Stigma Reduction Project is progressing (e.g., whether implementation activities are proceeding on target and as described in the County's MHSA Plan), and any major accomplishments and challenges.**

2. **Briefly report on how the Suicide Prevention and Stigma Reduction project has improved the overall mental health of the children, families, and communities by addressing the primary negative outcomes that are the focus of the Suicide Prevention and Stigma Reduction project (suicide and prolonged suffering).**

3. **Provide a brief narrative description of how the Suicide Prevention and Stigma Reduction services are provided in a culturally and linguistically competent manner, including activities to reduce racial/ethnic disparities.**

4. **Provide the outcome measures of the services provided and of customer satisfaction surveys. Outcome measures for the Suicide Prevention and Stigma Reduction project are:**

   - **Measurement 1: Using validated method, measure changes in attitudes, knowledge, and/or behavior regarding suicide related to mental illness.**

   - **Measurement 2: Using a validated method, measure changes in attitudes, knowledge, and/or behavior related to seeking mental health services.**

5. **Provide total project expenditures and the type and dollar amount of leveraged resources and/or in-kind contributions.**

6. **Provide any additional relevant information.**

Community Services and Supports (CSS) Projects

Introduction

Community Services and Supports (CSS) Projects provide direct services to adults and children who have a severe mental illness (adults) or serious emotional disturbance (children) who meet the criteria for receiving Specialty Mental Health Services as set forth in WIC Section 5600.3.

This Outcome Measures Report accompanies the Fiscal Year 2022/23 MHSA Annual Update and provides outcome information for the projects included in the Fiscal Year 2020-21 – 2022-23 MHSA Three-Year Program and Expenditure Plan.

MHSA programs represent only a portion of the Specialty Mental Health Services provided by the BHD. Non-MHSA funded services are not reported in this document.

The State has not yet identified standardized outcomes and indicators for CSS programs, however MHSA programs use standard service level indicators and outcome tools utilized by the Behavioral Health Division and its contracted providers:

- Measurement 1: Levels of Care Utilization System (LOCUS) for adults; Child and Adolescent Levels of Care Utilization System (CALOCUS) for children and youth
- Measurement 2: Outcome measurement tools (e.g., Child and Adolescent Needs and Strengths (CANS); Adult Needs and Strengths Assessment (ANSA))

Full Service Partnership (FSP) Program

Children's Full Service Partnership

Providers: New Morning Youth and Family Services, West Slope;
Sierra Child and Family Services, West Slope and South Lake Tahoe;
Stanford Youth Solutions, West Slope;
Summitview Child and Family Services, West Slope;
Tahoe Youth and Family Services, South Lake Tahoe; CASA
El Dorado, West Slope

Project Goals

- Reduce out-of-home placement for children
- Safe and stable living environment
- Strengthen family unification or reunification
- Improve coping skills
- Reduce at-risk behaviors
- Reduce behaviors that interfere with quality of life

Numbers Served and Cost

Expenditures	FY 2018-19	FY 2019-20	FY 2020-21
MHSA Budget	$2,000,000	$2,780,000	$3,448,000
Total Expenditures	$1,148,686	$2,476,393	$2,919,060
Unduplicated Individuals Served	120	187	287
Cost per Participant	$9,572	$13,243	$10,171
Age Group	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
0-15 (children/youth)	82	116	173
16-25 (transitional age youth)	38	71	114
26-59 (adult)	0	0	0
Ages 60+ (older adults)	0	0	0
Unknown or declined to state	0	0	0
Gender	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
Female	67	99	156
Male	53	88	131
Region of Residence	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
West County	25	42	51
Placerville Area	31	64	116
North County	10	17	24
Mid County	14	16	35
South County	3	3	6
Tahoe Basin	22	29	45
Unknown or declined to state	0	0	0
Out of County	15	16	10

Race	FY 2018-19	FY 2019-20	FY 2020-21
American Indian or Alaska Native	2	5	5
Asian	0	1	1
Black or African American	4	8	2
Caucasian or White	74	99	239
Native Hawaiian or Other Pacific Islander	0	0	1
Other Race	8	15	11
Unknown or declined to state	31	59	28
Ethnicity	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
Hispanic or Latino	4	12	22
Other Hispanic / Latino	6	9	15
Not Hispanic	62	99	115
Unknown or declined to state	48	77	135
Primary Language	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
English	104	152	226
Spanish	1	2	4
Other Language	0	0	0
Unknown or declined to state	15	33	57

In 2020, EDC Behavioral Health began using the Pathways to Wellbeing checklist (see below) to determine what program a minor would be most appropriately served through. The majority of the minors assessed met criteria for Pathways to Wellbeing services, which are best provided via MHSA FSP programs, this increasing the MHSA services provided.

Eligibility for Pathways to Wellbeing and Katie A. Subclass Services

Name:	Avatar #:
Date Determination Made:	Assessing Clinician:
Provider: ☐ Sierra ☐ Summitview ☐ New Morning ☐ TYFS ☐ Stanford ☐ Charis	

1. Child/youth meets medical necessity criteria for Specialty Mental Health services (SMHS) ☐Yes ☐No

2. Child/youth is eligible for full-scope Medi-Cal ☐Yes ☐No

3. Child/youth is under the age of 21 ☐Yes ☐No

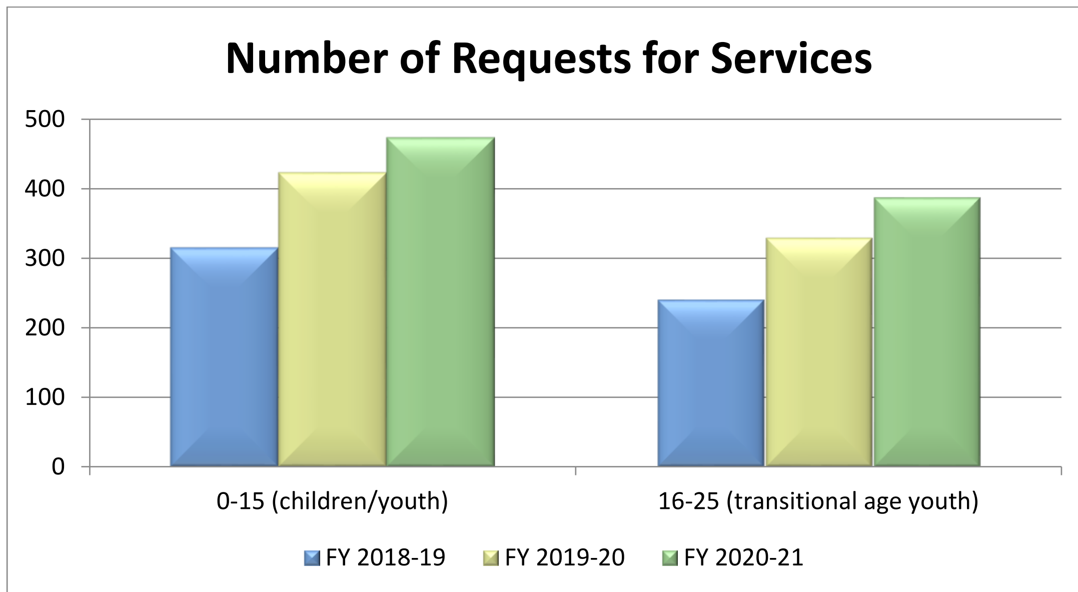
4. Child/youth meets at least one of the criteria below: ☐Yes ☐No

   - ☐ Are currently in or being considered for Wraparound, TFC, TBS, STRTP, or has specialized care rate due to behavioral health needs
   - ☐ Has experienced two or more hospitalizations in the last 12 months or has had two or more ER visits in the last 6 months due to primary mental health conditions
   - ☐ Has experienced three or more placements within 24 months due to behavioral health needs
   - ☐ Age 0-5 and more than 1 psychotropic medication or more than 1 mental health diagnosis
   - ☐ Age 6-11 and more than 2 psychotropic medications or more than 2 mental health diagnoses
   - ☐ Age 12-17 and more than 3 psychotropic medications or more than 3 mental health diagnoses
   - ☐ Has been discharged within 90 days from, currently reside in, or are being considered for placement in a psychiatric hospital or 24-hour mental treatment facility
   - ☐ Has been detained pursuant to W&I code 601 and 602, primarily due to mental health needs
   - ☐ Has been reported homeless within the prior six months
   - ☐ Are involved with two or more child-serving systems, including, but not limited to: child welfare system, special education, juvenile probation, drug &alcohol, other HHSA or legal system

5. Child/youth has an open Child Welfare Services Case (including voluntary) ☐ Yes ☐No

ELIGIBLITY DETERMINTATION
A. Child/youth meets criteria for Intensive Care Coordination (ICC) and Intensive Home Based Services (IHBS) through Pathways to Well-Being services, if: • Answers to items 1-4 are YES ☐ **Eligible for ICC and IHBS services though Pathways to Well-Being services** **<u>OR</u>** B. Child/youth meets criteria for Intensive Care Coordination (ICC) and Intensive Home Based Services (IHBS) through membership of the Katie A Subclass, if: • Answers to items 1-4 are YES **<u>AND</u>** • Answer to item 5 is YES ☐ **Eligible for ICC and IHBS services through membership of the Katie A. Subclass** **<u>OR</u>** C. Answers to 1, 2, 3, **OR** 4 are NO ☐ **Not Eligible for ICC and IHBS services**

Submit completed form to El Dorado County Behavioral Health Fax: (530) 303-1526 or email to Access Program Coordinator



Outcome Measures

Measurement 1 (Days of psychiatric hospitalization)

Children's FSP and Enhanced Foster Care	FY 2018-19	FY 2019-20	FY 2020-21
Children Enrolled in this Program:			
Unduplicated Children Served	120	187	287
Unduplicated Children Hospitalized	13	9	12
Number of Hospitalizations	15	13	16

Average Length of Stay	9.8 days[1]	9.8 days[2]	12.2[3]
All El Dorado County Children Medi-Cal Beneficiaries (under age 18): (whether receiving Specialty Mental Health Services or not)			
Unduplicated Children Hospitalized	51	48	55
Number of Hospitalizations	59	57	76
Average Length of Stay	8.5 days	7.0 days	8.4 days

[1] Two (2) children were hospitalized for three (3) or more weeks, accounting for the increase in average Length of Stay. Without those two (2) hospitalizations, the average Length of Stay is 6.2 days.

[2] One (1) child was hospitalized for three (3) or more weeks. Without that one (1) hospitalization, the average Length of Stay is 8.7 days.

[3] Three (3) children were hospitalized for three (3) or more weeks, and one (1) of those 3 children was hospitalized on three (3) separate occasions, each time in excess of 24 days.

Cost

Expenditures	FY 2018-19	FY 2019-20	FY 2020-21
MHSA Budget	$20,000	$20,000	$20,000
Total Expenditures	$20,000	$20,000	$20,000
Unduplicated Individuals Served	308	268	296

CASA reported the following information in its FY 2020-21 Year-End Report:

1. Implementation: We serve the abused, neglected, and at-risk children in the El Dorado County foster care system by recruiting, training, and supervising volunteer Court Appointed Special Advocates who, as officers of the court, act as the "eyes and ears of the judge and voice of the child".

   We serve the families involved in Child Protective System that have not had their children removed by providing the parents a Family Coach. The Family coach supports the parents in multiple independent living areas to help mitigate the current circumstances in order to avoid their children being removed.

   We serve the Family Law Court providing trained CASA advocates to help alleviate the miscommunication that comes with children custody battles.

   Our agreement with El Dorado County stipulates that we provide outreach, training, and group supervision. These services were successfully delivered through the following.

   A number of program changes in our operations were implemented during the reporting period that resulted in marked growth in our ability recruit and train volunteers to positively impact the mental health of the children we serve. These include:

   - Program staff implemented two new programs to serve the population of children not previously served with an advocate; Family Law Program and Family Coach Program.
   - Both of these new programs provide advocates with more choice regarding their personal schedules, these programs are a shorter service period allowing for a higher advocate availability.
   - We provide our Zoom In-Person trainings monthly at varying times to ensure all new applicants can accommodate their personal schedules.
   - We have shifted all of our continuing education and peer coordinating meetings to a virtual format. This allows us to record the continuing education session in a webinar format and provide to advocates that were unable to attend, thus allowing for all CASA advocates access to the same information.

Our ongoing management and supervisory duties include providing direction to our volunteers, holding monthly continuing education classes, assuring that volunteers comply with record keeping and other duties, as well as assuring advocates build strong partner agency relationships for the benefit of the children.

Overall mental health of foster care population: Nationwide, it is estimated that 80% of the children in foster care suffer from mental health issues. The abuse, abandonment, or neglect that lead to a child being removed from his or her parents has traumatic effect. These Adverse Childhood Experiences (ACEs) are understood to lead to long term learning disabilities, behavioral problems and long term health problems. A comprehensive study by Kaiser Permanente in 1997 found that as the number of ACEs increases, there is a corresponding increase in risk of substance abuse, violent behavior, depression, and suicidal tendencies, among other mental health issues. It has been our experience virtually all of the children that we serve are provided therapeutic services to combat anxiety, dramatic mood swings, depression, medication needs and behavioral issues.

Given the above, and through our long experience with working with children in foster care, we feel that it is clear that the overall mental health of the foster care population is poor and in need of our intervention. It has been shown, per a 2006 audit study by the Office of the Inspector General, that when a foster child has a CASA advocate he or she is:

- Half as likely to reenter the foster care system and/or to end up in long term foster care (3 years or more)
- Likely to have more services ordered for them by the court
- More likely to be adopted
- And, perhaps most significantly, 98% of the children we serve do not re-experience abuse and neglect.
- Having a CASA advocate builds resiliency in children which is the factor that helps alleviate the effects of trauma.

2. Progress: During the 2020-21 reporting period, compared to the previous 12 months, Child Advocates of El Dorado County:

- Served fewer children, largely due to the reduction of detentions by CPS during the COVID-19 pandemic.
- Successfully served every child brought into the foster care system in 2020-21 FY.
- Successfully implemented new programs to serve more children in El Dorado County.

As such, the $20,000 MHSA grant has enabled us to make significant progress in offering enhanced services to the abused and neglected children in the El Dorado County foster

care system.

3. Cultural & linguistic considerations: Over the course of time we have seen that our volunteers reflect the overall demographics of El Dorado County, and understanding cultural diversity is one of the cornerstones of CASA volunteer training. After training, cultural and linguistic compatibility are key determinants when assigning volunteers to new cases. Additionally, the program manager in our South Lake Tahoe office is bi-lingual in Spanish and English.

   Over the past fiscal year, we increased the number of continuing education classes covering diversity, including cultural diversity, LGTBQ diversity, Language barriers, economic diversity and many others. We are committed to training our volunteers to be educated in all areas that will help be better advocates for the children.

4. Collaboration: Organizations that we collaborate with in Placerville include:

   - Unity Care, an independent living service
   - Environmental Alternatives, a group home
   - 3 Strands, human trafficking counseling and education
   - Marshall CARES
   - Center for Violence Free Relationships
   - On MY Own

   Our South Lake Tahoe office works closely with:

   - Tahoe Turning Point, a group home with substance abuse services
   - Live Violence Free, which addresses domestic violence

   Mandatory continuing education classes provide instruction on mental health topics such as Adverse Childhood Experiences, Trauma Informed Care, and Substance Abuse. These classes are held at our office and typically presented by experts from the community. Volunteers are also notified of classes and workshops at other local agencies, including Summitview Child Treatment Center, New Morning Children's Shelter, and Folsom Lake College.

Transitional Age Youth (TAY) Full Service Partnership

Provider: El Dorado County Health and Human Services Agency, Behavioral Health Division, South Lake Tahoe;
Sierra Child and Family Services, West Slope

Project Goals

- Decreased days of homelessness, institutionalization, hospitalization, and incarceration
- Safe and adequate housing
- Increased access to and engagement with mental health services
- Increased use of peer support resources
- Increased connection to their community
- Increased independent living skills

Numbers Served and Cost

Expenditures	FY 2018-19	FY 2019-20	FY 2020-21
MHSA Budget – Total	$400,000	$500,000	$323,250
Total Expenditures	$5,454	$107,418	$60,316
Unduplicated Individuals Served	16	35	44
Cost per Participant	$341	$3,069	$1,371

FY 2020-21 includes both the services provided directly through the County in its TAY FSP and Mental Health Block Grant First Episode of Psychosis program (15 clients), and also through its Mental Health Block Grant First Episode of Psychosis contracted provider, Sierra Child and Family Services (19 clients).

Age Group	FY 2018-19	FY 2019-20	FY 2020-21
0-15 (children/youth)	0	2	0
16-25 (transitional age youth)	16	33	44
26-59 (adult)	0	0	0
Ages 60+ (older adults)	0	0	0
Unknown or declined to state	0	0	0
Gender	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
Female	7	17	29
Male	9	18	15

Region of Residence	FY 2018-19	FY 2019-20	FY 2020-21
West County	0	14	5
Placerville Area	7	12	19
North County	0	0	1
Mid County	2	2	5
South County	0	1	0
Tahoe Basin	7	5	11
Unknown or declined to state / out of county	0	1	3
Race	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
American Indian or Alaska Native	1	1	1
Asian	1	2	0
Black or African American	0	2	0
Caucasian or White	10	23	39
Native Hawaiian or Other Pacific Islander	0	1	1
Other Race	3	3	2
Unknown or declined to state	1	3	1
Ethnicity	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
Hispanic or Latino	3	2	7
Other Hispanic / Latino	0	1	6
Not Hispanic	10	18	26
Unknown or declined to state	3	14	5
Primary Language	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
English	15	33	41
Spanish	1	1	1
Other Language	0	1	0
Unknown or declined to state	0	0	2

Outcome Measures

- Measurement 1: Key Event Tracking (KET) - As changes occur in a client's status related to housing, employment, education, entry or exit from a psychiatric hospital, emergency department or jail/juvenile hall
- Measurement 2: Number of Clients Graduating from Specialty Mental Health Services
- Measurement 3: Education attendance and performance
- Measurement 4: Number of days of homelessness / housing stability
- Measurement 5: Education attendance and performance
- Measurement 6: Employment status
- Measurement 7: Continued engagement in mental health
- Measurement 8: Linkage with primary health

Measurement 1: Key Event Tracking (KET)
Measurement 3: Education attendance and performance
Measurement 4: Number of days of homelessness / housing stability
Measurement 5: Education attendance and performance
Measurement 6: Employment status

These outcomes come from reporting that is entered into the Data Collection Reporting (DCR) Systems, a database maintained by the State. Please see the Appendix for outcomes from the DCR.

Measurement 2 Number of Clients Graduating from Specialty Mental Health Services
Measurement 7 Continued engagement in mental health

The following data is only reflective of the clients served by Mental Health directly.

Participants	FY 2018-19	FY 2019-20	FY 2020-21
Unique Clients	16	22	70
Total FSP Episodes FSP Episodes Opened:	18	23	98
Total FSP Episodes Opened	12	18	84
New/Returning Client	*9*	*13*	
Changed Program (same level of service)	*2*	*3*	
Dropped Down in Level of Services	*0*	*0*	
Increased Level of Services	*1*	*2*	
FSP Episodes Closed:			
Total FSP Episodes Closed	13	13	52
Graduated / Exited Services	*9*	*8*	
Decreased Level of Services	*1*	*2*	
Increased Level of Services	*1*	*2*	
Changed Program (same level of service)	*2*	*1*	

Individuals within the TAY age range continue to be challenging to engage in services. However, of all age groups served by Mental Health, the TAY population has been the one to most quickly adapt to the use of telephone and telehealth for the provision of services. This age group is familiar with, and very comfortable with, using technology to communicate with others. The need to use telephone and telehealth for services during the public health emergency has been beneficial to these clients.

Adult Full Service Partnership

Providers: El Dorado County Health and Human Services Agency, Behavioral Health Division; Summitview Child and Family Services (for operation of an Adult Residential Facility)

Project Goals

- Reduction in institutionalization
- People are maintained in the community
- Services are individualized
- Work with clients in their homes, neighborhoods and other places where their problems and stresses arise and where they need support and skills
- Team approach to treatment

Numbers Served and Cost

Costs for this project include the Adult Residential Facility (ARF) and the Intensive Case Management (ICM) team, which bring individuals who have been placed in a locked facility out of county back to El Dorado County for continued treatment, and help clients continue living in the community rather than being placed out of county. These FSP clients require a high level of staff support and the client to clinician ratio is low.

Expenditures	FY 2018-19	FY 2019-20	FY 2020-21
MHSA Budget	$5,500,000	$5,400,000	$6,357,250
Total Expenditures	$4,360,421	$4,359,998	$4,346,250
Unduplicated Individuals Served	123	128	132
Cost per Participant	$35,451	$34,062	$32,678
Age Group	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
0-15 (children/youth)	0	0	0
16-25 (transitional age youth)	6	7	24
26-59 (adult)	102	107	95
Ages 60+ (older adults)	15	14	13
Unknown or declined to state	0	0	0
Gender	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
Female	50	52	56
Male	73	76	77

Region of Residence	FY 2018-19	FY 2019-20	FY 2020-21
West County	8	9	11
Placerville Area	73	64	63
North County	2	6	5
Mid County	8	7	10
South County	2	1	3
Tahoe Basin	28	38	30
Out of County	2	3	11
Unknown or declined to state	0	0	0
Race	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
American Indian or Alaska Native	1	3	1
Asian	2	4	0
Black or African American	2	3	2
Caucasian or White	104	112	129
Native Hawaiian or Other Pacific Islander	0	0	0
Other Race	7	4	1
Unknown or declined to state	7	2	1
Ethnicity	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
Hispanic or Latino	3	1	4
Other Hispanic / Latino	7	4	3
Not Hispanic	108	112	114
Unknown or declined to state	5	11	12
Primary Language	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
English	121	123	129
Spanish	1	2	2
Other Language	1	3	2
Unknown or declined to state	0	0	0

Outcome Measures

- Measurement 1: Key Event Tracking (KET) - As changes occur in a client's status related to housing, employment, education, entry or exit from a psychiatric hospital, emergency department or jail
- Measurement 2: Number of Clients Graduating from Specialty Mental Health Services
- Measurement 3: Continued engagement in services

These outcomes will be adjusted in the FY 2021-22 MHSA Annual Update, if needed, to better align with available data.

Measurement 1 (Key Event Tracking)

These outcomes come from reporting that is entered into the Data Collection Reporting (DCR) Systems, a database maintained by the State. Please see the Appendix for outcomes from the DCR.

Measurement 2 (Number of Clients Graduating from Specialty Mental Health Services)
Measurement 3 (Continued engagement in services)

Eighty-seven (87) adult clients who were enrolled as an FSP at any time in FY 2019-20 remained open to SMHS at the end of FY 2019-20.

Participants	FY 2018-19	FY 2019-20	FY 2020-21
Unique Clients	123	128	133
Total Episodes	131	136	153
FSP Episodes Opened:			
Total FSP Episodes Opened	70	70	153
New/Returning Client	*30*	*48*	
Changed Program (same level of service)	*1*	*4*	
Dropped Down in Level of Services	*21*	*8*	
Increased Level of Services	*17*	*10*	
FSP Episodes Closed:			
Total FSP Episodes Closed	66	73	71
Graduated / Exited Services	*29*	*35*	
Decreased Level of Services	*18*	*22*	
Participants	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
Increased Level of Services	*18*	*10*	
Changed Program (same level of service)	*1*	*6*	

Older Adult Full Service Partnership

There are no FY 2019-21 outcomes to report for this program. Older Adult FSP clients were provided the full range of FSP services through the Adult FSP program.

Numbers Served and Cost

Expenditures	FY 2018-19	FY 2019-20	FY 2020-21
MHSA Budget	$200,000	$300,000	$300,000
Total Expenditures	$0	$0	$0
Clients Served	Through Adult FSP	Through Adult FSP	Through Adult FSP
Cost per Participant	$0	$0	$0

Assisted Outpatient Treatment (AOT)

Provider: El Dorado County Health and Human Services Agency, Behavioral Health Division

Numbers Served and Cost

For AOT, the number of clients served means the number of individuals who were referred to AOT and individuals referred in a previous year but whose AOT referral has not been discharged (for example, if the referral is still open because the individual could not be located).

When an individual becomes engaged in Specialty Mental Health Services, their services are provided through the appropriate outpatient team, generally the Intensive Case Management team (FSP level of services) initially.

Expenditures	FY 2018-19	FY 2019-20	FY 2020-21
MHSA Budget	$40,000	$34,862	$25,000
Total Expenditures	$47,611	$10,725	$866
AOT Referrals Open at any time During the FY	18	3	7
Cost per Participant	$2,645	$2,681	$ 124

The AOT program was initially designed with the intent to provide direct services to clients engaged in Specialty Mental Health Services as a result of an AOT referral. However, this model did not allow for AOT clients to receive the benefits of a treatment team approach. Therefore, AOT referred clients are served by the ICM team, which maintains a low client to clinician ratio and takes a team approach to help clients in achieving their treatment goals.

In the FY 2020-21 MHSA Plan, the AOT Program will be aligned with the Outreach and Engagement Projects rather than the FSP programs.

Additionally, to address the low referral rates, Mental Health is developing a Training and Education Plan for stakeholders, including consumers and families, as well as for Mental Health service providers.

Outcome Measures

- Measurement 1: Number of referrals received and the sources of those referrals.
- Measurement 2: Number of referrals resulting in engagement in services.
- Measurement 3: Number of days between receipt of an AOT referral and clients' engagement in outpatient Specialty Mental Health Services, if individual becomes engaged in services.
- Measurement 4: Number of AOT petitions filed.
- Measurement 5: Number of AOT referrals who remained engaged in services for at least six months.

Measurement 1: Number of referrals received and the sources of those referrals.

Welfare and Institutions Code section 5346(b)(2) identifies who may make a referral for AOT. Referrals came from the following sources:

Referral Source	FY 2018-19 Referrals	FY 2019-20 Referrals	FY 2020-21 Referrals
Adult Housemate/Roommate	0	0	0
Immediate Family Member	8	3	5
Treatment/Care Facility	0	0	0
Hospital	1	0	0
El Dorado County Psychiatric Health Facility (PHF)	6	0	0
Treatment Provider	2	0	0
Law Enforcement/Justice	1	0	1
Court (effective 2021)	N/A	N/A	1

Measurement 2: Number of referrals resulting in engagement in services. Measurement 4: Number of AOT petitions filed.

Status	FY 2018-19	FY 2019-20	FY 2020-21
Voluntarily Engaged with SMHS	7	1	2
Voluntarily Engaged with Mild to Moderate or other Mental Health Services	3	0	0
Engaged via Petition / Petitions Filed	0	0	0
Engaged via Conservatorship	2	0	0
Not Eligible for AOT	2	2	4
Incarcerated Prior to Engagement	3	0	1
Engagement Attempts Continue	1	0	0

Measurement 3: Number of days between receipt of an AOT referral and clients' engagement in outpatient Specialty Mental Health Services, if individual becomes engaged in services.

For the one individual who voluntarily engaged with SMHS: 25 days.

Measurement 5: Number of AOT referrals who remained engaged in services for at least six months.

The one individual who voluntarily engaged in SMHS, the individual remained voluntarily engaged for at least 6 months.

Wellness Centers (which include Outpatient Specialty Mental Health Services)

Provider: El Dorado County Health and Human Services Agency, Behavioral Health Division

Project Goals

- Recovery and resiliency for participants.
- Participants gain greater independence through staff interaction, peer interaction and educational opportunities.
- Participants linked with community-resources.
- Increased engagement in mental health services.

Numbers Served and Cost

Both the South Lake Tahoe and West Slope Wellness Centers closed in March 2020 as a result of the public health emergency. As such, the number of individuals who accessed the Wellness Center were lower than usual. The average cost per client increased significantly in FY 2019-20 due to lower number of clients attending Wellness, but the same number of staff employed by Mental Health through the public health emergency. Data is not yet available for the 2020-21 fiscal year.

Expenditures	FY 2018-19	FY 2019-20	FY 2020-21
MHSA Budget	$2,700,000	$2,600,000	$2,849,000
Total Expenditures	$2,085,334	$2,404,852	$2,402,242
Wellness Center (West Slope Only):			
Wellness Center Visits	7,100+	N/A[4]	
Cost per Visit	$293		
Unduplicated Clients	324		
Outpatient Wellness Program Clients Served	371	364	
Cost per Client	$5,621	$6,607	$
Age Group	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
0-15 (children/youth)	0	0	
16-25 (transitional age youth)	21	18	
26-59 (adult)	309	304	
Ages 60+ (older adults)	41	42	
Unknown or declined to state	0	0	0

[4] Evaluation of the data reflected the data was not accurately collected and therefore it is not available for FY 19/20.

Gender	FY 2018-19	FY 2019-20	FY 2020-21
Female	196	183	
Male	175	181	
Region of Residence	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
West County	46	46	
Placerville Area	124	120	
North County	10	16	
Mid County	38	27	
South County	12	12	
Tahoe Basin	135	129	
Unknown or declined to state	1	1	
Out of County	5	13	
Race	**FY 20118-19**	**FY 2019-20**	**FY 2020-21**
American Indian or Alaska Native	11	9	
Asian	4	5	
Black or African American	9	8	
Caucasian or White	298	283	
Native Hawaiian or Other Pacific Islander	1	2	
Other Race	25	32	
Unknown or declined to state	23	25	
Ethnicity	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
Hispanic or Latino	12	10	
Other Hispanic / Latino	25	21	
Not Hispanic	297	278	
Unknown or declined to state	37	55	
Primary Language	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
English	359	356	
Spanish	3	1	
Other Language	3	4	
Unknown or declined to state	6	3	

Outcome Measures

- Measurement 1: Number of participants and frequency of attendance
- Measurement 2: Number of Clients Graduating from Specialty Mental Health Services

Measurement 1 (Number of participants and frequency of attendance)

Category	FY 2018-19	FY 2019-20	FY 2020-21
Wellness Center (West Slope Only):			

Wellness Center Visits	7,100+	n/a	
Cost per Visit	$293	n/a	
Unduplicated Clients	324	n/a	
Frequency of Attendance	n/a	n/a	
Outpatient Wellness Program Clients Served	371	364	

The frequency of attendance has not been reportable and was removed from the outcomes in the FY 2020-21 MHSA Plan.

Measurement 2 (Number of Clients Graduating from Specialty Mental Health Services from the Wellness program)

Participants	FY 2018-19	FY 2019-20	FY 2020-21
Unique Clients	371	364	
Total Episodes	387	382	
Episodes Opened:			
Total Episodes Opened	182	245	
New/Returning Client	*166*	*212*	
Changed Program (same level of service)	*4*	*8*	
Dropped Down in Level of Services	*4*	*19*	
Increased Level of Services	*8*	*6*	
Episodes Closed:			
Total Episodes Closed	249	180	
Graduated / Exited Services	*210*	*148*	
Decreased Level of Services	*26*	*2*	
Participants	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
Increased Level of Services	*10*	*14*	
Changed Program (same level of service)	*3*	*16*	

Numbers Served and Cost

Expenditures	FY 2018-19	FY 2019-20	FY 2020-21
MHSA Budget – Total	$600,000	$415,000	$500,500
Total Expenditures	$381,515	$331,838	$408,006
Unduplicated Individuals Served	42	43	
Cost per Participant	$9,084	$7,717	$
Age Group*	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
0-15 (children/youth)	0	0	
16-25 (transitional age youth)	41	43	
26-59 (adult)	1	0	
Ages 60+ (older adults)	0	0	
Unknown or declined to state	0	0	
Gender	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
Female	27	28	
Male	15	15	
Region of Residence	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
West County	9	6	
Placerville Area	15	14	
North County	1	2	
Mid County	4	3	
South County	1	2	
Tahoe Basin	11	14	
Unknown or declined to state	1	2	
Race	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
American Indian or Alaska Native	1	0	
Asian	1	1	
Black or African American	0	0	
Caucasian or White	30	29	
Native Hawaiian or Other Pacific Islander	1	0	
Other Race	2	8	
Unknown or declined to state	7	5	

Ethnicity	FY 2018-19	FY 2019-20	FY 2020-21
Hispanic or Latino	3	5	
Other Hispanic / Latino	4	5	
Not Hispanic	28	24	
Unknown or declined to state	7	9	
Primary Language	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
English	42	42	
Spanish	0	0	
Other Language	0	0	
Unknown or declined to state	0	1	

Outcome Measures

- Measurement 1: Number of participants
- Measurement 2: Number of Clients Graduating from Specialty Mental Health Services

Measurement 1 (Number of participants); and

Measurement 2 (Number of Clients Graduating from Specialty Mental Health Services from the TAY Engagement and Wellness program)

Participants	FY 2018-19	FY 2019-20	FY 2020-21
Unique Clients	42	43	
Total Episodes	44	45	
Episodes Opened:			
Total Episodes Opened	24	20	
New/Returning Client	21	17	
Changed Program (same level of service)	1	2	
Dropped Down in Level of Services	2	0	
Increased Level of Services	0	1	
Episodes Closed:			
Total Episodes Closed	22	23	
Graduated / Exited Services	21	19	
Decreased Level of Services	0	1	
Increased Level of Services	1	2	
Participants	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
Changed Program (same level of service)	0	1	

Community Transition and Support Team

Due to staffing shortages, clients eligible for this project have been served through the Adult Wellness program and their demographics are included with that program.

Community System of Care Program

Outreach and Engagement Services

Provider: El Dorado County Health and Human Services Agency, Behavioral Health Division

Project Goals

- To engage individuals with a serious mental illness in mental health services.
- Continue to engage clients in services by addressing barriers to service.

Numbers Served and Cost

Expenditures	FY 2018-19	FY 2019-20	FY 2020-21
MHSA Budget	$850,000	$1,000,000	$1,000,000
Total Expenditures	$446,978	$1,026,906[5]	$1,150,996
Requests for Services	1,322	1,593	1,493
Cost per Request	$338	$645	$771
Call Intakes (inquiries other than a Request for Service)	956	777	

Although costs significantly increased in FY 2019-20 for this project, those costs reflect the addition of the Student Outreach and Engagement Centers and Mental Health Supports project, and for the first time in many years, full staffing on the Access Team. Coupled with the increase in the number of request for service, the cost of this project is on target with the anticipated expenditures.

The following data reflects only Requests for Service received (no Call Intakes):

Request for Services Source	Total
General (self-refer, doctor, hospital)	1316
Child Welfare Services Referrals	88
Telecare Corp. (PHF) Referrals	38
Foster Care Presumptive Transfer Referrals	51
Total	1494

[5] Includes costs for the Student Outreach and Engagement Centers and Mental Health Supports, which is also reported separately below.

Age Group	FY 2018-19	FY 2019-20	FY 2020-21
0-15 (children/youth)	315	423	402
16-25 (transitional age youth)	240	329	325
26-59 (adult)	691	739	675
Ages 60+ (older adults)	72	100	91
Unknown or declined to state	0	21	1
Gender	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
Female	680	810	742
Male	635	783	751
Transgender	3	0	unknown
Region of Residence	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
West County	208	247	251
Placerville Area	413	447	452
North County	63	76	78
Mid County	122	130	157
South County	33	46	55
Tahoe Basin	378	554	403
Out of County	56	73	81
Unknown or declined to state	45	20	12
Race	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
American Indian or Alaska Native	29	25	
Asian	26	25	
Black or African American	20	24	
Caucasian or White	837	930	
Native Hawaiian or Other Pacific Islander	1	9	
Other Race	112	121	
Unknown or declined to state	293	459	
Ethnicity	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
Hispanic or Latino	68	87	87
Other Hispanic / Latino	82	80	82
Not Hispanic	742	816	630
Unknown or declined to state	426	610	694

Primary Language	FY 2018-19	FY 2019-20	FY 2020-21
English	1,211	1,438	1,283
Spanish	16	16	20
Other Language	3	14	12
Unknown or declined to state	88	125	179

Outcome Measures

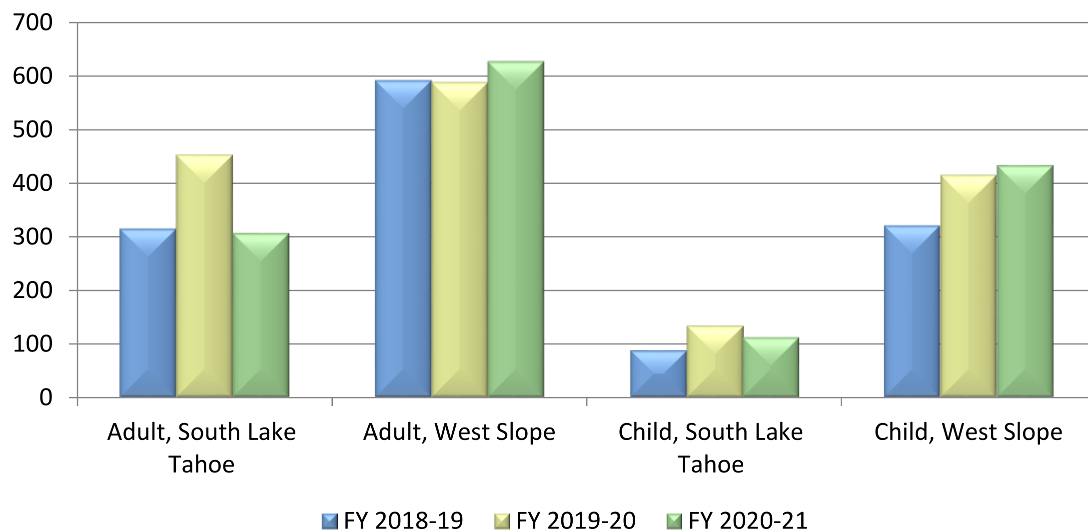
- Measurement 1: Number of and resulting determination for requests for services
- Measurement 2: Length of time from request for service to determination of eligibility for Specialty Mental Health Services

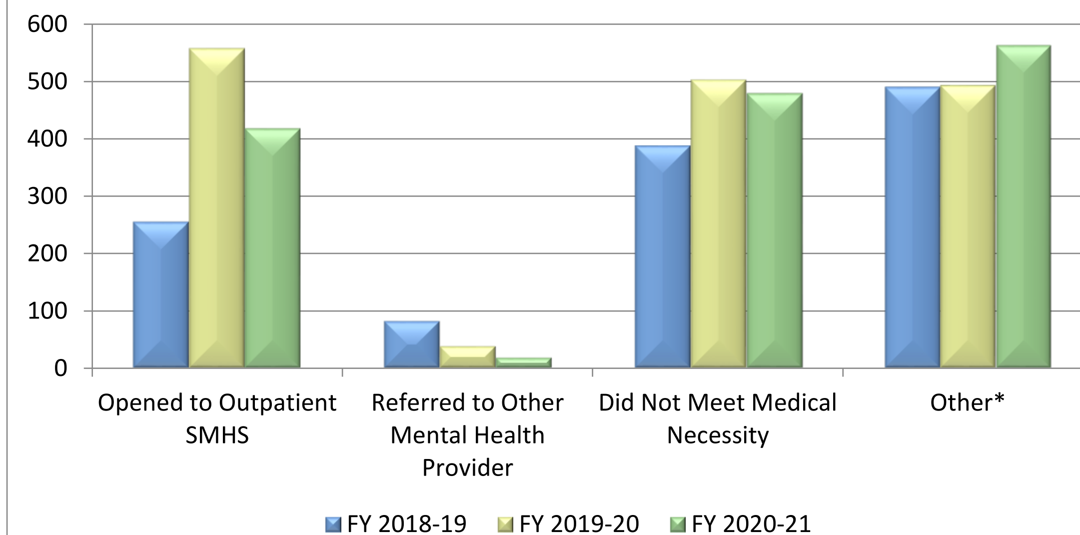
Measurement 1 (Number of and resulting determination for requests for services)

Age Group and Location	July 2020	Aug 2020	Sept 2020	Oct 2020	Nov 2020	Dec 2020
Adult, South Lake Tahoe	36	34	27	26	25	28
Adult, West Slope	70	52	53	53	40	50
Child, South Lake Tahoe	6	5	8	11	9	3
Child, West Slope	36	24	25	42	29	21
Overall	148	115	113	132	103	102

Age Group and Location	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	June 2021	Total FY 2020-21
Adult, South Lake Tahoe	12	16	26	25	26	25	306
Adult, West Slope	44	44	63	60	50	48	627
Child, South Lake Tahoe	11	7	13	13	14	12	112
Child, West Slope	28	53	35	49	52	39	433
Overall	95	120	137	147	142	124	1,478

The outcomes of the requests for services are:





Measurement 2 (Length of time from request for service to determination of eligibility for Specialty Mental Health Services)

The timeliness to assessment identifies how quickly individuals requesting services are assessed for eligibility for Specialty Mental Health Services. State standard for timeliness is that Medi-Cal beneficiaries must be offered an appointment within 10 business days of their request for service. Timeliness data is not yet available for FY 2020-21.

Student Outreach and Engagement Centers and Mental Health Supports (Student Wellness Centers)

Provider: Sierra Child and Family Services

Project Goals

- Provide a dedicated Student Outreach and Engagement Center at each high school. The Center shall be accessible, inviting, and supportive to students seeking mental health education, mental health services, and linkage to community services and outreach.
- Provide individual assessments and counseling services.
- Provide outreach and linkage to community resources.
- Provide customized trainings with input from high school staff, faculty, students, and parents.

Cost

Expenditures	FY 2018-19	FY 2019-20	FY 2020-21
MHSA Budget	Not Applicable	$218,000	$260,000
Total Expenditures	Not Applicable	$176,302	$260,000
Unduplicated Individuals Served	Not Applicable	523	628
Cost per Participant	Not Applicable	$337	$414

Sierra Child and Family Services reported the following information in its FY 2020-21 Year-End Report:

Outcome 1: Number of duplicated and unduplicated student contacts.

Total number of unduplicated student contacts 628
Total number of duplicated student contacts 1148

Reports from:
● Student Profile
● Wellness Brief Service Note
● Unique/Crisis Note
Unduplicated student contacts count for the number of Wellness Center students that have been newly imputed into the Electronic Health Records system. Duplicated student contacts count for all student contacts the Wellness Center made with students on an individual basis. This number does not account for groups, surveys or activities.

Total number of collateral contacts 572

Reports from:
● Collateral Note
Collateral contacts represent any communication Wellness Center staff had with a parent or an individual that is pertinent to the student's needs/case.

Outcome 2: The number of student mental health assessments performed.

Total number of mental health assessments performed 860

Report from:
Findings
CANS

CALOCUS
Safety Assessment
CRAFFT

Outcome 3: The number of training/education opportunities provided in person, writing or other means, along with the target population , number of attendees, and training/education topic.

Groups:
Total number of student groups 79
Total number of parent groups 5

Report from:
Group Note
Topics Offered:
- Coping Skills/Strategies
- DBT Groups
- Executive Functioning
- Grief
- Mindfulness
- Social Skills
- Substance Use
- Coffee Talk/Parent Talk (parent support group)

Opportunities provided:
Zoom/Telehealth
In Person
Target population:
Student
Parent

Outreach/Training:
Total number of outreach/training 21
Report From:
Newsletter (12 Newsletters)
Topics Offered:
- Apps and Resources
- Distance Learning
- Finals Prep
- Importance of Laughter
- Mixed Emotions
- Returning to Campus
- School Break Resources
- Self Compassion
- Self Love
- Setting Positive Intentions
- Thankfulness
- Virtual Calm Room

Staff Survey
- What Are You Seeing? (125 Responses)
- Stress Management Survey (149 Responses)

PA Announcement (5 Announcements)
- Mental Health Awareness Month

Staff Training
- How to Connect With Wellness (2 Trainings)

Opportunities provided:
In Person
In Writing
Online
Target population:
Student
Parent
Faculty/Staff

Media Outreach:
Website
Total number of website hits 3739
Total number of new visitor hits
● 98.1% Increase of new visitors to website
2580
Instagram
Total number of Instagram followers 119
Total number of Instagram posts 107
Report from:

Website
Instagram
Opportunities provided:
Online
Target population:
Student
Parent
Faculty/Staff

Outcome 4: The number of students linked to community services, the names of the community organizations to which students were referred; and the general reason for referral.
Number of students linked to an outside provider 84
Number of students linked to school-based provider 75
Parent led linkages following contact from Wellness Center staff
*Parent led navigation represents the following:
- Parents were notified of mental health concern and connected with an established provider
- Parents were offered a list of referral names and navigated privately

88
Number of students referred to TUPE Program 6
Number of students referred to FEP Program 3

Community providers utilized by the Wellness Center include:

Alice Rodriguez, APCC, CADC
April Paganelli
Cameron Park Counseling Center
Carmen Valentine, LMFT
Deloy Link, LMFT
Dr. Ashar
El Dorado Community Health Centers
El Dorado County Behavioral Health (EDCBH)
El Dorado County Hub
Jennifer Alexander, MFT
James Larson

Jillian Taylor McNew, LMFT
John Schroeder, PhD
Jayce Scott
Kaiser Permanente
Kathryn Garcia
Kimberly Salmon, LMFT
Lori Larson, MFT
Marlene Zerweck
Montessori Autism Programs and Services
Mother Lode Counseling
New Morning
Patrizia Ahlers, LMFT
Ruth Zermeno
Sarah Schumacher
Shingle Springs Health and Wellness (Tribal Health)
Stanford Youth Solutions
Sutter
Summitview Child and Family Services
Various primary care providers

General reasons for a referral:

Aggression
Anxiety
Communication
Depression
Eating Disorder
Family Dynamics
Gender Identity
Grief
Housing
Living Necessities
Low Self Esteem
Mood Management
Peer Relationships
Physical Health
School Achievement
School Attendance
School Discipline
Self Harm
Sexual Health/Pregnancy
Social Skills
Substance Abuse
Suicidal Ideation
Trauma

Outcome #5 Implementation Challenges, Successes, Lessons Learned and Relevant Examples

Successes

- Added one school site to the Wellness Center program- Golden Sierra High School, leaving the program with a total of 6 active Wellness Centers in the community.
- Growing presence on school campuses, leading to established trust with students, faculty and parents.
- All wellness sites have an established/furnished physical location on campus.
    - Provides space for individual and group services

- Wellness Center sites created a safe, clean environment utilizing COVID-19 guidelines presented by the CDC.
- Continued to provide ongoing support during pandemic closure via telehealth.
    - Wellness Center staff moved to in person support when deemed safe.
- Utilized pandemic school closure as a time to expand communication to school staff and
- community.
- Offered support to school faculty due to increased stress during pandemic and school
- closure.
    - Utilized surveys, hand written notes, mindfulness activities to connect with
- faculty and supported linkage to outside resources
- Increased communication with all school staff and continued to develop relationships
- with school personnel.
- Implemented a more efficient and streamlined process for crisis response.
- Implemented in-person groups for students on multiple school campuses.
- Offered parent support groups to extend support further into the community.
- Increased connections with community providers and identified possible providers for students who need navigation.
- Adjusted to the district schedule changes including; distant learning, hybrid and full time.
- Introduced the Wellness Center program to student organized programs including Queer Alliance, El Dorado County Library and Youth Commission and ASB/Leadership classes.
- Continued to develop and improve electronic record keeping system to manage records
- and capture data more efficiently.
- Began to streamline the onboarding process for new hires/interns.
    - Rewrote Handbook
    - New Apricot Training
- Supported ERMHS students over summer break to continue mental health support on an as needed basis.
- Created and established a social media account via Instagram to increase accessibility to students.
- Created 'Safety Assessment' to be utilized for every student contact- 5 question assessment.
- Created and distributed Wellness Center resources including crisis cards, magnets, stickers and business cards.

Implementation Challenges

- Referral process became inconsistent across school sites leading to disorganization in implementation of the Wellness Program and efficiency.
- Many community providers were 'work from home' status leading to less navigation success.
- Student preferred in person
- Many community providers had limited to no availability for new clientele.
- Training/onboarding process for new hires was confusing and not efficient as a result of:
    - No clear onboarding process
    - School sites were managed differently
    - Referral system was not consistent
- Lack of case management support for team members due to timing constraints, this led to a higher stress environment.
- Scheduling students during distance learning and hybrid schedules was difficult due to many time demands for students.
- Obtaining informed consent was difficult.
- Difficulty in confirming navigation success/status.
    - Parents do not return calls, emails, etc. after navigation referrals are offered.

Lessons Learned

- Need to establish one, consistent referral system across all school sites. There should be no variance between referral systems at different school campuses.

- For the upcoming 2021/2022 school year, the Wellness team is focusing on establishing protocol for obtaining Wellness Center informed consent from parents/guardians.
- Need to create a more concise and simple training process for new hires.
- Need for weekly case consultation meetings or supervision.
- An org chart may be beneficial for the Wellness Center team.
- With future expansion it will be important to continue to focus on the process and structure to make sure the Wellness Center program can sustain growth.
- Summertime in the Wellness Center slows down with referrals, which allows for growth opportunities and engagement with the school community.

Genetic Testing

Provider: Assurex Health

Project Goals

- To assist with the determination of appropriate medication(s) for clients.

Numbers Served and Cost

Expenditures	FY 2018-19	FY 2019-20	FY 2020-21
MHSA Budget	Not Applicable	$100,000	$100,000
Total Expenditures	Not Applicable	$0	$0
Requests for Services	Not Applicable	0	0

Outcome Measures

- Measurement 1: The number of clients who receive genetic testing.

Potential vendors were researched in late FY 2018-19 in anticipation of the approval of the FY 2019-20 Annual Update. The contract request for genetic testing using Assurex Health's "GeneSight®" product was submitted in June 2019, and the contract became effective on August 25, 2020. To date there have been no genetic tests ordered.

Numbers Served and Cost

Expenditures	FY 2018-19	FY 2019-20	FY 2020-21
MHSA Budget	--	$100,000	$100 ,000
Total Expenditures	--	$0	$0
Number of Clients Tested	--	0	0

Housing Projects

Program Goals

- Acquire, rehabilitate, construct and support permanent supportive housing for individuals with serious mental illness and who are homeless or soon-to-be homeless.

- Support clients in maintaining tenancy.

West Slope – Trailside Terrace, Shingle Springs

MHSA Housing funds were utilized to provide for five units in Shingle Springs targeting households that are eligible for services under the Full Service Partnership project. All units are occupied and the BHD maintains a waiting list.

The funds for this program were transferred to California Housing Finance Agency (CalHFA) for administration of this program.

East Slope – The Aspens at South Lake, South Lake Tahoe

MHSA Housing funds were utilized to provide for six units in South Lake Tahoe targeting households that are eligible for services under the Full Service Partnership project. All units are occupied and the property manager maintains any wait list.

The funds for this program were transferred to California Housing Finance Agency (CalHFA) for administration of this program.

Local Housing Assistance

These CSS-Housing funds include costs such as rental assistance, security deposits, utility deposits, other move-in costs, and/or moving costs. The funds were depleted in FY 2017-18. Housing supports for clients in the FSP and GSD programs is included in the costs for those programs.

Numbers Served and Cost

Expenditures	FY 2018-19	FY 2019-20	FY 2020-21
MHSA Budget	$0	$0	$0
Total Expenditures	$0	$0	$0
Number of Clients Served	0	0	0
Average Cost per Participant	$0	$0	$0

Innovation Projects

Introduction

Innovation Projects are defined as projects that contribute to learning, rather than a primary focus on providing a service. By providing the opportunity to "try out" new approaches that can inform current and future practices/approaches in communities, an Innovation project contributes to learning. Innovation plans must be approved ty the Mental Health Services Oversight and Accountability Commission (MHSOAC) prior to the expenditure of funds in this component.

This Outcome Measures Report accompanying the Fiscal Year 2022/23 MHSA Annual Update provides outcome information for the Innovation projects in Fiscal Year 2020/21.

Pursuant to Title 9 California Code of Regulations Section 3580.010, the Annual Innovation Report shall include: The name of the Innovative Project; whether and what changes were made to the Innovative Project during the reporting period and the reasons for the changes; available evaluation data, including outcomes of the Innovative Project and information about which elements of the Project are contributing to the outcomes; program information collected during the reporting period, including applicable Innovation Projects that serve individuals, number of participants served by age categories, race, ethnicity, primary language, sexual orientation, disability, veteran status, gender, and any other data the County considers relevant. For Innovation Projects that serve children or youth younger than 18 years of age, the demographic information shall be collected only to the extent permissible by Article 5 of Chapter 6.5 of Part 27 of Portability and Accountability Act of 1996 (HIPPA), California Information Practices Act, and other applicable state and federal privacy laws. Further, sexual orientation, current gender identity, and veteran status is not required to be collected for a minor younger than 12 years of age.

During this reporting period, the County had one active Innovation Project: Community-based Engagement and Support Services. This project ended on June 30, 2021.

Community-based Engagement and Support Services Project (aka "Community Hubs")

The Community-Based Engagement and Support Services program, more commonly known as "Community Hubs", has been in operation since September 2016, which has allowed the service providers to identify both challenges and successes.

This Innovation program was initially intended to end in September 2020, however the MHSA team held Stakeholder and Community Program Planning Process to discuss what has been learned from the program. It was determined that there is significant support for this program, but there is a need to modify the program to allow for accurate learning. Following implementation and with ongoing administration of the Community Hubs, MHSA and the service partners identified some programmatic challenges, which, if addressed, would enable continued learning, and if not addressed could negatively impact the County's ability to fully analyze the learning objectives from this Innovation program. Therefore, the community supported requesting an expansion of the project and an extension of the term for this project. When the expansion and extension was approved by the MHSOAC, this program was modified to address some of the challenges learned through initial implementation and expanded to address unanticipated and unmet program goals.

Expansion of this project was intended to address the following challenges:

Challenge: Resource Infrastructure

One of the first challenges faced by this program was inconsistent staffing. The Public Health Nurse allocations associated with this program were limited-term allocations, meaning staff's services with the County were shorter term in duration. Recruiting, interviewing, hiring, and training public health nurses is time-intensive. However, candidates who accepted the offer of employment, continued to search for more permanent employment and resigned from the limited-term Public Health Nurse position in favor of a permanent position. There was a continuous cycle of recruiting, interviewing, hiring, and training.

Additionally, because the position was a limited-term allocation, it was difficult to attract and recruit qualified individuals. Hiring and retaining qualified individuals is extremely time consuming and challenging.

Restructuring the staffing allocation and budget to accommodate converting permanent status, and changing the allocation for future recruitments to full-time alleviated some of the staffing turn-over, and resulted in a consistent workforce that was knowledgeable of local resources, practices and clients. Having consistent Public Health Nurses available to the community is vital to the mental health of the unserved and underserved members of our community.

Additionally, there was a need for a full-time supervising public health nurse to provide program oversight and supervision of the public health nurses. The initial allocation was .20 FTE which was not adequate to perform all the functions of this role, as well as to oversee the outcome reporting required for this program.

Due to the extensive outcome reporting responsibilities for both MHSA and the community partner grants, it was necessary to hire a Senior Department Analyst or Department Analyst to manage this function.

Once established and if shown to be successful, long-term sustainability of the Public Health Nurses and Analyst will be funded through other existing funding, grants, and funding partnerships. It is also anticipated that a natural attrition rate will occur.

Additionally, the community requested that the Community Hubs be open in the evenings, and that staff expand their area of reach to more places where individuals naturally meet. To accommodate these requests, full-time staff will need to be hired.

Challenge: Continued Family Engagement

The project expansion in 2020 included a 2.5 FTE Family Specialist allocation. The Family Specialist positions were co-located with the El Dorado County Office of Education. Family Specialists worked with parents, guardians, families, and community agencies to support practices and approaches which meet the needs of children age birth to 18 years old. The Family Support Specialists collaborated with Community Hub partner agencies, including the Public Health Nurses, for the purpose of increasing ongoing family engagement and awareness of childhood health, development, and literacy for families who are isolated or unserved.

Family engagement programming may include support groups, parenting classes, play groups or workshops for the purpose of increasing family knowledge of parenting and child development or to address mental health needs and issues, as well as other focuses of the Community Hubs program which is funded through various organizations such as First 5 El Dorado and Public Health. Family Specialists consulted with families

via phone and/or home visits to provide appropriate referrals for the purpose of supporting families and increasing connections with families, schools and community.

To support the staffing needs of the Family Specialists, the expansion also included a 0.10 FTE supervising Quality Improvement and Family Support Coordinator. This supervising position provided monthly observation of the Family Specialists and review of programming strategy and performance as it relates to Family Engagement.

Once established and if shown to be successful, long-term sustainability of the Family Specialists and Family Support Coordinator positions will be dependent upon partnerships with schools, Probation, Grants, Child Abuse Prevention funds, and other not yet identified funding streams.

Challenge: Technology

As identified in the FY 2016-17 and 2017-18 Innovation outcomes reports, technology was a challenge for this program. Several factors contributed to this issue, including lack of strong wireless signals in areas of the County, vast amount of data that is required to be collected for the numerous funding sources, and use of a separate, and very manual, record keeping system.

Health and Human Services, Public Health Division currently uses proprietary software called "Patagonia Health, Inc." (Patagonia) to maintain patient electronic medical records (EMR) and practice management with Patagonia's secure network. However, client information from the Public Health Nurses for the Community Hubs is captured through a separate process.

Integrating the Community Hubs Public Health data into Patagonia would have increased the ability to provide case management services to clients, provide health-related referrals through the EMR, reduce the amount of double entry that is needed, and develop reports to provide the needed data to further evaluate the program. This integration was never fully completed, primarily due to the onset of the COVID-19 pandemic.

Challenge: Other Costs of Doing Business

There was a continued need to provide funding for other costs related to doing business. Such costs include, but are not limited to, increases in staff wages and benefits, office supplies, printing costs, telephones, mileage, professional development/training costs, etc.

Additional Challenge: COVID-19

As the Hubs stakeholders worked to implement the changes described above, our world was hit with the COVID-19 pandemic. Just as it impacted almost all parts of society, the pandemic dramatically limited the ability of the Hubs to provide service. Contacts were limited for a time to phone calls and video meetings, and all Hubs staff were pulled away to assist with pandemic response in some way. Unfortunately, this limited our ability to thoroughly evaluate the success of the project.

Research on Community Hub Service

The Community Hubs project promotes integration of successful service delivery models in the early childhood, health, and community building systems to provide a local continuum of care for pregnant women,

families, and children birth through eighteen, including increasing access to mental health services. Key elements of the Community Hubs include:

Community-Based Access: The Oregon Model relies on a partnership of schools and primary care clinics to complete assessments to ensure school readiness for children. El Dorado County's model is similar with regards to community collaboration, but unlike the Oregon Model, El Dorado County's project established "hubs" – a one-stop-shop type of approach.

Community Hubs are located in the libraries in each of the five (5) supervisorial districts in El Dorado County. Since the Community Hubs program was implemented, service locations have expanded beyond the libraries and now include places such as apartment complexes, schools, and community events. By offering assessments and services at places where individuals and families naturally gather, we are able to provide an array of services while reducing the stigma associated with seeking mental health services.

Outreach to Isolated Communities: The Community Hubs engage pregnant women, families, and children, primarily age birth through 18, in isolated regions of the county using the Community Health Works Model. Community Health Advocates (CHAs) assist community members to increase access to care by using best public health practices in performing a variety of community outreach and education functions. As a trusted community partner, CHAs can offer linguistic and cultural translation; provide linkage and access to services; and develop relationships in a community setting, including communities in geographically isolated areas of the County. The CHAs act as a liaison between the community and the Public Health Department for improved service delivery.

Continuum of Care: The Community Hub partners develop trusted relationships to assist community members in assessing and developing an individualized plan, and in case management. Each Community Hub partner plays a vital role in the continuum of care, with the Public Health Nurses focusing on populations at risk needing interventions to address the prevention or amelioration of high risk conditions, whether it is chronic illness or mental health needs. The Public Health Nurses use a trauma-informed approach to provide services including, but not limited to, case management; health screenings; mental health screenings; and alcohol and drug screenings.

Community Assessments: Ongoing, local assessments promote continuous quality improvement in service delivery by engaging community members in determining successful implementation.

This project implemented an expansion of the previously approved Innovation program to address challenges that have been a barrier to learning.

Learning Goals/Project Aims

The initial question for this project was, "will a library-based access point for services, different than the multi-access point of the Oregon Learning Model, facilitated by a Public Health Nurse using trauma-informed approach, be successful in the rural areas of the County?" This Innovation project has been operational since 2016. However, due to the staffing and infrastructure challenges previously discussed, as well as the onset of the COVID-19 pandemic, conclusive data is not available. Even so, anecdotal reports and preliminary data analysis suggest that individuals are willing to access services in the libraries. However, the impact to mental health services is not yet fully understood. Collected data for fiscal year 2020-2021 follows this narrative.

There also is an increase in interagency collaboration. With multiple funding partners, employees are able to build relationships with other community agencies. Consequently, there is a sharing of knowledge and resources. Additionally, visitors to the Community Hubs receive a soft handoff to other programs and services, thus helping to ensure that the visitors receive the services and support needed.

Additional questions from the original Community Hubs project:

- Does providing services at the library reduce stigma?
- Does increasing access to prevention and early intervention reduce long-term mental health costs?
- Does improving coordination and integration of physical and behavioral health services increase the number of clients accessing mental health services?
- Does case management by a Public Health Nurse increase client screening and treatment for mental health services?
- Does a trauma-informed approach assist in reaching the hardest to serve mental health clients?
- Can Community Hubs be sustained through local planning and leveraging of resources?

Due to the multiple community partners and the fact that the Community Hubs are geographically spread throughout El Dorado County, these goals were prioritized to examine both the effectiveness and the sustainability of this project.

The learning goals directly relate to the unique aspect of providing mental and physical health services in a "one-stop shop" community setting where individuals and families naturally congregate.

Evaluation or Learning Plan

Client level data was collected via Community Health Advocates and Public Health Nurses. The number of clients served, type and amount of screenings performed, specialty health referrals made and to whom, as well as the number of clients who accessed these services was recorded.

Program level data was gathered by funding partner First 5. As previously mentioned, this data was gathered through the Family Strengthening Protective Factors Parent Survey.

Community level reporting was facilitated in partnership with El Dorado Community Foundation to better understand local needs and inform strategy implementation. Hub communities were convened on a regular basis to better understand service impact, access and barriers to services. This included weekly team meetings to better coordinate care and services at each of the Community Hubs. Additionally, members from each of the collaborating agencies met on a monthly basis to strategize quality improvement changes, if necessary, based on successes and challenges identified at the team meetings. This qualitative data was combined with county quantitative data to provide a better understanding of community need and provide a continuous quality improvement process. These data profiles guide program implementation.

Please report on the following Outcome Measures/Learning Objectives:

Learning Objective #1 - Does providing services at the library reduce stigma?

Promotion of health services, health education on resilience and mental health awareness by health staff within the library setting during programming is a primary prevention strategy to reduce stigma regarding

mental health. Each participating library within the Hub program has had capacity to offer private meeting space for clients and health staff which can be used as an alternative to a visit to the client's home. However, some library locations are more frequently used than others. Anecdotal reports from public health staff imply that clients are amenable to setting meetings to access health team services in the Library setting. Early on in the implementation of the Community Hubs program there were incidences where clients did not engage with staff when other patrons that they know were present. As the Community Hub program developed access points such as schools and Boys and Girls Club, these locations have become additional options beyond the home and library settings.

Libraries are also incorporating mental health topics into their routine programming in partnership with the Hub Health team. This increases awareness within the community, as well as introduces prevention strategies and resources for mental health treatment. The community has been receptive and engagement is building. Clients have connected with health staff at the library for assistance connecting to mental health providers as a result of the reduced stigma.

Community Hub services are offered in access points beyond the library. Home visiting allows health staff to connect with clients in the comfort of their own home. Partnerships throughout the community have expanded access points to include schools, Boys and Girls Club, churches, transitional housing, and apartments. With the expanded access points, awareness throughout the community is increased and, ultimately, stigma is reduced.

Learning Objective #2 - Does increasing access to prevention and early intervention reduce long-term mental health costs?

In theory, increasing access to prevention and early intervention reduces long-term mental health costs. "Studies around the country prove over and over again that we are able to prevent or mitigate the effects of mental illness and allow individuals to live fulfilling, productive lives in the community. From the influence of genetics and prenatal health all the way into early adulthood, we are learning more about the critical points in brain development and life experiences that increase the risk for or provide protection against the development of mental health disorders." https://www.mhanational.org/issues/prevention-and-early-intervention-mental-health

Learning Objective #3 - Does improving coordination and integration of physical and behavioral health services increase the number of clients accessing mental health services?

Coordination and integration of physical and behavioral health services has increased access to mental health services as well as individualized education during the course of Public Health Nurse (PHN) case management. 267 referrals for behavioral health services were initiated by public health staff during FY 19/20, with the most common resource connection being early intervention focused counseling services for clients.

Learning Objective #4 - Does case management by a Public Health Nurse increase client screening and treatment for mental health services?

Hub Public Health Nurses (PHN) screen adults for behavioral health concerns, including postpartum depression, ACEs, and child development during the course of case management with postpartum women and families with children 0-18 as applicable. Additionally, clients and families are assisted with connection to providers of behavioral health treatment by the PHNs. Clients may not be comfortable addressing their mental health concerns with their Primary Care Providers. PHNs can reduce this barrier by educating clients

to help reduce the stigma and by advocating on the patient's behalf. PHNs are also skilled in coordinating care between providers, which may include a Primary Care Provider, Mental Health provider and the client.

Learning Objective #5 – Does a trauma-informed approach assist in reaching the hardest to serve mental health clients?

Using a trauma-informed approach, Public Health Nurses (PHNs) develop trusting relationships with clients through the course of case management. Clients are often open to sharing their risk-factors, signs and symptoms, stressors and other concerns with PHNs as a result. More importantly, clients allow PHNs into their personal space - their home, and PHNs are able to truly assess all factors (environment, relationships, resources, etc.) to get a complete picture of what the client may need. PHNs are then able to connect clients with prevention and early intervention measures such as the Mothers and Babies program, mom groups, counseling, self-care and healthy coping skills or a treatment plan that meets the client's needs. Other prevention strategies utilized include reducing stressors through connections to community resources, education and role modeling behaviors to build protective factors and skills, and increase support.

Learning Objective #6 - Can Community Hubs be sustained thorugh local planning and leveraging of resources?

One of the positive outcomes of this identified challenge is that the partnering agencies have been creative with looking at how funding between their programs and potential funding from other sources can be coordinated to maximize benefits to the community and avoid duplication of efforts. The funding partners to this program are continually examining how to sustain this project in the long-term. At the conclusion of the Innovation funding period, the Community Health Advocates became employees of the county library system and have continued their work in the community.

Summary

This Innovation Project encountered numerous challenges from the start, but was in a position to provide significant positive community impact at the time the COVID-19 pandemic began. Unfortunately, the pandemic forced changes in procedures and reduced available resources dramatically. Key staff departures further complicated the situation to the point that meaningful data was no longer being generated. Even so, anecdotal reports have been very positive and it appears that county citizens are indeed willing to access services through library based "hubs" offering a "one stop shop" approach.

Community-based Engagement and Support Services Project (aka "Community Hubs")

Expenditures	FY 2018-19	FY 2019-20	FY 2020-21
MHSA Budget	$950,000	$1,250,000	$1,360,320
Total Expenditures	$536,847	$550,609	$647,831
Unduplicated Individuals Served	1,318	1,592	647
MHSA Cost per Participant	$407	$346	$1,001

Please refer to page 282 in the Appendix for complete demographic data in the section entitled "First 5 El Dorado Annual Report (Community Hubs)

Workforce Education and Training (WET) Projects

Introduction

The Workforce Education and Training (WET) component includes education and training projects and activities for prospective and current public mental health system employees, contractors, and volunteers.

WET Coordinator Project

Project Goals

- Increase participation in regional partnerships.
- Identify career enhancement opportunities and variety of promotional opportunities for existing public mental health system workforce.
- Increased utilization of WET funding for local trainings.
- Increase number of bilingual/bicultural public mental health workforce staff.
- Increase number and variety of employment and/or volunteer opportunities available to consumers and their families who want to work in the mental health field.

Cost

Expenditures	FY 2018-19	FY 2019-20	FY 2020-21
MHSA Budget	$30,000	$30,000	$25,000
Total Expenditures	$11,272	$15,699	$14,197

Outcome Measures

- Measurement 1: Increase the number of training opportunities for the mental health workforce.

  Information about upcoming trainings applicable to Behavioral Health is distributed to the Behavioral Health Division managers and supervisors, and to community-based organizations or the public depending upon the topic of the training. Additional, contracts with training vendors continue to be established to ensure training can be scheduled when needed.

Workforce Development Project

Project Goals

- Increase the number of training opportunities for the public mental health system workforce.
- Identify career enhancement opportunities for existing mental health workforce.
- Increase the retention rates for current mental health workforce staff.
- Increase the number of new staff recruited into the mental health workforce.
- Increase the number of bilingual/bicultural mental health workforce staff available to serve clients.

- Increase the number and variety of positions available to consumers and their family members who want to work in the mental health field.

Cost

Expenditures	FY 2018-19	FY 2019-20	FY 2020-21
MHSA Budget	$20,000	$85,000	$100,000
Total Expenditures	$34,894	$32,638	$19,024
Total Number of Trainings	12	115	423

Outcome Measures

- Measurement 1: The number of training opportunities for the public mental health system workforce, including staff, contractors, volunteers, and consumers.

Number of Staff Receiving Training: 73
Number of Training Topics: 423
Number of Hours of Training: 1,337.75

FY 20/21CULTURAL COMPETENCE TRAINING		
Title of Training	Number of Attendees	Duration of Training
A Provider's Introduction to Substance Abuse Treatment for LGBT Individuals	11	2 hour
Addressing Racial Disparities in Healthcare for Black American	1	1 hour
Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment with LGBTQIA+	2	2 hour
Addressing Trauma: Racism and Bias in Behavioral Health	1	1 hour
An Introduction to Cultural and Linguistic Competency	2	1 hour
Anti-Harassment Training for All Employees - CA SB1343	1	1.25 hours
Black Body Trauma/Cultural Semantics Part 2	1	1 hours
Black Trans Lives Matter	1	1 hour
Black Wellness: A Local Perspective	3	1.5 hours
Code Switching 101 Black Behavioral Health	3	1.5 hours
Counseling Lesbian Gay Bisexual and Transgender (LGBT) Clients v.2	3	1 hour
COVID 19 and the LatinX Community: Skills to Reduce Stress Stigma and Substance Use	1	1 hour
Cross Cultural Awareness: Working Through Unconscious Bias	1	3.5 hours
Cultivating a Blended Culture	1	2 hours
Cultural Awareness: Shingle Springs Band of Miwok Indians	5	1.5 hours

Cultural Competence: The Immigrant Experience Ethnicity and Families	9	1 hour
Cultural Competence: The Immigrant Experience The Impact of Migration on Families	2	1 hour
Cultural Competence: The Immigrant Experience The Legal Hoops of Immigration	2	1 hour
Culturally and Linguistically Appropriate Interventions and Services	2	1.5 hours
Culture Counts: Mental Health Care for African Americans	7	2 hours
Culture Counts: Mental Health Care for American Indians and Alaska Natives	3	2 hours
Culture Counts: Mental Health Care for Asian Americans and Pacific Islanders	4	2 hours
Culture Counts: Mental Health Care for Hispanic Americans	8	2 hours
Culture Counts: The Influence of Culture and Society on Mental Health	5	2 hours
Diversity in the Workplace	3	1 hour
Diversity: Embracing Diversity in the Workplace v.2	1	1 hour
Exploring Cultural Awareness Sensitivity and Competence v.2	9	1 hour
Gay Boys: Sexual Orientation and Psychotherapy	2	1 hour
Gender Competency: An Introduction What Does It Mean?	5	3 Hours
Hey White Therapist Here's Where We Start	2	1 hour
Implicit Bias: Understanding the Impact of What We Don't See	1	1.5 hours
Improving Cultural Competency for Behavioral Health Professionals	1	5 hours
Introduction to a Framework for Confronting Racism in Behavioral Health	1	1.5
Introduction to LGBTQIA+ Populations MH Disparities & Providing Culturally Competent Care	5	1 hour
Know Thyself - Increasing Self-Awareness	2	1 hour
Knowing Others - Increasing Awareness of your Client's Cultural Identity	2	1.5 hours
Lifting Black Voices: Therapy Trust and Racial Trauma	2	1 hour
Managing Anxiety and Depression for LGBTQ Populations in COVID 19	1	1 hour
Providing Culturally Responsive SUD Treatment in Indigenous Communities	2	2 hours
Providing Inclusive Respectful Care to Your Gender Questioning Transgender & Nonbinary Clients	1	1 hour
Racial Equality Through Action and Learning Summit Part 2-Targeted Universalism	1	1 hour
Racial Trauma	1	1.25 hours

Racialized Trauma/Cultural Semantics Part 1	1	1 hour
Skills to Reduce Stress, Stigma, & Substance Use	1	1.5 hours
Systemic Racism and Structural Racialization: Examining the Impact on BH Disparities	1	1 hour
The Impact of Historical Trauma on American Indian's Health & Wellbeing	1	1.5 hours
Understanding the Health Needs of LGBTQ People: An Introduction, Part 1	1	1.5 hours
White Supremacist Violence: Clinically Understanding the Resurgence and Stopping the Spread	7	1 hour
Women and Addiction: Consumption Patterns (R)	1	1 hour
Women and Addiction: Treatment Considerations (R)	2	1 hour
Women’s Mental Health - Action Steps for Improvement (R)	1	1 hour

Capital Facilities and Technology (CFTN) Projects

Introduction

The Capital Facilities and Technology (CFTN) Projects are items necessary to support the development of an integrated infrastructure and to improve the quality and coordination of care.

Electronic Health Record System

Cost

Expenditures	FY 2018-19	FY 2019-20	FY 2020-21
MHSA Budget	$252,617	$225,000	$250,000
Total Expenditures	$104,414	$189,521	$132,701

Full implementation of software to increase communication with community-based partners has not yet been completed.

Telehealth

Cost

Expenditures	FY 2018-19	FY 2019-20	FY 2020-21
MHSA Budget	$100,000	$110,000	$75,000
Total Expenditures	$1,856	$21,853	$4,839

With the continuing public health emergency, Mental Health continued to explore methods to maximize the use of telehealth (phone and video) to continue to serve its clients.

Community Wellness Center

Cost

Expenditures	FY 2018-19	FY 2019-20	FY 2020-21
MHSA Budget	$500,000	$1,000,000	$1,000,000
Total Expenditures	$0	$0	$0

Behavioral Health has not been able to locate a viable location for an integrated Community Wellness Center but continues to explore options in the community.

FY 2020-21
Revenue and Expenditure Report (RER)

State of California
Health and Human Services Agency

Department of Health Care Services

ANNUAL MHSA REVENUE AND EXPENDITURE REPORT and ADJUSTMENT WORKSHEET COUNTY CERTIFICATION

County/City: El Dorado

Local Mental Health Director

Name: Nicole Ebrahimi-Nuyken

Telephone: 530 621 6545

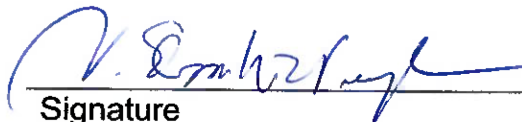
Email: nicole.ebrahimi-nuyken@edcgov.us

Document for Certification:

Annual MHSA Revenue and Expenditure Report **FY:** 2020-2021

I hereby certify[1] under penalty of perjury under the laws of the State of California that the attached Annual MHSA Revenue and Expenditure Report or Adjustments to Revenue or Expenditure Summary Worksheet is complete and accurate to the best of my knowledge.

Nicole Ebrahimi-Nuyken
Local Mental Health Director (PRINT)


Signature

1/26/22
Date

[1] Welfare and Institutions Code section 5899(a)

DHCS 1820 (02/19)

DHCS 1822 A (02/19)

Annual Mental Health Services Act (MHSA) Revenue and Expenditure Report
Fiscal Year: 2020-2021
Information Worksheet

1	Date:	1/26/2022
2	ARER Fiscal Year *(20YY-YY):*	2020-2021
3	County:	El Dorado
4	County Code:	09
5	Address:	3057 Briw Road, Ste B
6	City:	Placerville
7	Zip:	95667
8	County Population: Over 200,000? (Yes or No)	No
9	Name of Preparer:	Michele McAfee
10	Title of Preparer:	Accountant II
11	Preparer Contact Email:	michele.mcafee@edcgov.us
12	Preparer Contact Telephone:	(530) 295-6910

STATE OF CALIFORNIA
HEALTH AND HUMAN SERVICES AGENCY

Department of Health Care Services

DHCS 1822 B (02/19)

Annual Mental Health Services Act (MHSA) Revenue and Expenditure Report
Fiscal Year: 2020-2021
Component Summary Worksheet

County:	El Dorado	**Date:**	1/26/2022

		A	B	C	D	E	F
SECTION 1: Interest		**CSS**	**PEI**	**INN**	**WET**	**CFTN**	**TOTAL**
1	Component Interest Earned	$24,148.00	$18,770.00	$11,069.00	$490.00	$5,276.00	$59,753.00
2	Joint Powers Authority Interest Earned						$0.00

		A	B	C
SECTION 2: Prudent Reserve		**CSS**	**PEI**	**TOTAL**
3	Local Prudent Reserve Beginning Balance			$1,655,402.00
4	Transfer from Local Prudent Reserve			$0.00
5	CSS Funds Transferred to Local Prudent Reserve	$0.00		$0.00
6	Local Prudent Reserve Adjustments			$0.00
7	Local Prudent Reserve Ending Balance			$1,655,402.00

		A	B	C	D	E	F
SECTION 3: CSS Transfers to PEI, WET, CFTN, or Prudent Reserve		**CSS**	**PEI**	**WET**	**CFTN**	**PR**	**TOTAL**
8	Transfers	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

		A	B	C	D	E	F
SECTION 4: Program Expenditures and Sources of Funding		**CSS**	**PEI**	**INN**	**WET**	**CFTN**	**TOTAL**
9	MHSA Funds	$4,642,606.00	$2,014,588.00	$647,831.00	$33,221.00	$141,010.00	$7,479,256.00
10	Medi-Cal FFP	$6,087,921.00	$0.00	$0.00	$0.00	$0.00	$6,087,921.00
11	1991 Realignment	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
12	Behavioral Health Subaccount	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
13	Other	$803,307.00	$0.00	$0.00	$0.00	$0.00	$803,307.00
14	**TOTAL**	**$11,533,834.00**	**$2,014,588.00**	**$647,831.00**	**$33,221.00**	**$141,010.00**	**$14,370,484.00**

DHCS 1822 B (02/19)

Annual Mental Health Services Act (MHSA) Revenue and Expenditure Report
Fiscal Year: 2020-2021
Component Summary Worksheet

County:	El Dorado

Date:	1/26/2022

		A
SECTION 5: Miscellaneous MHSA Costs and Expenditures		**TOTAL**
15	**Total Annual Planning Costs**	$16,439.00
16	**Total Evaluation Costs**	$0.00
17	**Total Administration**	$152,238.00
18	**Total WET RP**	$0.00
19	**Total PEI SW**	$19,575.19
20	**Total MHSA HP**	$0.00
21	**Total Mental Health Services For Veterans**	$186,553.00

STATE OF CALIFORNIA
HEALTH AND HUMAN SERVICES AGENCY

Department of Health Care Services

DHCS 1822 C (02/19)

Annual Mental Health Services Act (MHSA) Revenue and Expenditure Report
Fiscal Year: 2020-2021
Community Services and Supports (CSS) Summary Worksheet

County:	El Dorado	Date:	1/26/2022

SECTION ONE

		A	B	C	D	E	F
		Total MHSA Funds (Including Interest)	Medi-Cal FFP	1991 Realignment	Behavioral Health Subaccount	Other	Grand Total
1	CSS Annual Planning Costs	$16,439.00	$0.00	$0.00	$0.00	$0.00	$16,439.00
2	CSS Evaluation Costs	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
3	CSS Administration Costs	$107,810.00	$0.00	$0.00	$0.00	$0.00	$107,810.00
4	CSS Funds Transferred to JPA	$0.00					$0.00
5	CSS Expenditures Incurred by JPA	$0.00					$0.00
6	CSS Funds Transferred to CalHFA	$0.00					$0.00
7	CSS Funds Transferred to PEI	$0.00					$0.00
8	CSS Funds Transferred to WET	$0.00					$0.00
9	CSS Funds Transferred to CFTN	$0.00					$0.00
10	CSS Funds Transferred to PR	$0.00					$0.00
11	CSS Program Expenditures	$4,518,357.00	$6,087,921.00	$0.00	$0.00	$803,307.00	$11,409,585.00
12	**Total CSS Expenditures (Excluding Funds Transferred to JPA)**	**$4,642,606.00**	**$6,087,921.00**	**$0.00**	**$0.00**	**$803,307.00**	**$11,533,834.00**
13	**Total CSS Expenditures (Excluding Funds Transferred to JPA, PEI, WET, CFTN and PR)**	**$4,642,606.00**	**$6,087,921.00**	**$0.00**	**$0.00**	**$803,307.00**	**$11,533,834.00**

DHCS 1822 C (02/19)

Annual Mental Health Services Act (MHSA) Revenue and Expenditure Report
Fiscal Year: 2020-2021
Community Services and Supports (CSS) Summary Worksheet

County:	El Dorado	**Date:**	1/26/2022

SECTION TWO

	A	B	C	D	E	F	G	H	I	J
#	**County Code**	**Program Name**	**Prior Program Name**	**Program Type**	**Total MHSA Funds (Including Interest)**	**Medi-Cal FFP**	**1991 Realignment**	**Behavioral Health Subaccount**	**Other**	**Grand Total**
14	09	Children's Full Service Partnership		FSP	$1,414,801.00	$1,422,081.00	$0.00	$0.00	$82,178.00	$2,919,060.00
15	09	Transitional Age Youth (TAY)		FSP	$0.00	$56,988.00	$0.00	$0.00	$3,328.00	$60,316.00
16	09	Adult Full Service Partnership		FSP	$1,218,451.00	$2,883,086.00	$0.00	$0.00	$244,713.00	$4,346,250.00
17	09	Forensic Services		FSP	$91,627.00	$28,071.00	$0.00		$2,151.00	$121,849.00
18	09	Adult Wellness Center		Non-FSP	$662,374.00	$1,532,651.00	$0.00		$207,217.00	$2,402,242.00
19	09	TAY Engagement and Wellness and Recovery		Non-FSP	$0.00	$164,673.00	$0.00		$243,333.00	$408,006.00
20		Commnity Transition and Support Team		Non-FSP	$0.00	$0.00	$0.00		$0.00	$0.00
21	09	Access Services		Non-FSP	$1,122,543.00	$0.00	$0.00		$0.00	$1,122,543.00
22	09	Project for Transition from Homeless (PATH)		Non-FSP	$8,099.00	$0.00	$0.00		$20,354.00	$28,453.00
23		Student Wellness Center & MH Support		Non-FSP	$0.00	$0.00	$0.00		$0.00	$0.00
24	09	Assisted Outpatient Treatment (AOT)		Non-FSP	$462.00	$371.00	$0.00		$33.00	$866.00
25		Genetic Testing		Non-FSP	$0.00	$0.00	$0.00		$0.00	$0.00
26										$0.00
27										$0.00
28										$0.00
29										$0.00
30										$0.00
31										$0.00
32										$0.00
33										$0.00
34										$0.00
35										$0.00
36										$0.00
37										$0.00
38										$0.00

STATE OF CALIFORNIA
HEALTH AND HUMAN SERVICES AGENCY

Department of Health Care Services

DHCS 1822 D (02/19)

Annual Mental Health Services Act (MHSA) Revenue and Expenditure Report
Fiscal Year: 2020-2021
Prevention and Early Intervention (PEI) Summary Worksheet

County:	El Dorado	El Dorado	Date:	1/26/2022

SECTION ONE

		A	B	C	D	E	F
		Total MHSA Funds (Including Interest)	Medi-Cal FFP	1991 Realignment	Behavioral Health Subaccount	Other	Grand Total
1	PEI Annual Planning Costs	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
2	PEI Evaluation Costs	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
3	PEI Administration Costs	$30,022.00	$0.00	$0.00	$0.00	$0.00	$30,022.00
4	PEI Funds Expended by CalMHSA for PEI Statewide	$19,575.19					$19,575.19
5	PEI Funds Transferred to JPA	$0.00					$0.00
6	PEI Expenditures Incurred by JPA	$0.00					$0.00
7	PEI Program Expenditures	$1,984,566.00	$0.00	$0.00	$0.00	$0.00	$1,984,566.00
8	**Total PEI Expenditures (Excluding Transfers and PEI Statewide)**	**$2,014,588.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$2,014,588.00**

SECTION TWO

		A	B
		Percent Expended for Clients Age 25 and Under, All PEI	Percent Expended for Clients Age 25 and Under, JPA
9	MHSA PEI Fund Expenditures in Program to Clients Age 25 and Under (calculated from weighted program values) divided by Total MHSA PEI Expenditures	60.90%	

STATE OF CALIFORNIA
HEALTH AND HUMAN SERVICES AGENCY

Department of Health Care Services

DHCS 1822 D (02/19)

Annual Mental Health Services Act (MHSA) Revenue and Expenditure Report
Fiscal Year: 2020-2021
Prevention and Early Intervention (PEI) Summary Worksheet

County:	El Dorado	El Dorado	**Date:**	1/26/2022

SECTION THREE

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O
#	**County Code**	**Program Name**	**Prior Program Name**	**Combined/Standalone Program**	**Program Type**	**Program Activity Name (in Combined Program)**	**Subtotal Percentage for Combined Program**	**Percent of PEI Expended on Clients Age 25 & Under (Standalone and Program Activities in Combined Program)**	**Percent of PEI Expended on Clients Age 25 & Under (Combined Summary and Standalone)**	**Total MHSA Funds (Including Interest)**	**Medi-Cal FFP**	**1991 Realignment**	**Behavioral Health Subaccount**	**Other**	**Grand Total**
10	9	Latino Outreach		Standalone	Prevention		100%	30%	30.0%	$231,150.00	$0.00	$0.00	$0.00	$0.00	$231,150.00
11	9	Older Adult Enrichment Projects		Standalone	Prevention		100%	0%	0.0%	$58,817.00	$0.00	$0.00	$0.00	$0.00	$58,817.00
12	9	Primary Project (PIP)		Standalone	Prevention		100%	100%	100.0%	$85,434.00	$0.00	$0.00	$0.00	$0.00	$85,434.00
13	9	Wennem Wadati: A Native Path to Healing		Standalone	Prevention		100%	100%	100.0%	$104,552.00	$0.00	$0.00	$0.00	$0.00	$104,552.00
14	9	Goods & Services to Promote Positive Mental Health and Reduce Mentla Health Risk Factors		Standalone	Prevention		100%	100%	100.0%	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
15	9	Child 0-5 amd Their Families		Standalone	Early Intervention		100%	100%	100.0%	$299,981.00	$0.00	$0.00	$0.00	$0.00	$299,981.00
16	9	Prevention Wraparound Services: Juvenile Services		Standalone	Early Intervention		100%	100%	100.0%	$242,585.00	$0.00	$0.00	$0.00	$0.00	$242,585.00
17	9	Forensic Access and Engagement		Standalone	Early Intervention		100%	30%	30.0%	$129,731.00	$0.00	$0.00	$0.00	$0.00	$129,731.00
18	9	Expressive Therapies		Standalone	Early Intervention		100%	100%	100.0%	$22,229.00	$0.00	$0.00	$0.00	$0.00	$22,229.00
19	9	National Suicide Pervention Lifeline		Standalone	Early Intervention		100%	31%	31.0%	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
20	9	Mental Health First Aid and SafeTALK		Standalone	Stigma & Discrimination Reduction		100%	25%	25.0%	$10,378.00	$0.00	$0.00	$0.00	$0.00	$10,378.00
21	9	LGBTQIA Community Education		Standalone	Stigma & Discrimination Reduction		100%	25%	25.0%	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
22	9	Statewide PEI Projects		Standalone	Stigma & Discrimination Reduction		100%	50%	50.0%	$58,253.00	$0.00	$0.00	$0.00	$0.00	$58,253.00
23	9	Community Education and Parenting Classes		Standalone	Outreach		100%	100%	100.0%	$60,085.00	$0.00	$0.00	$0.00	$0.00	$60,085.00
24	9	Peer Partner Services		Standalone	Outreach		100%	100%	100.0%	$102,934.00	$0.00	$0.00	$0.00	$0.00	$102,934.00
25	9	Mentoring for Youth		Standalone	Outreach		100%	100%	100.0%	$66,165.00	$0.00	$0.00	$0.00	$0.00	$66,165.00
26	9	Community-Based Outreach and Linkage/PERT		Standalone	Access and Linkage		100%	28%	28.0%	$290,949.00	$0.00	$0.00	$0.00	$0.00	$290,949.00
27	9	Veterans Outreach		Standalone	Access and Linkage		100%	0%	0.0%	$149,999.00	$0.00	$0.00	$0.00	$0.00	$149,999.00
28	9	Suicide Prevention and Stigma Reduction		Standalone	Suicide Prevention		100%	30%	30.0%	$71,324.00	$0.00	$0.00	$0.00	$0.00	$71,324.00
29															$0.00
30															$0.00
31															$0.00
32															$0.00
33															$0.00
34															$0.00
35															$0.00
36															$0.00
37															$0.00
38															$0.00

DHCS 1822 E (02/19)

Annual Mental Health Services Act (MHSA) Revenue and Expenditure Report
Fiscal Year: 2020-2021
Innovation (INN) Summary Worksheet

County:	El Dorado	Date:	1/26/2022

SECTION ONE

		A	B	C	D	E	F
		Total MHSA Fund (Including Interest)	Medi-Cal FFP	1991 Realignment	Behavioral Health Subaccount	Other	Grand Total
1	INN Annual Planning Costs	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
2	INN Indirect Administration	$529.00	$0.00	$0.00	$0.00	$0.00	$529.00
3	INN Funds Transferred to JPA	$0.00					$0.00
4	INN Expenditures Incurred by JPA	$0.00					$0.00
5	INN Project Administration	$10,407.00	$0.00	$0.00	$0.00	$0.00	$10,407.00
6	INN Project Evaluation	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
7	INN Project Direct	$636,895.00	$0.00	$0.00	$0.00	$0.00	$636,895.00
8	INN Project Subtotal	$647,302.00	$0.00	$0.00	$0.00	$0.00	$647,302.00
9	**Total Innovation Expenditures (Excluding Transfers to JPA)**	**$647,831.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$647,831.00**

DHCS 1822 E (02/19)

Annual Mental Health Services Act (MHSA) Revenue and Expenditure Report
Fiscal Year: 2020-2021
Innovation (INN) Summary Worksheet

County:	El Dorado	Date:	1/26/2022

SECTION TWO

#		County Code	Project Name	Prior Project Name	Project MHSOAC Approval Date	Project Start Date	MHSOAC-Authorized MHSA INN Project Budget	Amended MHSOAC-Authorized MHSA INN Project Budget	Project Expenditure Type	Total MHSA Funds (Including Interest)	Medi-Cal FFP	1991 Realignment	Behavioral Health Subaccount	Other
		A	B	C	D	E	F	G	H	I	J	K	L	M
10	A	9	Community Basted Engagement and Support		8/15/2016	9/19/2016	$705,992.00	$0.00	Project Administration	$10,407.00	$0.00	$0.00	$0.00	$0.00
10	B	9	Community Basted Engagement and Support		8/15/2016	9/19/2016	$705,992.00	$0.00	Project Evaluation	$0.00	$0.00	$0.00	$0.00	$0.00
10	C	9	Community Basted Engagement and Support		8/15/2016	9/19/2016	$705,992.00	$0.00	Project Direct	$636,895.00	$0.00	$0.00	$0.00	$0.00
10	**D**	**9**	**Community Basted Engagement and Support**		**8/15/2016**	**9/19/2016**	**$705,992.00**	**$0.00**	**Project Subtotal**	**$647,302.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**
11	A		Partnership between Senior Nutrition and Behavorial Health to Reach Home-bound Older Adulte in Need of Mental Health Services		1/23/2020		$900,000.00	$0.00	Project Administration	$0.00	$0.00	$0.00	$0.00	$0.00
11	B		Partnership between Senior Nutrition and Behavorial Health to Reach Home-bound Older Adulte in Need of Mental Health Services		1/23/2020		$900,000.00	$0.00	Project Evaluation	$0.00	$0.00	$0.00	$0.00	$0.00
11	C		Partnership between Senior Nutrition and Behavorial Health to Reach Home-bound Older Adulte in Need of Mental Health Services		1/23/2020		$900,000.00	$0.00	Project Direct	$0.00	$0.00	$0.00	$0.00	$0.00
11	**D**		**Partnership between Senior Nutrition and Behavorial Health to Reach Home-bound Older Adulte in Need of Mental Health Services**		**1/23/2020**		**$900,000.00**	**$0.00**	**Project Subtotal**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**
12	A													
12	B													
12	C													
12	**D**									**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**
13	A													
13	B													
13	C													
13	**D**									**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**
14	A													
14	B													
14	C													
14	**D**									**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**
15	A													
15	B													
15	C													
15	**D**									**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**

STATE OF CALIFORNIA
HEALTH AND HUMAN SERVICES AGENCY

Department of Health Care Services

DHCS 1822 F (02/19)

Annual Mental Health Services Act (MHSA) Revenue and Expenditure Report
Fiscal Year: 2020-2021
Workforce Education and Training (WET) Summary Worksheet

County:	El Dorado	**Date:**	1/26/2022

SECTION ONE

		A	B	C	D	E	F
		Total MHSA Funds (Including Interest)	**Medi-Cal FFP**	**1991 Realignment**	**Behavioral Health Subaccount**	**Other**	**Grand Total**
1	**WET Annual Planning Costs**	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
2	**WET Evaluation Costs**	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
3	**WET Administration Costs**	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
4	**WET Funds Transferred to JPA**	$0.00					$0.00
5	**WET Expenditures Incurred by JPA**	$0.00					$0.00
6	**WET Program Expenditures**	$33,221.00	$0.00	$0.00	$0.00	$0.00	$33,221.00
7	**Total WET Expenditures (Excluding Transfers to JPA)**	**$33,221.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$33,221.00**

SECTION TWO

	A	B	C	D	E	F	G	H
#	**County Code**	**Funding Category**	**Total MHSA Funds (Including Interest)**	**Medi-Cal FFP**	**1991 Realignment**	**Behavioral Health Subaccount**	**Other**	**Grand Total**
8	9	Workforce Staffing	$14,197.00	$0.00	$0.00	$0.00	$0.00	$14,197.00
9	9	Training/Technical Assistance	$19,024.00	$0.00	$0.00	$0.00	$0.00	$19,024.00
10		Mental Health Career Pathways						$0.00
11		Residency/Internship						$0.00
12		Financial Incentive						$0.00

STATE OF CALIFORNIA
HEALTH AND HUMAN SERVICES AGENCY

Department of Health Care Services

DHCS 1822 G (02/19)

Annual Mental Health Services Act (MHSA) Revenue and Expenditure Report
Fiscal Year: 2020-2021
Capital Facility Technological Needs (CFTN) Summary Worksheet

County:	El Dorado	**Date:**	1/26/2022

SECTION ONE

		A	B	C	D	E	F
		Total MHSA Funds (Including Interest)	**Medi-Cal FFP**	**1991 Realignment**	**Behavioral Health Subaccount**	**Other**	**Grand Total**
1	**CFTN Annual Planning Costs**	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
2	**CFTN Evaluation Costs**	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
3	**CFTN Administration Costs**	$3,470.00	$0.00	$0.00	$0.00	$0.00	$3,470.00
4	**CFTN Funds Transferred to JPA**	$0.00					$0.00
5	**CFTN Expenditures Incurred by JPA**	$0.00					$0.00
6	**CFTN Project Expenditures**	$137,540.00	$0.00	$0.00	$0.00	$0.00	$137,540.00
7	**Total CFTN Expenditures (Excluding Transfers to JPA)**	**$141,010.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$141,010.00**

SECTION TWO

A	B	C	D	E	F	G	H	I	J

DHCS 1822 G (02/19)

Annual Mental Health Services Act (MHSA) Revenue and Expenditure Report
Fiscal Year: 2020-2021
Capital Facility Technological Needs (CFTN) Summary Worksheet

County:	El Dorado	Date:	1/26/2022

#	County Code	Project Name	Prior Project Name	Project Type	Total MHSA Funds (Including Interest)	Medi-Cal FFP	1991 Realignment	Behavioral Health Subaccount	Other	Grand Total
8	9	Eletronic Health Record System Implementation		Technological Need	$132,701.00	$0.00	$0.00	$0.00	$0.00	$132,701.00
9	9	Telehealth		Technological Need	$4,839.00	$0.00	$0.00	$0.00	$0.00	$4,839.00
10		Community Wellness Center		Capital Facility	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
11										$0.00
12										$0.00
13										$0.00
14										$0.00
15										$0.00
16										$0.00
17										$0.00
18										$0.00
19										$0.00
20										$0.00
21										$0.00
22										$0.00
23										$0.00
24										$0.00
25										$0.00
26										$0.00
27										$0.00

STATE OF CALIFORNIA
HEALTH AND HUMAN SERVICES AGENCY

Department of Health Care Services

DHCS 1822 H (02/19)

Annual Mental Health Services Act (MHSA) Revenue and Expenditure Report
Fiscal Year: 2020-2021
MHSA Adjustments Worksheet

County:	El Dorado		**Date**	1/26/2022

SECTION ONE

	A	B	C	D	E	F
#	**County Code**	**Account**	**Adjustment Type**	**Adjustment to Fiscal Year**	**Amount**	**Reason**
1						
2						
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STATE OF CALIFORNIA
HEALTH AND HUMAN SERVICES AGENCY

Department of Health Care Services

DHCS 1822 I (02/19)

Annual Mental Health Services Act (MHSA) Revenue and Expenditure Report
Fiscal Year: 2020-2021
FFP Revenue Adjustment Worksheet

County:	El Dorado	**Date:**	1/26/2022

SECTION ONE

	A	B	C	D	E	F	G
#	**County Code**	**Adjustment to FY**	**Cost Report Stage**	**Account**	**Beginning Balance**	**Adjustment Amount**	**Ending Balance**
1							$0.00
2							$0.00
3							$0.00
4							$0.00
5							$0.00
6							$0.00
7							$0.00
8							$0.00
9							$0.00
10							$0.00
11							$0.00
12							$0.00
13							$0.00
14							$0.00
15							$0.00

STATE OF CALIFORNIA
HEALTH AND HUMAN SERVICES AGENCY

Department of Health Care Services

DHCS 1822 J (02/19)

Annual Mental Health Services Act (MHSA) Revenue and Expenditure Report
Fiscal Year: 2020-2021
Comments Worksheet

County:	El Dorado		**Date:**	1/26/2022

	A	B	C
#	**Account**	**Fiscal Year**	**Comments**
1	Prudent Reserve	2020-2021	The MHSA funds are held in one Fund which includes the Prudent Reserve. The interest earned is based on the total balance in the Fund. The interest is allocated to each of the components (CSS, PEI, INN, WET & CFTN) based on each components balance that is maintained through working documents. The Prudent Reserve interest is reported with the CSS interest.
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Appendix

FY 2020-21
External Quality Review (EQRO)

Behavioral Health Concepts, Inc.
5901 Christie Avenue, Suite 502
Emeryville, CA 94608

info@bhceqro.com
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855-385-3776

FY 2020-21
MEDI-CAL SPECIALTY MENTAL HEALTH EXTERNAL QUALITY REVIEW

EL DORADO MHP FINAL REPORT

Prepared for:

California Department of Health Care Services (DHCS)

Review Dates:

March 10, 2021

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INTRODUCTION

The United States Department of Health and Human Services (HHS), Centers for Medicare and Medicaid Services (CMS) requires an annual, independent external evaluation of State Medicaid Managed Care Organizations (MCOs) by an External Quality Review Organization (EQRO). External Quality Review (EQR) is the analysis and evaluation by an approved EQRO of aggregate information on access, timeliness, and quality of health care services furnished by Prepaid Inpatient Health Plans (PIHPs) and their contractors to recipients of State Medicaid Managed Care Services. The Code of Federal Regulations (CFR) specifies the requirements for evaluation of Medicaid MCOs (42 CFR, Section 438; Medicaid Program, External Quality Review of Medicaid Managed Care Organizations). These rules require an on-site review, or a desk review, of each Medi-Cal Mental Health Plan (MHP).

In addition to the Federal Medicaid EQR requirements, the California External Quality Review Organization (CalEQRO) also considers the State of California requirements for the MHPs. In compliance with California Senate Bill (SB) 1291 (Section 14717.5 of the Welfare and Institutions Code), the Annual EQR includes specific data for Medi-Cal eligible minor and nonminor dependents in foster care (FC).

The State of California Department of Health Care Services (DHCS) contracts with 56 county Medi-Cal MHPs to provide Medi-Cal covered Specialty Mental Health Services (SMHS) to Medi-Cal beneficiaries under the provisions of Title XIX of the federal Social Security Act.

This report presents the fiscal year (FY) 2020-21 findings of an EQR of the El Dorado MHP by the CalEQRO, Behavioral Health Concepts, Inc. (BHC).

The EQR technical report analyzes and aggregates data from the EQR activities as described below:

MHP Information

MHP Size — Small

MHP Region — Central

MHP Location — Diamond Springs

MHP Beneficiaries Served in Calendar Year (CY) 2019 — 1,311

MHP Threshold Language(s) — Spanish

CalEQRO obtained the MHP threshold language information from the DHCS Behavioral Health Information Notice (BHIN) 20-070.

Validation of Performance Measures[1]

Both a statewide annual report and this MHP-specific report present the results of CalEQRO's validation of eight mandatory performance measures (PMs) as defined by DHCS and other additional PMs defined by CalEQRO.

Performance Improvement Projects[2]

Each MHP is required to conduct two Performance Improvement Projects (PIPs)—one clinical and one non-clinical—during the 12 months preceding the review. The PIPs are reviewed in detail later in this report.

MHP Health Information System Capabilities[3]

Using the Information Systems Capabilities Assessment (ISCA) protocol, CalEQRO reviewed and analyzed the extent to which the MHP meets federal data integrity requirements for Health Information Systems (HIS), as identified in 42 CFR §438.242. This evaluation included a review of the MHP's Electronic Health Records (EHR), Information Technology (IT), claims, outcomes, and other reporting systems and methodologies for calculating PMs.

Network Adequacy

CMS has required all states with Managed Care Plans (MCPs) and PIHPs to implement new rules for Network Adequacy (NA) pursuant to Title 42 of the Code of Federal Regulations (CFR) Part 438.68. In addition, the California State Legislature passed Assembly Bill (AB) 205 to specify how the NA requirements must be implemented in California for MCPs and PIHPs, including the MHPs. The legislation and related DHCS policies and BHINs assign responsibility to the EQRO for review and validation of the data collected and processed by DHCS related to NA. DHCS identifies the following three main components for EQRO to review and verify: Out-of-Network Access (ONA), Alternative Access Standard (AAS), and Rendering Provider National Provider Identifier (NPI) taxonomy as assigned in National Plan and Provider Enumeration System (NPPES).

DHCS produced a detailed description and set of requirements for each type of MCP and MHP related to NA requirements. CalEQRO followed these

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[1] Department of Health and Human Services. Centers for Medicare and Medicaid Services (2019). Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity, October 2019. Washington, DC: Author.

[2] Department of Health and Human Services. Centers for Medicare and Medicaid Services (2019). Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity, October 2019. Washington, DC: Author.

[3] Department of Health and Human Services. Centers for Medicare and Medicaid Services (2019). Appendix A. Information Systems Capabilities Assessment, October 2019. Washington, DC: Author.

requirements in reviewing each of the MHPs. All MHPs submitted detailed information on their provider networks in April of 2020 per the requirements of DHCS BHIN 20-012 on the Network Adequacy Certification Tool (NACT) form. DHCS reviews these forms to determine if the provider networks meet required time and distance standards, as well as timeliness standards, for essential mental health services and psychiatry services for youth and adults. If these standards are not met, DHCS requires the MHP to improve the network to meet the standards or submit an application for an AAS. If approved by DHCS, CalEQRO will review the AAS and ONA information as part of its annual EQR.

CalEQRO will verify and report if an MHP can meet the time and distance standards with its provider distribution. As part of its scope of work for evaluating the accessibility of services, CalEQRO reviews access-related grievance and complaint log reports; facilitates beneficiary focus groups; reviews claims and other performance data; reviews DHCS-approved corrective action plans; and examines available beneficiary satisfaction surveys conducted by DHCS, the MHP, or its subcontractors.

Validation of State and MHP Beneficiary Satisfaction Surveys

CalEQRO examined available beneficiary satisfaction surveys conducted by DHCS, the MHP, or its subcontractors.

CalEQRO also conducted 90-minute focus groups with beneficiaries to obtain direct qualitative evidence from beneficiaries.

Review of Recommendations and Assessment of MHP Strengths and Opportunities

The CalEQRO review draws upon prior years' findings, including sustained strengths, opportunities for improvement, and actions in response to recommendations. Other findings in this report include:

- Changes, progress, or milestones in the MHP's approach to performance management—emphasizing utilization of data, specific reports, and activities designed to manage and improve quality.

- Ratings for key components associated with the following five domains: access to care, timeliness of services, quality of care, beneficiary progress/outcomes, and structure and operations. Submitted documentation as well as interviews with a variety of key staff, contracted providers, advisory groups, beneficiaries, and other stakeholders inform the evaluation of the MHP's performance within these domains. Detailed definitions for each of the review criteria can be found on the CalEQRO website, www.caleqro.com.

PRIOR YEAR REVIEW FINDINGS, FY 2019-20

In this section, the status of last year's (FY 2019-20) recommendations are presented, as well as changes within the MHP's environment since its last review.

Status of FY 2019-20 Review of Recommendations

In the FY 2019-20 virtual review report, the CalEQRO made several recommendations for improvements in the MHP's programmatic and/or operational areas. During the FY 2020-21 site visit, CalEQRO reviewed the status of those FY 2019-20 recommendations. The findings are summarized below.

Assignment of Ratings

Met is assigned when the identified issue has been resolved.

Partially Met is assigned when the MHP has either:

- Made clear plans and is in the early stages of initiating activities to address the recommendation; or
- Addressed some but not all aspects of the recommendation or related issues.

Not Met is assigned when the MHP performed no meaningful activities to address the recommendation or associated issues.

Recommendations from FY 2019-20

PIP Recommendations

None.

Access Recommendations

Recommendation 1: Expand telehealth and mobile services to remote areas to improve beneficiaries' access to services, to the Latino/Hispanic population.

Status: Partially Met

- The MHP laid the groundwork for expanded telehealth with the establishment of high-speed internet in the South County area. Once COVID-19 safety restrictions are lifted, the MHP plans to utilize this facility for telehealth services. In further preparation, the MHP obtained both

Zoom licenses and a Doxy license for telehealth at the South Lake Tahoe office.

- In May 2020, the MHP began acquisition of the Netsmart Telehealth module; however, implementation has been delayed due to vendor issues, staffing challenges, and competing technical priorities. Although the MHP has yet to get the system working, they are continuing to resolve the problems.
- The MHP obtained 51 laptops with webcams via the Coronavirus Aid, Relief, and Economic Security (CARES) Act funding for mobile staff and 35 webcams and headsets for stationary staff. The MHP also purchased seven iPads for distribution to its transitional houses and clinics for use with telehealth.
- Despite the MHP having the equipment, internet access remains an issue; further, many beneficiaries do not have technical equipment, mobile or in-house, to access telehealth.

Recommendation 2: Establish and maintain a formal Cultural Competency Committee (CCC) which meets regularly with minutes kept and which works closely with the Quality Improvement Committee (QIC) and has beneficiary representation.

Status: Not Met

- The MHP responded that it has been unable to pursue this recommendation due to COVID-19. The MHP plans to address this recommendation after the public health emergency.

Recommendation 3: Evaluate the usability of the website from the perspective of a beneficiary. Update the provider directory to include license and National Provider Identification (NPI) numbers and provide the directory in both English and Spanish.

Status: Not Met

- The MHP reported that it was unable to implement this recommendation under the COVID-19 precaution conditions. Once it is safe and feasible, the MHP plans to collaborate with a group of beneficiaries to review the current website and solicit feedback on needed changes.
- Once the changes have been made, the MHP will reconvene the workgroup to review the website and obtain further feedback on the format; further changes to the website will be made as needed.

Timeliness Recommendations

Recommendation 4: Provide training for staff on the identification and classification of urgent requests in relationship to network adequacy and required documentation. Include evaluation of training.

Status: Partially Met

- While training has not been provided, the MHP is meeting the 48-hour standard. The MHP amended timeliness and tracking policies to include DHCS and California Code of Regulations (CCR) standards for timely response to urgent requests. The MHP reports that all urgent requests are responded to within 48 hours regardless of authorization status. It does not separately track referrals needing prior authorization, within 96-hours.

Recommendation 5: Comply with Information Notice (IN) 18-011. Track and offer a first assessment appointment within ten business days.

Status: Met

- In February 2020, the MHP implemented the Client Service Information (CSI) Assessment to track first offered assessment appointments.
- Between February and December 2020, the MHP had 991 requests for services associated with a CSI Assessment. The MHP completed 847 CSI Assessments, which is 85 percent of net requests for services.
- For first offered assessment appointments, 97 percent meet the 10-business day standard, with an average of 3.61 days overall. This rate is calculated by measuring the number of days between a request for service and the closure of the request; meaning, a decision was already made on a beneficiary’s eligibility, an inability to make contact, or that the request was canceled.

Recommendation 6: Comply with Information Notice (IN) 18-011. Track and offer a first psychiatric appointment within 15 business days.

Status: Met

- An “initial request” for a psychiatry appointment is defined by the MHP as the beneficiary requesting psychiatry services for the first time in a year during a continuous period of service.
- The MHP reports that 100 percent of its first psychiatry appointments meet the 15-business day standard, with an average of 4.80 days.

- The MHP tracks available psychiatric appointments from a point-in-time, i.e., first available from today. The MHP does not have a method for tracking first offered appointments in the EHR.

Recommendation 7: Investigate and identify barriers to providing (or accurately tracking) urgent services within 48 hours. Implement interventions which directly address the barrier(s) identified.

Status: Met

- The MHP has worked diligently to address into policy the DHCS and CCR standards for timely response to urgent requests. Per the MHP's Assessment of Timely Access, 100 percent of the MHP's urgent appointments are meeting the 48-hour standard.

Recommendation 8: Investigate and identify barriers to providing follow-up hospital discharge appointments within the 7-day standard. Implement interventions which directly address the barrier(s) identified.

Status: Met

- A key barrier to timely post-hospitalization follow-up was the tracking method for out-of-county hospitalizations, manually using an Excel workbook, with no direct interface with the MHP's EHR.
- In FY 2020-21, the MHP started recording all in-county and out-of-county hospitalizations in its EHR. The MHP is now able to compare hospital admission and discharge dates against scheduled appointments.
- Further, the MHP collaborated with the operator of the in-county Psychiatric Health Facility (PHF) to streamline the discharge process. The process was re-distributed for review in February 2021.
- For out-of-county hospitalizations, the MHP has identified a single point of contact for the hospitals to contact to schedule aftercare appointments. Due to the large number of out-of-county hospitals, the County is unable to establish a written protocol like the one with Telecare Corp., with each provider, but instead, developed a phone list for each hospital's discharge contact.

Recommendation 9: Investigate and identify the cause of the high no-show rate for clinicians. Implement interventions which directly address the cause(s) identified.

Status: Partially Met

- The MHP's clinic support team evaluated attendance data for appointments at the beginning of FY 2019-20. For the first six months of

FY 2020-21, both psychiatry and clinicians reached target no-show rates of 12 percent and 20 percent, respectively. For the second half of FY 2020-21, no-show rates for clinicians and psychiatrists decreased to 10 percent and 15 percent.

- Although the MHP has not researched the causes of the improved no-show rates, the MHP believes the improvement is due to the impact of the pandemic on beneficiaries' mental health and the availability of telephone and telehealth appointments.

Quality Recommendations

Recommendation 10: Prioritize and implement aggregate reporting for outcome tools and CSI Assessments.

Status: Partially Met

- The MHP has not implemented aggregate reporting for outcome tools beyond the normal monthly, quarterly and annual reporting performed for the Behavioral Health Commission and the State.
- As noted above (Recommendation 5), the MHP starting using the CSI Assessment record to track first offered assessment appointments.
- Although the MHP intends to implement this recommendation, due to the public health emergency and an analyst position's vacancy, the MHP has been unable to focus on this recommendation.

Recommendation 11: Investigate methodology for determining rate of co-occurring diagnosis including compliance with related policies and procedures. Implement solutions to improve accuracy of data which include ongoing training

Status: Partially Met

- The MHP is aware of Assembly Bill (AB) 2265 and that Mental Health Service Act (MHSA) funds can be used for individuals who have a substance use disorder (SUD) and a mental health condition. Counties are required per AB 2265 to report how many individuals with co-occurring disorders (COD) are being served as a requirement of this funding.
- Of the beneficiaries that were open to an outpatient SMHS program in FY 2019-20, 274 (or 25 percent) reflected a co-occurring substance use disorder. When limited only to those in a Transitional Age Youth (TAY) or Adult outpatient program, 218 (or 34 percent) reflect a co-occurring substance use disorder.

- The MHP is reviewing this data and developing a strategy to evaluate the data for accuracy.

Recommendation 12: Implement the hiring of at least one designated peer employee whose duties also include sharing in the management/running of the wellness center.

Status: Not Met

- The MHP plans to use the training specifications in SB 803, and State guidance once released, to establish peer support specialist certifications..
- The MHP reports that several staff members have lived experience; however, the positions do not require lived experience, and therefore the MHP relies on staff self-disclosure to know whether an employee is a peer.
- The MHP’s Wellness Centers have been closed due to the public health emergency. At this time, the MHP does not know when its Wellness Centers will re-open.

Beneficiary Outcomes Recommendations

Recommendation 13: Implement a method to report and/or share survey results and service evaluation with contractors and MHP staff

Status: Met

- The MHP reports any survey results and service evaluations during its quarterly QIC meetings. The information is also shared with the Behavioral Health Commission in the MHP’s Monthly Report, which is posted with the meeting agenda online, emailed to all Mental Health staff, and emailed to select Health and Human Services Agency (HHSA) managers and supervisors.

Foster Care Recommendations

None.

Information Systems Recommendations

Recommendation 14: Work with the County to improve network connectivity for the South Lake Tahoe clinics centrally and located at other remote towns and small communities. Explore opportunities such as obtaining a federal or state grant award to implement fiber-optic network countywide.

Status: Partially Met

- In August 2020, high speed internet for the County's network became available at Pioneer Park in the South County area. The MHP will utilize this facility for telehealth services, as needed, based on beneficiaries' locations.
- In February 2021, the MHP received approval to upgrade the bandwidth at the South Lake Tahoe clinic. The order has been submitted to County IT. It is anticipated that the increased bandwidth will significantly improve the network services at the South Lake Tahoe clinic.
- El Dorado County has applied for a U.S. Department of Commerce, Economic Development Administration (EDA) grant to construct the El Dorado County Middle-Mile Fiber Project to improve broadband speed.
- The MHP must work through El Dorado County Information Technology (IT) Department to move this recommendation forward.

Structure and Operations Recommendations

Recommendation 15: Complete Medicare Part B provider enrollment application and submit to Noridian for site certification processing to bill services for Medicare/Medi-Cal eligible beneficiaries; and to comply with Department of Mental Health Information Notice 11-04 policy guidance. (This recommendation is a carry-over from FY 2016-17 and from FY 2018-19.)

Status: Not Met

- A new Administrative Analyst began the registration process but left employment shortly thereafter; however, she identified a list of outstanding items needed to complete the registration.
- The MHP is in the process of hiring a replacement for the Administrative Analyst position. Once this person is hired and onboarded, they will complete the registration process.

PERFORMANCE MEASURES

CalEQRO is required to validate the following eight mandatory PMs as defined by DHCS:

- Total beneficiaries served by each county MHP.
- Penetration rates in each county MHP.
- Total costs per beneficiary served by each county MHP.
- High-Cost Beneficiaries (HCBs) incurring $30,000 or higher in approved claims during a CY.
- Count of Therapeutic Behavioral Services (TBS) beneficiaries served compared to the 4 percent Emily Q. Benchmark (not included in MHP reports; this information is included in the Annual Statewide Report submitted to DHCS).
- Total psychiatric inpatient hospital episodes, costs, and average length of stay (LOS).
- Psychiatric inpatient hospital 7-day and 30-day rehospitalization rates.
- Post-psychiatric inpatient hospital 7-day and 30-day SMHS follow-up service rates.

In addition, CalEQRO examines the following SB 1291 PMs (Chapter 844; Statutes of 2016) for each MHP:[4]

- The number of Medi-Cal eligible minor and nonminor dependents.
- Types of mental health services provided to children, including prevention and treatment services. These types of services may include, but are not limited to screenings, assessments, home-based mental health services, outpatient services, day treatment, psychiatric hospitalizations, crisis interventions, case management, and psychotropic medication support services.
- Performance data for Medi-Cal eligible minor and nonminor dependents in FC.
- Utilization data for Medi-Cal eligible minor and nonminor dependents in FC.

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[4] Public Information Links to SB 1291 and foster care specific data requirements:

1. SB 1291 (Chapter 844). This statute would require annual mental health plan reviews to be conducted by an EQRO and, commencing July 1, 2018, would require those reviews to include specific data for Medi-Cal eligible minor and nonminor dependents in foster care, including the number of Medi-Cal eligible minor and nonminor dependents in foster care served each year. The bill would require the department to share data with county boards of supervisors, including data that will assist in the development of mental health service plans and performance outcome system data and metrics, as specified. More information can be found at http://www.leginfo.ca.gov/pub/15-16/bill/sen/sb_1251-1300/sb_1291_bill_20160929_chaptered.pdf
2. EPSDT POS Data Dashboards: https://www.dhcs.ca.gov/provgovpart/pos/Pages/default.aspx
3. HEDIS Measures and Psychotropic Medication: http://www.dhcs.ca.gov/dataandstats/Pages/Quality-of-Care-Measures-in-Foster-Care.aspx and http://cssr.berkeley.edu/ucb_childwelfare/ReportDefault.aspx includes:
   - 5A (1&2) Use of Psychotropic Medications
   - 5C Use of Multiple Concurrent Psychotropic Medications
   - 5D Ongoing Metabolic Monitoring for Children on Antipsychotic Medications New Measure
4. AB 1299 (Chapter 603; Statues of 2016). This statute pertains to children and youth in foster care and ensures that foster children who are placed outside of their county of original jurisdiction, are able to access mental health services in a timely manner consistent with their individualized strengths and needs and the requirements of EPSDT program standards and requirements. This process is defined as presumptive transfer as it transfers the responsibility to provide or arrange for mental health services to a foster child from the county of original jurisdiction to the county in which the foster child resides. More information can be found at http://www.leginfo.ca.gov/pub/15-16/bill/asm/ab_1251-1300/ab_1299_bill_20160925_chaptered.pdf
5. *Katie A. v. Bonta*:
   The plaintiffs filed a class action suit on July 18, 2002, alleging violations of federal Medicaid laws, the American with Disabilities Act, Section 504 of the Rehabilitation Act and California Government Code Section 11135. The suit sought to improve the provision of mental health and supportive services for children and youth in, or at imminent risk of placement in, foster care in California. More information can be found at https://www.cdss.ca.gov/inforesources/foster-care/pathways-to-well-being.

- Medication monitoring consistent with the child welfare psychotropic medication measures developed by the State Department of Social Services and any Healthcare Effectiveness Data and Information Set (HEDIS) measures related to psychotropic medications, including, but not limited to, the following:
    - Follow-Up Care for Children Prescribed Attention Deficit Hyperactivity Disorder Medication (HEDIS ADD).
    - Use of Multiple Concurrent Antipsychotics in Children and Adolescents (HEDIS APC).
    - Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (HEDIS APP).
- Metabolic Monitoring for Children and Adolescents on Antipsychotics (HEDIS APM).
- Access to, and timeliness of, mental health services, as described in Sections 1300.67.2, 1300.67.2.1, and 1300.67.2.2 of Title 28 of the California Code of Regulations and consistent with Section 438.206 of Title 42 of the Code of Federal Regulations, available to Medi-Cal eligible minor and nonminor dependents in FC.
- Quality of mental health services available to Medi-Cal eligible minor and nonminor dependents in FC.
- Translation and interpretation services, consistent with Section 438.10(c)(4) and (5) of Title 42 of the Code of Federal Regulations and Section 1810.410 of Title 9 of the California Code of Regulations, available to Medi-Cal eligible minor and nonminor dependents in FC.

Health Information Portability and Accountability Act Suppression Disclosure

To comply with the Health Information Portability and Accountability Act (HIPAA), and in accordance with DHCS guidelines, CalEQRO suppressed values in the report tables when the count was less than or equal to 11, and replaced it with an asterisk (*) to protect the confidentiality of MHP beneficiaries. Further suppression was applied, as needed, to prevent calculation of initially suppressed data; corresponding penetration rate percentages (n/a); and cells containing zero, missing data or dollar amounts (-).

Total Beneficiaries Served

Table 1 provides details on beneficiaries served by race/ethnicity.

Table 1: County Medi-Cal Beneficiaries and Those Served by the MHP in CY 2019 by Race/Ethnicity

El Dorado MHP				
Race/Ethnicity	**Average Monthly Unduplicated Medi-Cal Beneficiaries**	**Percentage of Medi-Cal Beneficiaries**	**Unduplicated Annual Count of Beneficiaries Served by the MHP**	**Percentage of Beneficiaries Served by the MHP**
White	22,452	60.1%	876	66.8%
Latino/Hispanic	7,097	19.0%	157	12.0%
African-American	309	0.8%	21	1.6%
Asian/Pacific Islander	1,004	2.7%	*	n/a
Native American	269	0.7%	*	n/a
Other	6,210	16.6%	231	17.6%
Total	**37,339**	**100%**	**1,311**	**100%**
The total for Average Monthly Unduplicated Medi-Cal Enrollees is not a direct sum of the averages above it. The averages are calculated independently.				

Table 2 provides details on beneficiaries served by threshold language identified in DHCS BHIN 20-070.

Table 2: Beneficiaries Served by the MHP in CY 2019 by Threshold Language

El Dorado MHP		
Threshold Language	**Unduplicated Annual Count of Beneficiaries Served by the MHP**	**Percentage of Beneficiaries Served by the MHP**
Spanish	44	3.4%
Other Languages	1,267	96.6%
Total	**1,311**	**100%**
Threshold language source: DHCS BHIN 20-070.		
Other Languages include English		

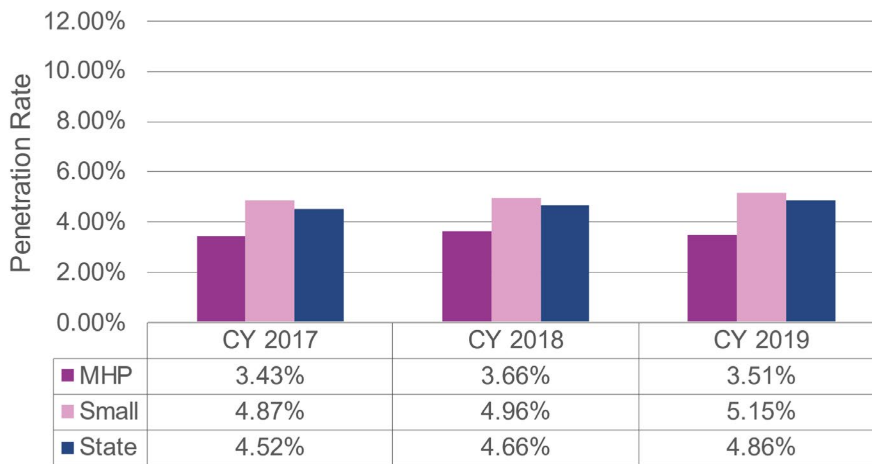
Penetration Rates and Approved Claims per Beneficiary

The penetration rate is calculated by dividing the number of unduplicated beneficiaries served by the monthly average Medi-Cal enrollee count. The annual average approved claims per beneficiary (ACB) served is calculated by dividing the total annual Medi-Cal approved claim dollars by the unduplicated number of Medi-Cal beneficiaries served during the corresponding year.

CalEQRO has incorporated the Affordable Care Act (ACA) Expansion data in the total Medi-Cal enrollees and beneficiaries served. Attachment E provides further ACA-specific utilization and performance data for CY 2019. See Table E1 for the CY 2019 ACA penetration rate and ACB.

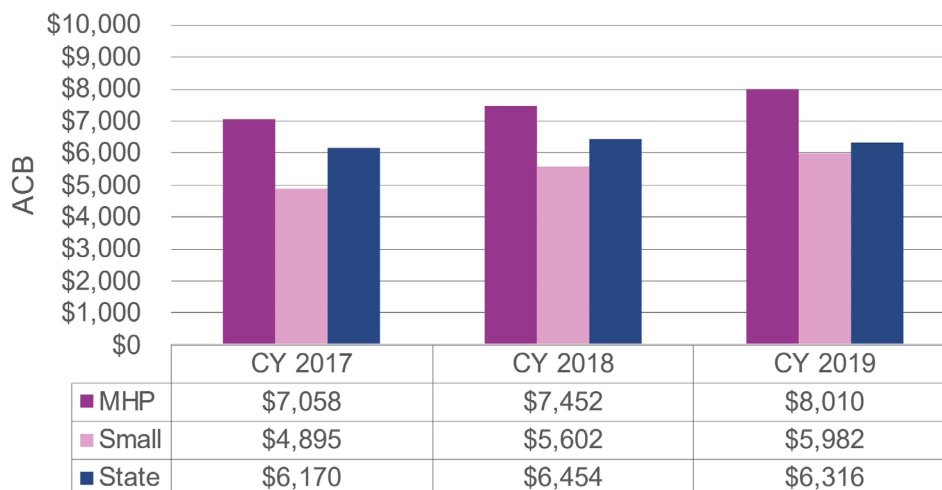
Regarding the calculation of penetration rates, the El Dorado MHP uses the same method used by CalEQRO. Figures 1 and 2 show three-year (CY 2017-19) trends of the MHP's overall penetration rates and ACB, compared to both the statewide average and the average for small MHPs.

Figure 1: Overall Penetration Rates CY 2017-19



	CY 2017	CY 2018	CY 2019
MHP	3.43%	3.66%	3.51%
Small	4.87%	4.96%	5.15%
State	4.52%	4.66%	4.86%

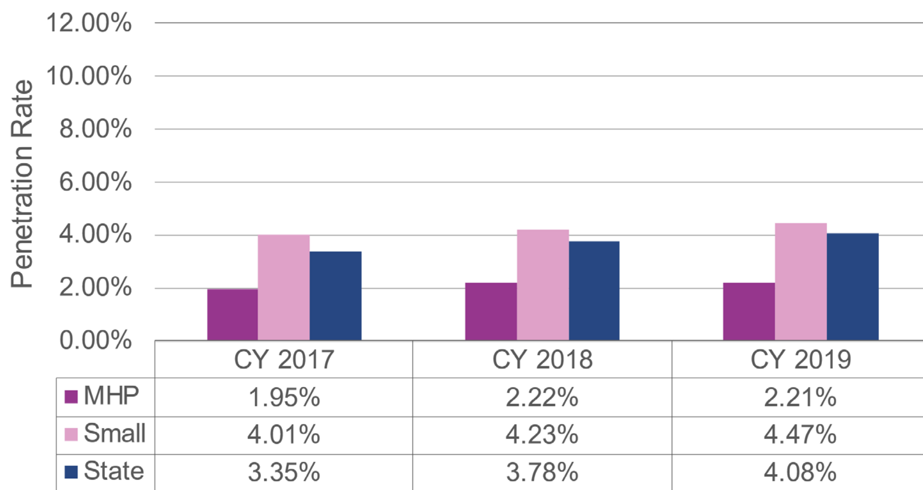
Figure 2: Overall ACB CY 2017-19



	CY 2017	CY 2018	CY 2019
MHP	$7,058	$7,452	$8,010
Small	$4,895	$5,602	$5,982
State	$6,170	$6,454	$6,316

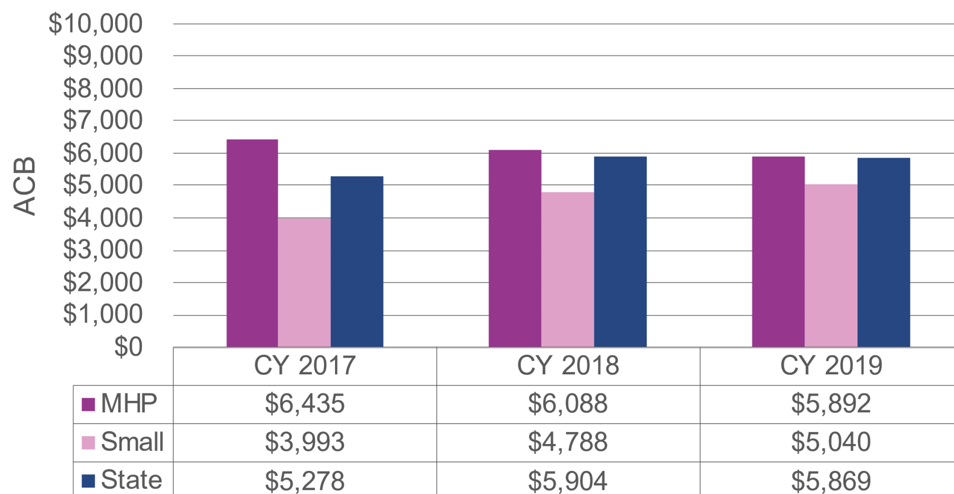
Figures 3 and 4 show three-year (CY 2017-19) trends of the MHP's Latino/Hispanic penetration rates and ACB, compared to both the statewide average and the average for small MHPs.

Figure 3: Latino/Hispanic Penetration Rates CY 2017-19



	CY 2017	CY 2018	CY 2019
MHP	1.95%	2.22%	2.21%
Small	4.01%	4.23%	4.47%
State	3.35%	3.78%	4.08%

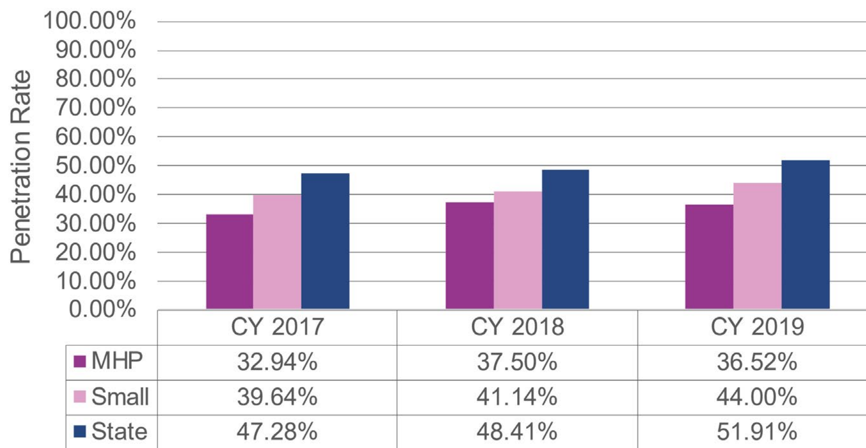
Figure 4: Latino/Hispanic ACB CY 2017-19



	CY 2017	CY 2018	CY 2019
MHP	$6,435	$6,088	$5,892
Small	$3,993	$4,788	$5,040
State	$5,278	$5,904	$5,869

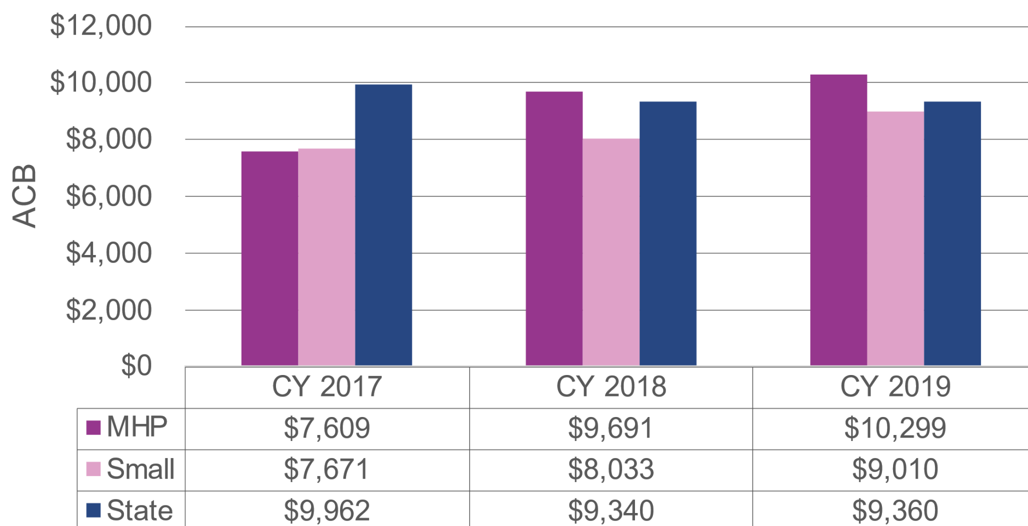
Figures 5 and 6 show three-year (CY 2017-19) trends of the MHP's FC penetration rates and ACB, compared to both the statewide average and the average for small MHPs.

Figure 5: FC Penetration Rates CY 2017-19



	CY 2017	CY 2018	CY 2019
MHP	32.94%	37.50%	36.52%
Small	39.64%	41.14%	44.00%
State	47.28%	48.41%	51.91%

Figure 6: FC ACB CY 2017-19



	CY 2017	CY 2018	CY 2019
MHP	$7,609	$9,691	$10,299
Small	$7,671	$8,033	$9,010
State	$9,962	$9,340	$9,360

Diagnostic Categories

Figures 7 and 8 compare statewide and MHP diagnostic categories by the number of beneficiaries served and total approved claims, respectively, for CY 2019.

Figure 7: Diagnostic Categories by Percentage of Beneficiaries CY 2019

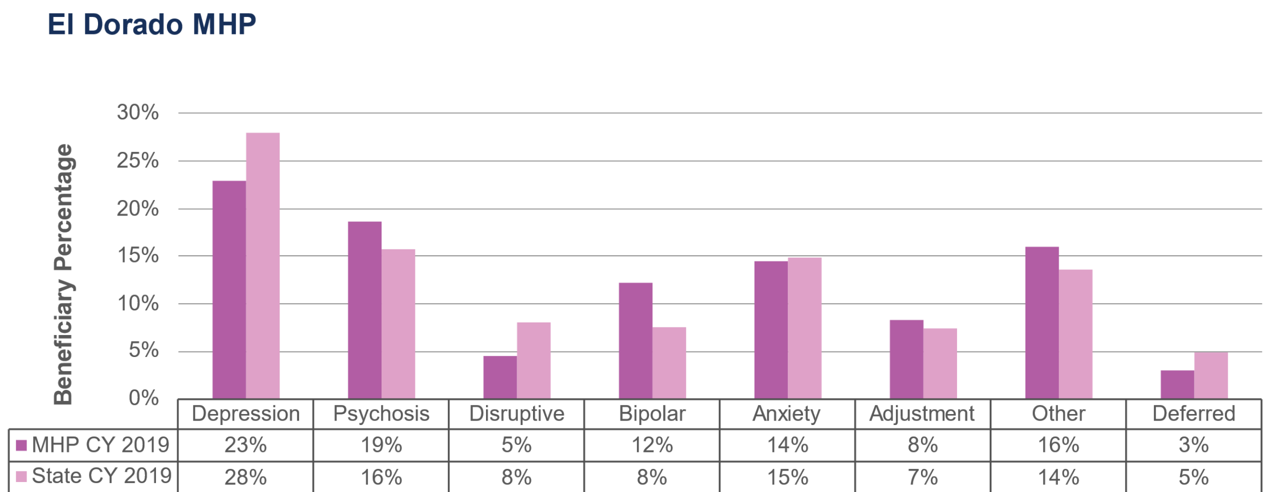
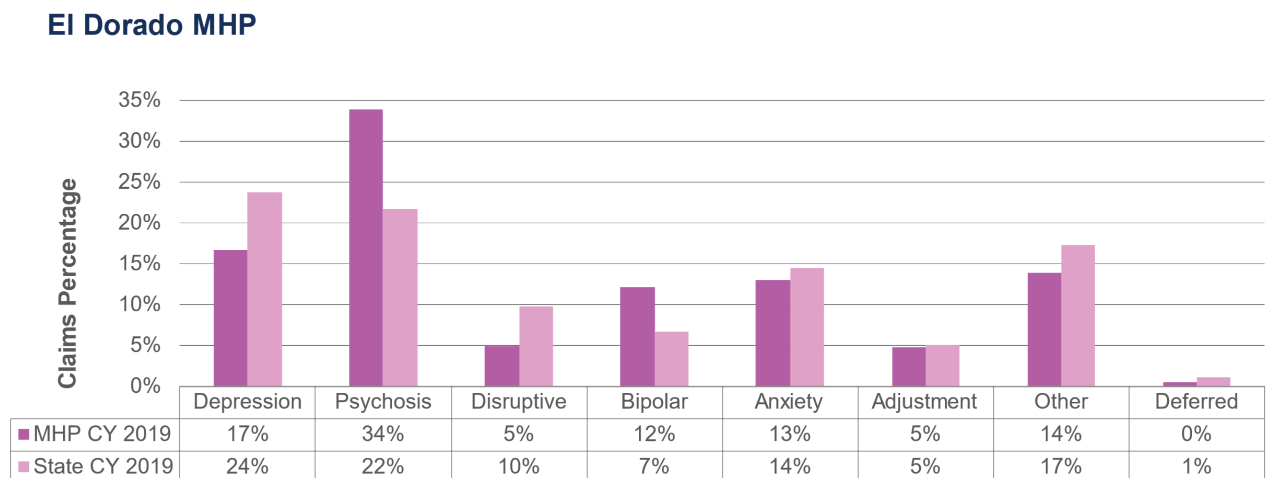


Figure 8: Diagnostic Categories by Percentage of Approved Claims CY 2019



High-Cost Beneficiaries

Table 3 provides a three-year summary (CY 2017-19) of HCB trends for the MHP and compares the MHP's CY 2019 HCB data with the corresponding statewide data. HCBs in this table are identified as those with approved claims of more than $30,000 in a year.

Table 3: High-Cost Beneficiaries CY 2017-19

El Dorado MHP							
	Year	HCB Count	Total Beneficiary Count	HCB % by Count	Average Approved Claims per HCB	HCB Total Claims	HCB % by Total Claims
Statewide	CY 2019	21,904	627,928	3.49%	$51,883	$1,136,453,763	28.65%
MHP	CY 2019	77	1,311	5.87%	$51,128	$3,936,861	37.49%
	CY 2018	75	1,404	5.34%	$61,091	$4,581,821	43.79%
	CY 2017	62	1,349	4.60%	$55,840	$3,462,091	36.36%

See Attachment E, Table E1 for the distribution of the MHP beneficiaries served by ACB range for three cost categories: under $20,000; $20,000 to $30,000; and above $30,000.

Psychiatric Inpatient Utilization

Table 4 provides a three-year summary (CY 2017-19) of MHP psychiatric inpatient utilization including beneficiary count, admission count, approved claims, and LOS.

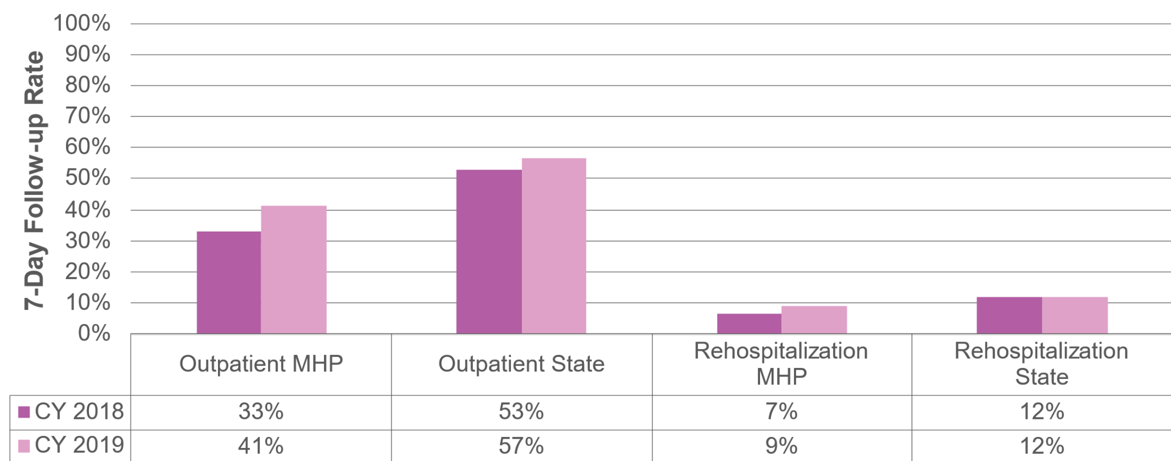
Table 4: Psychiatric Inpatient Utilization CY 2017-19

El Dorado MHP							
Year	Unique Beneficiary Count	Total Inpatient Admissions	MHP Average LOS in Days	Statewide Average LOS in Days	MHP ACB	Statewide ACB	Total Approved Claims
CY 2019	256	431	8.96	7.80	$10,571	$10,535	$2,706,130
CY 2018	252	393	9.02	7.63	$12,720	$9,772	$3,205,438
CY 2017	243	379	8.74	7.36	$9,145	$9,737	$2,222,327

Post-Psychiatric Inpatient Follow-Up and Rehospitalization

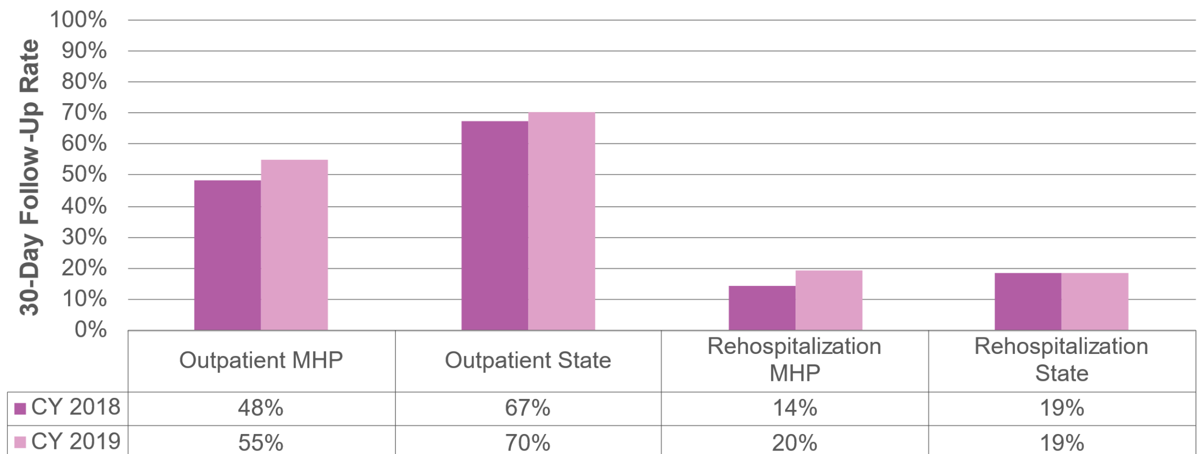
Figures 9 and 10 show the statewide and MHP 7-day and 30-day post-psychiatric inpatient follow-up and rehospitalization rates for CY 2018-19.

Figure 9: 7-Day Post Psychiatric Inpatient Follow-up CY 2018-19



	Outpatient MHP	Outpatient State	Rehospitalization MHP	Rehospitalization State
CY 2018	33%	53%	7%	12%
CY 2019	41%	57%	9%	12%

Figure 10: 30-Day Post Psychiatric Inpatient Follow-up CY 2018-19



	Outpatient MHP	Outpatient State	Rehospitalization MHP	Rehospitalization State
CY 2018	48%	67%	14%	19%
CY 2019	55%	70%	20%	19%

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

CMS' Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity defines a PIP as a project conducted by the PIHP (MHP) that is designed to achieve significant improvement, sustained over time, in health outcomes and enrollee satisfaction. A PIP may be designed to change behavior at a member, provider, and/or MHP/system level.

El Dorado MHP PIPs Identified for Validation

Each MHP is required to conduct two PIPs during the 12 months preceding the review. CalEQRO reviewed two PIPs and validated one PIP, as shown below.

Table 5: PIPs Submitted by El Dorado MHP

PIPs for Validation	Number of PIPs	PIP Titles
Clinical	1	Clinical PIP Improving Co-Occurring SUD identification
Non-Clinical	1	Early SMHS Engagement Enhancement Pilot

Clinical PIP

Table 6: General PIP Information – Clinical PIP

MHP Name	El Dorado
PIP Title	Clinical PIP Improving Co-Occurring SUD identification
PIP Aim Statement	"Will expanding the SUD assessment process (using the Simple Screening Instrument for Alcohol and Other Drugs (SSI-AOD) and developing a treatment plan objective and intervention related to SUD when applicable to improve standard of care, reduce client impairments/improve functioning as evidenced by reduced Level of Care Utilization System (LOCUS) level and increase referrals to SUD treatment over the next six months?"
Was the PIP state-mandated, collaborative, statewide, or MHP choice? (check all that apply) ☐ State-mandated (state required MHP to conduct PIP on this specific topic)	

MHP Name	El Dorado
☐ Collaborative (multiple MHPs or MHP and DMC-ODS worked together during planning or implementation phases) ☒ MHP choice (state allowed MHP to identify the PIP topic)	
Target age group (check one): ☐ Children only (ages 0-17)* ☐ Adults only (age 18 and above) ☒ Both Adults and Children *If PIP uses different age threshold for children, specify age range here:	
Target population description, such as specific diagnosis (please specify): Every individual enrolled in SMHS.	

Table 7: Improvement Strategies or Interventions – Clinical PIP

PIP Interventions (Changes tested in the PIP)
Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach): n/a
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): Interventions planned for March 2021 • Clinicians will complete the Simple Screening Instrument for Alcohol and Other Drugs (SSI-AOD) and refer beneficiaries to SUD treatment when appropriate. • Clinicians will create an additional treatment plan objective that addresses a beneficiary's co-occurring SUD and provide applicable interventions to address the SUD. • SUD diagnosis and referral to SUD treatment will increase by 5 percent and the LOCUS level will decrease by one point for beneficiaries with a co-occurring SUD.
MHP/DMC-ODS-focused interventions/system changes (MHP/DMC-ODS/system change interventions are aimed at changing MHP/DMC-ODS operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools): n/a

Table 8: Performance Measures and Results – Clinical PIP

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
Documented count of diagnosed co-occurring SUD diagnoses six months prior to PIP implementation	Schd. For 7/21		☒ n/a[5]		☐ Yes ☐ No	☐ Yes ☐ No p-value: ☐ <.01 ☐ <.05 Other (specify):
					☐ No test of statistical significance	
Documented count of SUD treatment plan objectives and interventions addressing SUD six months prior to PIP implementation	Schd. For 7/21		☒ n/a		☐ Yes ☐ No	☐ Yes ☐ No p-value: ☐ <.01 ☐ <.05 Other (specify):
					☐ No test of statistical significance	
Documented LOCUS Scores of undiagnosed SUD for beneficiaries with untreated	Schd. For 7/21		☒ n/a		☐ Yes ☐ No	☐ Yes ☐ No p-value:

[5] PIP is in planning and implementation phase if n/a is checked for all performance measures.

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
SUD six months prior to PIP implementation						☐ <.01 ☐ <.05 Other (specify):
					☐ No test of statistical significance	
Documented count of diagnosed co-occurring SUD six months post PIP implementation.	Schd. For 7/21		☒ n/a		☐ Yes ☐ No	☐ Yes ☐ No p-value: ☐ <.01 ☐ <.05 Other (specify):
					☐ No test of statistical significance	
Documented count of SUD treatment plan objectives and interventions addressing SUD six months post PIP implementation	Schd. For 7/21		☒ n/a		☐ Yes ☐ No	☐ Yes ☐ No p-value: ☐ <.01 ☐ <.05 Other (specify):

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
					☒ No test of statistical significance	
Documented LOCUS Scores of undiagnosed SUD for beneficiaries with untreated SUD six months prior to PIP implementation			☒ n/a		☐ Yes ☐ No	☐ Yes ☐ No p-value: ☐ <.01 ☐ <.05 Other (specify):
					☒ No test of statistical significance	

Was the PIP validated?	☐ Yes	☒ No

Validation phase:	PIP status (per DHCS requirement):
☐ Implementation phase	Active and Ongoing
☐ Baseline year	
☐ First remeasurement	
☐ Second remeasurement	
☐ Other, completed in ___ months prior to the current EQR	Completed
☐ PIP submitted for approval	Concept only, Not Yet Active
☒ Planning phase	
☐ Other, inactive	Inactive, Developed in a Prior Year

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
Validation rating:						
☐ High confidence[6] ☐ Moderate confidence[7] ☐ Low confidence[8] ☒ No confidence[9] Justification for validation rating: As this PIP is in the concept phase, the MHP did not provide enough documentation to determine whether credible, reliable, and valid methods were employed. "Validation rating" refers to the EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement.						
EQRO recommendations for improvement of PIP: • Determine the accurate rate based on reliable data to see if there really is a problem with the co-occurring rate. • Quantify the baseline. • Perform a barrier analysis to determine the cause of the problem and to clarify why beneficiaries with an SUD diagnosis are not getting treatment. • Provide information which justifies the use of chosen interventions (usually informed by a barrier or causation analysis). • Extend the timeframe - at least one year, up to two.						
The technical assistance (TA) provided to the MHP by CalEQRO consisted of: • Planning TA calls were held in December 2020 and February 2021. CalEQRO and the MHP discussed concepts for clinical PIPs and the need to connect interventions to causes. • The MHP should regularly meet with CalEQRO for TA to further develop this clinical PIP.						

[6] Credible, reliable, and valid methods for the PIP were documented.
[7] Credible, reliable, or valid methods were implied or able to be established for part of the PIP.
[8] Errors in logic were noted or contradictory information was presented or interpreted erroneously.
[9] The study did not provide enough documentation to determine whether credible, reliable, and valid methods were employed.

Non-Clinical PIP

Table 9: General PIP Information – Non-Clinical PIP

MHP Name	El Dorado
PIP Title	Early SMHS Engagement Enhancement Pilot
PIP Aim Statement	Will the new access process improve wait times and engagement as measured by no-show/ beneficiary cancelations rates and engagement rates over six months?
Was the PIP state-mandated, collaborative, statewide, or MHP choice? (check all that apply) ☐ State-mandated (state required MHP to conduct PIP on this specific topic) ☐ Collaborative (multiple MHPs or MHP and DMC-ODS worked together during planning or implementation phases) ☒ MHP choice (state allowed MHP to identify the PIP topic)	
Target age group (check one): ☐ Children only (ages 0-17)* ☐ Adults only (age 18 and above) ☒ Both Adults and Children *If PIP uses different age threshold for children, specify age range here:	
Target population description, such as specific diagnosis (please specify): The population for this PIP is new or returning adult beneficiaries who have requested services within the past 10 days, completed the Access screening and have been identified as meeting medical necessity for SMHS. The population includes West Slope beneficiaries who are identified as needing outpatient SMHS level of care.	

Table 10: Improvement Strategies or Interventions – Non-Clinical PIP

PIP Interventions (Changes tested in the PIP)
Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach): n/a
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach): n/a

PIP Interventions (Changes tested in the PIP)
MHP/DMC-ODS-focused interventions/system changes (MHP/DMC-ODS/system change interventions are aimed at changing MHP/DMC-ODS operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools): Initial appointment with case carrying clinician scheduled at end of Access screening.

Table 11: Performance Measures and Results – Non-Clinical PIP

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
Number of days between the access screening to initial appointment with case carrying clinician	2020	9.08 days	2021 ☐ n/a	2.85 days	☒ Yes ☐ No 68.61% improved wait times due to PIP	☐ Yes ☐ No p-value: ☐ <.01 ☐ <.05 Other (specify): ☒ No test of statistical significance
Decrease no-shows for the initial appointment with the case carrying clinician	2020	6 no-shows	2021 ☐ n/a	0 no-shows	☒ Yes ☐ No	☐ Yes ☐ No p-value: ☐ <.01 ☐ <.05 Other (specify):

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
					☒ No test of statistical significance	
Decrease beneficiary cancelations for the initial appointment with the case carrying clinician	2020	2 cancels	2021 ☐ n/a	0 beneficiary cancels	☒ Yes ☐ No	☐ Yes ☐ No p-value: ☐ <.01 ☐ <.05 Other (specify):
					☒ No test of statistical significance	
					☐ No test of statistical significance	

Was the PIP validated?	☒ Yes ☐ No

Validation phase:	PIP status (per DHCS requirement):
☐ Implementation phase	Active and Ongoing
☒ Baseline year	
☐ First remeasurement	
☐ Second remeasurement	
☐ Other, completed in __months prior to the current EQR	Completed
☐ PIP submitted for approval	Concept only, Not Yet Active

Performance Measures	Baseline Year	Baseline Sample Size and Rate	Most Recent Remeasurement Year	Most Recent Remeasurement Sample Size and Rate (if applicable)	Demonstrated Performance Improvement	Statistically Significant Change in Performance
☐ Planning phase						
☐ Other, inactive			Inactive, Developed in a Prior Year			

Validation rating:

☐ High confidence[6]
☒ Moderate confidence[7]
☐ Low confidence[8]
☐ No confidence[9]

Justification for validation rating: The PIP has a solid foundation and the MHP's baseline findings and methodology appear correct; however, for PIP results to be valid, steps to increase reliability are needed.

"Validation rating" refers to the EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement.

EQRO recommendations for improvement of PIP:

- Lengthen the duration of the PIP. Six months is a very short time to determine if interventions will have lasting success.
- Provide more information on how causes of the problem were identified/determined.
- Research and quantify (if possible) the impact of staffing on timely service and engagement.

The TA provided to the MHP by CalEQRO consisted of:

- Obtain regular and ongoing TA for PIP development and maintenance to ensure that PIP requirements are met.

INFORMATION SYSTEMS REVIEW

Understanding the capabilities of an MHP's information system is essential to evaluating its capacity to manage the health care of its beneficiaries. CalEQRO used the written responses to standard questions posed in the California-specific ISCA, additional documents submitted by the MHP, and information gathered in interviews to complete the information systems evaluation.

Key ISCA Information Provided by the MHP

The following information is self-reported by the MHP through the ISCA and/or the site review.

Table 12 shows the percentage of MHP budget dedicated to supporting IT operations, including hardware, network, software license, consultants, and IT staff for the current and the previous three-year period, as well as the corresponding similar-size MHP and statewide averages.

Table 12: Budget Dedicated to Supporting IT Operations

Entity	FY 2020-21	FY 2019-20	FY 2018-19	FY 2017-18
El Dorado	2.00%	1.00%	2.00%	2.00%
Small MHP Group	n/a	2.95%	3.25%	3.54%
Statewide	n/a	3.58%	3.35%	3.34%

The budget determination process for information system operations is:

☐ Under MHP control
☐ Allocated to or managed by another county department
☒ Combination of MHP control and another county department or agency

The following business operations information was self-reported in the ISCA tool and validated through interviews with key MHP staff by CalEQRO.

Table 13: Business Operations

Business Operations	Status	
There is a written business strategic plan for IS.	☐ Yes	☒ No
There is a Business Continuity Plan (BCP) for critical business functions that is compiled and maintained in readiness for use in the event of a cyber-attack, emergency, or disaster.	☒ Yes	☐ No

Business Operations	Status	
If the BCP status is “No,” the MHP uses an Application Service Provider (ASP) model to host the EHR system, which provides 24-hour operational support.	☒ Yes	☐ No
If the BCP status is “Yes,” it is tested at least annually.	☐ Yes	☒ No
There is at least one person within the MHP clearly identified as having responsibility for information security.	☐ Yes	☒ No
If no one within the MHP is identified as having responsibility for information security, the parent agency or county IT assume responsibility and control of information security.	☒ Yes	☐ No
The MHP performs cyber resiliency staff training on potential compromise situations.	☒ Yes	☐ No

- The BCP is not tested annually; however, it was followed during the four PG&E planned outages that occurred in the last year.
- El Dorado County hired a Chief Information Security Officer in 2020 and is in the process of updating its BCP.

Table 14 shows the percentage of services provided by type of service provider.

Table 14: Distribution of Services by Type of Provider

Type of Provider	Distribution
County-operated/staffed clinics	45%
Contract providers	55%
Network providers	0%
Total	**100%***

*Percentages may not add up to 100 percent due to rounding.

Summary of Technology and Data Analytical Staffing

MHP self-reported IT staff changes by full-time equivalents (FTE) since the previous CalEQRO review are shown in Table 15.

Table 15: Technology Staff

Fiscal Year	Total FTEs (Include Employees and Contractors)	Number of New FTEs	Employees / Contractors Retired, Transferred, Terminated (FTEs)	Currently Unfilled Positions (FTEs)
2020-21	1.00	0	1.00	0
2019-20	2.00	1	0.50	0
2018-19	2.50	2	0.50	1

MHP self-reported data analytical staff changes by FTEs since the previous CalEQRO review are shown in Table 16.

Table 16: Data Analytical Staff

Fiscal Year	Total FTEs (Include Employees and Contractors)	Number of New FTEs	Employees / Contractors Retired, Transferred, Terminated (FTEs)	Currently Unfilled Positions (FTEs)
2020-21	4.00	0	0.5	1
2019-20	3.50	0	0	0
2018-19	3.50	0.50	0	0

The following should be noted with regard to the above information:

- The MHP has 1.0 FTE budgeted for MH technology staff and 1.0 budgeted for SUD technology staff. In previous years both positions were reported under MH.
- In the last budget cycle, a .50 FTE was reassigned to another unit and a 1.0 FTE was added to data analytical staff.
- The number for data analytical staff reflects the total number of staff who provide this support; however, none of the staff is 100 percent dedicated to analytical work.

Summary of User Support and EHR Training

Table 17 provides the number of individuals with log-on authority to the MHP's EHR. The information was self-reported by the MHP and does not account for users' log-on frequency or time spent daily, weekly, or monthly using EHR.

Table 17: Count of Individuals with EHR Access

Type of Staff	Count of MHP Staff with EHR Log-on Account	Count of Contract Provider Staff with EHR Log-on Account	Total EHR Log-on Accounts
Administrative and Clerical	18	9	27
Clinical Healthcare Professional	57	39	96
Clinical Peer Specialist	0	0	0
Quality Improvement	4	0	4
Total	79	48	127

While there is no standard ratio of IT staff to support EHR users, the following information was self-reported by MHPs or compiled by CalEQRO from the FY 2019-20 ISCA. The results below reflect staffing-level resources; they do not include IT staff time spent on end user support, infrastructure maintenance, training, and other activities.

Table 18: Ratio of IT Staff to EHR User with Log-on Authority

Type of Staff	MHP FY 2020-21	Small MHP Average FY 2019-20
Number of IT Staff FTEs (Source: Table 15)	1.00	5.30
Total EHR Users Supported by IT (Source: Table 17)	127	200.00
Ratio of IT Staff to EHR Users	1:127	1:38

Table 19: Additional Information on EHR User Support

EHR User Support	Status	
The MHP maintains a local Data Center to support EHR operations.	☐ Yes	☒ No
The MHP utilizes an ASP model to support EHR operations.	☒ Yes	☐ No
The MHP also utilizes QI staff to directly support EHR operations.	☒ Yes	☐ No
The MHP also utilizes Local Super Users to support EHR operations.	☐ Yes	☒ No

Table 20: New Users' EHR Support

Support Category	QI	IT	ASP	Local Super Users
Initial network log-on access	☒	☒	☐	☐
User profile and access setup	☐	☒	☐	☐
Screen workflow and navigation	☒	☒	☐	☐

Table 21: Ongoing Support for the EHR Users

Ongoing EHR Training and Support	Status	
The MHP routinely administers EHR competency tests for users to evaluate training effectiveness.	☐ Yes	☒ No
The MHP maintains a formal record or attendance log of EHR training activities.	☒ Yes	☐ No
The MHP maintains a formal record of HIPAA and 42 CFR Security and Privacy trainings along with attendance logs.	☒ Yes	☐ No

Availability and Use of Telehealth Services

MHP currently provides services to beneficiaries using a telehealth application:

☒ Yes ☐ No ☐ Implementation Phase

The rest of this section is applicable: ☒ Yes ☐ No

Table 22: Summary of MHP Telehealth Services

Telehealth Services	Count
Total number of sites currently operational	15
Number of county-operated telehealth sites	2
Number of contract providers' telehealth sites	13
Total number of beneficiaries served via telehealth during the last 12 months	n/a
• Adults	n/a
• Children/Youth	n/a
• Older Adults	n/a
Total number of telehealth encounters (services) provided during the last 12 months:	10,031

The MHP was unable to provide detail information for telehealth.

Identify primary reason(s) for using telehealth as a service extender (check all that apply):

☒ Hiring healthcare professional staff locally is difficult
☐ For linguistic capacity or expansion
☒ To serve outlying areas within the county
☐ To serve beneficiaries temporarily residing outside the county
☐ To serve special populations (i.e., children/youth or older adult)
☒ To reduce travel time for healthcare professional staff
☒ To reduce travel time for beneficiaries
☐ To support NA time and distance standards
☒ To address and support COVID-19 contact restrictions

Summarize MHP's use of telehealth services to manage the impact of COVID-19 pandemic on beneficiaries and mental health provider staff.

- The MHP had staff provide services remotely due to COVID-19.
- The MHP experienced delays in expanding its use of telehealth during the COVID-19 pandemic.
- Laptops were ordered during the initial COVID-19 shelter in place order, they have been slow to come in and have taken some time to configure and deliver. Final laptops were just distributed in February 2021.

Identify from the following list of California-recognized threshold languages the ones that were directly supported by the MHP or by contract providers during the past year. Do not include language line capacity or interpreter services. (Check all that apply)

☐	Arabic	☐	Armenian	☐	Cambodian
☐	Cantonese	☐	Farsi	☐	Hmong
☐	Korean	☐	Mandarin	☐	Other Chinese
☐	Russian	☐	Spanish	☐	Tagalog
☐	Vietnamese	☒	n/a		

There were no specific programs set up for service delivery in languages other than English. All providers use translation services.

Telehealth Services Delivered by Contract Providers

Contract providers use telehealth services as a service extender:

☒ Yes ☐ No ☐ Implementation Phase

The rest of this section is applicable: ☒ Yes ☐ No

Table 23 provides telehealth information self-reported by the MHP in the ISCA tool and reviewed by CalEQRO.

Table 23: Contract Providers Delivering Telehealth Services

Contract Provider	Count of Sites
Sierra Child and Family Services (SCFS)	3
Telecare Corporation (at the PHF)	1
Summitview Child and Family Services, Inc.	9

Current MHP Operations

- The MHP continues to use Avatar, which is hosted by Netsmart, as its EHR.
- In response to the COVID-19 pandemic, the MHP deployed laptops to county staff in support of remote work. Prior to receiving the laptops, clinical staff used telephones to provide services.
- MHP staff require a Virtual Private Network (VPN) connection and login to the county network for remote work.
- MHP staff are actively preparing for Avatar NX launch, which will enable their team to access Avatar via a web browser.

Table 24 lists the primary systems and applications the MHP uses to conduct business and manage operations. These systems support data collection and storage; provide EHR functionality; produce Short-Doyle Medi-Cal (SD/MC) and other third-party claims; track revenue; perform managed care activities; and provide information for analyses and reporting.

Table 24: Primary EHR Systems/Applications

System/Application	Function	Vendor/Supplier	Years Used	Hosted By
Avatar Cal-PM	Billing	Netsmart	14	Netsmart
Avatar CWS	EHR	Netsmart	8	Netsmart
OrderConnect	ePrescribing	Netsmart	8	Netsmart
CareConnect	HIE	Netsmart	1	Netsmart
Avatar Telehealth	Telehealth	Netsmart	>1	Netsmart

Major Changes since Prior Year

- A large percentage of MHP staff have received new laptops to replace their desktops.
- In response to the COVID-19 public health emergency, staff were provided with equipment that includes integrated microphones and cameras to meet with beneficiaries remotely.

- The MHP has updated their systems to meet the initial phase of Avatar NX cloud preparation to include Cache 2017 updates, JBoss, and Representational State Transfer (REST) application program interface.
- VPN access was provided to secure Avatar remote usage.
- CSI assessments are being completed and the validation of data began in April 2021.

The MHP's Priorities for the Coming Year

- Prepare for Avatar NX launch, which will enable the MHP to access Avatar via a web browser.
- Build an Avatar NX learning tool for all roles and users of Avatar for the County of El Dorado
- Assist County IT with migration to a mobile workforce by replacing desktops with laptops.
- Develop and launch new reports and forms based on priorities identified for analysis and to move away from paper-based dependency.
- Develop and launch new reports and forms based on priorities identified for compliance and reporting requirements.
- Implement CareConnect Inbox to allow interoperability and Health Information Exchange (HIE).
- Fully implement video-based Telehealth.

Other Areas for Improvement

- The MHP is not enrolled in Medicare and therefore cannot claim to Medicare Part B, a prerequisite for submitting Medi-Cal claims for dually eligible beneficiaries.
- There is a need for the MHP to continue to work with County IT to improve network connectivity performance, as reliable connectivity is still an issue for some areas in the county.
- The Provider Directory on the website is out of date and lacking informational elements required by MHSUDS Information Notice 18-020, including National Provider Identifier and California license number.
- Develop aggregate reports from the beneficiary outcome tools used, including the Child and Adolescent LOCUS (CALOCUS), the Adult Needs

and Strengths Assessment (ANSA) and LOCUS, and the Child Adolescent Needs and Strengths (CANS-50) assessment, to assist the MHP in analysis and decision-making.

- Document procedures for handling data errors.
- Conduct time studies to more accurately reflect the FTE that work on data analysis.

Plans for Information Systems Change

- The MHP has no plans to replace the current system.

MHP EHR Status

Table 25 summarizes the ratings given to the MHP for EHR functionality.

Table 25: EHR Functionality

Function	System/ Application	Rating			
		Present	Partially Present	Not Present	Not Rated
Alerts	Avatar	☒	☐	☐	☐
Assessments	Avatar	☒	☐	☐	☐
Care Coordination		☐	☐	☒	☐
Document Imaging/Storage	Avatar	☒	☐	☐	☐
Electronic Signature—MHP Beneficiary	Avatar	☒	☐	☐	☐
Laboratory results (eLab)		☐	☐	☒	☐
Level of Care/Level of Service	Avatar	☒	☐	☐	☐
Outcomes	Avatar	☒	☐	☐	☐
Prescriptions (eRx)	OrderConnect	☒	☐	☐	☐
Progress Notes	Avatar	☒	☐	☐	☐
Referral Management	Avatar	☒	☐	☐	☐
Treatment Plans	Avatar	☒	☐	☐	☐
Summary Totals for EHR Functionality:					

Function	System/ Application	Rating			
		Present	Partially Present	Not Present	Not Rated
FY 2020-21 Summary Totals for EHR Functionality:		10	0	2	0
FY 2019-20 Summary Totals for EHR Functionality:		10	0	2	0
FY 2018-19 Summary Totals for EHR Functionality:		9	1	2	0

Contract Provider EHR Functionality and Services

The MHP currently uses local contract providers:

☒ Yes ☐ No ☐ Implementation Phase

Table 26 identifies methods available for contract providers to submit beneficiary clinical and demographic data; practice management and service information; and transactions to the MHP's EHR system, by type of input methods.

Table 26: Contract Providers' Transmission of Beneficiary Information to MHP EHR

Type of Input Method	Percent Used	Frequency
Health Information Exchange (HIE) securely shares beneficiary medical information from contractor EHR system to MHP EHR system and return message or medical information to contractor EHR	0%	Not Used
Electronic data interchange (EDI) uses standardized electronic message format to exchange beneficiary information between contract provider EHR systems and MHP EHR system	0%	Not Used
Electronic batch files submitted to MHP for further processing and uploaded into MHP EHR system	60%	Monthly
Direct data entry into MHP EHR system by contract provider staff	31%	Daily

Type of Input Method	Percent Used	Frequency
Electronic files/documents securely emailed to MHP for processing or data entry input into EHR system	8%	Daily
Paper documents submitted to MHP for data entry input by MHP staff into EHR system	1%	Weekly

- SCFS and Telecare have look-up view-only access to Alerts.
- SCFS has full access to Assessments, Level of Care/Level of Service and Outcomes.
- SCFS and Telecare have full access to Document Image/Storage, Electronic Signature (Beneficiary).
- SCFS has full access to Progress Notes and Treatment Plans. Telecare has look-up view-only access.
- Telecare has full access to Referral Management for PHF referrals only.

The rest of this section is applicable: ☒ Yes ☐ No

Some contract providers have EHR systems, which they rely on as their primary system to support operations. Table 27 lists the IS vendors currently in place to support transmission of beneficiary and services information from contract providers to the MHP.

Table 27: EHR Vendors Supporting Data Transmission from Contract Provider to MHP

EHR Vendor	Product	Count of Providers Supported
Netsmart	Avatar	1
TIER	TIER	1
KaleidaCare	KaleidaCare	1
Athena	Penelope	1

Personal Health Record

The beneficiaries have online access to their health records through a personal health record (PHR) feature provided within the EHR, a beneficiary portal, or a third-party PHR.

☐ Yes ☒ No ☐ Implementation Phase

Expected implementation timeline:

☐ Already in place	☐ Within 6 months
☐ Within the next year	☒ Within the next two years
☐ Longer than 2 years	☐ n/a

Table 28 lists the PHR functionalities available to beneficiaries (if already in place):

Table 28: PHR Functionalities

PHR Functionality	Status	
View current, future, and prior appointments through portal.	☐ Yes	☒ No
Initiate appointment requests to provider/team.	☐ Yes	☒ No
Receive appointment reminders and/or other health-related alerts from provider team via portal.	☐ Yes	☒ No
View list of current medications through portal.	☐ Yes	☒ No
Have ability to both send/receive secure text messages with provider team.	☐ Yes	☒ No

Medi-Cal Claims Processing

MHP performs end-to-end (837/835) claim transaction reconciliations:

☒ Yes ☐ No

If yes, product or application:

☐	Dimension Reports application
☒	Web-based application, including the MHP EHR system, supported by vendor or ASP staff

☐ Web-based application, supported by MHP or DMC staff

☐ Local SQL database, supported by MHP/Health/County staff

☐ Local Excel worksheet or Access database

Method used to submit Medicare Part B claims:

☐ Paper ☐ Electronic ☐ Clearinghouse

- The MHP is not Medicare Certified.

Table 29 summarizes the MHP's SD/MC claims.

Table 29: Summary of CY 2019 SD/MC Claims

El Dorado MHP							
Service Month	Number Submitted	Dollars Billed	Number Denied	Dollars Denied	Percent Denied	Dollars Adjudicated	Dollars Approved
TOTAL	**53,297**	**$11,106,101**	**873**	**$236,869**	**2.09%**	**$10,869,232**	**$9,981,449**
JAN19	4,443	$884,012	42	$10,238	1.14%	$873,774	$777,827
FEB19	5,549	$1,131,308	71	$18,124	1.58%	$1,113,184	$947,640
MAR19	4,827	$1,042,621	26	$6,383	0.61%	$1,036,238	$931,357
APR19	4,404	$914,161	22	$4,849	0.53%	$909,312	$813,039
MAY19	4,450	$934,331	72	$18,529	1.94%	$915,802	$807,279
JUN19	3,902	$864,122	224	$61,408	6.63%	$802,714	$662,810
JUL19	4,680	$1,057,243	181	$39,318	3.59%	$1,017,925	$974,294
AUG19	4,515	$1,054,555	53	$17,850	1.66%	$1,036,705	$1,011,798
SEP19	4,232	$932,894	55	$21,087	2.21%	$911,807	$883,374
OCT19	4,495	$901,092	38	$16,198	1.77%	$884,894	$843,614
NOV19	4,303	$768,310	37	$10,568	1.36%	$757,742	$739,574
DEC19	3,497	$621,451	52	$12,317	1.94%	$609,134	$588,844
The difference between Dollars Adjudicated and Dollars Approved column results does not reflect payments from Medicare and OHC plans, or state adjustments for maximum allowed reimbursement.							
Includes services provided during CY 2019 with the most recent DHCS claim processing date of **June 23, 2020**. Only reports Short-Doyle/Medi-Cal claim transactions, does not include Inpatient Consolidated IPC hospital claims. Statewide denial rate for CY 2019 was **2.99 percent.**							

Table 30 summarizes the top five reasons for claim denial.

Table 30: Summary of CY 2019 Top Five Reasons for Claim Denial

El Dorado MHP			
Denial Reason Description	**Number Denied**	**Dollars Denied**	**Percent of Total Denied**
ICD-10 diagnoses code or beneficiary demographic data or rendering provider identifier is missing, incomplete, or invalid.	292	$97,887	41%
Beneficiary not eligible.	280	$46,723	20%
NPI, Type 2 credentialing data missing, incomplete, or invalid.	110	$36,179	15%
Beneficiary not eligible or non-covered charges.	68	$26,370	11%
Medicare or Other Health Coverage must be billed before submission of claim.	79	$22,268	9%
Total	873	$236,869	n/a
The total denied claims information does not represent a sum of the top five reasons. It is a sum of all denials.			

- Denied claim transactions with reasons "ICD-10 diagnoses code or beneficiary demographic data or rendering provider identifier is missing, incomplete, or invalid"; "Medicare or Other Health Coverage must be billed before submission of claim" are generally re-billable within the State guidelines.
- The "Medicare or Other Health Coverage must be billed before submission of claim" denials are primarily a result of the MHP not being certified with the CMS intermediary.

NETWORK ADEQUACY

In accordance with the CMS rules and DHCS directives on NA, CalEQRO has reviewed and verified the following three areas: ONA, AAS, and Rendering Provider NPI taxonomy codes as assigned in the NPPES. DHCS produced a detailed description and a set of NA requirements for the MHPs. CalEQRO followed these requirements in reviewing each MHP's adherence to the NA rules.

Network Adequacy Certification Tool Data Submitted in April 2020

As described in the CalEQRO responsibilities, key documents were reviewed to validate NA as required by state law. The first document to be reviewed is the NACT that outlines in detail the MHP provider network by location, service provided, population served, and language capacity of the providers. The NACT also provides details of the rendering provider's NPI number as well as the professional taxonomy used to describe the individual providing the service. As previously stated, CalEQRO will be providing technical assistance in this area if there are problems with consistency with the federal register linked to these different types of important designations.

If DHCS found that the existing provider network did not meet required time and distance standards for all zip codes, an AAS recommendation would be submitted for approval by DHCS.

The travel time to the nearest provider for a required service level depends upon a county's size and the population density of its geographic areas. For El Dorado, the time and distance requirements are 75 minutes and 45 miles for mental health services, and 75 minutes and 45 miles for psychiatry services. The two types of care that are measured for MHP NA compliance with these requirements are mental health services and psychiatry services. These services are separately measured for time and distance in relation to two age groups-youth (0-20) and adults (21 and over).

Review of Documents

CalEQRO reviewed separately and with MHP staff all relevant documents (NACT, AAS) and maps related to NA issues for their Medi-Cal beneficiaries. CalEQRO also reviewed the special NA form created by CalEQRO for AAS zip codes, out-of-network providers, efforts to resolve these access issues, services to other disabled populations, use of technology and transportation to assist with access, and other NA related issues.

Review Sessions

CalEQRO conducted key informant interviews during the review process to identify any problems or barriers for the beneficiaries relating to access and timeliness issues. The key informants included beneficiaries, MHP staff and other stakeholders.

Findings

The county MHP met all time and distance standards and did not require an AAS or out-of-network providers to enhance access to services for specific zip codes for their Medi-Cal beneficiaries.

Plan of Correction/Improvement by MHP to Meet NA Standards and Enhance Access for Medi-Cal Patients

Not Applicable.

Provider NPI and Taxonomy Codes – Technical Assistance

CalEQRO provided the MHP a detailed list of its rendering provider's NPI, Type 1 number and associated taxonomy code and description. The data came from disparate sources. The primary source is the MHP's NA rendering service provider data submitted to DHCS. This data is linked to the NPPES using the rendering service provider's NPI, Type 1 number.

Table 31 below provides a summary of any NPI Type 1, NPI Type 2, or taxonomy code exceptions noted by CalEQRO.

Table 31: NPI and Taxonomy Code Exceptions

Description of NPI Exceptions	Number of Exceptions
NPI Type 1 number not found in NPPES	0
NPI Type 1 and 2 numbers are the same	0
NPI Type 1 number was reported by two or more MHPs and FTE percentages when combined are greater than 100 percent	13
NPI Type 1 number reported is associated with two or more providers	0

Description of NPI Exceptions	Number of Exceptions
NPI Type 1 number found in NPPES as Type 2 number associated with non-individual (facility) taxonomy codes	1
NPI Type 1 number found in NPPES and is associated with individual service provider taxonomy codes; however, that taxonomy code is generally not associated with providers who deliver behavioral health services	0

CONSUMER AND FAMILY MEMBER FOCUS GROUP(S)

CalEQRO conducted one 90-minute focus group with consumers (MHP beneficiaries) during the site review of the MHP. As part of the pre-site planning process, CalEQRO requested one focus group with 10 to 12 participants each, the details of which can be found in each section below.

The consumer and family member (CFM) focus group is an important component of the CalEQRO site review process. Feedback from those who are receiving services provides important information regarding quality, access, timeliness, and outcomes. The focus group questions emphasize the availability of timely access to care, recovery, peer support, cultural competence, improved outcomes, and CFM involvement. CalEQRO provides gift cards to thank the CFM focus group participants.

CFM Focus Group One

Table 32: Focus Group One Description and Findings

Topic	Description
Focus group type	CalEQRO requested a culturally diverse group of adult beneficiaries who are mostly new beneficiaries who have initiated/utilized services within the past 12 months. The group was consistent with that requested by CalEQRO. The focus group was held via Zoom video conferencing.
Total number of participants	Five
Number of participants who initiated services during the previous 12 months	Three
Interpreter used	No If yes, specify language: n/a
Summary of the main findings of the focus group:	
Access - new beneficiaries	All participants reported that the process for obtaining services was easy.

Topic	Description
Access – overall	Participants learned about services through a variety of referral sources – a family member, a provider, or a counselor. Most accessed transportation supports.
Timeliness	All participants receive weekly therapy and meet with a psychiatrist monthly. Participants did not have trouble rescheduling if they missed an appointment.
Urgent care and resource support	Participants reported that clinicians would provide their telephone numbers for after-hours contact in the case of crisis/urgency. They also stated that they could call the main office or 9-1-1.
Quality	Participants felt that they were included in treatment planning but that they had not received information about medication. Participants were frustrated with the frequency of being assigned a new counselor and having to start over each time. They also provide feedback on services through surveys or when asked by staff. They had not been invited to participate on a committee or focus group.
Peer employment	Participants had not been offered job services.
Structure and operations	Some wellness center groups have been held by Zoom.
Recommendations from this focus group	• Provide a talk line which allows beneficiaries to talk for any length of time to peers (not a crisis line). • Open the wellness center. • Add groups on anxiety, trauma, and exercise.
Any best practices or innovations (optional)	• n/a

PERFORMANCE AND QUALITY MANAGEMENT KEY COMPONENTS

CalEQRO emphasizes the MHP's use of data to promote quality and improve performance. Components widely recognized as critical to successful performance management include Access to Care, Timeliness of Services, Quality of Care, Beneficiary Progress/Outcomes, and Structure and Operations. The following tables in this section summarize CalEQRO's findings in each of these areas.

The MHPs are assigned a score using the Key Components Tool available on CalEQRO website. Each table also provides the maximum possible score for each component.

Access to Care

Table 33 lists the components that CalEQRO considers representative of a broad service delivery system in providing access to beneficiaries and family members. An examination of capacity, penetration rates, cultural competency, integration, and collaboration of services with other providers forms the foundation of access to and delivery of quality services.

Table 33: Access to Care Components

<table>
<tr><th colspan="2">Component</th><th>Maximum Possible</th><th>MHP Score</th></tr>
<tr><td>1A</td><td>Service Access and Availability</td><td>14</td><td>10</td></tr>
<tr><td colspan="4">The primary comprehensive access systems for adults and children were maintained throughout a very difficult year. COVID-19 pervasively impacted fiscal support, service delivery, beneficiary and community needs. Some direct access and outreach services were continued during the pandemic including the Psychiatric Emergency Response Team (PERT), direct joint outreach to schools and county partners.
Most direct services were converted to phone engagement, including screening and assessment. Zoom was introduced as a beneficiary care platform; however, roll-out of hardware was only completed in early 2021. Beneficiary capacity to use Zoom or other tele-health services varies and often, internet reliability is poor.
Planning and implementation to address access recommendations and PIPs have been postponed as the MHP recalibrates in the wake of COVID-19 and meeting beneficiary need in an outpatient service system no longer built upon direct face-to-face contact as its primary system.</td></tr>
</table>

Component		Maximum Possible	MHP Score
The MHP's overall low penetration rates have continued. Claims data indicates low engagement for new beneficiaries and a large portion of beneficiaries receiving over 15 services. Diagnostically, psychotic disorders are more prevalent than affective disorders. Taken together and confirmed by leadership this pattern is consistent with a tendency to refer affective disorders to managed care organizations (MCO). The MHP has time and different staff steps between screening, assessment and internal team or external MCO referral. Most steps are not "warm" handoffs but start and stop contacts. The MHP's provider directory has not been updated since April 2020. The provider directory does not provide NPI or license information and does not indicate the last update information and CalEQRO was unable to locate a Beneficiary Handbook on the website. The MHP's website is not intuitive for locating the directory as it is listed within an expandable menu at the bottom of the page. Outreach is primarily an MHSA project and community planning has continued via Zoom. The MHP has a Psychiatric Emergency Response Team (PERT) in partnership with EDSO on the West Slope, and they provide the mental health assessments and referrals to SUDS when needed. In Tahoe, the South Lake Tahoe Alternative Collaboration Services (STACS) team has been established, which has partners from key agencies such as law enforcement, ambulance service, behavioral health, schools, homeless services coordinators, and the hospital to provide focused non-traditional field interventions and follow-up to individuals to reduce barriers to accessing behavioral health services, increase stabilization, and end the cycle of homelessness.			
1B	Capacity Management	10	7
Cultural, linguistic need, and demographics are collected at assessment. Outreach and evaluation are provided by MHSA funded programs. The MHP is not currently measuring its own penetration rates due to low staffing. The MHP has engaged Innovative Development and Evaluation Associates (I.D.E.A.) consulting to review, assess their system and processes and provide recommendations for future improvements. The MHP's policies and procedures, PIPs, and the Cultural Competence Plan (CCP) are well documented and indicate a strong platform to address individualized culturally competent care; however, the MHP continues to suffer a chronically understaffed system and high turnover which is exacerbated by COVID-19. The MHP's move to a primarily non-direct service model has made it very challenging to implement these standards. As it was last year, approximately 30 percent of its positions are vacant.			
1C	Integration and Collaboration	24	20
This MHP shows evidence of very good and positive working relationships with their contractor community, other county departments, law enforcement, parallel agencies,			

Component	Maximum Possible	MHP Score
schools, hospitals and the MCO provider system. Clearly this is a strength of this MHP. The MHP is in a strong position to work to implement the new DHCS waivers and CalAIM requirements. The MHP is working with partners in Tahoe to implement the South Tahoe Alternative Collaborative Services (STACS) program. This collaborative project includes South Lake Tahoe Police Department, Cal Tahoe Ambulance, Barton Hospital and South Tahoe High School. The opportunity to establish HIE and "warm" referral handoffs, as noted under the access feedback, should be developed through these partnerships.		

Timeliness of Services

As shown in Table 34, CalEQRO identifies the following components as necessary for timely access to comprehensive specialty mental health services.

Table 34: Timeliness of Services Components

Component		Maximum Possible	MHP Score
2A	First Offered Appointment	16	12
The MHP reported an average time from first request to first offered appointment as 3.61 days with 97 percent of its appointments meeting the 10-business day goal. For adults and children, the average was 3.67 days and 3.5 days respectively, with 97 and 95 percent of appointments meeting the standard. This MHP has worked diligently to address into policy the DHCS standards for timely access. The next step is to fully implement county and contractor data tracking, reporting, and performance improvement.			
2B	First Offered Psychiatry Appointment	12	11
The MHP reported that 100 percent of first offered psychiatry appointments met the 15-business day standard, with an average of 4.8 days. Adult and children's appointments averaged 4.77 days and 4.91 days, respectively. As seen in the first offered appointment section, the MHP has worked diligently to address into policy the DHCS standards for timely access of psychiatric appointments. The next step is to fully implement county and contractor data tracking, reporting and performance improvement.			

Component		Maximum Possible	MHP Score
2C	Timely Appointments for Urgent Conditions	18	16
The MHP has worked diligently to address into policy the DHCS and CCR standards for timely response to urgent requests. Anecdotal feedback from staff and beneficiaries indicates that the MHP is responsive to urgent requests for service; however, the MHP needs to fully implement county and contractor data tracking, reporting and performance improvement. The MHP reports that 100 percent of its urgent appointments meet the 48-hour standard with an average of 5.62 hours overall. Children's data is not included as urgent requests for children are handled by the MHP's contractors.			
2D	Timely Access to Follow-up Appointments after Hospitalization	10	5
The MHP has worked with the local PHF contractor, TeleCare Corporation, Inc., to track, monitor and link beneficiaries. In the last year improved tracking for out-of-county returnees has been maintained for adult and minor beneficiaries. The MHP needs to fully implement county and contractor data tracking, reporting and performance improvement. There were 279 hospital discharges. Of the 93 beneficiaries who received a follow-up appointment within 30 days, 63 received follow-up appointments within seven days (68 percent), with an average of 3.41 days. The MHP's method for rate calculation artificially inflates the rate. The MHP divides the number of who received follow-up appointments within 7 days by the number who received follow-up within 30 days, when the rate should be determined by the total number of hospital discharges as the denominator. This would equal a 7-day follow-up rate of 22 percent. In response, the MHP found that most individuals who are not already connected with services are declining MH services upon discharge, do not meet criteria for SMHS, or discharge to another county. This is why the MHP uses the number of clients who meet criteria for SMHS and are willing to engage in outpatient services (within 30 days) as a denominator.			
2E	Psychiatric Inpatient Rehospitalizations	6	6
The MHP tracks readmissions of adults and minors with both groups with readmission rates of under 10 percent.			
2F	Tracks and Trends No-Shows	10	8
The MHP reports a no-show rate for adults for clinicians and psychiatrists of 15 percent and 22 percent, respectively. Adult services no-shows are reported as 16 percent for psychiatrists and 22 percent for clinicians. For children, it is 11 percent for			

Component	Maximum Possible	MHP Score
clinicians and is not reported for psychiatry. Tracking is incomplete for children's and FC services. Given the chronic staffing shortages and turnover, improving the efficiency of the time available should be a priority area to address.		

Quality of Care

In Table 35, CalEQRO identifies the components of an organization that are dedicated to the overall quality of care. These components ensure that the quality improvement efforts are aligned with the system's objectives and contributes to meaningful changes in the system to improve beneficiary care characteristics.

Table 35: Quality of Care Components

Component		Maximum Possible	MHP Score
3A	Cultural Competence	12	9
The MHP submitted its FY 2019-20 CCP. The MHP does not have an active CCC; however, the QIC develops and evaluates the goals of the CCP. The MHP has designated the MHSA Program Manager as the Cultural Competence/Ethnic Services Manager. As noted in other sections, the MHP has created a policy to address this requirement, but implementation, tracking and performance improvement are underdeveloped. Tools are in place to guide staff and beneficiaries in decision making. Anecdotally, beneficiaries generally report good care and services.			
3B	Beneficiary Needs are Matched to the Continuum of Care	12	12
The MHP provides a full range of services-level programs. Services to long-term, beneficiaries with over 15 contacts annually are a strength of this MHP. The MHP uses CALOCUS and CANS-50 for children and LOCUS and ANSA for adults. A medication management team works with beneficiaries and families. The MHP also offers higher levels of service including assisted outpatient treatment and conservatorship. The MHP hosts quarterly QIC meetings to evaluate efficacy of its strategies for beneficiary care transitions. The MHP uses data reports from the EHR to evaluate average length of stay in services, CFT feedback forms, rolling caseload numbers			

<table>
<tr><th colspan="2">Component</th><th>Maximum Possible</th><th>MHP Score</th></tr>
<tr><td colspan="4">from the highest levels of care, timeliness from time of referral to service, and number of referrals made to the managed care plans.</td></tr>
<tr><td>3C</td><td>Quality Improvement Plan</td><td>10</td><td>10</td></tr>
<tr><td colspan="4">The MHP has remained active in their quality improvement (QI) functions throughout the pandemic. Under the COVID-19 conditions, video-conferencing and phone calls have replaced face-to-face meetings. Daily, weekly and monthly layered meetings and coordination for care with emphasis on children’s services, and specialty PHF transitions are in place. Transitions between mild, moderate and significant treatment are managed with a bi-directional referral process.</td></tr>
<tr><td>3D</td><td>Quality Management Structure</td><td>14</td><td>14</td></tr>
<tr><td colspan="4">The MHP holds regular meetings to support the functions of QI. Leadership meets once per week and includes supervisors, managers, the public guardian and SUD staff. Caseloads are monitored via monthly report. The MHP uses bidirectional referral forms with its mild-to-moderate provider and reports a 2-day turnaround for beneficiaries. The MHP meets quarterly with managed care providers to review data on referrals and in-service numbers.</td></tr>
<tr><td>3E</td><td>QM Reports Act as a Change Agent in the System</td><td>10</td><td>7</td></tr>
<tr><td colspan="4">Leadership reviews reports on timely access and case load distribution. The LOCUS is used to guide program/therapist assignments. QI interfaces daily to manage referrals and authorizations. The MHP uses the CANS-50 and the ANSA as outcome tools for children and adults, respectively. The MHP does not aggregate data for programmatic evaluation but rather uses the tools to guide individual treatment. The MHP’s PIPs were evaluated. The clinical PIP is assessed is still in concept form while the non-clinical PIP was validated and is active. Both PIPs were started this last year.</td></tr>
<tr><td>3F</td><td>Medication Management</td><td>12</td><td>10</td></tr>
<tr><td colspan="4">The MHP does not track HEDIS measures related to medication management. The MHP has a Medication Chart Review Database. The Medication Support Team uses a medication support services referral to track and monitor medications. Also, the MHP has a quarterly Medication Monitoring Committee in which a physician’s assistant and nurses perform chart reviews of 28-30 charts each quarter. Chart review includes an evaluation of consents, labs, multiple medications, and documentation for need; however not all contractors are included.</td></tr>
</table>

Beneficiary Progress/Outcomes

In Table 36, CalEQRO identifies the components of an organization that are dedicated to beneficiary progress and outcomes as a result of the treatment. These components also include beneficiary perception or satisfaction with treatment and any resulting improvement in beneficiary conditions, as well as capture the MHP's efforts in supporting its beneficiaries through wellness and recovery.

Table 36: Beneficiary Progress/Outcomes Components

Component		Maximum Possible	MHP Score
4A	Beneficiary Progress	16	15
The MHP has adopted tools, several are State-required, to measure clinical and functional outcomes. The reporting is not performed in aggregate to track and address system-wide outcomes, but rather are used to guide individual treatment.			
4B	Beneficiary Perceptions	10	4
The MHP has administered the Consumer Perception Survey (CPS) in the past but has not entered its own data independently of the state survey, resulting in a long wait time and difficulty comparing the twice-yearly data. This an area of struggle for the MHP and is exacerbated by COVID-19 impacts at the local and state level as well as staff recruitment and retention. The November 2020 survey was cancelled statewide.			
4C	Supporting Beneficiaries through Wellness and Recovery	12	7
The beneficiary feedback was extremely supportive of the wellness centers. Peer volunteers interact with county leadership; however, the wellness center does not have peer employee positions. The wellness center included a host of beneficiary focused wellness activities and groups. Due to COVID-19 and state-wide mandates, the wellness center is closed. The peer leadership team is meeting by Zoom.			

Structure and Operations

In Table 37, CalEQRO identifies the structural and operational components of an organization that facilitate access, timeliness, quality, and beneficiary outcomes.

Table 37: Structure and Operations Components

<table>
<tr><th colspan="2">Component</th><th>Maximum Possible</th><th>MHP Score</th></tr>
<tr><td>5A</td><td>Capability and Capacity of the MHP</td><td>30</td><td>22</td></tr>
<tr><td colspan="4">The MHP provides an array of services utilizing a county and contractor model. Adult outpatient, wellness centers, adult and children’s Psychiatric Emergency Services (PES) are provided through county staff.” Children’s outpatient and specialty adult PHF and adult residential are performed by contractors.
The MHP is chronically understaffed; at the time of the review, there were just over 100 staff with more than 30 vacancies The MHP reports significant staff turnover, exacerbated by COVID-19, including several leadership changes in the past year.
The MHP has worked diligently to maintain communication channels. However, staff report ongoing stress as a result of staffing challenges.</td></tr>
<tr><td>5B</td><td>Network Enhancements</td><td>18</td><td>13</td></tr>
<tr><td colspan="4">South Lake Tahoe Behavioral Health (both SUDS and MH) is co-located with Adult Protective Services (APS), In Home Supportive Services (IHSS) and the Public Guardian. West Slope is co-located with Public Guardian and 1.5 FTE SUDS staff as well. There is also an eligibility worker stationed at the West Slope Clinic. The MHP does not have access to psychological testing nor is it part of the Whole Person Care program. The MHP does utilize telehealth, mobile crisis and field-based services.</td></tr>
<tr><td>5C</td><td>Subcontracts/Contract Providers</td><td>16</td><td>13</td></tr>
<tr><td colspan="4">The contractor community provides children’s outpatient services, adult residential and adult PHF services. Transition of care meetings with the MCO provider network also exists but could benefit from active referral tracking and direct (warm) handoffs, especially between access points.
The MHP meets frequently with its contractor Telecare PHF and has an ongoing dialogue regarding continuity of care. The MHP’s Quality Improvement Committee (QIC) meets quarterly with the QI team and stakeholders. The MHP also meets monthly with its other contractors. There is a liaison for the contractors for more frequent communication as needed.</td></tr>
<tr><td>5D</td><td>Stakeholder Engagement</td><td>12</td><td>11</td></tr>
<tr><td colspan="4">During the rating period the MHP has been very active with the stakeholder community. Both formal and informal communication across the system of care and specialty providers occurs regularly. Beneficiary and family are less formally involved outside of the Wellness Centers, which are closed due to COVID-19.</td></tr>
</table>

Component		Maximum Possible	MHP Score
5E	Peer Employment	8	2
The MHP does not have paid peer positions. Currently there are no active steps to develop county job descriptions or engaging contractor peer staff through a request for proposal (RFP) process. The MHP cited that they were “watching implementation of Senate Bill 803… to help establish a peer position. The MHP continues to offer the Peer Leadership Academy to help prepare beneficiaries for employment and volunteer positions.			

SUMMARY OF FINDINGS

This section summarizes the CalEQRO findings from the FY 2020-21 review of El Dorado MHP related to access, timeliness, and quality of care.

MHP Environment – Changes, Strengths and Opportunities

PIP Status

Clinical PIP Status: Concept only, not yet active (not rated)

Non-clinical PIP Status: Active and ongoing

- Title 42, CFR, §438.330 requires two PIPs; the MHP is urged to meet this requirement going forward.

Access to Care

Changes within the Past Year:

- Zoom video conferencing was introduced for providing telehealth beyond psychiatry services; however, connectivity is problematic resulting in limited use. Services, including screening and assessment, are being provided by phone.

Strengths:

- The MHP is developing a PIP aimed at expanding the SUD assessment process and developing a treatment plan objective based on the Center for Substance Abuse Treatment screening tool.

Opportunities for Improvement:

- The MHP does not have an active CCC and was not able to establish one per the recommendation from FY 2019-20.

Timeliness of Services

Changes within the Past Year:

- The MHP experienced a surge in crisis numbers during CY 2020 and onset of COVID-19, but now report that crisis numbers are leveling off.

Strengths:

- The MHP worked diligently to update its policies and procedures to reflect new State requirements and network adequacy.

Opportunities for Improvement:

- Much of its timeliness data does not include contractor data (for all elements).
- The MHP methodology for calculating follow-up after inpatient hospitalization is not consistent with customary healthcare quality measures but rather is limited to a subset of hospital discharges.

Quality of Care

Changes within the Past Year:

- The MHP hired a QI Mental Health Program Coordinator.

Strengths:

- The MHP uses bidirectional referral forms with its mild-to-moderate providers and reports a 2-day turnaround for beneficiaries.

Opportunities for Improvement:

- The MHP is awaiting State guidance on the implementation of SB 803 to establish its peer support specialist position/program.

Beneficiary Outcomes

Changes within the Past Year:

- Wellness centers have been closed due to the COVID-19 pandemic; however, the peer leadership team has been meeting by Zoom video conference.

Strengths:

- None noted.

Opportunities for Improvement:

- The MHP does not evaluate aggregate data (CANS-50, ANSA) at the program level or system level.
- The MHP does not enter its own state survey data and instead relies on the return of results from the State.

Foster Care

Changes within the Past Year:

- In 2020, the MHP and Child Welfare Services teamed up to streamline the referral process, including creating a specific “PreAdmit” episode type in Avatar.

Strengths:

- The MHP has a Medication Monitoring Committee that reviews requests for psychiatry services, past medication treatments, and current medication monitoring.

Opportunities for Improvement:

- The MHP does not have any providers who are willing and able to provide Therapeutic Foster Care (TFC) nor have they received any requests for TFC.

- The MHP reports delays in presumptive transfer notification from other counties; furthermore, they have received notification errors and denials from other counties.

Information Systems

Changes within the Past Year:

- The MHP updated the Avatar system to meet the initial phase of Avatar NX cloud preparation to include CACHE2017 updates, JBoss, and REST standards.

Strengths:

- The county website provides the ability to translate pages into a wide variety of languages.

Opportunities for Improvement:

- The MHP is not enrolled in Medicare and therefore cannot claim to Medicare Part B, a prerequisite for submitting Medi-Cal claims for dually eligible beneficiaries

- The Provider Directory on the website does not include all the required elements found in MHSUDS Information Notice 18-020.

- Use of aggregate reports from the available beneficiary outcome tools used (LOCUS; ANSA, CANS-50) would assist the MHP in its QI efforts towards a data-driven decision making.

Structure and Operations

Changes within the Past Year:

- A large percentage of staff have received new laptops, replacing their desktops.
- In response to the COVID-19 public health emergency staff were provided with equipment that included integrated microphones and cameras.
- VPN access provided to secure Avatar remote usage.
- The MHP had several leadership changes including a Behavioral Health Director, Deputy Director, two Mental Health Program Coordinators, a Manager, and Chief Financial Officer.

Strengths:

- The MHP contracted with I.D.E.A. Consulting to perform a comprehensive assessment of the MHP and SUDS to determine recommendations for system improvement. The outcome report is expected in early March of 2021.

Opportunities for Improvement:

- Continue to work with County IT to improve network connectivity performance to support telehealth services and staff who work remotely during COVID-19 pandemic emergency.
- The MHP is chronically understaffed with a position vacancy rate of 30 percent. COVID-19 has exacerbated the staffing problem with family leaves. Also, there have been several leadership changes.

FY 2020-21 Recommendations

PIP Status

Recommendation 1: Seek ongoing and regular technical assistance (TA) from CalEQRO for Performance Improvement Projects. As per Title 42, CFR, Section 438.330, the MHP is contractually required to have two active PIPs.

Access to Care

Recommendation 2: Establish and maintain a regularly scheduled, formal Cultural Competency Committee (CCC) with meeting minutes. (*This recommendation is a modification of a recommendation from FY 2019-20.*)

Recommendation 3: Update the online Provider Directory to include all the required elements, National Provider Identifier and California license number.

Timeliness of Services

Recommendation 4: Fully implement combined county and contractor data tracking, reporting and performance improvement.

Quality of Care

Recommendation 5: Independent of the Senate Bill (SB) 803 outcome, develop formal employment opportunities for peers, such as peer navigator.

Beneficiary Outcomes

None noted.

Foster Care

None noted.

Information Systems

Recommendation 6: Complete the enrollment process with Medicare to bill Medicare Part B claims, a prerequisite for submitting Medi-Cal claims for dually eligible beneficiaries.

Structure and Operations

Recommendation 7: Investigate network infrastructure grant opportunities from Rural Utility Services and/or Health Resources and Services Administration.

SITE REVIEW PROCESS BARRIERS

The following conditions significantly affected CalEQRO's ability to prepare for and/or conduct a comprehensive review:

- In accordance with the California Governor's Executive Order N-33-20 promulgating statewide Shelter-In-Place, it was not possible to conduct an on-site external quality review of the MHP. Consequently, some areas of the review were limited, and others were not possible.

ATTACHMENTS

Attachment A: Review Agenda

Attachment B: Review Participants

Attachment C: Approved Claims Data

Attachment D: ACA Penetration Rates and ACBs

Attachment E: ACB Range Distributions

Attachment F: List of Commonly Used Acronyms

Attachment A—Review Agenda

The following sessions were held during the EQR, either individually or in combination with other sessions.

Table A1: EQRO Review Sessions

El Dorado
Opening Session – Changes in the past year; current initiatives; and status of previous year's recommendations
Use of Data to Support Program Operations
Cultural Competence, Disparities and Performance Measures
Timeliness Performance Measures/Timeliness Self-Assessment
Quality Management, Quality Improvement and System-wide Outcomes
Beneficiary Satisfaction and Other Surveys
Primary and Specialty Care Collaboration and Integration
Acute and Crisis Care Collaboration and Integration
Health Plan and Mental Health Plan Collaboration Initiatives
Clinical Line Staff Group Interview
Clinical Supervisors Group Interview
Program Managers Group Interview
Clinical Directors Group Interview
Consumer and Family Member Focus Group(s)
Information Systems Billing and Fiscal Interview
Information Systems Capabilities Assessment (ISCA)
Telehealth
Final Questions and Answers - Exit Interview

Attachment B—Review Participants

CalEQRO Reviewers

Cyndi Lancaster, Lead Quality Reviewer
Bill Walker, Quality Reviewer
Leda Frediani, Information Systems Reviewer
Caroline Yip, Information Systems Reviewer
Valerie Garcia, Consumer/Family Member Consultant

Additional CalEQRO staff members were involved in the review process, assessments, and recommendations. They provided significant contributions to the overall review by participating in both the pre-site and the post-site meetings and in preparing the recommendations within this report.

MHP Review Sites and Participants

MHP Sites

El Dorado County Health and Human Services Agency
Behavioral Health Division
Mental Health Plan (EDC HHSA BHD MHP)
768 Pleasant Valley Road, Suite 201
Diamond Springs, CA 95619

All sessions were held via video conference due to COVID-19 restrictions.

Table B1: Participants Representing the MHP

Last Name	First Name	Position	Agency
Cable	Nicole	Manager of Mental Health Programs	EDC
Clavere, Ph.D	Stephen	Psychologist, Vice Chair	BH Commission
Collinsworth	Justine	Mental Health Program Coordinator	EDC
Diaz	Ramona	Program Manager, Fiscal	EDC
Ebrahimi-Nuyken	Nicole	Director of Behavioral Health	EDC
Gula	Kristin	Supervising Accountant/Auditor	EDC
Haynes	Amy	Deputy Director of Behavioral Health	EDC
Kernes	Chris	Manager of Mental Health Programs	EDC
Kwachak Hall	Jody	Mental Health Program Coordinator	EDC
Larrigan	Angelina	Manager of Mental Health Programs	EDC
Le Pore	Matthew	Sr. Administrative Analyst	EDC
Longo	Heather	Sr. Administrative Analyst / MHSA Coordinator	EDC
Martinez	Jose	Supervising Accountant/Auditor	HHSA
McAfee	Michele	Accountant II	EDC
Pardo	Malissa	Mental Health Program Coordinator	EDC
Price	Robert	Behavioral Health Medical Director	EDC
Rodriguez	Lisa	Department Systems Analyst	EDC
Salazar	Arturo	BH Commission, Chair	BH Commission
Schumacher	John	Mental Health Program Coordinator	EDC
Semon	Don	Health and Human Services Agency Director	EDC

Last Name	First Name	Position	Agency
Strong	Ren	Program Manager	EDC
VanSloten	Lesly	Mental Health Program Coordinator	EDC
Watts	Courtney	Accountant II	EDC
Weldy	Moriah	Administrative Technician	EDC

Attachment C—Approved Claims Data

Approved Claims Summaries are provided separately to the MHP in a HIPAA-compliant manner. Values are suppressed to protect confidentiality of the individuals summarized in the data sets where beneficiary count is less than or equal to 11 (*). Additionally, suppression may be required to prevent calculation of initially suppressed data, corresponding penetration rate percentages (n/a); and cells containing zero, missing data or dollar amounts (-).

Attachment D—ACA Penetration Rates and ACBs

Table D1 shows the ACA Penetration Rate and ACB separately. Since CY 2016, CalEQRO has included the ACA Expansion data in the PMs presented in the Performance Measurement section.

Table D1: CY 2019 Medi-Cal Expansion (ACA) Penetration Rate and ACB

El Dorado MHP					
Entity	Average Monthly ACA Enrollees	Beneficiaries Served	Penetration Rate	Total Approved Claims	ACB
Statewide	3,719,952	159,904	4.30%	$824,153,538	$5,154
Small	171,297	8,082	4.72%	$39,384,225	$4,873
MHP	11,764	362	3.08%	$2,212,959	$6,113

Attachment E—ACB Range Distributions

Table E1 shows the distribution of the MHP beneficiaries served by ACB range for three cost categories: under $20,000; $20,000 to $30,000; and above $30,000.

Table E1: CY 2019 Distribution of Beneficiaries by ACB Range

El Dorado MHP								
ACB Range	MHP Beneficiaries Served	MHP Percentage of Beneficiaries	Statewide Percentage of Beneficiaries	MHP Total Approved Claims	MHP ACB	Statewide ACB	MHP Percentage of Total Approved Claims	Statewide Percentage of Total Approved Claims
< $20K	1,166	88.94%	93.31%	$4,912,342	$4,213	$3,998	46.78%	59.06%
>$20K - $30K	68	5.19%	3.20%	$1,651,291	$24,284	$24,251	15.73%	12.29%
>$30K	77	5.87%	3.49%	$3,936,861	$51,128	$51,883	37.49%	28.65%

Attachment F—List of Commonly Used Acronyms

Table F1: List of Commonly Used Acronyms

Acronym	Full Term
AAS	Alternative Access Standard
AB	Assembly Bill
ACA	Affordable Care Act
ACB	Approved Claims per Beneficiary
ACO	Accountable Care Organization
ACT	Assertive Community Treatment
ANSA	Adult Needs and Strengths Assessment
ANSI	American National Standards Institute
API	Asian/Pacific Islander
ASAM	American Society of Addiction Medicine
BAL	Beneficiary Access Line
BHC	Behavioral Health Concepts
BHIN	Behavioral Health Information Notice
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CalEQRO	California External Quality Review Organization
CalOMS	California Outcomes Measurement System
CANS	Child and Adolescent Needs and Strengths
CBO	Community Based Organizations
CBT	Cognitive Behavioral Therapy
CCC	Cultural Competency Committee
CDSS	California Department of Social Services
CFM	Consumer and Family Member
CFR	Code of Federal Regulations
CFT	Child Family Team
CIO	Chief Information Officer
CMS	Centers for Medicare and Medicaid Services

Acronym	Full Term
COVID-19	Corona Virus Disease-2019
CPM	Core Practice Model
CPS	Client Perception Survey
CSI	Client Services Information
CSU	Crisis Stabilization Unit
CURES	Controlled Substances Utilization Review and Evaluation System
CWS	Child Welfare Services
CY	Calendar Year
DBT	Dialectical Behavioral Therapy
DHCS	Department of Health Care Services
DMC-ODS	Drug Medi-Cal Organized Delivery System
EBP	Evidence-based Program or Practice
EDI	Electronic Data Interchange
EHR	Electronic Health Record
EMR	Electronic Medical Record
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment
EQR	External Quality Review
EQRO	External Quality Review Organization
FC	Foster Care
FG	Focus Group
FQHC	Federally Qualified Health Center
FSP	Full-Service Partnership
FTE	Full Time Equivalent
FY	Fiscal Year
HCB	High-Cost Beneficiary
HEDIS	Healthcare Effectiveness Data and Information Set
HIE	Health Information Exchange
HIPAA	Health Insurance Portability and Accountability Act

Acronym	Full Term
HIS	Health Information System
HITECH	Health Information Technology for Economic and Clinical Health Act
HPSA	Health Professional Shortage Area
HR	Human Resources
IA	Inter-Agency Agreement
ICC	Intensive Care Coordination
IHBS	Intensive Home-Based Services
IMD	Institution for Mental Diseases
IN	Information Notice
IOT	Intensive Outpatient Treatment
IS	Information Systems
ISCA	Information Systems Capabilities Assessment
IT	Information Technology
KPI	Key Performance Indicator
LCSW	Licensed Clinical Social Worker
LGBTQ	Lesbian, Gay, Bisexual, Transgender or Questioning
LMFT	Licensed Marriage and Family Therapist
LOC	Level of Care
LOS	Length of Stay
LPHA	Licensed Practitioner of the Healing Arts
MAT	Medication Assisted Treatment
MCO	Managed Care Organizations
MCP	Managed Care Plan
MDT	Multi-Disciplinary Team
MFA	Multi-Factor Authentication
MHBG	Mental Health Block Grant
MHP	Mental Health Plan
MHSA	Mental Health Services Act

Acronym	Full Term
MHST	Mental Health Screening Tool
MI	Motivational Interviewing
MOU	Memorandum of Understanding
MSO	Management Services Organization
NA	Network Adequacy
n/a	Not Applicable
NACT	Network Adequacy Certification Tool
NP	Nurse Practitioner
NPI	National Provider Identifier
NPPES	National Plan and Provider Enumeration System
NTP	Narcotic Treatment Program
OON	Out-of-Network
OTP	Opioid Treatment Program
PA	Physician Assistant
PDSA	Plan Do Study Act
PHF	Psychiatric Health Facility
PHI	Protected Health Information
PHR	Personal Health Record
PIHP	Prepaid Inpatient Health Plan
PIN	Personal Identification Number
PIP	Performance Improvement Project
PM	Performance Measure
QI	Quality Improvement
QIC	Quality Improvement Committee
RFP	Request for Proposal
RN	Registered Nurse
ROI	Release of Information
SAR	Service Authorization Request
SAMHSA	Substance Abuse and Mental Health Services Administration

Acronym	Full Term
SB	Senate Bill
SBIRT	Screening, Brief Intervention, and Referral to Treatment
SD/MC	Short-Doyle Medi-Cal
SED	Seriously Emotionally Disturbed
SMHS	Specialty Mental Health Services
SMI	Seriously Mentally Ill
STCs	Special Terms and Conditions
STRTP	Short-Term Residential Therapeutic Program
SUD	Substance Use Disorders
TAY	Transition Age Youth
TBS	Therapeutic Behavioral Services
TFC	Therapeutic Foster Care
TPS	Treatment Perception Survey
VOIP	Voice Over Internet Protocol
WET	Workforce Education and Training
WM	Withdrawal Management
WRAP	Wellness Recovery Action Plan

Appendix

FY 2020-21
First 5 El Dorado Annual Report (Community Hubs)

FIRST 5 EL DORADO

FY 2020-2021 Semi-Annual Report

First 5 El Dorado – Children's Health Program

2020-2021

Report Period: ☐ Mid-Year Report (Jul-Dec) ☒ Year-End Report (July-Jun) *All information included must be YTD*

Person Completing Report:	Adriana De Persia and Donald Duval	**Date:**	September 16, 2021
Telephone:	(530) 957-1172	**Email:**	Adriana.depersia@edcgov.us

Technical Assistance

Please indicate by checking one of the boxes below, whether technical assistance is needed at this time.

☐ **No** ☒ **Yes** *(if you checked this box, please describe below what your TA needs are)*

In past fiscal years, challenges existed in data collection and evaluation of the health team services at a client level, as well as overall project level. However, promising improvements have begun FY 20-21. Data Analyst, Don Duval, joined the health team in August-bringing expertise in data collection and analysis to the team. Don's primary focus has been implementing the electronic health record system (Patagonia), which will replace the current data collection mechanisms (i.e. Excel spreadsheets) that have been expanded and modified over time to better align with data needs of multiple funders but have had limitations. The utilization of Patagonia will improve data collection by reducing challenges associated with manual entry, increasing efficiency, reducing labor intensity and decreasing potential for human error.

For Internal Use Only

1-833-EDC-HUBS: Services Provided to Children and Families

Commission Objective	Activity	Unduplicated Quantity of Individuals Served		Number of Services Provided (Duplicated)	
		Contract Goal	Achievement To Date	Contract Goal	Achievement To Date
Children receive early screening and intervention for developmental delays.	Families are provided information about developmental screenings and community resources through calls made to the 1-833# (number of calls incoming to the #)	-	42	-	43
	Families are referred to community resources through calls made to the 1-833# (number of referrals provided to families calling the 1-833 line)	-	40	-	43

Hub 1: Demographics of Individuals Receiving Services (Unduplicated Count)

This section must be completed for all individuals served through First 5-contracted services (i.e. families that include a child aged 0-5 years old that received health education and/or service navigation). Do not include data on families served through interactions within this section.

Age	Total
Children Less Than 3 years old	1
Children from 3rd to 6th Birthday	4
Children Age Unknown (birth – 6th Birthday)	3
Primary Caregivers	16
Other Family Members (*children/young adults 6-18)*	5*
Providers	N/A
Total Population Served	29

Race/Ethnicity	Children Birth – 6th Birthday	Primary Caregivers	Other Family Members	Providers
Alaska Native/American Indian	0	0	0	N/A
Asian	0	0	0	N/A
Black/African American	0	0	0	N/A
Hispanic/Latino	0	1	0	N/A
Native Hawaiian or Other Pacific Islander	0	0	0	N/A
White	4	8	0	N/A
Two or More Races	0	0	0	N/A
Other (Specify)	0	0	0	N/A
Unknown	4	7	5	N/A
Decline to State	0	0	0	N/A
Total	8	16	5	N/A

Primary Language	Children Birth – 6th Birthday	Primary Caregivers	Other Family Members	Providers
English	8	15	0	N/A
Spanish	0	0	0	N/A
Cantonese	0	0	0	N/A
Mandarin	0	0	0	N/A
Vietnamese	0	0	0	N/A
Korean	0	0	0	N/A
Other (Specify)	0	0	0	N/A
Unknown	0	1	5	N/A
Decline to State	0	0	0	N/A
Total	8	16	5	N/A

Family Surveys Collected	

Hub 1: Registration Data from Families Receiving Services

(*qualifying families must include children age 0-5)

This section must be completed for all individuals served through First 5-contracted services (i.e. families that include a child aged 0-5 years old that received health education and/or service navigation from any source, including 1-833#)

Do you have medical insurance? If yes, select all that apply?	No	Yes- Medi-Cal	Yes- Medicare	Yes- Employer	Yes- Other	Decline to state
Insert number of responses for each answer here		1				

What is the highest level of education completed by adults in your household?	Primary School	Some High School	High School Diploma/GED	Some College	2-year college/AA	4-year college/BA	Post-graduate or professional degree	Decline to state
Insert number of responses for each answer here							1	

Please describe your current housing situation (select one):	My family has permanent, safe, and stable housing	My family currently has housing, but I'm worried we may lose that housing soon	My family does not have safe and stable housing (including staying with others, in a hotel, in a shelter, living outside, in a car, or in a park)	Decline to state
Insert number of responses for each answer here	1			

Please indicate which ONE of the following best describes the support you have available	I have a strong social support network and always have people I can go to for support	I sometimes have people I can go to when I need support	I rarely have people I can go to when I need support	I have no one I can turn to when I need support	Decline to state
Insert number of responses for each answer here		1			

Are you currently having trouble affording any of the following?	Rent or mortgage	Utilities or bills	Groceries /food	Childcare/ daycare	Medical expense	Basic household or hygiene items	Transport -ation	No, we can afford all of these	Decline to state
Insert number of responses for each answer here			1			1	1		

Would you like help with any of these needs?	Yes	No
Insert number of responses for each answer here	1	

Describe any challenges experienced in collecting registration data from families, the plan to mitigate those challenges moving forward, and the plan to collect missing data from families.	The health team was involved in planning discussions regarding collection of registration data in November of FY20-21. Supervising Public Health Nurse and Data Analyst immediately began strategizing collection and analysis of this data. The CHA's began collecting this data in December, utilizing the tools developed by the Data Analyst, in anticipation of the Commission's approval in January. The health team is confident in the current mechanism of collecting registration data, and anticipates further improvement with the implementation of Patagonia.

Hub 1: Services Provided to Qualifying* Families (*qualifying families must include children age 0-5)

This section must be completed for all individuals served through First 5-contracted services (i.e. families that include a child aged 0-5 years old that received health education and/or service navigation). Do not include data on families served through interactions within this section and do not include families served through the 1-833 number (that data goes on page 1).

Commission Objective	Activity	Unduplicated Quantity of Individuals Served		(Duplicated) Number of Service Contacts Made	
		Contract Goal	Achievement To Date	Contract Goal	Achievement To Date
Children birth through 5 have well child visits and preventive dental care.	CHA's connect qualifying individuals to health insurance	**30**	3	**-**	3
	CHA's connect children aged 0-5 to medical providers		2	**-**	2
	CHA's connect adult caregivers of children aged 0-5 to medical providers		3		5
	CHA's connect qualifying individuals to mental health services				
	CHA's connect qualifying individuals to developmental services				
	CHA's connect qualifying individuals to Public Health Nursing programs (included with other services)				
	CHA's connect qualifying individuals to other community services (this includes all other services not broken out by category above)		10		22
	CHA's refer qualifying individuals to Public Health Nurse for care coordination/case management	**6**	3	**-**	3
	CHA's connect children aged 0-5 to dental van and/or other dental providers	**10**	1	**-**	3
	CHA's connect adult caregivers of children aged 0-5 to dental providers		2		4
		Unduplicated Quantity of Families Served		**Number of Classes Offered (To Date)**	
		Contract Goal	**Achievement To Date**	**Contract Goal**	**Achievement To Date**
	Provide health education series to families of young children.	**10**	1	**6**	6

Hub 1: Interactions with Qualifying* Families (*qualifying families include children age 0-5)

This section must be completed for all individuals that connected with the CH program during an interaction that is not considered a First 5-contracted service (e.g. a brief warm-line call that did not result in referral or service navigation, a drive-thru event, food distribution, via a Facebook live event, or that accessed a recorded service).

Event Name	Event Date	Event Description	Number of Participating Families (must include a child 0-5)
Food/Diaper Distribution	9/23/20	Distribution of diapers and promotion of Hub services	11
Warm-line call	11/4/20	Brief warm-line call that did not result in referral or service navigation	1

Hub 1: Outreach Conducted (This includes outreach to community members and providers)

Please describe the outreach that has been conducted to promote program services within the Hub during this reporting period.

Outreach Event Description (include target population – community members/providers)	**Date of Event**	**Estimated Number of Individuals Reached through Event**
Halloween Event- families with children 0-18 in El Dorado Hills community	10/30/20	75

Hub 1: Evening/Weekend Activities

Please describe the evening/weekend activities that were supported to promote access to routine health and dental care during this reporting period.

Evening/Weekend Event Description	**Date of Event**	**Estimated Number of Individuals Reached through Event**
EDH Valentine's Day evening event- health tip provided along with promotion of resource navigation offered by CHA	2/11/21	40

Hub 1: Challenges and Solutions

Please describe any challenges or delays experienced in implementing the program, and what solutions the program has identified to address the challenge.

The Hub 2 CHA continued coverage of Hub 1 in order to fill the vacancy. The COVID-19 pandemic continued to present unique challenges for the community, Hubs, and Public Health department. Hub 2 CHA played a key role in the public health response by taking contact tracing, case investigation, and clinic administrative responsibilities. These responsibilities allowed the CHA to promote Hub services to families who were facing barriers in addition to COVID-19 exposure/infection. The program adapted creative ways of outreaching to the community and addressing community needs throughout the course of the pandemic, with the mutual intent with that of California's equity rule that addresses the elimination of health disparities within the community at large, which would otherwise be exacerbated by the pandemic. The broader and longer objective is to create equity without regard to an event. The below compelling story demonstrates an inequity of resources exacerbated by the pandemic of which Hub intervention provided a balancing. In response to the increased need for basic needs resources, the CHA took additional measures in order to meet clients and support with resource access/navigation. The CHA also supported during a diaper/food distribution and drive-thru event to provide basic need resources, promote hub services, and decrease social isolation. Stay at home orders created challenges related to staying connected with the community. The health team increased outreach through Hub Facebook and Instagram accounts to address such challenges. In collaboration with Hub partners, the CHA provided a virtual Health Education series which was promoted to Hub 1 and Hub 2.

Hub 1: Priority Populations

Please define the isolated or underserved populations you targeted each quarter and describe the strategies you used to reach them.

Quarter	1st Quarter (Jul-Sep)	2nd Quarter (Aug-Dec)	3rd Quarter (Jan-Mar)	4th Quarter (Apr-Jun)
Target Population	Underserved families with children 0-18 with a lack of resources.	Underserved families with children 0-18 and families with children 0-18 at risk for social isolation.	Working class families with children 0-18.	Families with children 0-18 at risk for social isolation and lack of resources.
Strategy	Participated in food/diaper distribution outreach event to provide tangible items to families in need and promote hub health services/support accessing resources. Promptly responded to 833 line and client referrals for support navigating resources.	Participated in Hub 1 Halloween event- provided energy conservative activity and information on Hub services/community resources. Continued to respond to 833 line and client referrals for support navigating resources.	Participated in Hub 1 Valentine's event, offered during the evening to reach working families. Provided health tip, dark chocolate and information on Hub services.	Collaborated with FES to offer virtual Health Education series to families with children 0-18. Individualized resource navigation for families with children 0-18.

Hub 1: Compelling Success Story

Please describe a compelling Hub story to highlight the impact Hub services has on families served. Please provide a description of the family make-up, the service or intervention that was provided and the impact or benefits that the family experienced.

During FY 19-20, the PHN connected with a single mother of a toddler who was experiencing a high-risk pregnancy, was new to the area and had a lack of resources/support. The PHN assisted the client in accessing medical care as it related to her pregnancy, establishing a pediatrician, and getting her child's immunizations up to date. This support resulted in a healthy pregnancy and the delivery of a healthy infant. The PHN later made a referral to the CHA for assistance navigating community resources when the client reported she was at risk for homelessness. The CHA discussed the clients' situation with her and they weighed her options together. They then chose to pursue CalWORKS, and through that program, Temporary Homeless Assistance was able to secure a room for her and her children. She was also connected with a more long-term program that has extended her hotel stay while she looks for permanent housing.

Leading into this FY, because of these connections and the support offered during times of need, this family now has stabile housing, reliable transportation, quality childcare, employment, and a strong support group. Since the families' basic needs were fully addressed, and the mother could now focus on the importance of child development and family engagement, the health team encouraged the mother to complete developmental screenings with Together We Grow and follow Hub Facebook pages for information on parenting, health, literacy and programming.

A mother struggling to breastfeed and presenting with postpartum depression joined several sessions of the El Dorado County Breastfeeding Coalition support group on zoom. She received anticipatory guidance related to breastfeeding and maternal mental health from the Hub PHN during those sessions. She often cried during the meetings while sharing the challenges she experienced as an older mother trying to conceive, having a high-risk pregnancy, and then faced with breastfeeding challenges in the midst of feeling isolated due to being new to the county, with friends and family far away during the pandemic. The Hub PHN developed a connection with this mother during these meetings and offered to support her on an individual basis to address her mental health concerns, breastfeeding challenges and social isolation. The mother quickly joined several groups the PHN suggested including a New Moms group offered by the FES and CHA, and LENA with the ECLS. She engaged with weekly PHN zoom meetings over the course of twelve weeks. The mother connected with a mental health provider, completed the Mothers & Babies course with the PHN, successfully pumped and provided optimal nutrition for her baby (longer than her original goal), and increased social support through groups. At the end of the Mothers & Babies course the client reported an improvement in her mental health with tearful eyes (this time positive) as she expressed her appreciation for the support offered through the Hubs. She reflected on the changes that had resulted from Hub activities and stated she now has more control over her thoughts, participates in more positive activities, asks for help, has more support, and better self-esteem.

Hub 2: Demographics of Individuals Receiving Services (Unduplicated Count)

This section must be completed for all individuals served through First 5-contracted services (i.e. families that include a child aged 0-5 years old that received health education and/or service navigation). Do not include data on families served through interactions within this section.

Age	Total
Children Less Than 3 years old	19
Children from 3rd to 6th Birthday	7
Children Age Unknown (birth – 6th Birthday)	7
Primary Caregivers	45
Other Family Members (**children/young adults 6-18)*	23*
Providers	N/A
Total Population Served	101

Race/Ethnicity	Children Birth – 6th Birthday	Primary Caregivers	Other Family Members	Providers
Alaska Native/American Indian	0	0	0	N/A
Asian	0	0	0	N/A
Black/African American	2	1	0	N/A
Hispanic/Latino	4	8	0	N/A
Native Hawaiian or Other Pacific Islander	0	0	0	N/A
White	7	11	0	N/A
Two or More Races	0	0	0	N/A
Other (Specify)	0	0	0	N/A
Unknown	20	25	23	N/A
Decline to State	0	0	0	N/A
Total	33	45	23	N/A

Primary Language	Children Birth – 6th Birthday	Primary Caregivers	Other Family Members	Providers
English	28	40	0	N/A
Spanish	2	5	0	N/A
Cantonese	0	0	0	N/A
Mandarin	0	0	0	N/A
Vietnamese	0	0	0	N/A
Korean	0	0	0	N/A
Other (Specify)	0	0	0	N/A
Unknown	3	0	23	N/A
Decline to State	0	0	0	N/A
Total	33	45	23	N/A

Family Surveys Collected	

Hub 2: Registration Data from Families Receiving Services

(*qualifying families must include children age 0-5)

This section must be completed for all individuals served through First 5-contracted services (i.e. families that include a child aged 0-5 years old that received health education and/or service navigation from any source, including 1-833#)

Do you have medical insurance? If yes, select all that apply?	No	Yes- Medi-Cal	Yes- Medicare	Yes- Employer	Yes- Other	Decline to state
Insert number of responses for each answer here		1			2	

What is the highest level of education completed by adults in your household?	Primary School	Some High School	High School Diploma/GED	Some College	2-year college/AA	4-year college/BA	Post-graduate or professional degree	Decline to state
Insert number of responses for each answer here		1						2

Please describe your current housing situation (select one):	My family has permanent, safe, and stable housing	My family currently has housing, but I'm worried we may lose that housing soon	My family does not have safe and stable housing (including staying with others, in a hotel, in a shelter, living outside, in a car, or in a park)	Decline to state
Insert number of responses for each answer here	2	1		

Please indicate which ONE of the following best describes the support you have available	I have a strong social support network and always have people I can go to for support	I sometimes have people I can go to when I need support	I rarely have people I can go to when I need support	I have no one I can turn to when I need support	Decline to state
Insert number of responses for each answer here	1	1	1		

Are you currently having trouble affording any of the following?	Rent or mortgage	Utilities or bills	Groceries /food	Childcare/ daycare	Medical expense	Basic household or hygiene items	Transport -ation	No, we can afford all of these	Decline to state
Insert number of responses for each answer here	1	1						1	1

Would you like help with any of these needs?	Yes	No
Insert number of responses for each answer here	1	2

Describe any challenges experienced in collecting registration data from families, the plan to mitigate those challenges moving forward, and the plan to collect missing data from families.	The health team was involved in planning discussions regarding collection of registration data in November of FY20-21. Supervising Public Health Nurse and Data Analyst immediately began strategizing collection and analysis of this data. The CHA's began collecting this data in December, utilizing the tools developed by the Data Analyst, in anticipation of the Commission's approval in January. The health team is confident in the current mechanism of collecting registration data, and anticipates further improvement with the implementation of Patagonia.

Hub 2: Services Provided to Qualifying* Families (*qualifying families must include children age 0-5)

This section must be completed for all individuals served through First 5-contracted services (i.e. families that include a child aged 0-5 years old that received health education and/or service navigation). Do not include data on families served through interactions within this section and do not include families served through the 1-833 number (that data goes on page 1).

Commission Objective	Activity	Unduplicated Quantity of Individuals Served		(Duplicated) Number of Service Contacts Made	
		Contract Goal	Achievement To Date	Contract Goal	Achievement To Date
Children birth through 5 have well child visits and preventive dental care.	CHA's connect qualifying individuals to health insurance	60	9	-	9
	CHA's connect children aged 0-5 to medical providers			-	
	CHA's connect adult caregivers of children aged 0-5 to medical providers		3		3
	CHA's connect qualifying individuals to mental health services		7		7
	CHA's connect qualifying individuals to developmental services				
	CHA's connect qualifying individuals to Public Health Nursing programs (included with other services)				
	CHA's connect qualifying individuals to other community services (this includes all other services not broken out by category above)		41		69
	CHA's refer qualifying individuals to Public Health Nurse for care coordination/case management	18	3	-	3
	CHA's connect children aged 0-5 to dental van and/or other dental providers	10		-	
	CHA's connect adult caregivers of children aged 0-5 to dental providers				
		Unduplicated Quantity of Families Served		Number of Classes Offered (To Date)	
		Contract Goal	Achievement To Date	Contract Goal	Achievement To Date
	Provide health education series to families of young children.	10	1	6	6

Hub 2: Interactions with Qualifying* Families (*qualifying families include children age 0-5)

This section must be completed for all individuals that connected with the CH program during an interaction that is not considered a First 5-contracted service (e.g. a brief warm-line call that did not result in referral or service navigation, a drive-thru event, food distribution, via a Facebook live event, or that accessed a recorded service).

Event Name	Event Date	Event Description	Number of Participating Families (must include a child 0-5)
Food/Diaper Distribution Outreach	8/6/20, 9/3/20, 10/1/20, 11/5/20, 12/3/20, 2/4/21, 3/4/21, 5/6/21, 6/3/21	Food/diaper distribution outreach/promotion of hub services at Cameron Park Library	90-240

Hub 2: Outreach Conducted (This includes outreach to community members and providers)

Please describe the outreach that has been conducted to promote program services within the Hub during this reporting period.

Outreach Event Description (include target population – community members/providers)	Date of Event	Estimated Number of Individuals Reached through Event
Back to School Immunization Outreach- Families with school-aged children with a lack of resources and at risk for isolation in the Somerset community.	8/5/20	10
Flu Clinic Outreach- Families with children 0-18 at risk for isolation in the Somerset community.	10/8/20	10
Flu Clinic Outreach- Families with children 0-18 at risk for isolation in the Grizzly Flats community.	10/15/20	31

Hub 2: Evening/Weekend Activities

Please describe the evening/weekend activities that were supported to promote access to routine health and dental care during this reporting period.

Evening/Weekend Event Description	Date of Event	Estimated Number of Individuals Reached through Event
Day of the Young Child evening event- provided energy conservative activity, nutrition education, and information on Hub services/community resources.	4/30/21	85

Hub 2: Challenges and Solutions

Please describe any challenges or delays experienced in implementing the program, and what solutions the program has identified to address the challenge.

The COVID-19 pandemic continued to present unique challenges for the community, Hubs, and Public Health department. Hub 2 CHA played a key role in the public health response by taking contact tracing and case investigation responsibilities. These responsibilities allowed the CHA to promote Hub services to families who were facing barriers in addition to COVID-19 exposure/infection. The program adapted creative ways of outreaching to the community and addressing community needs throughout the course of the pandemic, with the mutual intent with that of California's equity rule that addresses the elimination of health disparities within the community at large that would otherwise be exacerbated by the pandemic. The broader and longer objective is to create equity without regard to an event. The below compelling story (1.) demonstrates an inequity of resources exacerbated by the pandemic of which Hub intervention provided a balancing. In response to the increased need for basic resources, the CHA took additional measures in order to meet clients and support with resource access/navigation. The CHA also supported during diaper/food distributions and community immunization clinics in rural communities to provide basic need/preventative health resources and promote hub services. Stay at home orders created challenges related to staying connected with the community. The health team increased outreach through Hub Facebook and Instagram accounts to address such challenges.

Hub 2: Priority Populations

Please define the isolated or underserved populations you targeted each quarter and describe the strategies you used to reach them.

Quarter	1st Quarter (Jul-Sep)	2nd Quarter (Aug-Dec)	3rd Quarter (Jan-Mar)	4th Quarter (Apr-Jun)
Target Population	Underserved families with children 0-18 with a lack of resources and at-risk for social isolation.	Underserved families with children 0-18 with a lack of resources and at-risk for social isolation.	Underserved families with children 0-18 with a lack of resources.	Working families with children 0-18 and at-risk for social isolation.
Strategy	Participated in food/diaper distribution outreach event and immunization clinic (in rural community) to provide tangible items and promote hub health services/support accessing resources. Promptly responded to 833 line and client referrals for support navigating resources.	Participated in food/diaper distribution outreach events and immunization clinics (in rural communities) to provide tangible items and promote hub health services/support accessing resources. Promptly responded to 833 line and client referrals for support navigating resources.	Participated in food/diaper distribution outreach events to provide tangible items and promote hub health services/support accessing resources.	Collaborated with Hub team on the Day of the Young Child Hub Event outside of normal business hours to promote hub health services/support accessing resources.

Hub 2: Compelling Success Story

Please describe a compelling Hub story to highlight the impact Hub services has on families served. Please provide a description of the family make-up, the service or intervention that was provided and the impact or benefits that the family experienced.

1. In the fall of 2020, the CHA began working with a mom who had escaped a domestic violence situation. She had two young children and many needs to address. The CHA assisted her with emotional support (eventually connecting her to behavioral health services), a CalFresh application and the follow up paperwork, and other food and financial resources. All of these steps have enabled her to gain some confidence, stability, and motivation to move forward in her life. To demonstrate her appreciation, upon wrapping up a phone call in which the CHA had information on mindfulness tools to get her through hard times, she said, "Thank you for what you are doing for me and also having time to talk. I don't have the words to say thank you."

In addition to the above, this same client was connected to Klaudia, the Hub 2 Family Engagement Specialist. After making this connection, the client attended one of Klaudia's zoom playgroups with her two boys. A few days later, in a follow up call with this client, she told the CHA that it was a wonderful experience for both herself and her two boys. For the first time, the CHA could hear some joy in the clients voice.

This story illustrates the efficacy and power of hub team members working together- and the difference that it can make in people's lives.

2. As a Community Health Advocate for the last two and a half years, one of the most significant and impactful forms of help I have given my clients is that of behavioral health assistance. This became especially true during the pandemic.
To illustrate the benefits of this assistance (and the subsequent gratitude) I would like to share a vignette about one family:

In February of 2021, a mother reached out to the hubs because of her concern about how some recent emotional strife within the family had affected her four year old daughter. I interviewed her to understand insurance parameters, etc. and went to work researching counseling options.

After several phone calls to the insurance company and various counseling agencies, I was able to offer the mom many different options so that she could choose what worked for her without having to do the legwork herself. She thanked me for my time and even at that point, was very grateful.

When I followed up with this family later, the mom told me that her daughter had seen one of the counselors and that she was "doing great". She went on to say, "I really appreciate your care and concern" and "it means the world to our family."

Obviously this feedback is validating on a personal level, but more importantly, this expression of appreciation, in my opinion, encapsulates what we are trying to do for families in El Dorado County and illustrates the success of the Community Hubs.

3. A family was referred to the Community Hubs PHN by a healthcare provider with concern for an overweight child presenting with illness and family with food concerns and resource needs. After connecting with the child's mother, the PHN realized the family needed assistance connecting to healthcare providers (including PCP and dentist), nutritional education, possible counseling, cash and rental assistance too. The mother was provided information on local food banks, c4yourself website (cash & housing assistance), and healthcare providers. Mom expressed concern that one or two children might have social or behavioral disorders. ASQ screenings were given to the two younger children. Developmental delays in fine and gross motor, social and communication skills were found. Information and activity ideas were encouraged and shared with children's teachers. Care collaboration was accomplished with PCP on nutrition, neurology and Behavioral Health provider referral requests. Home visits helped build trust, provide education, reassurance & support to family, most needed especially around Christmas when family was stuck at home with illness, lack of food and cash resources. Second ASQ screenings were given to the younger children with improvements noted in motor skills, but some concerns remained, so activities and skill developments were discussed with parent, and reinforced with teachers with support from our Hubs family engagement specialist (FES). Two new medical diagnoses were identified by the healthcare provider; medication, diet and lifestyle changes were commenced to support the family's health and well-being. Educational collaboration with healthcare providers, plus counseling and referrals to a nutrition health educator and specialist are in process. The mother is back to work with flexible hours and children are supported by trusted child care providers when they are not in school. The client stated that the Hubs have really helped her get through a difficult Christmas and year, and she is "so grateful" to the Hubs for supporting her family in so many ways.

Hub 3: Demographics of Individuals Receiving Services (Unduplicated Count)

This section must be completed for all individuals served through First 5-contracted services (i.e. families that include a child aged 0-5 years old that received health education and/or service navigation). Do not include data on families served through interactions within this section.

Age	Total
Children Less Than 3 years old	6
Children from 3rd to 6th Birthday	5
Children Age Unknown (birth – 6th Birthday)	2
Primary Caregivers	35
Other Family Members (**children/young adults 6-18)*	15*
Providers	N/A
Total Population Served	63

Race/Ethnicity	Children Birth – 6th Birthday	Primary Caregivers	Other Family Members	Providers
Alaska Native/American Indian	0	0	0	N/A
Asian	0	0	0	N/A
Black/African American	0	0	0	N/A
Hispanic/Latino	3	5	0	N/A
Native Hawaiian or Other Pacific Islander	0	0	0	N/A
White	6	14	0	N/A
Two or More Races	0	0	0	N/A
Other (Specify)	0	0	0	N/A
Unknown	4	16	15	N/A
Decline to State	0	0	0	N/A
Total	13	35	15	N/A

Primary Language	Children Birth – 6th Birthday	Primary Caregivers	Other Family Members	Providers
English	12	29	0	N/A
Spanish	1	2	0	N/A
Cantonese	0	0	0	N/A
Mandarin	0	0	0	N/A
Vietnamese	0	0	0	N/A
Korean	0	0	0	N/A
Other (Specify)	0	0	0	N/A
Unknown	0	4	15	N/A
Decline to State	0	0	0	N/A
Total	13	35	15	N/A

Family Surveys Collected	

Hub 3: Registration Data from Families Receiving Services

(*qualifying families must include children age 0-5)

This section must be completed for all individuals served through First 5-contracted services (i.e. families that include a child aged 0-5 years old that received health education and/or service navigation from any source, including 1-833#)

Do you have medical insurance? If yes, select all that apply?	No	Yes- Medi-Cal	Yes- Medicare	Yes- Employer	Yes- Other	Decline to state
Insert number of responses for each answer here	3	9		1	2	

What is the highest level of education completed by adults in your household?	Primary School	Some High School	High School Diploma/GED	Some College	2-year college/AA	4-year college/BA	Post-graduate or professional degree	Decline to state
Insert number of responses for each answer here		1	1	6		3		4

Please describe your current housing situation (select one):	My family has permanent, safe, and stable housing	My family currently has housing, but I'm worried we may lose that housing soon	My family does not have safe and stable housing (including staying with others, in a hotel, in a shelter, living outside, in a car, or in a park)	Decline to state
Insert number of responses for each answer here	8	5	2	

Please indicate which ONE of the following best describes the support you have available	I have a strong social support network and always have people I can go to for support	I sometimes have people I can go to when I need support	I rarely have people I can go to when I need support	I have no one I can turn to when I need support	Decline to state
Insert number of responses for each answer here	3	6	4	1	1

Are you currently having trouble affording any of the following?	Rent or mortgage	Utilities or bills	Groceries /food	Childcare/ daycare	Medical expense	Basic household or hygiene items	Transport -ation	No, we can afford all of these	Decline to state
Insert number of responses for each answer here	5	5	6	2	6	5	1	2	

Would you like help with any of these needs?	Yes	No
Insert number of responses for each answer here	13	2

Describe any challenges experienced in collecting registration data from families, the plan to mitigate those challenges moving forward, and the plan to collect missing data from families.	The health team was involved in planning discussions regarding collection of registration data in November of FY20-21. Supervising Public Health Nurse and Data Analyst immediately began strategizing collection and analysis of this data. The CHA's began collecting this data in December, utilizing the tools developed by the Data Analyst, in anticipation of the Commission's approval in January. The health team is confident in the current mechanism of collecting registration data, and anticipates further improvement with the implementation of Patagonia.

Hub 3: Services Provided to Qualifying* Families (*qualifying families must include children age 0-5)

This section must be completed for all individuals served through First 5-contracted services (i.e. families that include a child aged 0-5 years old that received health education and/or service navigation). Do not include data on families served through interactions within this section and do not include families served through the 1-833 number (that data goes on page 1).

Commission Objective	Activity	Unduplicated Quantity of Individuals Served		(Duplicated) Number of Service Contacts Made	
		Contract Goal	Achievement To Date	Contract Goal	Achievement To Date
Children birth through 5 have well child visits and preventive dental care.	CHA's connect qualifying individuals to health insurance	75	6	-	22
	CHA's connect children aged 0-5 to medical providers		2	-	4
	CHA's connect adult caregivers of children aged 0-5 to medical providers		4		8
	CHA's connect qualifying individuals to mental health services		6		8
	CHA's connect qualifying individuals to developmental services				
	CHA's connect qualifying individuals to Public Health Nursing programs (included with other services)				
	CHA's connect qualifying individuals to other community services (this includes all other services not broken out by category above)		19		36
	CHA's refer qualifying individuals to Public Health Nurse for care coordination/case management	18	3	-	3
	CHA's connect children aged 0-5 to dental van and/or other dental providers	10	2	-	3
	CHA's connect adult caregivers of children aged 0-5 to dental providers				
		Unduplicated Quantity of Families Served		**Number of Classes Offered (To Date)**	
		Contract Goal	**Achievement To Date**	**Contract Goal**	**Achievement To Date**
	Provide health education series to families of young children.	10	8	6	6

Hub 3: Interactions with Qualifying* Families (*qualifying families include children age 0-5)

This section must be completed for all individuals that connected with the CH program during an interaction that is not considered a First 5-contracted service (e.g. a brief warm-line call that did not result in referral or service navigation, a drive-thru event, food distribution, via a Facebook live event, or that accessed a recorded service).

Event Name	Event Date	Event Description	Number of Participating Families (must include a child 0-5)
Food/Diaper Distribution	9/9/20, 11/4/20	Food/diaper distribution outreach/promotion of hub services at Placerville Library	80
Food Distribution	10/16/20	Promotion of hub services/community resources during Food Distribution event at Markham Middle School	205

Hub 3: Outreach Conducted (This includes outreach to community members and providers)

Please describe the outreach that has been conducted to promote program services within the Hub during this reporting period.

Outreach Event Description (include target population – community members/providers)	Date of Event	Estimated Number of Individuals Reached through Event
Flu Clinic Outreach- Families with children 0-18 in the Placerville community	10/21/20	60

Hub 3: Evening/Weekend Activities

Please describe the evening/weekend activities that were supported to promote access to routine health and dental care during this reporting period.

Evening/Weekend Event Description	Date of Event	Estimated Number of Individuals Reached through Event
Food/Diaper Distribution- health team provided items and handout to promote physical activity	11/4/20	15
Beach Party Super Hub event via zoom- Health team promoted physical activity	6/17/21	25

Hub 3: Challenges and Solutions

Please describe any challenges or delays experienced in implementing the program, and what solutions the program has identified to address the challenge.

The Hub 4 CHA provided coverage of Hub 3 in order to fill the vacancy. The COVID-19 pandemic continued to present unique challenges for the community, Hubs, and Public Health department. Hub 4 CHA played a key role in the public health response by taking contact tracing responsibilities. These responsibilities allowed the CHA to promote Hub services to families who were facing barriers in addition to COVID-19 exposure/infection. The program adapted creative ways of outreaching to the community and addressing community needs throughout the course of the pandemic, with the mutual intent with that of California's equity rule that addresses the elimination of health disparities within the community at large that would otherwise be exacerbated by the pandemic. The broader and longer objective is to create equity without regard to an event. The below compelling story demonstrates an inequity of resources exacerbated by the pandemic of which Hub intervention provided a balancing. In response to the increased need for basic needs resources, the CHA took additional measures in order to meet clients and support with resource access/navigation. The CHA also supported during diaper/food distribution events and a community immunization clinic to provide basic need/preventative health resources and promote hub services. Stay at home orders created challenges related to staying connected with the community. The health team increased outreach through Hub Facebook and Instagram accounts to address such challenges.

Hub 3: Priority Populations

Please define the isolated or underserved populations you targeted each quarter and describe the strategies you used to reach them.

Quarter	1st Quarter (Jul-Sep)	2nd Quarter (Aug-Dec)	3rd Quarter (Jan-Mar)	4th Quarter (Apr-Jun)
Target Population	Underserved families with children 0-18 with a lack of resources.	Underserved families with children 0-18 with a lack of resources.	Underserved families with children 0-18 with a lack of resources.	Working families with children 0-18 and at-risk for social isolation.
Strategy	Participated in food/diaper distribution outreach event to provide tangible items and promote hub health services/support accessing resources. Promptly responded to client referrals for support navigating resources.	Participated in food/diaper distribution outreach event and immunization clinic to provide tangible items and promote hub health services/support accessing resources. Promptly responded to client referrals for support navigating resources.	Provided client navigation of resources for families needing assistance accessing basic resources including food, housing, utilities, health insurance, and providers.	Collaborated with Hub team on the Day of the Young Child Hub Event outside of normal business hours to promote hub health services/support accessing resources.

Hub 3: Compelling Success Story

Please describe a compelling Hub story to highlight the impact Hub services has on families served. Please provide a description of the family make-up, the service or intervention that was provided and the impact or benefits that the family experienced.

CHA received a call from ECLS requesting assistance for a mom in tears in the Library. The client was a recently discharged veteran who was struggling with her experience while in the military. Due to discharge status she was unable to use the VA services. She had medi-cal but was having a hard time finding a provider to get connected with support and counseling. In addition, her child was behind on vaccinations and unable to enroll in school. CHA helped the client connect with the Community Health Center for both herself and her son. In addition, CHA assisted the client in getting an appointment at the Public Health clinic to get her son vaccinated and back into school right away. During the appointment, the client also revealed that they didn't have much food. The ECLS provided the CHA with boxes of food to provide the family to tide them over until she was able to pick up from the Food Bank and her CalFresh renewed. CHA was able to connect mom with other community resources such as HEAP and Christmas basket to support the family as well. The client remarked how grateful she was that the Hubs were there to help her right in the moment she needed the extra support.

A previous client referred their sister and her 10 children to the Hubs for assistance obtaining Medi-cal. The mom and dad had recently brought their 10 children across the country from out of state. Shortly after arriving in California, the dad suffered a severe nervous breakdown and had been hospitalized since. The mom was shocked to discover the “insurance” plan she thought she had been paying into would not cover his stay. They had been paying into a group plan to help cover medical expenses for years through their church group in their previous state. However, since their move, they were no longer able to apply for funds. The CHA helped the client collect all the needed documents, apply for expedited Medi-cal insurance coverage and figure out which managed care plan would work with the out of county facility her husband was already receiving treatment at. In addition, the client connected to services to support their family’s resilience including a Foodbank, clothing closets and youth activities. Since the children had not seen a dentist in many years, they were connected with a dental provider that could help get their dental health back on track. The client said she felt helpless where her husband’s mental health was concerned, but she felt like she was contributing to his recovery by getting the insurance issues sorted out. She also said it was wonderful to have someone to guide her to available services since she was so unfamiliar with the area.

Hub 4: Demographics of Individuals Receiving Services (Unduplicated Count)

This section must be completed for all individuals served through First 5-contracted services (i.e. families that include a child aged 0-5 years old that received health education and/or service navigation). Do not include data on families served through interactions within this section.

Age	Total
Children Less Than 3 years old	9
Children from 3rd to 6th Birthday	10
Children Age Unknown (birth – 6th Birthday)	47
Primary Caregivers	99
Other Family Members (*children/young adults 6-18)*	43*
Providers	N/A
Total Population Served	208

Race/Ethnicity	Children Birth – 6th Birthday	Primary Caregivers	Other Family Members	Providers
Alaska Native/American Indian	0	0	0	N/A
Asian	0	0	0	N/A
Black/African American	1	0	0	N/A
Hispanic/Latino	1	9	0	N/A
Native Hawaiian or Other Pacific Islander	0	0	0	N/A
White	63	87	0	N/A
Two or More Races	0	0	0	N/A
Other (Specify)	0	0	0	N/A
Unknown	1	3	43	N/A
Decline to State	0	0	0	N/A
Total	66	99	43	N/A

Primary Language	Children Birth – 6th Birthday	Primary Caregivers	Other Family Members	Providers
English	65	95	0	N/A
Spanish	1	4	0	N/A
Cantonese	0	0	0	N/A
Mandarin	0	0	0	N/A
Vietnamese	0	0	0	N/A
Korean	0	0	0	N/A
Other (Specify)	0	0	0	N/A
Unknown	0	0	43	N/A
Decline to State	0	0	0	N/A
Total	66	99	43	N/A

Family Surveys Collected	

Hub 4: Registration Data from Families Receiving Services

(*qualifying families must include children age 0-5)

This section must be completed for all individuals served through First 5-contracted services (i.e. families that include a child aged 0-5 years old that received health education and/or service navigation from any source, including 1-833#)

Do you have medical insurance? If yes, select all that apply?	No	Yes- Medi-Cal	Yes- Medicare	Yes- Employer	Yes- Other	Decline to state
Insert number of responses for each answer here	22	30	1	6	8	3

What is the highest level of education completed by adults in your household?	Primary School	Some High School	High School Diploma/GED	Some College	2-year college/AA	4-year college/BA	Post-graduate or professional degree	Decline to state
Insert number of responses for each answer here		8	8	17	1	4		32

Please describe your current housing situation (select one):	My family has permanent, safe, and stable housing	My family currently has housing, but I'm worried we may lose that housing soon	My family does not have safe and stable housing (including staying with others, in a hotel, in a shelter, living outside, in a car, or in a park)	Decline to state
Insert number of responses for each answer here	25	22	11	12

Please indicate which ONE of the following best describes the support you have available	I have a strong social support network and always have people I can go to for support	I sometimes have people I can go to when I need support	I rarely have people I can go to when I need support	I have no one I can turn to when I need support	Decline to state
Insert number of responses for each answer here	17	30	12		11

Are you currently having trouble affording any of the following?	Rent or mortgage	Utilities or bills	Groceries /food	Childcare/ daycare	Medical expense	Basic household or hygiene items	Transport -ation	No, we can afford all of these	Decline to state
Insert number of responses for each answer here	22	35	23	9	48	18	3	2	12

Would you like help with any of these needs?	Yes	No
Insert number of responses for each answer here	55	15

Describe any challenges experienced in collecting registration data from families, the plan to mitigate those challenges moving forward, and the plan to collect missing data from families.	The health team was involved in planning discussions regarding collection of registration data in November of FY20-21. Supervising Public Health Nurse and Data Analyst immediately began strategizing collection and analysis of this data. The CHA's began collecting this data in December, utilizing the tools developed by the Data Analyst, in anticipation of the Commission's approval in January. The health team is confident in the current mechanism of collecting registration data, and anticipates further improvement with the implementation of Patagonia.

Hub 4: Services Provided to Qualifying* Families (*qualifying families must include children age 0-5)

This section must be completed for all individuals served through First 5-contracted services (i.e. families that include a child aged 0-5 years old that received health education and/or service navigation). Do not include data on families served through interactions within this section and do not include families served through the 1-833 number (that data goes on page 1).

Commission Objective	Activity	Unduplicated Quantity of Individuals Served		(Duplicated) Number of Service Contacts Made	
		Contract Goal	Achievement To Date	Contract Goal	Achievement To Date
Children birth through 5 have well child visits and preventive dental care.	CHA's connect qualifying individuals to health insurance	70	38	-	101
	CHA's connect children aged 0-5 to medical providers		9	-	9
	CHA's connect adult caregivers of children aged 0-5 to medical providers		22		22
	CHA's connect qualifying individuals to mental health services		23		23
	CHA's connect qualifying individuals to developmental services				
	CHA's connect qualifying individuals to Public Health Nursing programs (included with other services)				
	CHA's connect qualifying individuals to other community services (this includes all other services not broken out by category above)		145		196
	CHA's refer qualifying individuals to Public Health Nurse for care coordination/case management	12	1	-	1
	CHA's connect children aged 0-5 to dental van and/or other dental providers	10	15	-	15
	CHA's connect adult caregivers of children aged 0-5 to dental providers		22		30
		Unduplicated Quantity of Families Served		**Number of Classes Offered (To Date)**	
		Contract Goal	**Achievement To Date**	**Contract Goal**	**Achievement To Date**
	Provide health education series to families of young children.	10	15	6	10

Hub 4: Interactions with Qualifying* Families (*qualifying families include children age 0-5)

This section must be completed for all individuals that connected with the CH program during an interaction that is not considered a First 5-contracted service (e.g. a brief warm-line call that did not result in referral or service navigation, a drive-thru event, food distribution, via a Facebook live event, or that accessed a recorded service).

Event Name	Event Date	Event Description	Number of Participating Families (must include a child 0-5)
Food/Diaper Distribution	8/20/20	Food/diaper distribution outreach/promotion of hub services in Georgetown	100

Hub 4: Outreach Conducted (This includes outreach to community members and providers)

Please describe the outreach that has been conducted to promote program services within the Hub during this reporting period.

Outreach Event Description (include target population – community members/providers)	Date of Event	Estimated Number of Individuals Reached through Event
Flu clinic- families with children 0-18 in the divide community	10/3/20 & 10/13/20	120
Health Education Series focused on building resiliency through healthy habits- children in grades K-1 via zoom with the Boys and Girls Club	10/7/20, 11/17/20, 12/10/20	15
Health and Wellness Clinic/COVID IZ- families with children 0-18 in the divide community	4/30/21, 5/15/21, 6/19/21	200
Mountain Kids Parent Outreach- families with children 0-5 in the divide community- hub services and ASQ promotion	5/25/21	30
Kindergarten Roundup- families with children 4-6 in the divide community	4/21/21 & 4/28/21	100

Hub 4: Evening/Weekend Activities

Please describe the evening/weekend activities that were supported to promote access to routine health and dental care during this reporting period.

Evening/Weekend Event Description	Date of Event	Estimated Number of Individuals Reached through Event
Christmas PJ Super Hub evening event via zoom- promoted physical activity through indoor play and stress reducing activities for parents/children	12/15/20	50
Spring PJ Super Hub evening event via zoom- promoted nutrition through planting activity followed by recipe using the herbs	3/30/21	50

Hub 4: Challenges and Solutions

Please describe any challenges or delays experienced in implementing the program, and what solutions the program has identified to address the challenge.

The COVID-19 pandemic continued to present unique challenges for the community, Hubs, and Public Health department. Hub 4 CHA played a key role in the public health response by taking contact tracing responsibilities. These responsibilities allowed the CHA to promote Hub services to families who were facing barriers in addition to COVID-19 exposure/infection. The program adapted creative ways of outreaching to the community and addressing community needs throughout the course of the pandemic, with the mutual intent with that of California's equity rule that addresses the elimination of health disparities within the community at large that would otherwise be exacerbated by the pandemic. The broader and longer objective is to create equity without regard to an event. The below compelling story demonstrates an inequity of resources exacerbated by the pandemic of which Hub intervention provided a balancing. In response to the increased need for basic needs resources, the CHA took additional measures in order to meet clients and support with resource access/navigation. The CHA also supported during diaper/food distribution events and a community immunization clinic to provide basic need/preventative health resources and promote hub services. Stay at home orders created challenges related to staying connected with the community. The health team increased outreach through Hub Facebook and Instagram accounts to address such challenges. Hub 4 CHA addressed consequences of social isolation and increased stress related to COVID-19 by providing related health education during a virtual series to children in collaboration with the local Boys and Girls Club. Health education was focused on building resiliency through healthy habits to assist children in coping and thriving during and beyond current circumstances.

Hub 4: Priority Populations

Please define the isolated or underserved populations you targeted each quarter and describe the strategies you used to reach them.

Quarter	1st Quarter (Jul-Sep)	2nd Quarter (Aug-Dec)	3rd Quarter (Jan-Mar)	4th Quarter (Apr-Jun)
Target Population	Underserved families with children 0-18 with a lack of resources and at-risk for isolation.	Underserved families/working families with children 0-18 with a lack of resources and at-risk for isolation.	Working families with children 0-18 at-risk for isolation.	Families with children 0-5 and 0-18 at-risk for a lack of resources due to geographical isolation.
Strategy	Participated in food/diaper distribution outreach event to provide tangible items and promote hub health services/support accessing resources. Promptly responded to client referrals for support navigating resources.	Participated in immunization clinics (in rural communities) and evening event to provide preventative health resources and health education, and promote hub health services/support accessing resources. Promptly responded to client referrals for support navigating resources.	Collaborated with Hub team on the Spring PJ Super Hub Event outside of normal business hours to promote hub health services/support accessing resources.	Promoted Hub services with local preschool group, Kindergarten Roundup, and Health and Wellness clinics.

Hub 4: Compelling Success Story

Please describe a compelling Hub story to highlight the impact Hub services has on families served. Please provide a description of the family make-up, the service or intervention that was provided and the impact or benefits that the family experienced.

A referral came to the CHA from one of the outside partners requesting assistance for a single mom with an unemployment insurance issue. She had not received any wages, unemployment or her stimulus payment since the pandemic began. The CHA assisted the mom with getting her unemployment application completed, filing for a duplicate stimulus check and connecting to other supportive resources such as WIC, Medi-cal and HEAP. In addition, the CHA connected her to activities offered by the library for her toddler to reduce their isolation. Now that mom is feeling better about her basic needs resources and is ready to move forward with taking care of other essential healthcare needs, the CHA is helping the mom connect to a Primary Care Provider and Dentist, so that her toddler can get back on track with vaccinations and get treatment for dental cavities. The mom expressed gratitude that the Hubs have been there for her when other services have been closed for help.

A former Hub client referred a friend, a medically separated veteran and single mom, with her five-year-old son to the CHA. The new client came seeking assistance reinstating her Medi-cal so she could get her son vaccinated for the upcoming school year. During the first meeting with the CHA, the mom shared that in addition to medical needs, she was also struggling to get her unemployment application processed, get food on the table and keep a roof over their heads. She also shared that she was desperate to get into counseling for herself and had little luck with the VA. Over the course of several visits, they were able to sort out her unemployment application, apply and receive Medi-cal and CalFresh benefits, schedule PCP and dentist appointments for her son, connect to local foodbank distributions, find a safe place to park her travel trailer and connect with Mental Health services and the local VA to help support her and her son. The client was incredibly grateful for her friend who referred her and for the support with connecting to services that could help her family provided by the CHA. She said she felt too overwhelmed when trying to reach out to so many different places for help before, and felt like she was always failing to provide all they were asking for from her. With Hub support to help her figure out the requirements for each program, she was able to follow through with all the different resources and get the help she needed.

The Library referred a brand new mom struggling to get heat for her newborn baby. The mom and her boyfriend were blessed with a brand new baby boy. The dad was unemployed and struggling to receive his benefits. The mom was trying to find a way to get their propane tank filled so they could have heat in the house for their new baby. During the first CHA meeting, she shared that she had struggled to get her HEAP application completed and without any income, they were living in the house without heat. The CHA and client worked together to track down acceptable documentation to meet the requirements for HEAP assistance and apply for a grant from the Women's fund to get a full propane tank ASAP. In addition, they reviewed documentation from Unemployment to determine what they were requesting of dad and got that submitted. They also reviewed eligibility for additional programs they qualified for and completed applications to get CalFresh and WIC and connected her to resources for diapers and local food banks as well as Mother Goose on the Loose online programing. The sound of the mom's voice on the phone when she called to say, "it's finally warm in this

place!!" let the CHA know she was very appreciative for the ability to get support from Hubs. The mom has since referred multiple family members to Hub services for a variety of assistance from financial support to social isolation.

Hub 5: Demographics of Individuals Receiving Services (Unduplicated Count)

This section must be completed for all individuals served through First 5-contracted services (i.e. families that include a child aged 0-5 years old that received health education and/or service navigation). Do not include data on families served through interactions within this section.

Age	Total
Children Less Than 3 years old	8
Children from 3rd to 6th Birthday	4
Children Age Unknown (birth – 6th Birthday)	0
Primary Caregivers	167
Other Family Members (**children/young adults 6-18)*	67*
Providers	N/A
Total Population Served	246

Race/Ethnicity	Children Birth – 6th Birthday	Primary Caregivers	Other Family Members	Providers
Alaska Native/American Indian	0	0	0	N/A
Asian	0	0	0	N/A
Black/African American	0	0	0	N/A
Hispanic/Latino	11	159	0	N/A
Native Hawaiian or Other Pacific Islander	0	0	0	N/A
White	1	7	0	N/A
Two or More Races	0	0	0	N/A
Other (Specify)	0	0	0	N/A
Unknown	0	1	67	N/A
Decline to State	0	0	0	N/A
Total	12	167	67	N/A

Primary Language	Children Birth – 6th Birthday	Primary Caregivers	Other Family Members	Providers
English	1	9	0	N/A
Spanish	11	158	0	N/A
Cantonese	0	0	0	N/A
Mandarin	0	0	0	N/A
Vietnamese	0	0	0	N/A
Korean	0	0	0	N/A
Other (Specify)	0	0	0	N/A
Unknown	0	0	67	N/A
Decline to State	0	0	0	N/A
Total	12	167	67	N/A

Family Surveys Collected	

Hub 5: Registration Data from Families Receiving Services

(*qualifying families must include children age 0-5)

This section must be completed for all individuals served through First 5-contracted services (i.e. families that include a child aged 0-5 years old that received health education and/or service navigation from any source, including 1-833#)

Do you have medical insurance? If yes, select all that apply?	No	Yes- Medi-Cal	Yes- Medicare	Yes- Employer	Yes- Other	Decline to state
Insert number of responses for each answer here	14	15	2	2	2	

What is the highest level of education completed by adults in your household?	Primary School	Some High School	High School Diploma/GED	Some College	2-year college/AA	4-year college/BA	Post-graduate or professional degree	Decline to state
Insert number of responses for each answer here	15	17		2		1		

Please describe your current housing situation (select one):	My family has permanent, safe, and stable housing	My family currently has housing, but I'm worried we may lose that housing soon	My family does not have safe and stable housing (including staying with others, in a hotel, in a shelter, living outside, in a car, or in a park)	Decline to state
Insert number of responses for each answer here	14	14	3	3

Please indicate which ONE of the following best describes the support you have available	I have a strong social support network and always have people I can go to for support	I sometimes have people I can go to when I need support	I rarely have people I can go to when I need support	I have no one I can turn to when I need support	Decline to state
Insert number of responses for each answer here	13	7	2	3	10

Are you currently having trouble affording any of the following?	Rent or mortgage	Utilities or bills	Groceries /food	Childcare/ daycare	Medical expense	Basic household or hygiene items	Transport-ation	No, we can afford all of these	Decline to state
Insert number of responses for each answer here	20	16			21	3	3	5	5

Would you like help with any of these needs?	Yes	No
Insert number of responses for each answer here	25	10

Describe any challenges experienced in collecting registration data from families, the plan to mitigate those challenges moving forward, and the plan to collect missing data from families.	The health team was involved in planning discussions regarding collection of registration data in November of FY20-21. Supervising Public Health Nurse and Data Analyst immediately began strategizing collection and analysis of this data. The CHA's began collecting this data in December, utilizing the tools developed by the Data Analyst, in anticipation of the Commission's approval in January. The health team is confident in the current mechanism of collecting registration data, and anticipates further improvement with the implementation of Patagonia.

Hub 5: Services Provided to Qualifying* Families (*qualifying families must include children age 0-5)

This section must be completed for all individuals served through First 5-contracted services (i.e. families that include a child aged 0-5 years old that received health education and/or service navigation). Do not include data on families served through interactions within this section and do not include families served through the 1-833 number (that data goes on page 1).

Commission Objective	Activity	Unduplicated Quantity of Individuals Served		(Duplicated) Number of Service Contacts Made	
		Contract Goal	Achievement To Date	Contract Goal	Achievement To Date
Children birth through 5 have well child visits and preventive dental care.	CHA's connect qualifying individuals to health insurance	70	27	-	43
	CHA's connect children aged 0-5 to medical providers			-	
	CHA's connect adult caregivers of children aged 0-5 to medical providers		9		9
	CHA's connect qualifying individuals to mental health services		3		5
	CHA's connect qualifying individuals to developmental services				
	CHA's connect qualifying individuals to Public Health Nursing programs (included with other services)				
	CHA's connect qualifying individuals to other community services (this includes all other services not broken out by category above)		221		316
	CHA's refer qualifying individuals to Public Health Nurse for care coordination/case management	12	8	-	8
	CHA's connect children aged 0-5 to dental van and/or other dental providers	10	1	-	1
	CHA's connect adult caregivers of children aged 0-5 to dental providers		4		8
		Unduplicated Quantity of Families Served		Number of Classes Offered (To Date)	
		Contract Goal	Achievement To Date	Contract Goal	Achievement To Date
	Provide health education series to families of young children.	10	4	6	6

Hub 5: Interactions with Qualifying* Families (*qualifying families include children age 0-5)

This section must be completed for all individuals that connected with the CH program during an interaction that is not considered a First 5-contracted service (e.g. a brief warm-line call that did not result in referral or service navigation, a drive-thru event, food distribution, via a Facebook live event, or that accessed a recorded service).

Event Name	Event Date	Event Description	Number of Participating Families (must include a child 0-5)
Diaper Distribution	7/2/20	Diaper distribution outreach/promotion of hub services at SLT Family Resource Center	60
Food/Diaper Distribution	9/23/20 & 10/14/20	Food/diaper distribution outreach/promotion of hub services at Pollock Pines Community Center	200

Hub 5: Outreach Conducted (This includes outreach to community members and providers)

Please describe the outreach that has been conducted to promote program services within the Hub during this reporting period.

Outreach Event Description (include target population – community members/providers)	Date of Event	Estimated Number of Individuals Reached through Event
Flu Clinic Outreach- Families with children 0-18 at risk for isolation in the South Lake Tahoe community	9/24/20, 10/1/20, 10/8/20, 10/15/20, 10/22/20	70-200
Dental Drive with EDC Oral Health Program at Bijou school and Tahoe Valley School – Families with children 0-18 with a lack of resources and at risk for poor oral health	10/21/20 & 10/28/20	1
COVID Clinic- Families with children 0-18 at risk for isolation in the South Lake Tahoe community, targeted outreach to Hispanic population	1/7/21, 1/8/21, 1/14/21, 1/15/21, 1/21/21, 1/22/21, 1/25/21, 2/1/21, 2/2/21, 2/4/21, 2/5/21, 2/8/21,	
Cafesitos/Family Resource Center- Hispanic families with children 0-18 at risk for isolation, evening event to target working class families	3/11/21	30

Hub 5: Evening/Weekend Activities

Please describe the evening/weekend activities that were supported to promote access to routine health and dental care during this reporting period.

Evening/Weekend Event Description	Date of Event	Estimated Number of Individuals Reached through Event
Health education provided on COVID 19 and resulting stress during virtual Book Club- Families with children 0-18 at risk for social isolation	10/30/20, 11/25/20, 12/28/20, 1/29/21, 3/26/21, 5/28/21	4
Dia de los Ninos- evening event targeting working class/Hispanic families with children 0-18 at risk for social isolation	4/28/21	25

Hub 5: Challenges and Solutions

Please describe any challenges or delays experienced in implementing the program, and what solutions the program has identified to address the challenge.

The COVID-19 pandemic continued to present unique challenges for the community, Hubs, and Public Health department. Hub 5 CHA played a key role in the public health response by taking contact tracing and interpreting responsibilities. These responsibilities allowed the CHA to promote Hub services to families who were facing barriers in addition to COVID-19 exposure/infection. The program adapted creative ways of outreaching to the community and addressing community needs throughout the course of the pandemic, with the mutual intent with that of California's equity rule that addresses the elimination of health disparities within the community at large that would otherwise be exacerbated by the pandemic. The broader and longer objective is to create equity without regard to an event. The below compelling story demonstrates an inequity of resources exacerbated by the pandemic of which Hub intervention provided a balancing. In response to the increased need for basic needs resources, the CHA took additional measures in order to meet clients and support with resource access/navigation. The CHA also supported during diaper/food distribution events and community immunization clinics to provide basic need/preventative health resources and promote hub services. Hub 5 CHA assisted in planning and promoting drive-thru dental events in collaboration with EDC Oral health program to address the communities increased need for dental services. Stay at home orders created challenges related to staying connected with the community. The health team increased outreach through Hub Facebook and Instagram accounts to address such challenges. Hub 5 CHA addressed consequences of social isolation and increased stress related to COVID-19 by providing related health education during a virtual series in collaboration with FES.

Hub 5: Priority Populations

Please define the isolated or underserved populations you targeted each quarter and describe the strategies you used to reach them.

Quarter	1st Quarter (Jul-Sep)	2nd Quarter (Aug-Dec)	3rd Quarter (Jan-Mar)	4th Quarter (Apr-Jun)
Target Population	Underserved families with children 0-18 with a lack of resources.	Underserved families with children 0-18 with a lack of resources, at risk for poor oral health and at risk for social isolation.	Hispanic and working class families with children 0-18 at risk for social isolation.	Hispanic and working class families with children 0-18 at risk for a lack of resources and social isolation.
Strategy	Participated in food/diaper distribution outreach events and flu clinics to provide tangible items/preventative health resources and promote hub health services/support accessing resources. Promptly responded to client referrals for support navigating resources.	Participated in food/diaper distribution outreach event, flu clinics, dental drive, and book club to provide tangible items/preventative health resources, health education and promote hub health services/support accessing resources. Promptly responded to client referrals for support navigating resources.	Provided outreach to Hispanic and working families to increase access to COVID clinics offered outside of normal business hours. Participated in evening events to promote Hub services and provide health education.	Evening Hub event to promote Hub services and address barriers to preventative healthcare for Hispanic and working class families. Provided health education during evening book club series to working class families.

Hub 5: Compelling Success Story

Please describe a compelling Hub story to highlight the impact Hub services has on families served. Please provide a description of the family make-up, the service or intervention that was provided and the impact or benefits that the family experienced.

The CHA connected with a Hispanic family of three. The single father needed assistance finding physical and behavioral health for his daughter. In addition, his working hours were reduced and his car broke down. First, the family was assessed for essential needs. The father stated that the immediate needs were securing food and shelter for his two children. He also mentioned that his daughter was experiencing behavioral issues and that she needed a referral to behavioral health. In addition, the nurse from the SLT school district made a referral for the daughter to PHN for physical health and optic needs. Moreover, the father mentioned that his working hours were reduced and his car broke down and this was making harder to find a second job. In addition, the father mentioned that he needed assistance accessing EDC Child Support Services (CSS). The health team referred the family to behavioral health, Barton Clinic, UC Davis, EDC Fondo Milagroso, Tahoe Magic, Christmas Cheer, Bread &Broth and EDC CSS. With the CHA's support navigating these resources, the family was able to secure food and shelter for two months and consequently save enough money to fix their car. The father was able to connect with Barton Health Clinic and obtain assistance for his daughters' physical and behavioral concerns, obtain new glasses, and schedule an appointment with a specialist at UC Davis. Additionally, the father was able to connect with EDC CSS and reopen his child support case.

Hub 5 PHN- Working in the Community Hubs has given me a chance to contribute to many families and individuals in a positive way. My story is about a mother who suffered from Postpartum Depression with her second child, making her anxiety heightened during this time. Due to Covid19 restrictions, this mother was isolated at home in South Lake Tahoe. Her partner works full time in Sacramento and he drives back and forth each day. She was faced with having two children in the home alone with her partner away a large amount of time. Also, her second baby suffered from reflux (unlike her first, now- "easy baby") and this added to her anxiety as well, causing her not to sleep even more. Since working with this family, I was able to get mental health counseling for the mother to treat and work with her PPD and Anxiety. I was also able to work with the mother giving her some therapeutic interventions to help her manage her baby's reflux. What makes this story so meaningful for me, is the human connection that was so missed during covid-19. Isolation can play havoc on a brain when it is left alone to go down any pathway it sees fit. Add a pandemic and the world can seem like it is crushing down on you. Sometimes I feel like my only job is to pull people out of their minds. I get that. In the trenches of raising children it is hard to see the forest through the trees. BUT, through a little education, some coaching and a grounded ear, sleep has improved, anxiety is more controlled and mother is getting back to her old self every day and baby is thriving.

During a Covid 19 clinic, a woman came up to the CHA who was supporting with registration, and asked for assistance. She mentioned that lately she had many sad and anxiety episodes. She stated that in early January she contacted Barton Health Clinic, but they were too busy to schedule an appointment and that they were supposed to call her back later to schedule an appointment. Two months later, she still hadn't received a call. She stated that the episodes of sadness and anxiety were getting longer and more often. I immediately

contacted Barton Health Clinic, requested a return call to the client, and rescheduled her appointment. The client was seen within two weeks and she is now receiving treatment.