El Dorado County
Health and Human Services Agency
Behavioral Health Division

CULTURAL COMPETENCE PLAN

2018

"Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs."

- National CLAS Standards

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EL DORADO COUNTY
HEALTH AND HUMAN SERVICES AGENCY (HHSA)

Mission Statement

With integrity and respect we provide effective, efficient, collaborative services that strengthen, empower and protect individuals, families and communities, thereby enhancing their quality of life.

HHSA Vision

Transforming lives and improving futures

HHSA Values

Fiscal Accountability

We apply conservative principles in a responsible manner and adhere to all government guidelines when working with our stakeholders

Adaptability

We embrace and implement best practices based on an ever changing environment

Excellence

We provide the best possible services to achieve optimal results

Integrity

Our communication is honest, open, transparent, inclusive and consistent with our action

National Culturally and Linguistically Appropriate Services Standards

Principal Standard

1. Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

Governance, Leadership and Workforce

2. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.
3. Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.
4. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

Communication and Language Assistance

5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.
6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.
7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.
8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

Engagement, Continuous Improvement, and Accountability

9. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.
10. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.
11. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.
12. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.
13. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.
14. Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.
15. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.

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Exhibits:

Introduction

The Cultural Competence Plan Requirements, as detailed in DMH Information Notice 10-02 and 10-17, establish standards and criteria for the entire County Mental Health System, including Medi-Cal services, Mental Health Services Act (MHSA), and Realignment as part of working toward achieving cultural and linguistic competence.

El Dorado County Health and Human Services Agency (HHSA), Behavioral Health Division (BHD), originally developed its Cultural Competence Plan in 2010. The following information is provided as an update to that plan.

The Cultural Competence Plan consists of eight criteria:

Criterion I: Commitment to Cultural Competence

Criterion II: Updated Assessment of Service Needs

Criterion III: Strategies and Efforts for Reducing Racial, Ethnic, Cultural, and Linguistic Mental Health Disparities

Criterion IV: Client/Family Member/Community Committee: Integration of the Committee Within the County Mental Health System

Criterion V: Culturally Competent Training Activities

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

Criterion VII: Language Capacity

Criterion VIII: Adaptation of Services

The BHD's Cultural Competence Plan shall be reviewed on an annual basis, or more frequently as needed, and revisions to the Cultural Competence Plan shall be made as needed and submitted to DHCS.

Criterion 1, Commitment To Cultural Competence

I. County Mental Health System commitment to cultural competence

The BHD remains committed to cultural competence. This updated Cultural Competence Plan reflects the latest areas of enhanced awareness of unique needs within El Dorado County.

II. County recognition, value, and inclusion of racial, ethnic, cultural, and linguistic diversity within the system

A. Provide a copy of the county's CSS plan that describes practices and activities that demonstrate community outreach, engagement, and involvement efforts with identified racial, ethnic, cultural, linguistic, and other relevant small county cultural communities with mental health disparities.

The County's MHSA Three-Year Program and Expenditure Plan covering Fiscal Years (FY) 2017/18 through FY 2019/20, and the County's MHSA Annual Update for FY 2018/19 can be found online on the BHD's MHSA Page at: https://edcgov.us/Government/MentalHealth/mhsa/Pages/mhsa_plans.aspx.

The primary unserved and underserved communities in El Dorado County were originally identified as the Latino and Native American communities. In more recent years, this has expanded to include individuals recently released from jail; lesbian, gay, bisexual, transgender, questioning (LGBTQ) individuals; Veterans; and individuals experiencing homelessness. Poverty, substance use disorders, domestic violence, and intergenerational patterns are also cultural issues within El Dorado County.

Age-specific populations that are frequently seen as underserved are school aged children, transitional age youth (TAY) (age 16-25), and older adults.

A copy of the current MHSA Plan and any associated Annual Updates, can be located on the MHSA website at: https://www.edcgov.us/Government/MentalHealth/mhsa/Pages/mhsa_plans.aspx. The Community Services and Supports (CSS) section identifies how the County is providing outreach, engagement and services to the community.

In addition to the CSS activities, the County's Prevention and Early Intervention (PEI) programs provide prevention and early intervention services that may lead to engagement in Specialty Mental Health Services and is discussed in greater detail below.

B. A one page description addressing the county's current involvement efforts and level of inclusion with the above identified underserved communities on the advisory committee.

The general public and stakeholders are invited annually to participate in or host MHSA planning opportunities and provide initial comment to contribute to the development of the

County's MHSA Plan/Annual Update. Meetings are held in various locations throughout the County, and the County also offers the opportunity to provide input via email, letter, fax, online survey or comment form. The survey and the comment forms are available in English and Spanish, which are the County's threshold languages.

Additionally, the MHSA project team maintains a MHSA email distribution list for individuals who have expressed an interest in MHSA activities. The distribution list of over 600 members includes:

- adults and seniors with severe mental illness
- families of children, adults and seniors with severe mental illness
- providers of services
- law enforcement agencies
- education
- social services agencies
- veterans and representatives from veterans organizations
- providers of alcohol and drug services
- health care organizations
- other interested individuals.

Updates about community involvement opportunities may be sent to the MHSA email distribution list, distributed via press release, discussed at the Behavioral Health Commission meetings, and/or posted on the County's web site.

As part of the MHSA Community Planning Process, the public, including stakeholders representing diverse cultural backgrounds, is invited to provide input into the County's mental health services, needs, and programming. More details about the FY 18/19 Community Planning Process is included in the FY 18/19 MHSA Annual Update. Historical information about previous Community Planning Processes can be found in the corresponding MHSA Plan or MHSA Annual Update, which are available online at: https://www.edcgov.us/Government/MentalHealth/mhsa/Pages/mhsa_plans.aspx.

Additional Opportunities for Learning and Raising Awareness

Throughout the year, Behavioral Health staff may attend many community-based meetings that provide an opportunity to engage with diverse individuals, discuss how to become more culturally competent, and learn about the general needs of the community. Some of these meetings include:

- Adverse Childhood Experiences Survey (ACEs) Collaborative
- Latino Outreach Workgroup
- Chronic Disease Coalition
- Continuum of Care
- El Dorado County Commission on Aging

- Community Mental and Behavioral Health Cooperative
- Stepping Up Initiative

C. Share lessons learned on efforts made on the items A and B above and any identified county technical assistance needs. Information on the county's current MHSA Annual Plan may be included to respond to this requirement.

The importance of maintaining close working relationships with individuals and providers who are respected and trusted by the underserved or unserved populations cannot be stressed enough. It is frequently through those relationships that individuals in need of services will receive the needed assistance, whether it be mental health services, physical health services, domestic violence assistance, or other services available in the community.

One of the greatest challenges in El Dorado County continues to be engaging the community in discussions about Mental Health and improving penetration rates into the unserved and underserved communities and populations. Additional challenges exist in engaging individuals who may have a mental illness, but are unwilling to seek services due to anosognosia, which is a lack of awareness or insight that one has a mental illness. Technical assistance in these areas is always welcome.

III. Each county has a designated Cultural Competence/Ethnic Services Manager (CC/ESM) who is responsible for cultural competence

The CC/ESM will report to, and/or have direct access to, the Executive Leadership for the BHD regarding issues related to the racial, ethnic, cultural, and linguistic populations within the county.

In El Dorado County, the BHD has designated the MHSA Program Manager as the CC/ESM, with the WET Coordinator providing additional support related to cultural competence. The CC/ESM and WET Coordinator also ensures appropriate trainings are offered.

The CC/ESM works in collaboration with the Quality Assurance/Quality Improvement/Utilization Review Manager and Team regarding issues of access, timeliness and services in regard to the diverse needs of the County's racial, ethnic, cultural, and linguistic populations.

IV. Identify budget resources targeted for culturally competent activities

The BHD has specific funds budgeted for cultural competence activities, including interpreter and translation services, disparities reduction, and outreach to target populations.

Budget Item	FY 18/19 Budget
Interpreter*	$2,500
Latino Outreach	$231,150
Wennem Wadati - A Native Path to Healing	$125,750
LGBTQ Community Education	$5,000
Veterans Outreach	$150,000

* Whenever possible, the BHD accesses bilingual services through its staff who have been certified through the County's process as bilingual in the threshold language (Spanish).

BHD training funds are available for cultural competence trainings.

Criterion 2, Updated Assessment of Services Needs

I. General Population

Based on the 2018 estimated demographic data retrieved from the County's Well Dorado website at http://www.welldorado.org, the El Dorado County demographic profile is outlined below.

As of the 2018 estimated demographic data, the County's current population is 186,428.

Race	Number	Percent of Total Population
American Indian or Alaska Native	2,043	1.10%
Asian	8,089	4.34%
Black or African American	1,853	0.99%
Native Hawaiian or Other Pacific Islander	313	0.17%
White or Caucasian	157,512	84.49%
Multiracial	8,438	4.53%
Other Race	8,180	4.39%

Ethnicity	Number	Percent of Total Population
Hispanic or Latino	24,692	13.24%
Non-Hispanic or Latino	161,736	86.76%

Language Spoken in the Home (over the age of 5 only)	Number	Percent of Total Population
English Only	157,925	88.60%
Spanish	11,615	6.52%
Other Indo-European Languages	4,243	2.38%
Asian and Pacific Island Languages	3,609	2.02%
Other Languages	861	0.48%

Age	Number	Percent of Total Population
Under 5 years	8,175	4.39%
5 to 9 years	9,329	5.00%
10 to 14 years	11,281	6.05%
15 to 17 years	7,483	4.01%
18 to 20 years	6,744	3.62%
21 to 24 years	8,929	4.79%
25 to 34 years	19,027	10.21%
35 to 44 years	19,910	10.68%
45 to 54 years	25,496	13.68%
55 to 64 years	32,789	17.59%
65 to 74 years	23,450	12.58%
75 to 84 years	9,822	5.27%
85+ years	3,993	2.14%

Gender	Number	Percent of Total Population
Female	93,151	49.97%
Male	93,277	50.03%

II. Medi-Cal population service needs (Use current CAEQRO data if available.)

A. Summarize the following two categories by race, ethnicity, language, age, gender, and other relevant small county cultural populations:

1. The county's Medi-Cal population (County may utilize data provided by DMH. See the Note at the beginning of Criterion 2 regarding data requests)

2. The county's client utilization data.

El Dorado County Medi-Cal Approved Claims Data - Calendar Year 2016				
	Average Number of Eligibles per Month	Number of Beneficiaries Served per Year	El Dorado County Penetration Rate	Statewide Penetration Rate
Total	39,231	1,427	3.64%	4.44%
Age group				
0-5	4,352	25	0.57%	2.04%
6-17	8,866	409	4.61%	6.01%
18-59	21,390	900	4.21%	4.70%
60 +	4,623	93	2.01%	2.75%
Gender				
Female	20,241	722	3.57%	4.07%
Male	18,990	705	3.71%	4.87%

El Dorado County Medi-Cal Approved Claims Data - Calendar Year 2016				
	Average Number of Eligibles per Month	**Number of Beneficiaries Served per Year**	**El Dorado County Penetration Rate**	**Statewide Penetration Rate**
Race/Ethnicity				
White	24,705	954	3.86%	6.01%
Hispanic	7,211	163	2.26%	3.38%
African-American	321	20	6.23%	7.76%
Asian/Pacific Islander	1,301	23	1.77%	2.25%
Native American	286	9	3.15%	7.38%
Other	5,410	258	4.77%	6.23%
Eligibility Categories				
Disabled	3,522	440	12.49%	18.33%
Foster Care	322	115	35.71%	46.26%
Other Child	8,717	266	3.05%	4.58%
Family Adult	6,725	138	2.05%	2.81%
Other Adult	2,783	48	1.72%	1.17%

B. Provide an analysis of disparities as identified in the above summary.

Age Group

Consistent with Statewide findings, the highest penetration rates occur between the ages of 6 and 59. The El Dorado County penetration rate for ages 6-17 is slightly higher than the Statewide average and reflects the community's strong commitment to mental health services for school-aged children.

Consistent with Statewide access rates, young children (age 0 to 5 years) receive mental health services at a rate far lower than either school-aged youth or adults. While some of this disparity may reflect difficulties that parents face in accessing mental health care for young children, it is likely that the low penetration ratio also reflects a lower rate of severe emotional and behavioral problems exhibited by pre-school-aged children.

Age Group	Average Number of Eligibles Per Month	Number Served	El Dorado County Penetration Rate	Statewide Penetration Rate
0-5	4,154	68	1.64%	2.14%
6-17	8,153	635	7.79%	6.48%
18-59	10,183	606	5.95%	6.21%
60 +	3,107	68	2.19%	3.10%

Older adults in El Dorado County utilize mental health services at significantly lower rate compared to adults 18 to 59 years of age. This could be due to a number of reasons, including receiving services through Medicare or concerns as evidenced by the 2013 Older Adults Survey:

Summary Category	Specifically	Percent of Respondents Identifying This as a Barrier
Transportation	Lack of private transportation	50.63%
	Lack of or insufficient public transportation	31.88%
	Travel distance to services from home	25.00%
	Lack of private transportation	50.63%
Cost	Cost of services	49.38%
	Cost of transportation	31.25%
Impact to Others	Not wanting to bother others	66.25%
Stigma	Stigma associated with mental health/illness	36.88%
	Concern friends or family may find out	16.25%
Lack of Information	Not knowing where to start	48.13%
Physical Health Limitation	Physical health limitation	43.75%
Provider Issue	Lack of trust in service provider	15.63%
	Inconvenient appointment times	13.75%
Cultural/Language Differences	Cultural differences	3.13%
	Language differences	1.25%

Gender

Relatively little disparity exists between men and women in El Dorado County or within the State.

Gender	Average Number of Eligibles Per Month	Number Served	El Dorado County Penetration Rate	Statewide Penetration Rate
Female	13,943	680	4.88%	4.45%
Male	11,653	646	5.54%	5.49%

Race/Ethnicity

Consistent with Statewide findings, the access of the Latino population is lower than white Medi-Cal beneficiaries in El Dorado County. While there have been decreases in this disparity over the last several years, outreach and the provision of culturally competent services to the County's Latino community remains a high priority.

Geographic Area / Year	Average Number of Eligibles Per Month	Latino		White		Penetration Ratio[1]
		Number Served	Penetration Rate	Number Served	Penetration Rate	
State (2016)	*unknown*	*unknown*	3.38%	*unknown*	6.01%	0.56
EDC (2016)	39,231	163	2.26%	954	3.86%	0.59
EDC (2015)	26,625	129	2.35%	775	4.83%	0.49
EDC (2014)	25,596	138	2.57%	1,009	6.53%	0.39
EDC (2013)	21,115	130	2.85%	1,101	8.43%	0.34
EDC (2012)	20,327	98	2.21%	1,044	7.92%	0.28

[1] Penetration ratio is calculated by dividing the Latino penetration rate by the White penetration rate, resulting in a ratio that depicts the relative access for Latinos when compared to Whites. A ratio of 1.0 reflects parity; less than 1.0 reflects disparity in access for Latinos in comparison to Whites; and a ratio of more than 1.0 would indicate a higher rate of access for Latinos in comparison to Whites.

Geographic Area / Year	Average Number of Eligibles Per Month	Latino		White		Penetration Ratio[1]
		Number Served	Penetration Rate	Number Served	Penetration Rate	
EDC (2011)	20,350	109	2.44%	1,197	8.82%	0.28
EDC (2010)	19,077	116	2.75%	1,171	8.89%	0.31
EDC (2009)	18,188	118	3.00%	1,350	10.57%	0.28
EDC (2008)	16,572	134	3.8%	1,469	12.5%	0.30
EDC (2007)	unknown	101	2.9%	1,239	11.2%	0.26
EDC (2006)	unknown	92	2.7%	1,278	11.9%	0.22
EDC (2005)	unknown	83	2.5%	1,271	11.9%	0.21

The remaining race categories reflect a relatively small number of beneficiaries, so it is difficult to gain insight as to why penetration rates for these groups vary from Statewide penetration rates.

Race	Average Number of Eligibles Per Month	Number Served	El Dorado County Penetration Rate	Statewide Penetration Rate
African-American	321	20	6.23%	7.76%
Asian/Pacific Islander	1,301	23	1.77%	2.25%
Native American	286	9	3.15%	7.38%
Other	5,410	258	4.77%	6.23%

Eligibility Categories

It is difficult to determine why the El Dorado County and Statewide penetration rate varies for the Disabled and Foster Care populations. There could be numerous reasons for this, including other sources of services for those who may be disabled, such as Veterans who may receive services through the Veteran

Administration, or the number of foster care children placed out of county or that services are provided directly by Child Welfare Services contracted providers via a "Purchase Disbursement Authorization."

Categories	Average Number of Eligibles Per Month	Number Served	El Dorado County Penetration Rate	Statewide Penetration Rate
Disabled	3,522	440	12.49%	18.33%
Foster Care	322	115	35.71%	46.26%
Other Child	8,717	266	3.05%	4.58%
Family Adult	6,725	138	2.05%	2.81%
Other Adult	2,783	48	1.72%	1.17%

Finally, clients who participate in prevention and early intervention activities are often not included in CAEQRO data. In El Dorado County, Prevention and Early Intervention programs have increased over the past several years to meet the needs of specific groups such as Latinos, Native Americans, Children 0-5 and their Families, and Older Adults. And, with the implementation of the Affordable Care Act, many individuals are seeking mental health services through their primary care provider and/or their Managed Care Plan.

III. 200% of Poverty (minus Medi-Cal) population and service needs: The county shall include the following in the CCPR:

A. Summarize the 200% of poverty (minus Medi-Cal population) and client utilization data by race, ethnicity, language, age, and gender (other social/cultural groups may be addressed as data is available and collected locally).

The BHD was not successful in locating a current breakdown of the 200% of poverty data.

With the introduction of the Medi-Cal expansion, children below 266% of the federal poverty level, pregnant women below 208% of the federal poverty level and adults below 138% of the federal poverty level may now be eligible for Medi- Cal, so the increased number of Medi-Cal eligibles identified above would have been previously reflected in the 200% of federal poverty level data.

B. Provide an analysis of disparities as identified in the above summary.

The data is not available to analyze in this current year update. Please see the 2010 Cultural Competence Plan for analysis of the data available at that time.

IV. MHSA Community Services and Supports (CSS) population assessment and service needs.

A. From the county's approved CSS plan, extract a copy of the population assessment. If updates have been made to this assessment, please include the updates. Summarize population and client utilization data by race, ethnicity, language, age, and gender (other social/cultural groups may be addressed as data is available and collected locally).

Race	Total	Percent of County
American Indian or Alaska Native	2,043	0.79%
Asian	8,089	3.98%
Black or African American	1,853	0.82%
Native Hawaiian and Other Pacific Islander	313	0.16%
White or Caucasian	157,512	78.06%
Multiracial	8,438	3.17%
Other Race	8,180	0.17%

Ethnicity	Number	Percent of Total Population
Hispanic or Latino	24,692	13.24%
Non-Hispanic or Latino	161,736	86.76%

The median age in the County is 45.9, distributed as follows:

Age	Total	Percent of County
Under 5	8,175	4.39%
5 to 9	9,329	5.00%
10 to 14	11,281	6.05%
15 to 17	7,483	4.01%
18 to 20	6,744	3.62%
21 to 24	8,929	4.79%

Age	Total	Percent of County
35 to 44	19,910	10.68%
45 to 54	25,496	13.68%
55 to 64	32,789	17.59%
65 to 74	23,450	12.58%
75 to 84	9,8221	5.27%
85 and Over	3,993	2.14%

Age	Total	Percent of County
25 to 34	19,027	10.21%

Age	Total	Percent of County

Children 0 to 20 comprise 23.07% of the population and adults age 65 and over comprise 19.99% of the population.

Income Levels

Place of Residence within the County	Median Household Income
Cameron Park	$93,941
Camino	$72,146
Cool	$98,333
Diamond Springs	$61,620
Echo Lake	$87,500
El Dorado	$69,035
El Dorado Hills	$138,719
Fair Play	$60,093
Garden Valley	$83,185
Georgetown	$65,074
Greenwood	$75,316
Grizzly Flats	$61,970
Kyburz	$85,227
Lotus	$84,295
Pilot Hill	$90,141
Placerville	$68,288
Pollock Pines	$75,551
Rescue	$112,654
South Lake Tahoe	$59,812
Tahoma	$46,292
Twin Bridges	$87,500

Place of Residence within the County	Median Household Income
El Dorado County Average Median Income	$84,483,483

Languages

The primary language spoken within El Dorado County is English. As of August 2013, California DHCS identified Spanish as the only "threshold language" within El Dorado County.[2] A "threshold language" is the primary language identified by 3,000 or five percent of the Medi-Cal beneficiaries, whichever is lower, in an identified geographic area. MHSA considers threshold languages when determining other languages to be considered in program design and implementation.

	CSS Client Utilization as of March 2018	Countywide Population (regardless of Medi-Cal eligibility)	Penetration Rate (not Medi-Cal specific)
Age Group			
Child and Youth (0-17)	268	36,268	0.74%
Transitional Age Youth (18-24)	70	15,673	0.45%
Adult (25-64)	358	97,222	0.37%
Older Adult (65+)	35	37,265	0.09%
Race			
American Indian or Alaska Native	17	2,043	0.83%
Asian	12	8,089	0.15%
Black or African American	16	1,853	0.86%
Native Hawaiian or Other Pacific Islander	2	313	0.64%
White	564	157,512	0.36%
Unknown / Other / Multiracial	120	16,618	0.72%
Ethnicity			
Hispanic or Latino	101	24,692	0.41%

[2] California Department of Health Care Services. MHSD Information Notice No.: 13-09, Enclosure 1. http://www.dhcs.ca.gov/formsandpubs/Documents/13-09Encl1.pdf.April2013.

	CSS Client Utilization as of March 2018	Countywide Population (regardless of Medi-Cal eligibility)	Penetration Rate (not Medi-Cal specific)
Non-Hispanic or Latino	537	161,736	0.33%
Unknown/Declined to State	93	--	--
Primary Language			
English	683	157,925	0.43%
Spanish	13	11,615	0.11%
Other/Declined to State	35	8,713	0.40%

B. Provide an analysis of disparities as identified in the above summary.

By age group, the CSS penetration rate for children (aged 0 to 17 years) is highest among all age groups. The CSS programs are only one of several programs that provide services to children and youth in El Dorado County and therefore it appears that children are some of the highest served individuals in the County.

The finding of lower utilization in CSS services among older adults represents a more pervasive disparity in access to mental health services, which is also evidenced in the utilization data among Medi-Cal beneficiaries (see Criterion 2, section II). Barriers to care include low income, isolation, lack of transportation, and stigma. Additionally, the BHD is not a Medicare provider, and the vast majority of individuals age 65 and older have Medicare. Since Medi-Cal is the payer of last resort, the BHD works to connect older adults to Medicare providers. The County's Prevention and Early Intervention plan addresses this disparity with two programs designed specifically to engage older and vulnerable adults. The Senior Peer Counseling program provides outreach services, and assessment and brief treatment. The Senior Link program provides mobile outreach, and services are designed to provide access, support, and linkage for older adults to a variety of community-based services with the goal of improving overall mental health.

By ethnicity, penetration rates for all races except Asians are higher than the penetration for the White population, but this is skewed by the County's relatively small number of residents in specific racial/ethnic categories. In addition, County population data does not account for variance in the potential need for County mental health services among racial and ethnic groups.

The analysis of disparity by primary language is likely also skewed by the variance in the estimated need for County mental health services among non-English-speaking residents. Those reporting Spanish as their primary language account for approximately 6.23% of the

language preference in the County for individuals above age 5. Although the penetration rate for individuals reflecting Spanish as their primary language, the penetration rate for individuals identifying as Hispanic or Latino is higher than the penetration rate for those who are not Hispanic or Latino.

V. Prevention and Early Intervention (PEI) Plan: The process used to identify the PEI/priority populations

A. Describe which PEI priority population(s) the county identified in their PEI plan and describe the process and rationale used by the county in selecting them. PEI Plan sections should be used to respond to priority populations identified by the county.

In preparation for development of the County's initial PEI Plan, the BHD conducted community and planning meetings, focus groups, and key interviews, which generated hundreds of community contacts. Confidential surveys were disseminated online, via mail, via e-mail, and during community meetings, focus groups and planning meetings.

Since the initial Plan was developed, the BHD continues to hold community and planning meetings and disseminate confidential surveys at these meetings as well as online, via mail, and via e-mail each year.

Through the data gathered via the Community Planning Processes, along with information gathered throughout the year in individual and group meetings, telephone calls, requests for services and penetration rate data, the BHD identified the following priority populations:

- The initial priority populations were identified as school-aged children, Latinos and Native Americans.

- The primary unserved and underserved communities in El Dorado County were originally identified as the Latino and Native American communities. In more recent years, this has expanded to include individuals recently released from jail; lesbian, gay, bisexual, transgender, questioning (LGBTQ) individuals; Veterans; and individuals experiencing homelessness. Poverty, substance use disorders, domestic violence, and intergenerational patterns are also cultural issues within El Dorado County.

- Most recently, individuals with specific service needs are facing disparities due to lack of coverage or indetermination as to how coverage can be provided. These include individuals with dementia, traumatic brain injury, eating disorders, and individuals in need of institutionalization.

Some of these priority populations are addressed through PEI programs, while others are addressed through programs under CSS. PEI specific programs that address culturally unique communities include:

- "Wennem Wadati" provides culturally specific Native American services through use of Cultural Specialists, who are Native American community members, working in a professional capacity that access unique cultural contexts and characteristics through the use of traditional Native American healing approaches.

- "Latino Outreach" addresses isolation in the Spanish speaking or limited English-speaking Latino adult population, peer and family problems in the youth population, and community issues resulting from unmet mental health needs, by contributing to system of care designed to engage Latino families and provide greater access to culturally competent mental health services.

- "Early Intervention for Youth in Schools" provides services to middle and high school students, by incorporating activities such as outreach, referrals, groups, classes, and individual and family therapeutic services.

- Peer Advocates (both parents and former foster youth) are provided through CSS Full Service Partnership and the PEI activities of "Foster Youth Continuum" under "Community Education and Parenting Classes". Peer Partner services are individuals with lived experience, participating in systems of care as a consumer, parent, or caregiver. Peer Partner services are designed to enhance service delivery, provide a continuum of care, and share organizational knowledge and resources with the common goal of engaging families and promoting the safety and well-being of at-risk children and families.

- "Juvenile Services/Wraparound Services" project will be a pilot program that is designed to provide intensive services utilizing a strength-based, needs-driven, family-centered and community-based planning process to help connect youth involved with the Juvenile Justice program with necessary mental health services.

- "Senior Link", under the "Older Adults Enrichment Project" is designed to provide access, support, and linkage for older adults to a variety of community-based services with the goal of improving their mental health.

- "Veterans Outreach" provides outreach and linkage services for Veterans and their families, including assisting Veterans to obtain necessary mental health services and secure permanent and affordable housing.

Criterion 3, Strategies and Efforts For Reducing Racial, Ethnic, Cultural and Linguistic Mental Health Disparities

I. Target populations, with disparities identified in Medi-Cal and MHSA components (CSS, WET, and PEI).

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

In preparation for development of the County's initial PEI Plan, the BHD conducted community and planning meetings, focus groups, and key interviews, which generated hundreds of community contacts. Confidential surveys were disseminated online, via mail, via e-mail, and during community meetings, focus groups and planning meetings.

Since the initial Plan was developed, the BHD continues to hold community and planning meetings and disseminate confidential surveys at these meetings as well as online, via mail, and via e-mail each year.

The information gathered via the Community Planning Processes, along with information gathered throughout the year in individual and group meetings, telephone calls, requests for services and penetration rate data, is reviewed annually to identify priority populations and develop strategies to address the needs of these populations.

II. List of disparities in each of the populations (within Medi-Cal, CSS, WET, and PEI).

Disparity	Medi-Cal	CSS	WET	PEI
School-aged children				
Lack of identification of early symptoms		x		x
Stigma		x		x
Untreated mental illness leading to academic failure				x
Stressed families				x
Latino Population:				
Disproportionately low Medi-Cal penetration rate	x	x		
Barriers to health care (lack of citizenship and low income)	x	x		
Stigma	x	x	x	x
Transportation challenges		x		x
Insufficient numbers of bilingual, bicultural Spanish-speaking providers and peers		x	x	x
Unstable housing	x	x		x
Native American Population:				
Lack of cultural awareness from providers		x	x	x
Lack of trust of governmental agencies	x	x	x	x

Disparity	Medi-Cal	CSS	WET	PEI
Foster Care Youth:				
At risk of out of home placement or higher level of placement	x	x		x
Disproportionately at risk of homelessness and criminal justice involvement		x		x
Higher levels of mental illness than children not in the foster care system	x	x		x
Lack of local foster care homes lead to out of county placement, and not all counties will provide higher level of services to children from other counties	x	x		
Lack of role models/mentors		x	x	x
Transportation challenges		x		x
Stigma	x	x	x	x
Not represented in the FSP level of care (children in Group Homes/STRTPs are not eligible for FSP services)		x		
Transition Age Youth:				
Newly found independence		x		
Stigma		x	x	x
Co-occurring disorders	x	x	x	
Limited mental health service engagement		x		
Unstable housing		x		
Older Adults:				
Transportation	x	x		x
Cost	x	x		
Impact to others	x	x		
Stigma	x	x	x	
Lack of information	x	x	x	x
Physical health limitation	x	x	x	
Provider issues	x	x	x	
Cultural/language differences	x	x	x	x
Isolation		x		x

Disparity	Medi-Cal	CSS	WET	PEI
LGBTQ population:				
Lack of local culturally-specific resources		x	x	x
Co-occurring disorders	x	x		
Stigma		x	x	x
Parents:				
Their own mental health needs	x	x		x
Co-occurring disorders	x	x		x
Lack of involvement with children	x	x		x
Lack of education regarding mental health	x	x		x
Transportation	x	x		x
Stigma	x	x	x	x
Unstable housing		x		x
Homeless individuals/families:				
Homeless / unstable housing		x		x
Co-occurring disorders	x	x	x	x
Transportation	x	x		x
Rural populations:				
Transportation challenges	x	x		x
Geographically isolated individuals		x		x
Service needs:				
Dementia		x		
Traumatic brain injury		x		
Eating disorders		x		x

III. Then list strategies for the Medi-Cal population as well as those strategies identified in the MHSA plans (CSS, WET, and PEI) for reducing those disparities identified above.

Disparity	Strategies
School-aged children	
Lack of identification of early symptoms	The majority of PEI and CSS projects focus on identifying early symptoms.
Stigma	The majority of PEI and CSS projects focus on stigma reduction.
Untreated mental illness leading to academic failure	The CSS projects, Youth and Family Full Service Partnership and Foster Care Enhanced Services, along with the PEI projects of Prevention and Early Intervention for Youth in Schools, Children 0-5 and Their Families, Mentoring, Parenting Skills, Primary Intervention Project (PIP) all address untreated mental illness leading to academic failure.
Stresses families	Several MHSA projects including Children 0-5 and Their Families, Mentoring, Parenting Skills, Primary Intervention Project (PIP), Nurtured Hearth Approach, Prevention and Early Intervention for Youth in Schools, Foster Care Enhanced Services, Youth and Family Full Service Partnership focus on reducing family stresses.

Disparity	Strategies
Latino Population:	
Disproportionately low Medi-Cal penetration rate	The PEI Latino Outreach project provides for Spanish speaking Promotoras to work with the Latino population to provide linkage to Medi-Cal and traditional MH services.
Barriers to health care (lack of citizenship and low income)	The PEI Latino Outreach project provides for Spanish speaking Promotoras to work with the Latino population to provide linkage to legal and social services to help reduce the barriers to health care.
Stigma	The PEI Latino Outreach project provides for Spanish speaking Promotoras to work with the Latino population to help reduce the stigma often associated with mental health services.
Transportation challenges	The WS Wellness Center shuttle, provision of bus passes, and the Managed Care Plans' transportation assistance.
Insufficient numbers of bilingual, bicultural Spanish-speaking providers and peers	The WET Workforce Development project addresses this issue.
Unstable housing	The PEI Latino Outreach project provides for Spanish speaking Promotoras to work with the Latino population to provide linkage to available housing options. This includes MHSA Housing and transitional housing for individuals eligible for Full Service Partnerships (Youth and Family, TAY and Adults).
Native American Population:	
Lack of cultural awareness from providers	PEI Wennem Wadati - A Native Path to Healing and Community Information Access and the Workforce Education and raining projects address this issue.
Lack of trust of governmental agencies	The PEI projects, Wennem Wadati - A Native Path to Healing and Community Information Access address this issue.

Disparity	Strategies
Foster Care Youth:	
At risk of out of home placement or higher level of placement	The CSS Full Service Partnership, and Transitional Age Youth Engagement, Wellness and Recovery Services, as well as the PEI Foster Care Continuum Training address these issues.
Disproportionately at risk of homelessness and criminal justice involvement	The CSS Full Service Partnership, and Transitional Age Youth Engagement, Wellness and Recovery Services, as well as the PEI Foster Care Continuum Training address these issues.
Higher levels of mental illness than children not in the foster care system	The CSS Full Service Partnership, and Transitional Age Youth Engagement, Wellness and Recovery Services, as well as the PEI Foster Care Continuum Training address these issues.
Lack of local foster care homes lead to out of county placement, and not all counties will provide higher level of services to children from other counties	The CSS Full Service Partnership, and Transitional Age Youth Engagement, Wellness and Recovery Services, as well as the PEI Foster Care Continuum Training address these issues.
Lack of role models/mentors	The CSS Full Service Partnership, and Transitional Age Youth Engagement, Wellness and Recovery Services, as well as the PEI Foster Care Continuum Training address these issues.
Transportation challenges	The WS Wellness Center shuttle, provision of bus passes, and the Managed Care Plans' transportation assistance.
Stigma	The majority of PEI and CSS projects focus on stigma reduction.
Not represented in the FSP level of care (children in Group Homes/STRTPs are not eligible for FSP services)	The CSS Full Service Partnership program addresses the lack of representation in FSP services by foster care youth.

Disparity	Strategies
Transition Age Youth:	
Newly found independence	The focus of PEI projects and CSS Outreach and Engagement Services include those with newly found independence.
Stigma	The majority of PEI and CSS projects focus on stigma reduction.
Co-occurring disorders	The PEI projects, Mental Health First Aid, Prevention and Early Intervention for Youth in Schools and the CSS project, Full Service Partnerships (TAY and Adults), address those with co-occurring disorders.
Limited mental health service engagement	The PEI projects and the CSS project, Full Service Partnerships (TAY and Adults) reach out to those with limited engagement.
Unstable housing	The CSS projects, Full Service Partnerships (TAY and Adults) and MHSA Housing address housing for those at risk.
Older Adults:	
Transportation	The WS Wellness Center shuttle, provision of bus passes, and the Managed Care Plans' transportation assistance.
Cost	PEI Older Adults project addresses this issue.
Impact to others	The concern for impact to others would be addressed during the services provided by PEI and CSS projects
Stigma	The majority of PEI and CSS projects focus on stigma reduction.
Lack of information	PEI, CSS and Innovation projects, including CSS Resource Management, include providing information to providers of physical healthcare services, senior centers, libraries and other locations that may be frequented by older adults.
Physical health limitation	PEI, CSS and Innovation projects, including CSS Resource Management, include providing information to providers of physical healthcare services.

Disparity	Strategies
Provider issues	PEI, CSS and Innovation projects, including CSS Resource Management, include providing information to providers of physical healthcare services.
Cultural/language differences	The following PEI, CSS & WET projects address these issues: Community Outreach and Engagement Wennem Wadati - A Native Path to Healing Community Information Access Workforce Education and Training
Isolation	The PEI and the CSS projects, including Adult Full Service Partnership, Outreach and Engagement Services, Community Based Mental Health Services, Assisted Outpatient Treatment, and Resource Management Services all address the issue of isolation.
LGBTQ population:	
Lack of local culturally-specific resources	The PEI project Parents, Families, Friends of Lesbians and Gays (PFLAG) Community Education addresses this issue.
Co-occurring disorders	The PEI project Parents, Families, Friends of Lesbians and Gays (PFLAG) Community Education and the CSS project, Full Service Partnerships, address those with co-occurring disorders.
Stigma	The majority of PEI and CSS projects focus on stigma reduction; however, the PEI project Parents, Families, Friends of Lesbians and Gays (PFLAG) Community Education addresses the additional stigma the PFLAG community experiences.
Parents:	
Their own mental health needs	The PEI projects of Community Outreach and Linkage, Mental Health First Aid, Parents, Families, Friends of Lesbians and Gays (PFLAG), and Community Outreach and Linkage address these issues.

Disparity	Strategies
Co-occurring disorders	PEI Parenting Skills, Mental Health First Aid and Community Outreach and Linkage address these issues.
Lack of involvement with children	PEI Parenting Skills, Foster Care Continuum Training, Nurtured Heart Approach, Mental Health First Aid, and Community Outreach and Linkage assist parents and foster parents with this issue.
Lack of education regarding mental health	PEI Parenting Skills, Mental Health First Aid, Parents, Families, Friends of Lesbians and Gays (PFLAG) Community Education, and Community Outreach and Linkage address this issue.
Transportation	The West Slope Wellness Center shuttle, provision of bus passes, and the Managed Care Plans' transportation assistance.
Stigma	The majority of PEI and CSS projects focus on stigma reduction.
Unstable housing	The CSS projects Full Service Partnerships and MHSA Housing address the housing issue.
Homeless individuals/families:	
Homeless / unstable housing	CSS Outreach and Engagement program, including PATH, provides linkage to available housing options. This includes MHSA Housing and transitional housing for individuals eligible for Full Service Partnerships.
Co-occurring disorders	PEI Community Outreach and Linkage, and service integration with ADP, address these issues.
Transportation	The Wellness Center shuttle, provision of bus passes, and Managed Care Plan transportation assistance.
Rural populations:	
Transportation challenges	A greater focus on community-based services, as well as the Wellness Center shuttle, provision of bus passes, and Managed Care Plan transportation assistance.
Geographically isolated individuals	A greater focus on community-based services, including telehealth as available.

Disparity	Strategies
Service needs:	
Dementia	Continue working with Managed Care Plans.
Traumatic brain injury	Continue working with Managed Care Plans.
Eating disorders	Continue working with Managed Care Plans.

IV. Then discuss how the county measures and monitors activities/strategies for reducing disparities.

The El Dorado County Mental Health Services Act (MHSA) Plan includes specific programs that are designed to reduce disparities within the County. These programs identify the Outcome Measures that will be used to measure and monitor the success of the programs.

Additional measures and monitors include penetration rates, participation in programs by clients as distinguished by certain demographic markers (e.g., race, ethnicity, gender, age), the mandated Full Service Partnership data elements submitted by providers for all individuals enrolled in Full Service Partnership services, and training attendance sheets.

The County's Quality Improvement Work Plan also includes measures for monitoring Cultural and Linguistic Competency.

V. Share what has been working well and lessons learned through the process of the county's development and implementation of strategies that work to reduce disparities (within Medi-Cal, CSS, WET and PEI).

Strengths:

- Medi-Cal and MHSA Community Services and Supports (CSS) programs are aligned by age group, which assists the BHD in better addressing the unique needs that individuals experience in their childhood, as a transitional age youth, as an adult, and as an older adult.

- There is a Mental Health Clinician embedded in Child Welfare Services to address the mental health needs of the children and families. This Clinician regularly interfaces with the BHD's Access Team to ensure timely services are provided to children and families.

- The BHD expanded its services to Transitional Age Youth through a Mental Health Block Grant specifically for prevention (services provided on high school campuses using Dialectical Behavior Therapy (DBT) to address the needs of the students) and early intervention (through Navigate, a program designed to address the unique needs of youth experiencing their first episode of psychosis).

- In the South Lake Tahoe region, the South Lake Tahoe Family Resource Center (FRC) is a well-known centralized service hub for the Latino Community. The County has long contracted with FRC for the Latino Outreach MHSA Prevention and Early Intervention (PEI) program in the South Lake Tahoe community.

- MHSA Housing funds were utilized to designate 11 apartment units (five on the West Slope and six in the Tahoe Basin) for individuals who have a serious mental illness and are facing homelessness. Additional housing supports are available through CSS FSP programs and some PEI programs (e.g., Veterans Outreach).

- The BHD works closely with the El Dorado County Sheriff's Office and the Placerville and South Lake Tahoe Police Departments. This assists all participants with helping individuals experiencing a serious mental illness obtain the necessary services to address their needs.

Challenges:

- Attempts to hire Clinicians and Psychiatrists who are bilingual / bicultural have been difficult. However, this is not solely limited to bilingual / bicultural individuals as the County has experienced difficulty in hiring Clinicians and Psychiatrists, regardless of their language capabilities. Service providers in the community face similar challenges at recruiting bilingual / bicultural Clinicians, and Psychiatrists regardless of their language capabilities.

- Low-cost housing options are very limited in El Dorado County.

- Some reporting challenges exist due to the nature of and access to various State reporting sites (including outcomes of the Consumer Perception Survey and the FSP data).

Opportunities:

- The County recently completed a Classification and Compensation Study which may help with the recruitment of qualified staff, including those who are bilingual / bicultural (the County offers an additional $1.00 per hour for employees who are certified Spanish bilingual).

- The County is exploring additional contracting opportunities with the FRC for Specialty Mental Health Services and Substance Use Disorder services, which will benefit both the English and Spanish language speaking communities.

- The MHSA Team is bringing together representatives of the Latino community, along with representatives of organizations that serve the Latino community (e.g., schools). This group is designed to identify the needs of the Latino community and identify means of reaching the Latino community and potential bilingual / bicultural service providers.

- The current MHSA Plan includes programs to address the specific needs of Older Adults in the County.

Criterion 4, Client/Family Member/Community Committee: Integration of the Committee Within the County Mental Health System

I. The county has a Cultural Competence Committee, or similar group that addresses cultural issues, has participation from cultural groups, that is reflective of the community, and integrates its responsibilities into the mental health system.

A. If so, briefly describe the committee or other similar group (organizational structure, frequency of meetings, functions, and role). If the committee or similar group is integrated with another body (such as a Quality Improvement Committee), inclusive committee shall demonstrate how cultural competence issues are included in committee work.

Currently, the BHD does not have an established Cultural Competence Committee. Rather, the Quality Improvement Committee (QIC) and Behavioral Health Commission are providing support in this area.

Once re-established, the committee will be made up of BHD staff, contract providers and other representatives of groups who have typically been underserved and underrepresented in relationship to mental health service delivery in our rural community.

The Cultural Competence Committee will meet quarterly. During the meetings, issues such as quality improvement, exploration of culturally relevant client outcomes, strategies to outreach to underserved community groups and challenges in providing services to populations that have not traditionally sought mental health treatment will be discussed. Monitoring of critical tools and compliance issues (signage, translation and interpreter services) will also be addressed by this group.

B. If so, briefly describe how the committee integrates with the county mental health system by participating in and reviewing MHSA planning process.

The Cultural Competence Committee will serve as a vehicle for collaboration among providers, BHD staff, County partners, and contract providers who serve underserved populations, for monitoring of service delivery to underserved populations, and for planning, evaluation, and training related to services for underserved populations. Through mechanisms such as meeting collaboration, reporting requirements, and monitoring activities (outcomes data collection) for QI and program evaluation purposes, this committee will be informed and provided with the authority to advise the QIC related to the efficacy of the BHD's cultural competence activities.

The Cultural Competence Committee will be well-integrated in the County mental health system and MHSA planning and review process. The Cultural Competence Committee members will also be routinely invited to actively participate in the MHSA Community Planning Processes and a representative will sit on the MHSA Advisory Board.

Criterion 5, Culturally Competent Training Activities

I. The county system shall require all staff and shall invite stakeholders to receive annual cultural competency training.

A. The county shall develop a three year training plan for required cultural competence training that includes the following:

1. **Steps the county will take to provide required cultural competence training to 100% of their staff over a three year period.**

2. **How cultural competence has been embedded into all trainings.**

3. **A report of annual training for staff, documented stakeholder invitation. Attendance by function to include: Contractors, Support Services, Community Members/General Public; Community Event; Interpreters; Mental Health Board and Commissions; and Community-based Organizations/Agency Board of Director; and if available, include if they are clients and/or family members.**

The following areas continue to be of high focus for the BHD:

- Meaningful consumer and family workforce participation;
- Spanish-speaking language capacity;
- Ethnic diversity (in particular Latino representation given our community profile) in the workforce; and
- Increased employment of licensed clinicians.

There are similar needs in the mild-to-moderate and Medicare mental health community, however psychiatrists serving mild-to-moderate and Medicare beneficiaries also continue to be a need.

The action plan to address these training needs include:

- Use of trainings for BHD staff, contract providers, and the community (ongoing);
- Career pathway for consumer and family members (ongoing).

The cultural competence strategy includes using monthly training as the venue for a significant portion of training. Quarterly training will focus specifically on cultural competency, whereas the other trainings will be clinical in nature and may address how the

clinical treatment/issue may vary for specific racial, ethnic, linguistic, age, gender, sexual orientation or other unique needs of specific client populations.

Strengthening of cultural competency among the attendees is the goal of the trainings, and will be achieved by ensuring that the training agendas consistently address at least one of the following cultural competence training issues:

1. Cultural Formulation
2. Multicultural Knowledge
3. Cultural Sensitivity
4. Cultural Awareness
5. Social/Cultural Diversity (Diverse groups, LGBTQ, Elderly, Disabilities, Veterans, etc.)
6. Interpreter Training in Mental Health Settings
7. Training Staff in the Use of Mental Health Interpreters

The Cultural Competence Training Plan is aligned with the MHSA workforce training needs, the requirements of the Cultural Competence Plan, and will be tied to the programs and practices of the participants, thereby delivered in an integrated fashion. The monitoring processes provided through the MHSA Annual Updates and the Cultural Competence Committee/Quality Improvement Committee quarterly meetings and work plans will provide mechanisms for ongoing review to use the training plan as a vehicle to create and maintain a culturally competent workforce and service delivery system.

Sign in sheets are used in each of these trainings to document attendance and a feedback survey is emailed to each attendee. BHD contracts specify that providers must attend trainings, which include cultural competence trainings. Invitations to trainings may include the following groups, depending upon the training topic:

- Administration/Management
- Direct Service Providers
- Contract Providers
- Support Services
- Community Members/General Public
- Interpreters
- Mental Health Board and Commissions
- Community-based Organizations/Agency Board of Director

B. Annual cultural competence trainings topics shall include, but not be limited to the following:

1. Cultural Formulation
2. Multicultural Knowledge
3. Cultural Sensitivity
4. Cultural Awareness

5. Social/Cultural Diversity (diverse groups, LGBTQ, older adults, disabilities, Veterans, etc.)
6. Interpreter Training in Mental Health Settings
7. Training Staff in the Use of Mental Health Interpreters

Recent cultural competence trainings offered by the BHD include:

- Older Adults
- Military Family Support Group Veterans and Their Families
- NAMI – Family Perspective
- RESPECT – An understanding of the LGBTQ population and terms
- Veteran Administration Services
- Cultural Diversity
- Patient's Rights
- Client Culture

Cultural competence training for BHD staff will continue to cover the seven required areas.

II. Counties must have process for the incorporation of Client Culture Training throughout the mental health system.

A. Evidence of an annual training on Client Culture that includes a client's personal experience inclusive of racial, ethnic, cultural, linguistic, and relevant small county cultural communities. Topics for Client Culture training are detailed on page 18 of the CCPR (2010) from DMH Information Notice 10-02.

B. The training plan must also include, for children, adolescents, and transition age youth, the parent's and/or caretaker's, personal experiences with the following:

1. **Family focused treatment;**
2. **Navigating multiple agency services; and**
3. **Resiliency.**

Training Event	Description of Training	How long (hours) and often	Attendance by Function	Number of Attendees and Total	Date of Training	Name of Presenter
Cultural Competence – Client and Family Perspective	Consumer and family member panel – topics include: • Family-focused treatment; • Navigating multiple agency services; • Resiliency; • Culture-specific expressions of distress (e.g., nervous); • Explanatory models and treatment pathways (e.g., indigenous healers); • Relationship between client and mental health provider from a cultural • perspective ; • Trauma; • Economic impact; • Housing; • Diagnosis/labeling; • Medication; • Hospitalization; • Societal/familial/personal; • Discrimination/stigma; • Effects of culturally and linguistically incompetent services; • Involuntary treatment; • Wellness; • Recovery; and • Culture of being a mental health client, including the experience of having a mental illness and of the mental health system.	1.5 hours	Direct Services Staff Administration/ Management Interpreters	48	2/13/18	Client Names Redacted

Training Event	Description of Training	How long (hours) and often	Attendance by Function	Number of Attendees and Total	Date of Training	Name of Presenter
Veterans and Their Families	A training to provide information about the unique needs of Veterans and their families as it relates to mental health, community integration, and ongoing support.	2 hours	Direct Services Staff Administration/ Management Interpreters	40 12 (included in Direct Services Staff) --- 52 Total	12/15/16	Lance Poinsett, Julie LaConte, Sheila Webb
National Culturally & Linguistically Appropriate Services Standards Training	The National CLAs Standards are a set of 15 action steps intended to advance health equity, improve quality, and help eliminate health care disparities by providing a blueprint for individuals and health and health care organizations to implement culturally and linguistically appropriate services. This training will provide a focused look at the CLAS Standards and service/program participation, as well as discuss implicit bias.	6 hours	Administration/ Management	2	1/11/17	Dr. Irán Barrera

Training Event	Description of Training	How long (hours) and often	Attendance by Function	Number of Attendees and Total	Date of Training	Name of Presenter
Patients' Rights	An overview of the role of the Patients' Rights Advocate and the rights of patients receiving Specialty Mental Health Services	1.5 hours	Direct Services Staff Administration / Management Interpreters	24 5 (included in Direct Services Staff) --- 30 total	6/27/17	Dani Mills, El Dorado County Patients' Rights Advocate
Cultural Competence RESPECT	An understanding of the LGBTQ population and terms associated	2 hours	Mandatory Training for all HHSA Staff	65	3/30/18	Stephanie Carlson and Nick Giantassio

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

I. Recruitment, hiring, and retention of a multicultural workforce from, or experienced with, the identified unserved and underserved populations

A. Extract and attach a copy of the Mental Health Services Act (MHSA) workforce assessment submitted to DMH for the Workforce Education and Training (WET) component. Rationale: Will ensure continuity across the County Mental Health System.

Please see the County's Workforce Needs Assessment for more details: https://www.edcgov.us/government/mentalhealth/mhsa%20plans/documents/El+Dorado+FinalWET.pdf.

B. Compare the WET Plan assessment data with the general population, Medi- Cal population, and 200% of poverty data. Rationale: Will give ability to improve penetration rates and eliminate disparities.

The comparison in the Workforce Needs Assessment remains unchanged.

C. Provide a summary of targets reached to grow a multicultural workforce in rolling out county WET planning and implementation efforts.

The current progress towards targets provided in the Workforce Needs Assessment are not available for the BHD and community-based organizations.

D. Share lessons learned on efforts in rolling out county WET implementation efforts.

While the public mental health system workforce development needs remain significant, the BHD has been carefully reviewing its operations to prioritize client outcomes while maximizing current staffing levels. Additionally, the BHD has contracted all children's outpatient services to community-based organizations.

However, current staffing trends continue to identify challenges in staffing psychiatric technicians, mental health marriage and family therapists (especially licensed clinicians), clinical social workers (especially licensed social workers); bilingual/bicultural staff; and all positions that work nights, evenings, weekends, and part-time and/or on-call.

E. Identify county technical assistance needs.

- Recruitment and collaborative strategies may be helpful, particularly for small counties.

- Use of technology to make high quality and desirable trainings easily accessible (taped trainings available on DVD or on-line that offer CMEs and CEUs – perhaps at no or low cost), including:

- The identification and use of easily accessible technology (on line classes, webinars, and training) that expands staff knowledge of the cultures represented in the community.

- Assistance with the identification and/or development of culturally competent educational and training materials that can be integrated into the County's required orientation and employment courses.

Criterion 7, Language Capacity

I. Increase bilingual workforce capacity

A. Evidence of dedicated resources and strategies counties are undertaking to grow bilingual staff capacity, including the following: (Counties shall document the constraints that limit the capacity to increase bilingual staff.)

1. Evidence in the Workforce Education and Training (WET) Plan on building bilingual staff capacity to address language needs.

The challenge of competing with nearby counties that offer higher pay, higher benefits, and serve as sites for educational institutions continues. However, the County has recently undertaken a Classification and Competence Study to bring El Dorado County into a more competitive standing with surrounding counties.

Additionally, the MHSA Team has brought together representatives of the Latino community, along with representatives of organizations that serve the Latino community (e.g., schools). This group is designed to identify the needs of the Latino community and identify means of reaching the Latino community and potential bilingual/bicultural service providers.

2. Updates from Mental Health Services Act (MHSA), Community Service and Supports (CSS), or WET Plans on bilingual staff members who speak the languages of the target populations.

The BHD has 7 staff who are bilingual and/or bilingual/bicultural. These staff are identified on the BHD's internal staff directory so that all BHD staff know who can assist them when interpreter needs arise.

3. **Total annual dedicated resources for interpreter services in addition to bilingual staff.**

The BHD maintains a contract for interpretation services via phone line and in-person. The annual amount budgeted is $2,500.

In addition, all BHD contracts for Specialty Mental Health Services and Prevention and Early Intervention services include a requirement that the contractors maintain access to and utilize interpreters, if needed, at no charge to the clients.

Additionally, the BHD is exploring options for interpreter training as a result of discussion with the Latino Outreach Workgroup, which identified the need for standardized training for all individuals assisting with interpreter services in the County.

II. Provide services to persons who have Limited English Proficiency

A. Evidence of policies, procedures, and practices for meeting clients' language needs, including the following:

1. **A 24-hour phone line with statewide toll-free access that has linguistic capability, including TDD or California Relay Service, shall be available for all individuals. Note: The use of the language line is viewed as acceptable in the provision of services only when other options are unavailable.**

2. **Least preferable are language lines. Consider use of new technologies such as video language conferencing as resources are available. Use new technology capacity to grow language access.**

3. **Description of protocol used for implementing language access through the county's 24-hour phone line with statewide toll-free access including staff training protocol.**

The BHD operates a 24-hour phone line with statewide toll-free access (800-929-1955) and a TTY/TTD (530-295-2576, or via the California Relay Service) that has linguistic capability available for all individuals. Linguistic capability is assured 24-hours a day via the language line contracted by the BHD. For calls received by the BHD during regular business hours, an attempt is made to contact staff who speak the language of the caller, and the call is transferred if this can be completed in a timely manner.

A description of the protocol used for implementing language access through the county's 24-hour phone line with statewide toll-free access, including staff training protocol is documented in Policy and Procedure II-B-0-004 "Cultural and Linguistic Competence at Mandated Points of Contact".

B. Evidence that clients are informed in writing in their primary language, of their rights to language assistance services.

Rights are explained in the "Guide to Medi-Cal Mental Health Services", given to each new client in the preferred language (the Guide is available in Spanish as the only threshold language in El Dorado County), and available to anyone upon request.

Additionally, rights are posted at all service sites and language preference is asked and documented in the electronic medical record.

C. Evidence that the county/agency accommodate persons who have limited English proficiency (LEP) by using bilingual staff or interpreter services.

Accommodation of persons who have LEP is demonstrated by the following:

- Language preference is asked and documented in the electronic medical record on the client contact page. The Initial Assessment document indicates the client's preferred language.

- During regular business hours an attempt is made to contact staff who speak the language of the caller. Staff are provided with a listing of county personnel and language(s) spoken, who are available to provide interpretation services.

- Contracts include the requirement that the contractor provide written materials in the format preferred by the client and maintain access to and utilize interpreters, if needed, at no charge to the clients.

D. Share historical challenges on efforts made on the items A, B, and C above. Share lessons learned.

- El Dorado County faces the ongoing challenge of "competing" with nearby counties that offer higher pay, better benefits, and serve as sites for educational institutions. As a small, rural county El Dorado has struggled with recruiting and retaining bilingual, bicultural staff. However, the County recently completed a Classification and Compensation Study which may help with the recruitment of qualified staff.

- Some LEP clients may have limited or poor reading skills, thus the BHD is exploring the use of videos to address reading limitations.

E. Identify county technical assistance needs. (DMH is requesting counties identify language access technical assistance needs so that DMH may aggregate information and find solutions for small county technical assistance needs.)

El Dorado County continues to need technical assistance in developing small county strategies to more effectively recruit bilingual/bicultural staff.

II. Provide bilingual staff and/or interpreters for the threshold languages at all points of contact.

Note: The use of the language line is viewed as acceptable in the provision of services only when other options are unavailable. Counties should train their staff for the proper use of language lines but should seek other options such as training interpreters or training bilingual community members as interpreters.

A. Evidence of availability of interpreter (e.g. posters/bulletins) and/or bilingual staff for the languages spoken by community.

- Flyers announcing the availability of free interpreter services are posted at all service sites.
- List of staff available to provide interpreter services are available to all staff.
- Provider list includes the languages spoken by each provider.

B. Documented evidence that interpreter services are offered and provided to clients and the response to the offer is recorded.

- This is documented in the intake assessment document.

C. Evidence of providing contract or agency staff that are linguistically proficient in threshold languages during regular day operating hours.

- The BHD contracts with bilingual and bicultural agencies in South Lake Tahoe and Western Slope regions. For example, South Lake Tahoe Family Resource Center is located in the heart of a predominantly Latino community in South Lake Tahoe and is an ethnic-services agency dedicated to serving this community. All contracts with providers include the requirement that services be available in multiple languages either directly by provider staff or through an interpreter service at no charge to the clients.
- The BHD certifies its staff who are bilingual in Spanish, the threshold language in El Dorado County.
- Additionally, BHD staff document in the medical record if services are offered and/or provided in Spanish.

D. Evidence that counties have a process in place to ensure that interpreters are trained and monitored for language competence (e.g., formal testing).

- The BHD's process to certify bilingual competence in Spanish is contained in Policy and Procedure II-B-0-001 "Certification of Bilingual Competence and Eligibility for Pay Differential" (see attached).

- The BHD maintains a contract with a contractor for language services, including ASL interpreting services.

- It is acknowledged that even if bilingual competence has been certified, the skills needed to interpret are distinct. Technical assistance is requested from DMH for El Dorado and possibly other small counties in how to train and establish proficiency in interpretation given very limited resources.

IV. Provide services to all LEP clients not meeting the threshold language criteria who encounter the mental health system at all points of contact.

A. Policies, procedures, and practices that include the capability to refer, and otherwise link, clients who do not meet the threshold language criteria (e.g., LEP clients) who encounter the mental health system at all key points of contact, to culturally and linguistically appropriate services.

- This is contained in Policy and Procedure II-B-0004 "Cultural and Linguistic Competence at Mandated Points of Contact".

B. Provide a written plan for how clients who do not meet the threshold language criteria, are assisted to secure, or linked to culturally and linguistically appropriate services.

- This is contained in Policy and Procedure II-B-0004 "Cultural and Linguistic Competence at Mandated Points of Contact".

C. Policies, procedures, and practices that comply with the following Title VI of the Civil Rights Act of 1964 (see page 27) requirements:

1. **Prohibiting the expectation that family members provide interpreter services;**

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

3. **Minor children should not be used as interpreters.**

- Compliance with the following Title VI of the Civil Rights Act of 196 requirements is itemized in Policy and Procedure II-B-0-004.

V. Required translated documents, forms, signage, and client informing materials

A. Culturally and linguistically appropriate written information for threshold languages, including the following, at minimum:

1. **Member service handbook or brochure;**
2. **General correspondence;**

3. **Beneficiary problem, resolution, grievance, and fair hearing materials;**
4. **Beneficiary satisfaction surveys;**
5. **Informed Consent for Medication form;**
6. **Confidentiality and Release of Information form;**
7. **Service orientation for clients;**
8. **Mental health education materials, and**
9. **Evidence of appropriately distributed and utilized translated materials.**

The BHD will maintain and distribute as required the above-identified forms/written materials.

B. Documented evidence in the clinical chart, that clinical findings/reports are communicated in the clients' preferred language.

Documentation of preferred language is provided in the electronic medical record, minimally under the CSI data and in the assessment. Additionally, when services are offered and/or provided in a client's preferred non-English language, that information is documented in the progress note.

C. Consumer satisfaction survey translated in threshold languages, including a summary report of the results (e.g., back translation and culturally appropriate field testing).

The BHD participates in the Statewide Consumer Perception Survey. These forms are available in both English and Spanish, and are provided to the BHD by the State's contractor.

D. Report mechanisms for ensuring accuracy of translated materials in terms of both language and culture (e.g., back translation and culturally appropriate field testing).

Items that are generated by the BHD undergo the initial translation by a staff member who is certified bilingual, and the translated document is then distributed to another bilingual staff for review of the translation. Any discrepancies between the translations are reviewed by a third bilingual staff member, and if needed, there is a meeting to discuss the translation.

E. Report mechanisms for ensuring translated materials are at an appropriate reading level (6th grade). Source: Department of Health Services and Managed Risk Medical Insurance Boards.

The MHP is in the process of reviewing all of its written materials to ensure materials are at an appropriate reading level.

Criterion 8, County Mental Health System Adaptation of Services

I. Client driven/operated recovery and wellness programs

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

The BHD's programs are all client driven, recovery oriented, and wellness directed. Some specific programs that address the culturally unique populations include:

PEI: Mental Health First Aid
There are two program instructors who are bilingual/bicultural and one instructor who is a Veteran. This evidence-based project introduces participants to risk factors and warning signs of mental health problems, builds understanding of their impact, and provides an overview of common treatments, using the curriculum developed by Mental Health First Aid USA, including a module specific to Veterans and their families.

PEI: Parents, Families, Friends of Lesbians and Gays (PFLAG) Community Education
This project supports differences, build understanding through community involvement, and provide education to reduce shame and support to end discrimination. Written materials are provided in both English and Spanish.

PEI: Wennem Wadati: A Native Path to Healing
Foothill Indian Education Alliance provides culturally specific Native American services through use of Cultural Specialists, who are Native American community members, working in a professional capacity that access unique cultural contexts and characteristics through the use of traditional Native American healing approaches. The project employs various prevention strategies to address all age groups in the target population with the intent to maintain mental health well- being, improve wellness, and decrease health disparities experienced by the Native American community.

PEI: Latino Outreach
New Morning Youth and Family Services and the South Lake Tahoe Family Resource Center provide Promotoras to address needs in the Spanish-speaking or limited English-speaking Latino adult population and peer and family problems in the youth population as community issues resulting from unmet mental health needs by contributing to system of care designed to engage Latino families and provide greater access to culturally competent mental health services. All staff are bilingual or bilingual/bicultural.

PEI: Older Adult Programs
This project focuses on depression among older adults and the community issues of isolation and the inability to manage independence that result from unmet mental health needs. The goal is to reduce institutionalization or out of home placement. The programs include Senior Peer Counseling and Senior Link. Senior Peer Counseling provides free confidential individual peer counseling to adults age 55 and older. Senior Peer Counseling

volunteers evaluate the needs of potential clients, frequently referring them or assisting them in making contact with other community services, including Behavioral Health evaluation and treatment. Senior Link is designed to provide access, support, and linkage for older adults to a variety of community-based services with the goal of improving mental health.

PEI: Veterans Outreach
This project is an outreach project aimed at reaching Veterans who may be in need of behavioral health services. The goals are to provide a single point of entry for homeless Veterans to receive needed services, assist Veterans to secure permanent and affordable housing, and to reduce the number of homeless Veterans in our community.

PEI: Psychiatric Emergency Response Team (PERT) (Community-Based Outreach and Linkage)
PERT is a dedicated team that responds to mental health-related calls in the community. PERT pairs a mental health clinician with a Sheriff Deputy, who provide field-based mental health outreach, referrals and linkage to services. PERT reaches community members where they live, work and play to allow greater access to services for individuals who may not seek out traditional access points, including those who are homeless, underserved, or have other social or cultural pressures to avoid mental health services. PERT may interact with individuals who are victims of domestic violence, use substances as a means of self-medicating, or are experiencing poverty or multi-generational impacts of untreated mental illness.

CSS: Full Service Partnership
This project encompasses services for children, Transitional Age Youth, Adults, and Older Adults. Each client's personal and cultural needs are addressed. According to California Code of Regulations (CCR), Title 9, Section 3200.130, a FSP is "the collaborative relationship between the County and the client, and when appropriate, the client's family, through which the County plans for and provides the full spectrum of community services so that the client can achieve the identified goals. Included in the services are FSP projects provide an individualized approach to meeting needs for mental health and support services to children/youth, Transitional Age Youth, adults, and older adults.

CSS: TAY Engagement, Wellness and Recovery Services
This project provides services to meet the unique needs of transitional age youth and encourages continued participation in mental health services.

CSS: Outreach and Engagement Services
This project includes Projects for Assistance in Transition from Homelessness (PATH) services, including services provided by a homeless advocate. This project engages individuals with a serious mental illness in mental health services and to continue to keep clients engaged in services by addressing barriers to service.

II. Responsiveness of mental health services

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

(Counties may develop a listing of available alternatives and options of cultural/linguistic services that shall be provided to clients upon request. The county may also include evidence that it is making efforts to include additional culture-specific community providers and services in the range of programs offered by the county).

El Dorado County maintains a list of Specialty Mental Health Service providers that includes languages spoken other than English, experience with specific cultural and spiritual groups, and specialty services. This list is available in both English and Spanish at all BHD locations.

B. Evidence that the county informs clients of the availability of the above listing in their member services brochure. If it is not already in the member services brochure, the county will include it in their next printing or within one year of the submission of their Cultural Competence Plan Update.

El Dorado County maintains a list of mental health service providers that includes languages spoken other than English, experience with specific cultural and spiritual groups and specialty services. The list is included in the beneficiary informing materials provided to beneficiaries at intake.

A flyer (English and Spanish) is posted in the lobby areas of mental health service sites that advise clients that a Guide to Medi-Cal Mental Health Services is available upon request, and the Guide to Medi-Cal Mental Health Services if provided to clients upon initial intake.

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

(Counties may include a.) Evidence of community information and education plans or policies that enable Medi-Cal beneficiaries to access specialty mental health services; or b.) Evidence of outreach for informing under-served populations of the availability of cultural and linguistic services and programs (e.g., number of community presentations and/or forums used to disseminate information about specialty mental health services, etc.)

Please see the attached information (Exhibit A).

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

Location, transportation, hours of operation, or other relevant areas;

There are six geographic areas that are generally seen as comprising the distinct regions of the County:

West County	Cameron Park, Shingle Springs, Rescue, El Dorado Hills
Placerville Area	Placerville, Diamond Springs, El Dorado, Pleasant Valley, Kelsey, Swansboro
North County	Coloma, Cool, Lotus, Garden Valley, Georgetown, Greenwood, Pilot Hill
South County	Somerset, Grizzly Flats, Mt. Aukum
Mid County	Pollock Pines, Camino, Cedar Grove, Kyburz, Pacific House, Riverton
Tahoe Basin	SLT, Tahoma

Behavioral Health offices are in Diamond Springs and South Lake Tahoe. Additionally, a bilingual/bicultural Mental Health Clinician is stationed full time at the Community Corrections Center in Shingle Springs. This Mental Health Clinician works closely with County Probation and Substance Use Disorder Services. Additionally, a Mental Health Clinician is stationed at the Marshall Hospital Emergency Department from 8:00 pm to 12:00 am seven days per week.

Individuals receiving Full Service Partnership level of services may receive those services anywhere in the community that is appropriate and safe, including clients' homes.

In determining the location of the Outpatient Behavioral Health Clinics, concerns such as proximity to local transportation is considered. For example, when the West Slope Clinic relocated to Diamond Springs, the County partnered with El Dorado Transit to install a new bus stop in front of the Diamond Springs office and the BHD developed a Transportation Plan.

Standard business hours for both the West Slope (Diamond Springs) and South Lake Tahoe offices are Monday through Friday, 8:00 a.m. to 5:00 p.m. The Intensive Case Management (ICM) team is available seven days per week from 8:00 a.m. to 8:00 p.m. ICM services are available after those hours through Psychiatric Emergency Services staff.

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

The BHD service sites are easily accessible by public transportation, are ADA-compliant, and have limited after business hour services (e.g., Psychiatric Emergency Services). Collaboration with law enforcement, school districts and primary care providers greatly enhances geographic access, increases early identification, and decreases the barriers presented by stigma.

2. **Locating facilities in settings that are non-threatening and reduce stigma, including co-location of services and /or partnerships, such as primary care and in community settings. (The county may include evidence of a study or analysis of the above factors, or evidence that the county program is adjusted based upon the findings of their study or analysis.)**

During site visits and Medi-Cal certification/recertification processes, application of culturally appropriate strategies to ensure a welcoming and accessible environment is considered.

III. Quality Assurance

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

A. Grievances and Complaints: Provide a description of how the county mental health process for Medi-Cal and non-Medi-Cal client Grievance and Complaint/Issues Resolution Process data is analyzed and any comparison rates between the general beneficiary population and ethnic beneficiaries.

The State Department of Health Care Services requires that local Mental Health Plans (MHPs) have in place problem resolution processes for Medi-Cal beneficiaries and MHP providers. In addition, it is the policy of the BHD to offer this problem resolution process to all individuals receiving or requesting services, with the exception of the right to a State Fair Hearing, which is limited to Medi- Cal beneficiaries.

The BHD sets the following objectives for our problem resolution process:

- To respond in a timely, sensitive, and confidential manner to all public complaints, queries, and reports regarding mental health services in El Dorado County.
- To assist individuals in accessing medically necessary, high quality, client- centered mental health services.

- To provide a process for resolution of problems in a client-focused atmosphere.
- To provide a formal process for resolution of grievances and appeals.
- To protect the rights of clients during the grievance and appeal process.

The BHD ensures that the individuals who make decisions on grievances and appeals are:

- individuals who were not involved in any previous level of review or decision-making; and
- who are health care professionals who have the relevant and appropriate clinical expertise and licensure meeting State and Federal regulations.

The Problem Resolution Coordinator:

- receives all grievances and appeals and serves as the MHP's representative;
- is available to consult and assist patients upon request; and
- assign each grievance or appeal to the appropriate staff for investigation and findings.

Upon request for mental health services, MHP beneficiaries shall receive a copy of the "Guide To Medi-Cal Mental Health Services" booklet created by the State Department of Mental Health available in English and Spanish. This booklet includes a description of the problem resolution process and useful information on how to contact the Patients' Rights Advocate and the MHP's Problem Resolution Coordinator. Additionally, a list of providers is also available.

Brochures explaining the Grievance and Appeal processes (available in English and Spanish) explain in greater detail the Grievance, Appeals and Expedited Appeals processes designed to resolve problems, including Medi-Cal beneficiaries' right to request a State Fair Hearing.

A sign indicating the availability of the booklet and both brochures is accessible and visibly posted in the waiting room of all MHP service locations and on the BHD's web site. In addition, informational brochures, grievance and appeals forms, and self-addressed envelopes for submitting grievances and appeals forms, are provided with easy access and in full view in all BHD service locations.

If at any time a client or family member expresses dissatisfaction with the BHD, they should be provided with a copy of the Grievance and/or Appeals packet, which includes information about Grievances/Appeals and the Grievance/Appeal form. All staff, including those answering the (800) 929-1955 Access Line, shall be able to provide information on how to access copies of the agency's

Grievance and Appeals forms and how to contact the Problem Resolution Coordinator and Patients' Rights Advocate.

Full detail on the MHP's handling of Grievances and Appeals is documented in Policy & Procedure N-MH-002. Grievance and Appeal forms are available in English and Spanish.

Exhibit A
Consumer Informing Materials

El Dorado County
Health and Human Services Agency
Behavioral Health Division

Access and set up for ASL interpretation (for hearing impaired)

The Behavioral Health Division has a contract with "Language People"

Call:

Diamond Springs
(530) 621-6290

South Lake Tahoe
(530) 573-7970

Agencia de Salud y Servicios Humanos
de el Condado de El Dorado
División de Salud de Comportamiento

Acceso y arreglo para obtener servicio de interpretación (para los que no oyen)

La División de Salud del Comportamiento tiene un contrato con "Language People"

Llame:

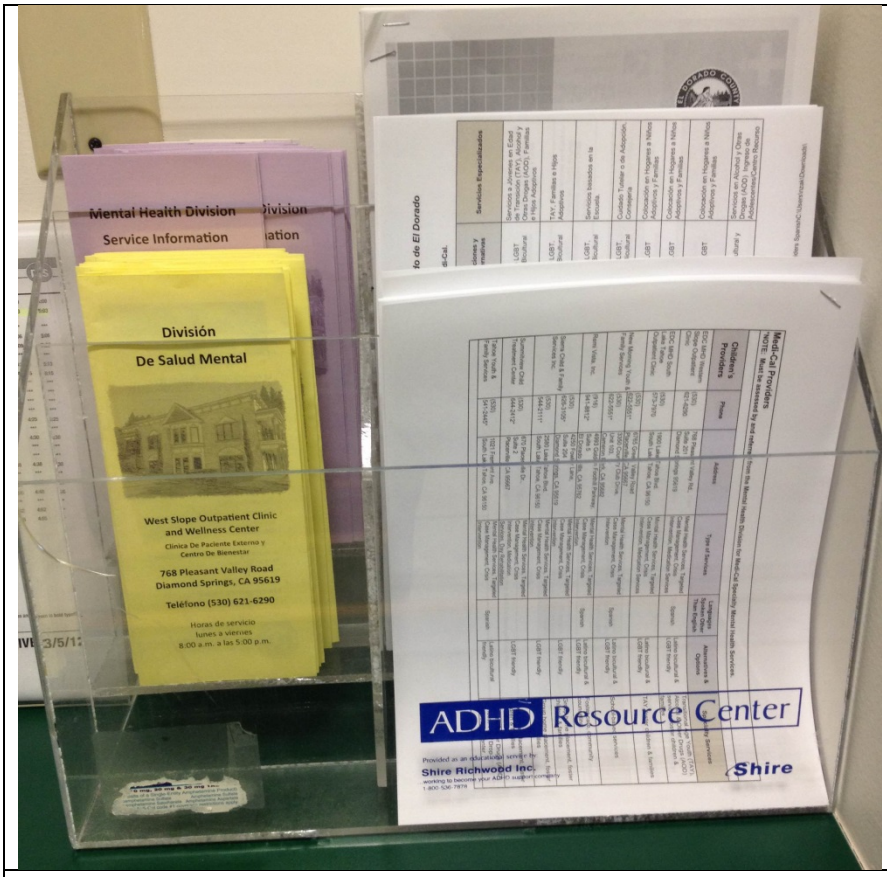
Diamond Springs
(530) 621-6290

South Lake Tahoe
(530) 573-7970

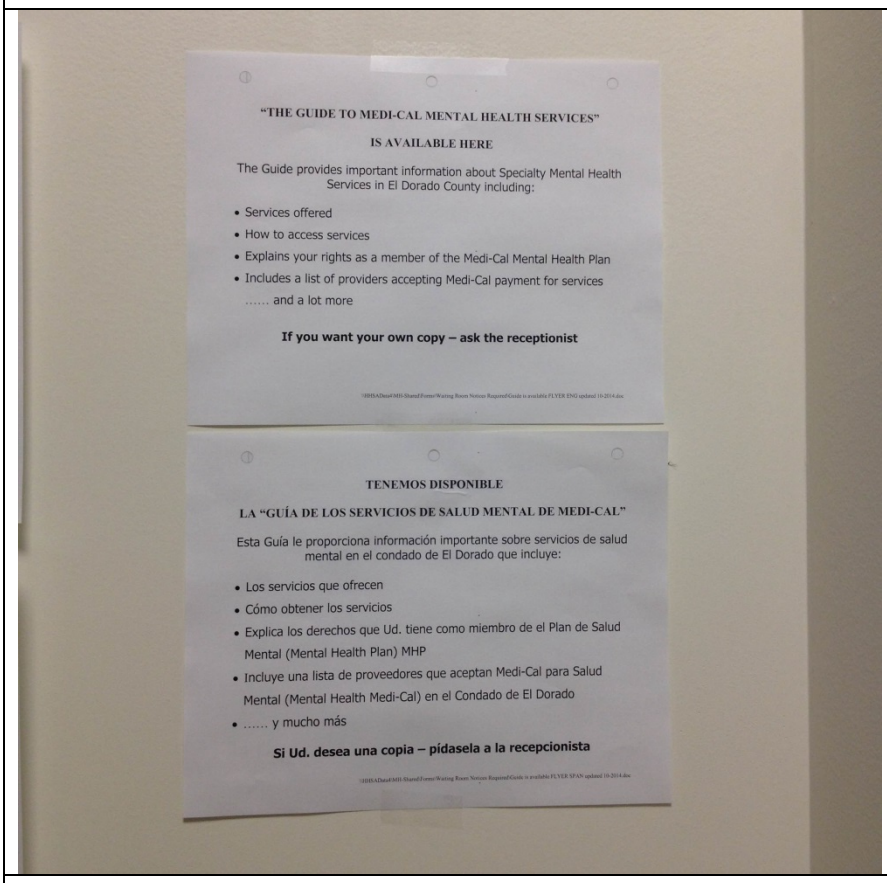
Ofrecemos servicios de salud mental en su propio idioma
Si Ud. así lo requiere, le brindamos los servicios de un intérprete sin costo alguno.
También ofrecemos ayuda apropiada para personas sordas o con vista limitada
Por favor informe a la recepcionista o a su consejero que Ud. necesita estos servicios.

Mental health services are available to you in your primary language.
When necessary, interpreter services will be made available at no cost to you.
Accommodations for the visually and hearing impaired are also available.
Please speak with the receptionist or with your counselor if you need these services.

Lobby Postings – English and Spanish

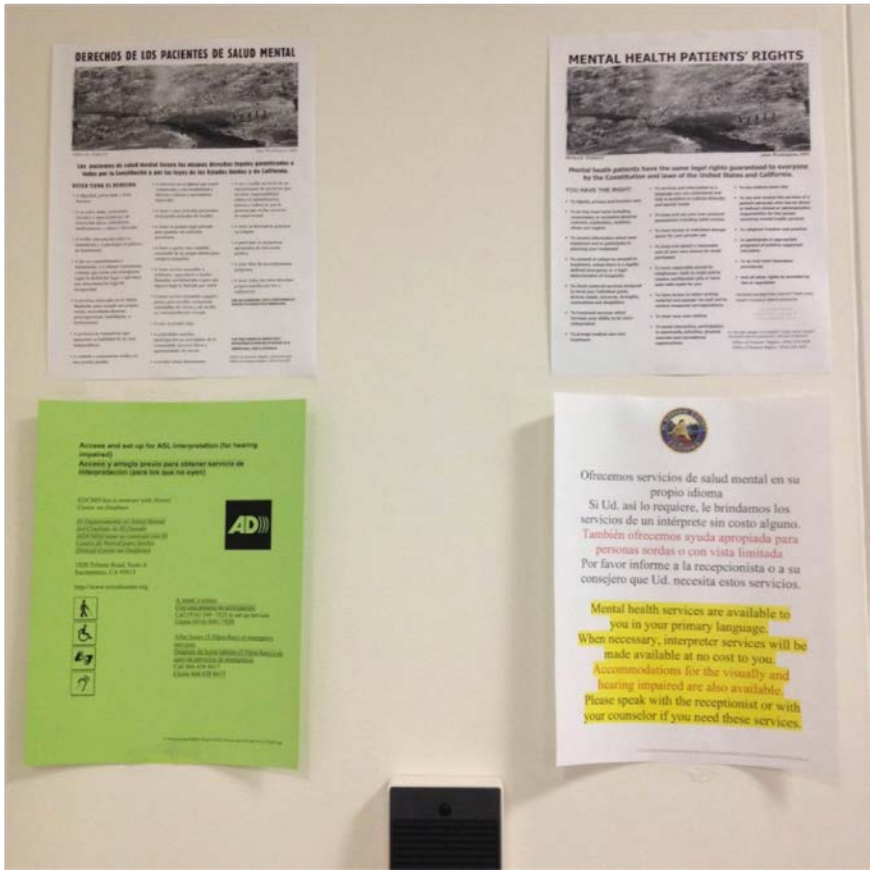


- Guide to Medi-Cal
- Provider Lists
- Mental Health Division Service Information

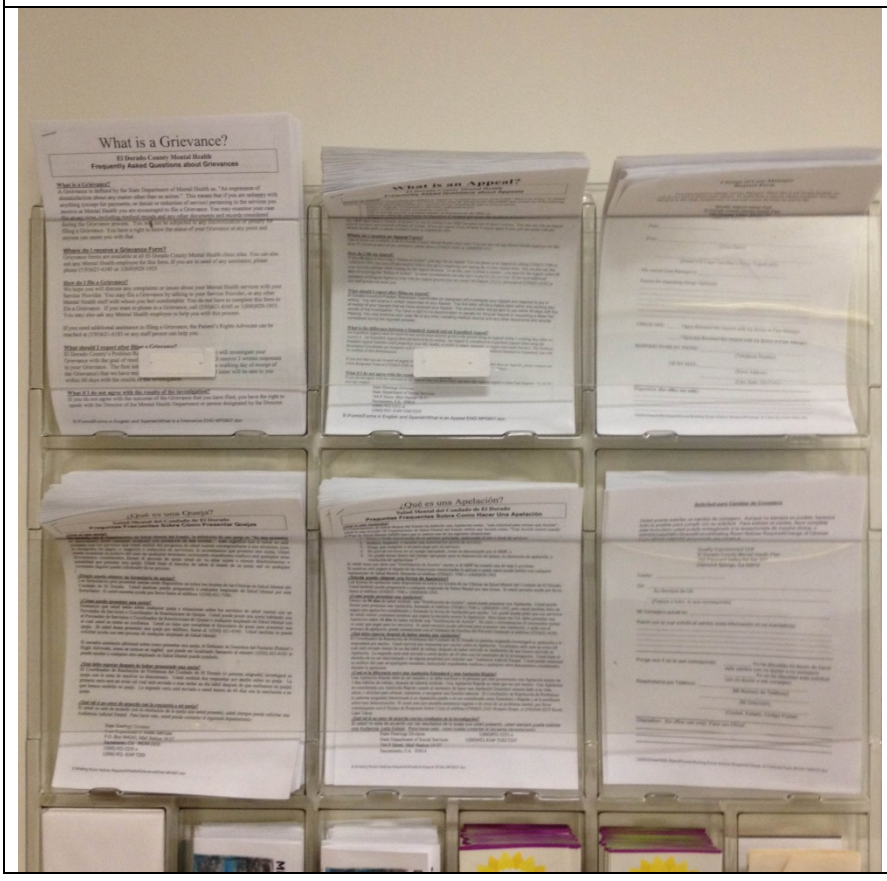


- Guide to Medi-Cal Mental Health Services Notice

Lobby Postings – English and Spanish



- Mental Health Patients' Rights
- ASL poster
- Free Interpreter Service



- What is a Grievance and Form
- What is an Appeal and Form
- Change of Case Manager

Additional Informing Material are located on the Behavioral Health Division's website at: https://www.edcgov.us/MentalHealth.

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Exhibit B
Behavioral Health Division
Policies, Procedures, and Forms

EL DORADO COUNTY
MENTAL HEALTH DEPARTMENT

POLICY/PROCEDURE

SUBJECT: Certification for Bilingual Differential Pay Benefit	**Policy Number: II-B-0-001**
AUTHOR: Barry Wasserman, LCSW **Date:** 9/1/2005	**PAGE 1 of 2**
Revised by: Stephanie Carlson **Date:**	**APPROVED BY:** John Bachman **Date:** 9/20/07 **John Bachman, PhD. Director**

POLICY

Bilingual Differential shall be awarded for bilingual proficiency in Spanish, sign language or any language determined by the Department Head as necessary to meet regulatory requirements and/or the needs of the community. Staff who will receive bilingual differential pay must be certified by the Department Head as proficient in the designated language and must utilize their proficiency skills as part of their job duties. The bilingual differential benefit is not an ongoing entitlement and should be granted only if necessary to meet agency needs. As appropriate, the Department Director will complete the documentation for an annual re-certification.

PROCEDURE

The proficiency determination process will be implemented after the Department Director receives and approves a written request from the Cultural Competency Committee to fill an identified need.

After receiving approval from the Department Director for a proficiency review, the Chair of the Cultural Competency Committee shall appoint bilingual county personnel and, if available, one consumer representing the language and culture, to interview the candidate for his/her level of proficiency and cultural awareness.

An employee seeking bilingual status must meet the minimum qualifications for their desired position as determined by the Human Resources Department.

The proficiency determination should accurately assess the applicant's proficiency in the area of need, e.g., cultural awareness and verbal and written translation skills.

If a newly hired candidate is required to have bilingual capability upon being hired, the bilingual proficiency review should be a part of the interview/hiring process before the candidate is offered a position.

Upon completion of the proficiency determination assessment, the Department Director and the Cultural Competency Committee Chair shall be notified in writing by the bilingual proficiency interview team of the proficiency capabilities of the applicant. If the applicant is determined to be proficient, the

Department Director shall notify the site Program Manager and complete the Human Resources Resources bilingual certification form, "Certification of Eligibility for receipt of Bilingual Differential." If the applicant is not determined to be proficient, the Chair of Cultural Competency Committee shall notify the candidate in writing.

Certification of the employee's bilingual status shall be reviewed and renewed annually, as needed. The Cultural Competency Committee will notify the Department Director if the employee continues to use bilingual skills which are necessary in the delivery of services. The Department Director will then provide written authorization to the Human Resources Department, if warranted, per the El Dorado County Salary and Benefits Resolution Section 14 (1412).

NOTE: Only certified staff should interpret. Uncertified staff members attempting to interpret could misunderstand and create more problems. Staff will find a <u>certified</u> staff member to assist with interpreting needs.

EL DORADO COUNTY
MENTAL HEALTH DEPARTMENT

POLICY/PROCEDURE

SUBJECT: Cultural Competency Program Documentation Standards	**POLICY NUMBER:** II-B-0-002
APPROVED BY:  Barry Wasserman, LCSW, Interim Director	**DATE:** 7/8/05

Policy:

Consumer's from diverse ethnic backgrounds shall have input in the development of culturally and linguistically competent Mental Health Treatment Plans.

Procedure:

1. The Consumer's cultural / linguistic concerns, issues and preferences will be documented in the client's record.

2. The Consumer's request for cultural input from family, friends and community support persons will be documented in the Client Assessment.

3. The Client Plan, and Progress Notes will reflect the inclusion of the consumer's input and participation, as well as well as efforts to include input from family, friends, and community support persons in the development of culturally and linguistically competent service delivery.

EL DORADO COUNTY
MENTAL HEALTH DEPARTMENT

POLICY/PROCEDURE

SUBJECT: Cultural Competency Training Requirements	**POLICY NUMBER:** II-B-0-003
APPROVED BY: Signed by: B Wasserman Barry Wasserman, LCSW, Interim Director	**DATE:** 7/5/05

Policy:
To provide Cultural Competency Training to staff, providers, and interpreters in order to facilitate the acquisition of the skills necessary to serve clients of diverse ethnic backgrounds with the appropriate services.

Procedure:
All staff shall attend cultural competency training at least twice a year.

Attendance at an annual training regarding accessing cultural proficient services and language skills and the effective use of an interpreter is required. The training will consist of presentations by staff, guest speakers, consumers, family members, handouts, and informational materials.

Additional trainings shall include one of the following Core Curriculum topics:

1. Overview of Mental Health Services
2. County Geography and Cultural Issues
3. Socio-economic Cultural Issues
4. Information and training regarding the major ethnic groups in the county
5. Ethnicity, Culture, and Mental Illness

Additional topics may be added to the Core Curriculum such as:

1. Interpreters: Ethical issues related to translating, role of service provider and interpreter.
2. Consumer Culture (including issues related to family members)
3. Training for Work with Special Populations (0-5 and Elder Adults)

Attendees at all training sessions will be asked to complete a written evaluation of the program.

EL DORADO COUNTY MENTAL HEALTH DEPARTMENT

POLICY/PROCEDURE

SUBJECT: Cultural and Linguistic Competency, at Mandated Points of Contact		Policy Number: II-B-0-004
AUTHOR: Barry Wasserman, LCSW	Date: 7/5/2005	PAGE 1 of 1
Revised by: Laura Eakin, MFT	Date: 9/5/2007	APPROVED BY: John Bachman, PhD. Director	Date: 9/10/07

Policy:

It is the policy of the El Dorado County Mental Health (EDCMH) Department to provide culturally and linguistically competent services to consumers and their families. At mandated key points of contact, EDCMH will access the appropriate resource to remove barriers to verbal or written communication for beneficiaries who speak a language other than English, or have limited English proficiency. Mandated key points are common points of entry into the mental health system, including the 24 hour toll free line, beneficiary problem resolution system, the Psychiatric Health Facility (PHF) or the outpatient clinics.

Procedure:
If a consumer is requesting services, EDCMH staff will determine their preferred language. Their primary language preference will be documented on the request for services log, the Crisis Intake form, the PHF admission form and elsewhere to assure clear communication between staff and consumer.

The EDCMH will have documented evidence that beneficiaries who speak a language other than English or have limited English proficiency are informed that they have the right to free language assistance. A consumer may choose to use a family member or friend as an interpreter after being informed of the availability of free interpreter services. EDCMH providers may NOT put the burden of responsibility to identify a resource for interpretation or translation upon the consumer. It is strongly recommended that minor children not be used as interpreters.

A list of names and phone numbers of interpreters and providers with cultural and linguistic capabilities will be maintained at all mental health service sites.

Reception and direct service staff will be trained yearly, and on an as-needed basis, in the appropriate role of interpreter and how and when to access interpreters.

If a bilingual staff member from anywhere in the system of care is needed to interpret or provide direct services, the staff member's supervisor should be contacted. Priority is to be given to staff availability for interpretation.

EDC always maintains a contract with a provider for telephone interpreting services.

If the beneficiary speaks a non-threshold language, or has limited English proficiency interpretation services can be access via the contracted telephone services. Priority is always given to locating a staff person within the system of care who speaks the non-threshold language.

EDCMH maintains a list of names and phone numbers of interpreters and providers with cultural and linguistic capabilities at all service sites. The use of the contracted telephone language line is viewed as acceptable in the provision of services only when other options are unavailable.

EL DORADO COUNTY
MENTAL HEALTH DEPARTMENT

POLICY/PROCEDURE

SUBJECT: Cultural Competency, Community Outreach	**POLICY NUMBER:** II-B-0-005
APPROVED BY: Barry Wasserman, LCSW, Interim Director	**DATE:** 7/7/05

POLICY

Mental Health Department will provide community outreach to underserved cultural and ethnic populations. The overall purpose is to disseminate information regarding availability and access to county mental health services.

PROCEDURE

Each year the Cultural Competency Committee will develop a community education outreach plan in which they identify events, populations and/or communities for outreach activities. Materials and information will be disseminated regarding access and availability of services at county facilities or contract provider locations.

The community education outreach plan will be included in the annual cultural competency work plan.

EL DORADO COUNTY
MENTAL HEALTH DEPARTMENT

POLICY/PROCEDURE

SUBJECT: Beneficiary Rights	**Policy Number: II-E-0-001**
AUTHOR: Laura Eakin, MFT **Date:** 3/15/2006	**PAGE 1 of 2**
Revised by: Laura Eakin MFT **Date:** 8/16/07 **Laura Eakin, MFT** **8/16/07**	**APPROVED BY:** John Bachman **Date:** 9/10/07 **John Bachman, PhD.** **Director**

Policy: Consistent with the requirements of Title 42, Code of Federal Regulations (CFR) Part 438, Section 438.100 and as described in the DMH Information Notice 03-13, it is the policy of the El Dorado County Mental Health Department to maintain a written policy guaranteeing beneficiaries of certain basic rights as outlined below. EDCMH will communicate these rights to beneficiaries, employees, and providers and will ensure that beneficiaries' treatment are not adversely affected as a result of exercising these rights.

BACKGROUND

As described in DMH Information Notice 03 –13, new Medicaid Managed Care (MMC) regulations were issued by the Centers for Medicare and Medicaid Services (CMS) on June 14, 2002 with a required implementation date of August 13, 2003. These regulations apply to the Medi-Cal mental health managed care program and create new procedural requirements that affect the Department of Mental Health (DMH) and MHPs. Under the new MMC regulations, MHPs are considered Prepaid Inpatient Health Plans (PIHPs) and are required to comply with MMC regulations that apply to PIHPs. The new MMC regulations supersede the regulations governing the Medi-Cal managed mental health care program (Title 9, California Code of Regulations (CCR), Division 1, Chapter 11) when there is a conflict.

Procedure:

1. The following rights apply to all Medi-Cal Beneficiaries:
    a. Be treated with respect and with due consideration for his or her dignity and privacy;
    b. Receive information on available treatment options and alternatives, presented in a manner appropriate to his or her condition and ability to understand;
    c. Participate in decisions regarding his or her health care, including the right to refuse treatment;
    d. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation;
    e. Request and receive a copy of his or her medical records, and request that they be amended or corrected;

f. Receive information in accordance with Title 42, CFR, Section 438.10, which describes information requirements; and
g. Be furnished health care services in accordance with Title 42, CFR, Sections 438.206 through 438.210, which cover requirements for availability of services, assurances of adequate capacity and services, coordination and continuity of care, and coverage and authorization of services.

2. These Beneficiary Rights will be included in the Member Brochure.

3. All staff will be informed of these rights upon joining the EDCMH staff.

4. All mental health providers on contract with EDCMH to serve Medi-Cal recipients must adhere to these rights, as well. They will be informed of these expectations in writing, provided with copies of the updated member brochure, and this requirement will be incorporated into all future contracts.

EL DORADO COUNTY
MENTAL HEALTH DEPARTMENT

POLICY/PROCEDURE

SUBJECT: Informing Materials for El Dorado County Consumers of Mental Health Services		**Policy Number: II-E-0-004**
AUTHOR: Laura Eakin	**Date:** 12/8/2005	**PAGE 1 of 1**
Revised by: Laura Eakin	**Date:** 8/16/2007	**APPROVED BY:** John Bachman **Date:** 8/17/07 **John Bachman, PhD.** **Director**

Policy: El Dorado County Mental Health Department provides all consumers with informing materials. The informing materials are available in El Dorado County's threshold languages. The content of the informing materials includes all information outlined in Title 42, Code of Federal Regulations, Section 438.10.

Reference: Sec. 438.10, Code of Federal Regulations
El Dorado County Mental Health Contract with State Department of Mental Health, Exhibit E, Section 6, and F
Title 9 California Code of Regulations, Chapter 11, and Section 1810.360

Scope: All service providers within the El Dorado County Mental Health Plan
All El Dorado County Medi-Cal beneficiaries, consumers of Specialty Mental Health Services.

Procedure:

1. All consumers newly admitted to the Mental Health Plan will be given, as applicable, the materials listed on the "Intake Check Sheet" as applicable.
2. If, at the time of admission, the consumer is unable to accept and utilize these materials due to their mental health condition, the information will be given as soon as the consumer is able to accept and utilize it.
3. At any point in time, informing materials are available to current consumers of mental health services or any interested party upon their request. Signs advising consumers of this availability are posted in lobbies of each provider site. [Exhibit "Informing Materials for El Dorado County Consumers of Mental Health Services" binder]
4. The informing materials will be available in written and audiotape formats in El Dorado County's threshold languages.

Intake Check Sheet

Retain in the medical record

I certify that I have been given each of the below listed items:

- ☐ EDCMH Informed Consent form
- ☐ EDCMHP Providers list
- ☐ Authorization for Treatment of a Minor
- ☐ Guide to Medi-Cal Mental Health Services booklet
- ☐ What is a Grievance? document
- ☐ What is an Appeal? document
- ☐ Right to an Interpreter disclosure
- ☐ California Advance Health Care Directives document
- ☐ Request for Services form
- ☐ EDC Notice of Privacy Practices document
- ☐ EDC Acknowledgement of Receipt of Notice of Notice of Privacy Practices form
- ☐ EDCMH UMDAP form
- ☐ EDCMHP Client Registration form
- ☐ Client Cost Explanation and Agreement (if not Medi-Cal) form
- ☐ EDCMH Authorization for use or disclosure of PHI – 1 Party
- ☐ EDCMH Authorization for use or disclosure of PHI – Multi Party
- ☐ Would you like to Register to Vote? form
- ☐ Register to Vote application

Patient signature

_____

Intake provider signature

_____

LANGUAGE ASSISTANCE

English
ATTENTION: If you speak another language, language assistance services, free of charge, are available to you. Call 1-530-621-6290 (TTY: 711 (California Relay Service)).

ATTENTION: Auxiliary aids and services, including but not limited to large print documents and alternative formats, are available to you free of charge upon request. Call 1-530-621-6290 (TTY: 711 (California Relay Service)).

Español (Spanish)
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-530-621-6290 (TTY: 711 California Relay Service).

Tiếng Việt (Vietnamese)
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-530-621-6290 (TTY: (California Relay Service)).

Tagalog (Tagalog – Filipino)
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-530-621-6290 (TTY: (California Relay Service)).

한국어 (Korean)
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-530-621-6290 (TTY: 711 (California Relay Service)) 번으로 전화해 주십시오.

繁體中文(Chinese)
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-530-621-6290 (TTY: 711 (California Relay Service))。

Հայ ե ր ե ն (Armenian)
ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայ ե ր ե ն, ապա ձե զ ան վճար կարո ղ են տրամադրվել լե զ վական աջակց ու թյ ան ծառայ ու թյ ուններ: Զանգահարե ք 1-530-621-6290 (TTY: 711 (California Relay Service)).

Русский (Russian)
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-530-621-6290 (TTY: 711 (California Relay Service)).

فارسی (Farsi)

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با (TTY: 711 (California Relay Service)) 1-530-621-6290 تماس بگیرید.

日本語(Japanese)

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-530-621-6290 (TTY: 711 (California Relay Service)) まで、お電話にてご連絡ください。

Hmoob (Hmong)

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-530-621-6290 (TTY: 711 (California Relay Service)).

ਪੰਜਾਬੀ (Punjabi)

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-530-621-6290 (TTY: 711 (California Relay Service)) 'ਤੇ ਕਾਲ ਕਰੋ।

العربية (Arabic)

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-530-621-6290

(رقم هاتف الصم والبكم: 711 (California Relay Service)

हिंदी (Hindi)

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। [1-530-621-6290 (TTY: 711 (California Relay Service)) पर कॉल करें।

ภาษาไทย (Thai)

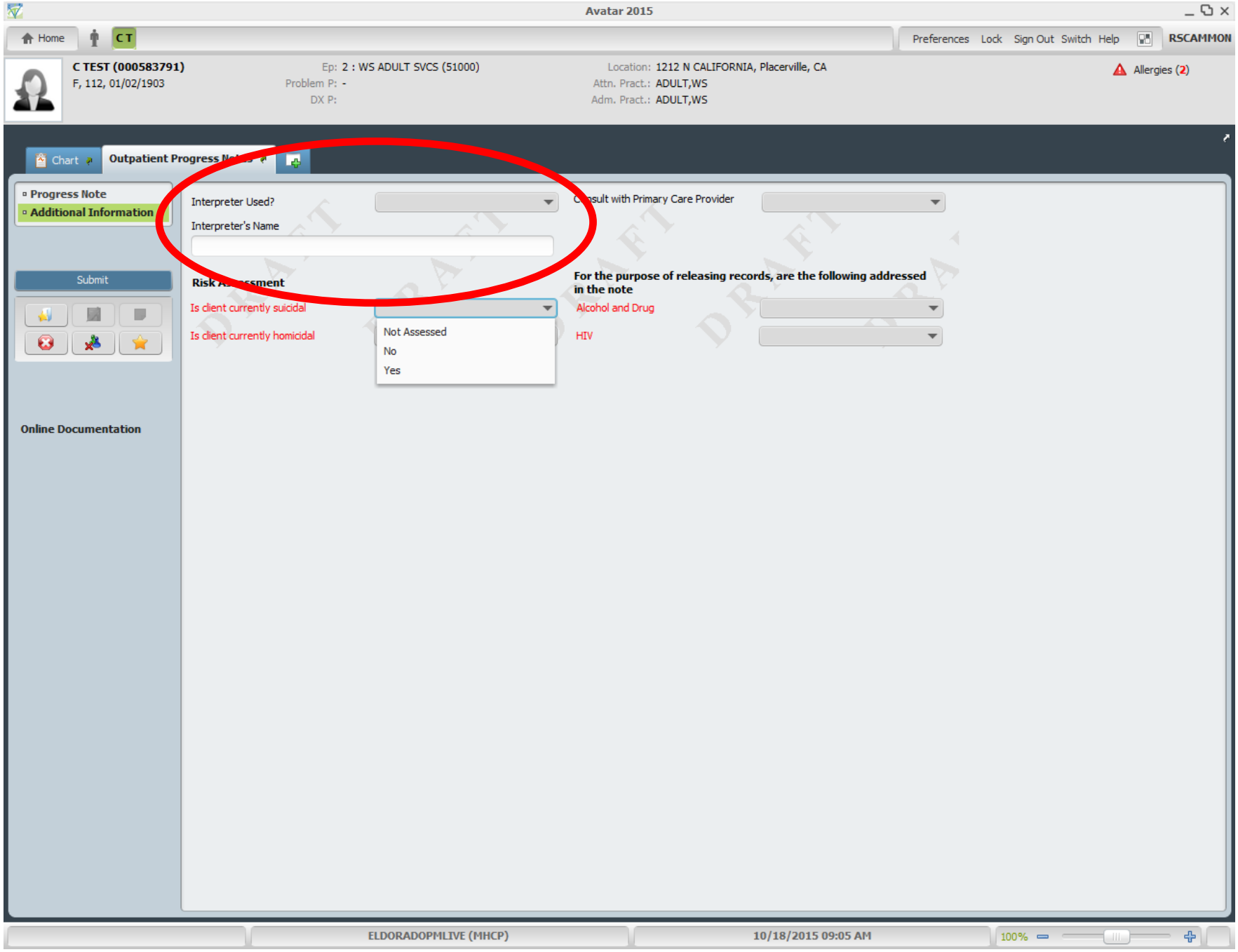
เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-530-621-6290 (TTY: 711 (California Relay Service)).

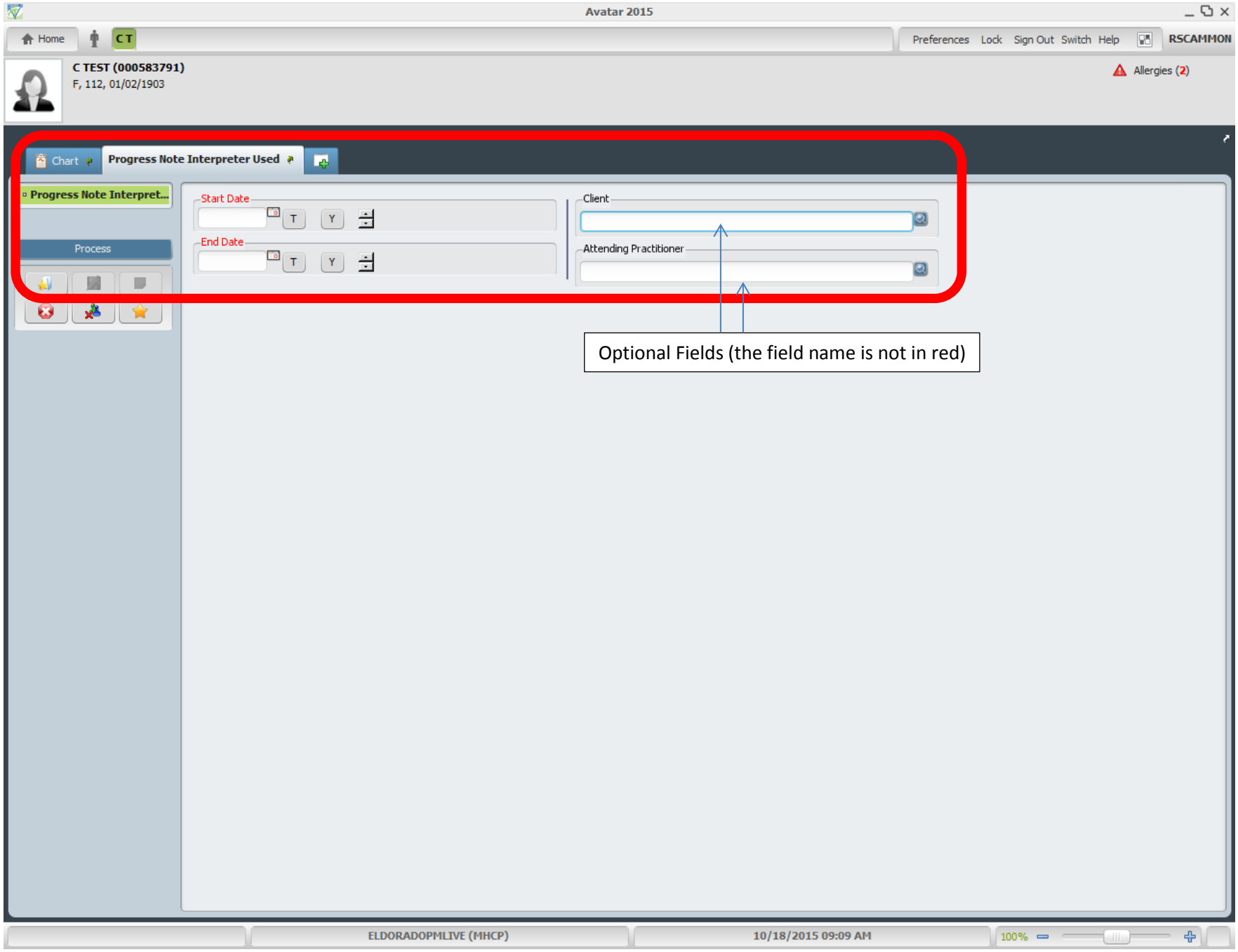
ខ្មែរ (Cambodian)

ប្រយ័ត្ន៖ រ សើ ិនជាអ្នកនិយាយ ភាសាខ្មែ , រសវាជំនួយមននកភាសា រោយមិនគិត្ួ ួន គឺអាចមានសំរា ់ ំរ អ្ើ នក។ ចូ ទូ ស័ព្ទ1-530-621-6290 (TTY: 711 (California Relay Service))។

ພາສາລາວ (Lao)

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-530-621-6290 (TTY: 711 (California Relay Service)).


Avatar 2015
Home
CT
Preferences Lock Sign Out Switch Help
RSCAMMON
C TEST (000583791)
F, 112, 01/02/1903
Ep: 2 : WS ADULT SVCS (51000)
Problem P: -
DX P:
Location: 1212 N CALIFORNIA, Placerville, CA
Attn. Pract.: ADULT,WS
Adm. Pract.: ADULT,WS
Allergies (2)
Chart
Outpatient Progress Note
Progress Note
Additional Information
Submit
Online Documentation
Interpreter Used?
Interpreter's Name
Consult with Primary Care Provider
Risk Assessment
Is client currently suicidal
Is client currently homicidal
Not Assessed
No
Yes
For the purpose of releasing records, are the following addressed in the note
Alcohol and Drug
HIV
DRAFT
ELDORADOPMLIVE (MHCP)
10/18/2015 09:05 AM
100%


Avatar 2015
Home
C T
Preferences Lock Sign Out Switch Help
RSCAMMON
C TEST (000583791)
F, 112, 01/02/1903
Allergies (2)
Chart
Progress Note Interpreter Used
Progress Note Interpret...
Process
Start Date
End Date
T
Y
Client
Attending Practitioner
Optional Fields (the field name is not in red)
ELDORADOPMLIVE (MHCP)
10/18/2015 09:09 AM
100%

Telephone Interpreting

Community Services

[redacted]

25TH ANNIVERSARY

Enter Account Number [redacted] ***when prompted***

Enter Language Code or choose from a list of options

- *Face-to-Face Interpreting*
- *Video Remote Interpreting*
- *Document Translations*
- *ASL/Sign Language*
- *Foreign Language*

More info Online at languagepeople.com

LANGUAGE PEOPLE

This card should be placed in a location that is accessable by your staff in the event of any language service needs.

To reach our main line, please call [redacted]

38750 Sky Canyon Drive • Murrieta • CA • 92563 • [redacted]

LANGUAGE PEOPLE

Telephone Interpreting

[redacted]

25

LANGUAGE CODES

Commonly Used Languages

Afrikaans	2011	Cantonese	2035	Finnish	2064	Indonesian	2087	Min Nan	2112	Slovak	2137
Albanian	2130	Catalan	2036	Flemish	2065	Italian	2088	Mixteco	2114	Somali	2138
Amharic	2014	Chamorro	2039	French (Ca)	2067	Japanese	2089	Moldovan	2115	Spanish	2140
Arabic	2016	ChaoChow	2038	French	2066	Javanese	2090	Mongolian	2116	Sudanese	2141
Armenian	2006	Cherokee	2042	Fula	2068	Kanjobal	2091	Navajo	2118	Swahili	2142
Assyrian	2018	Cree	2044	Ganda	2071	Karen	2093	Nepali	2119	Swedish	2143
Badini	2020	Creole (F.)	2046	Georgian	2072	Korean	2094	Nigerian	2120	Tagalog	2146
Bahasa	2022	Creole (H)	2163	German	2073	Kurdish	2095	Norwegian	2121	Tamil	2147
Bajuni	2021	Croatian	2050	Greek	2007	Lahu	2097	Pampango	2124	Thai	2008
Bambara	2024	Czech	2051	Guarani	2074	Lakota	2096	Pangasinan	2125	Tigrinya	2149
Basque	2025	Danish	2053	Gujarati	2075	Lao	2098	Pashto	2126	Tongan	2151
Behdini	2026	Dari	2054	Hakka	2076	Latvian	2099	Polish	2127	Turkish	2152
Belroussian	2027	Dinka	2055	Hebrew	2078	Lithuanian	2101	Portuguese	2128	Ukrainian	2162
Bengali	2028	Dutch	2056	Hindi	2079	Maay	2102	Punjabi	2129	Urdu	2153
Berber	2029	Eskimo	2058	Hmong	2081	Malayalam	2103	Romanian	2130	Vietnamese	2154
Bosnian	2031	Estonian	2059	Hungarian	2082	Maltese	2105	Russian	2131	Visayan	2155
Bulgarian	2032	Farsi	2061	Ibanag	2083	Mandarin	2106	Samoan	2132	Yiddish	2158
Burmese	2033	Fijian (F)	2062	Ilocano	2085	Mandinka	2107	Serbian	2133	Zapotec	2160
Cambodian	2034	Fijian (H)	2063	Ilongot	2086	Marshallese	2109	Sicilian	2135	Zulu	2161

LANGUAGE PEOPLE

LANGUAGE IDENTIFICATION CARD

For service, call [redacted]

	Language
☐ أنا أتحدث اللغة العربية	Arabic
☐ Ես խոսում եմ հայերեն	Armenian
☐ আমী বাংলা কথা বলতে পারী	Bengali
☐ Ja govorim bosanski	Bosnian
☐ Аз говоря български	Bulgarian
☐ ကျွန်တော်/ကျွန်မ မြန်မာ လို ပြောတတ် ပါတယ်	Burmese
☐ 如果你能读中文或讲中文，请选择此框。	Cantonese Simplified
☐ 我講廣東話	Cantonese Traditional
☐ ខ្ញុំនិយាយភាសាខ្មែរ	Cambodian
☐ Parlo català	Catalan
☐ Motka i kahhon ya yangin ûntûngnu' manaitai pat ûntûngnu' kumentos Chamorro.	Chamorro
☐ Govorim hrvatski	Croatian
☐ Mluvím česky	Czech
☐ من دری حرف می زنم	Dari
☐ Ik spreek het Nederlands	Dutch
☐ من فارسی صحبت می کنم	Farsi

LANGUAGE PEOPLE

LANGUAGE IDENTIFICATION CARD

	Language
☐ Je parle français	French
☐ Ich spreche Deutsch	German
☐ Μιλώ τα ελληνικά	Greek
☐ હું ગુજરાતી બોલુ છુ	Gujarati
☐ M pale kreyòl ayisyen	Haitian Creole
☐ אני מדבר עברית	Hebrew
☐ मैं हिंदी बोलता हूँ ।	Hindi
☐ Kuv has lug Moob	Hmong
☐ Beszélek magyarul	Hungarian
☐ Agsaonak ti Ilokano	Ilocano
☐ Parlo italiano	Italian
☐ 私は日本語を話す	Japanese
☐ Quin chagüic´ká chábal´ ruin´ri tzújon cakchiquel	Kackchiquel
☐ 한국어 합니다	Korean
☐ man Kurdii zaanim	Kurdish
☐ man Kurmaanjii zaanim	Kurmanci
☐ ຂ້ອຍປາກພາສາລາວ	Laotian

LANGUAGE PEOPLE

Telephone System Instructions

1) Dial [redacted]
2) Tell the operator what type of service is needed:
    a. in person or telephone appointment
    b. when you need assistance (immediately or at a future date/time)
    c. in which language you need assistance

If at all possible, please schedule an appointment in advance. If you are in need of immediate assistance, you will experience a brief delay as Language People contacts an interpreter for you.

Conference Calls

If you need us to connect someone else onto the call for you, we can do multiple-party calls. Let the operator know, and this will be performed for you.

Ending Calls Before You Are Finished

When you are connected to one of our Interpreters, you will be told which Interpreter # you are speaking to. This # is the # inside our phone system of the individual you are speaking to. If, in the middle of your call, you have to end the call before your conversation is finished, you can dial back into the system and, when asked for the Language Code, you can enter the Interpreter #, and you will be transferred back to that individual *if they are available*. If that individual is not available to help you, your call will be routed to the Operator for assistance.

What To Do If You Have A Problem With A Phone Call

Telephone reception problems are extremely rare, but if you should experience call problems, please report them as soon as possible to our Operator. If you are done with your call, call back into the system and press 0 for the Operator and report the problem. If you are in the middle of the call and need to terminate, remember to obtain the Interpreter # and call back into the system using that #.

USING *LANGUAGE PEOPLE, INC.* PHONE INTERPRETERS

INCOMING CALL in any non-English language, ask, "What language do you speak?"_____. "One moment, please."
Then select ***CONF*** on the telephone screen (not *hold*), and call the Language People, Inc. [redacted] and follow the prompts: #2 for current customers (that's us), then #1 to request an interpreter.

Once you are connected:

- "I am calling from El Dorado County Public Health, our contract with you is # [redacted], our billing address is **3057 Briw Rd., Placerville, CA 95667**"
- "I need an over the phone interpreter in _____ [what language?] The call should take about [how many?] minutes."
- "The caller's first name is _____", **OR**, "I don't know the caller's name yet."

Wait for the interpreter to get on the phone. Jot *their* name here: _____

- Tell the interpreter, "We are a mental health agency; I think the caller is asking about our services. Now I am conferencing you in with the caller."
- Select ***JOIN*** on the telephone screen.
- Then continue the call, first making sure we get the *caller's* name and phone #. If the caller is requesting services, get the information needed to complete an AVATAR "Pre-Admit Request for Service":
  Name _____,_____ Phone # (___) _____
  Last First
  Birth Date _____ Medi-Cal insurance? YES NO
  _____
  Street Address City State ZIP
- Then say, "You will receive a call back from a counselor within 2 weeks. If you have a mental health emergency call, any time:
  WS (530) 622-3345 SLT (530)544-2219
- Make sure the caller's "Pre-Admit Request for Service" is entered into AVATAR.
- Hang up, you're done!

USING *LANGUAGE PEOPLE, INC.* PHONE INTERPRETERS

OUTGOING CALL to a non-English speaker.

If the individual is a Spanish speaker, consider asking an EDC MHD certified bilingual staff person to make the call. Bilingual staff extensions can be found at [redacted]. If none are available:

- phone the Language People, Inc. [redacted] and follow the phone prompts: #2 for current customers (that's us), then #1 to request an interpreter.

Once you are connected with Language People, Inc.:

- "I am calling from El Dorado County Public Health, our contract with you is # [redacted], our billing address is 3057 Briw Rd., Placerville, CA 95667"
- "I need an over the phone interpreter in _____"[what language?] The call should take about [how many?] minutes."
- "The caller's first name is _____. The caller's phone number is _____. My name is [_], and phone number is _____."
- "I'll wait for you to call me back with the interpreter and client conferenced in."

The Language People, Inc. staff will contact one of their interpreters, call the client, then conference those 2 with each other. They will then phone you back in order to have a 3-way conversation: you, the client, and the interpreter. Jot down the interpreter's name: _____.

- Tell the interpreter, "We are a mental health agency. I need to talk to this client about _____" [give the interpreter a general sense of what the content of the conversation will be.]
- Proceed with the business you have with the client.
- Hang up, you're done!

Language People, Inc. Contract Agreement [redacted]

*Over-the-Phone Interpreting **and** Face-to-Face Interpretation (including American Sign Language)*
This agency is bonded, and contractually obligated to treat all PHI within HIPAA regulations of confidentiality.

Exhibit C
Quality Improvement Work Plan

El Dorado County Health & Human Services Agency, Mental Health Division
Annual Quality Improvement Work Plan
Fiscal Year 2018-19

Measurable Goals in Red

The content and structure of this QI Work Plan is taken from the MHP's contract with the State Department of Health Care Services (DHCS).

1. Quality Improvement

QI Directive	Goal	Responsible parties	Auditing Tool	Goal Assessment Date
a. MHP will evaluate effectiveness of QI program annually	Complete QI Year-End Report for FY 17-18	• MH Director • Assistant Director of Adult Services • Deputy Director of Behavioral Health • QI Committee Members • QI Program Manager • UR Coordinator	• QI Committee Minutes	Nov. 2019
b. Consumers and family member shall have substantial involvement in QI activities and MHSA planning	Ensure that the QI Committee includes at least one consumer and one family member.	• QI Committee Members • QI Program Manager • UR Coordinator • MHSA Coordinator	• QI Committee Sign-In Sheets and Minutes • MHSA Sign-In Sheets, Comment Forms, and Minutes	Ongoing through June 2019
c. QI Activities shall include collaboration & exchange of information with MHSA stakeholders and MH Commission	Ensure QI representation at MHSA stakeholders' and MH Commission meetings; report progress to QI Committee	• MH Director • Assistant Director of Adult Services • Deputy Director of Behavioral Health QI Program Manager • UR Coordinator • MHSA Coordinator • QI/UR Staff • MHSA Staff	• QI Committee Minutes	Ongoing through June 2019

2. Performance Improvement Projects (PIPs)

QI Directive	Goal	Responsible parties	Auditing Tool	Goal Assessment Date
a. Two QI activities shall meet the criteria for Performance Improvement Projects (PIP), one clinical and one non-clinical	**PIP #1 GOAL (non-clinical):** Place an Access Team Clinician at the Community Health Center (CHC) office for up to one day per week (or as otherwise appropriate based upon the number of referrals) to increase the number of referrals that meet medical necessity. **PIP #2 Goal (clinical):** Develop a Brief Model of Care program for adults that encourages clients to develop the skills needed to live independently in the community without developing a reliance upon the support of the MHP.	• QI Program Manager • UR Coordinator • QI/UR Staff • Appointed PIP Committees • Outpatient Managers • Outpatient Teams for implementation	• EQRO Auditing Tool and "Road Maps to a PIP"	PIP #1 December 2019 PIP #2 March 2018

3. Service Delivery and Capacity

QI Directive	Goal	Responsible parties	Auditing Tool	Goal Assessment Date
a. MHP will describe and monitor data to ensure capacity	MHD will use AVATAR reports to monitor crisis and access trends. Management Team to review data regularly to ensure adequate resource allocations.	• QI Program Manager • UR Coordinator • MHP Leadership Team	• AVATAR Reports • Leadership Team meeting minutes	Ongoing through June 2019
b. Ensure capacity and timeliness for consumers with urgent conditions	Consumers presenting in person or on the telephone with urgent MH conditions will be served within 24 business hours of request (excludes Psychiatric Emergency Services).	• Front Desk Staff • Worker of the Day Staff • UR Clinicians • UR Coordinator • QI Program Manager	• AVATAR "Request for Service" report	Ongoing through June 2019

QI Directive	Goal	Responsible parties	Auditing Tool	Goal Assessment Date
c. Ensure capacity and timeliness	A triage assessment with consumers requesting MH services will be conducted within 10 business days of request	• UR Clinicians • Front Desk Staff • UR Coordinator • QI Program Manager	• AVATAR "Request for Service" report	Ongoing through June 2019
d. Ensure capacity and timeliness	Consumers requesting a psychiatric evaluation appointment will be seen by a psychiatrist within 15 business days of request	• MH Medical Director & Staff Psychiatrists • Management Team • UR Clinicians • UR Coordinator • QI Program Manager	• AVATAR report	Ongoing through June 2019
e. Ensure capacity and timeliness	Beneficiaries will have access to after-hours care via telephone, clinic and/or at the hospital emergency department 100% of the time (after hours defined as outside 8:00 am to 5:00 pm, Monday through Friday)	• PES Managers • PES Clinicians • ICM Teams • UR Clinicians • UR Coordinator • QI Program Manager	• AVATAR report • Contractor reports	Ongoing through June 2019

4. Accessibility of Services

QI Directive	Goal	Responsible parties	Auditing Tool	Goal Assessment Date
a. Ensure access lines answered by front-desk staff are providing linguistically appropriate services to callers	Outcome of Test Calls will demonstrate 100% success in accessing a bilingual staff or "Language People" for non-English speaking callers	• UR Coordinator • QI/UR Staff	• Test Calls with outcomes logged	Ongoing through June 2019
b. Ensure the accessibility to medically necessary after-hours care	Beneficiaries will have access to after-hours care via telephone and/or at the hospital emergency department 100% of the time (after hours defined as outside 8:00 am to 5:00 pm, Monday through Friday)	• PES Managers • PES Clinicians • Contract Providers	• AVATAR report • Contractor reports	Ongoing through June 2019

QI Directive	Goal	Responsible parties	Auditing Tool	Goal Assessment Date
c. Ensure time and distance standards are met	• For psychiatry, travel time and distance shall not exceed 45 miles or 75 minutes • For other outpatient Specialty Mental Health Services, travel time and distance shall not exceed 45 miles or 75 minutes	• UR Coordinator • QI/UR Staff	• AVATAR report • Geographic mapping program (e.g., ArcGIS)	Ongoing through June 2019

5. Program Integrity

QI Directive	Goal	Responsible parties	Auditing Tool	Goal Assessment Date
a. MHP shall have a process to verify services reimbursed by Medi-Cal were actually furnished to beneficiaries	The service verification tool was implemented July 2013. 100% of services verified were confirmed by client. Corrective action will be taken with staff 100% of the time if indicated.	• UR Coordinator • Admin Support Staff • QI Program Manager • Management Team	• Service Verification Log	Ongoing through June 2019

6. Cultural and Linguistic Competency

QI Directive	Goal	Responsible parties	Auditing Tool	Goal Assessment Date
a. MHP shall ensure services are provided in culturally and linguistically competent manner	MHD will provide at least four trainings annually to build cultural competence; at least one will address client culture and family member perspectives	• Management Team • Cultural Competency Manager	• Training Attendance Log & Outlines/Handouts	Ongoing through June 2019
b. MHP shall ensure services are provided in culturally and linguistically competent manner	HHSA will certify bilingual and cultural competence of all staff receiving bilingual compensation	• EDC Personnel Unit	• HR report	Ongoing through June 2019

QI Directive	Goal	Responsible parties	Auditing Tool	Goal Assessment Date
c. MHP shall update the Cultural Competence Plan (CCP) and submit these updates to DHCS for review and approval annually	CCP shall be updated in compliance with State issued requirements.	• MHSA Coordinator	• CCP • DHCS Notices	December 2018

7. Beneficiary Satisfaction

QI Directive	Goal	Responsible parties	Auditing Tool	Goal Assessment Date
a. MHP shall monitor and Evaluate Beneficiary Satisfaction	MHD shall administer the Consumer Perception Surveys at least twice annually or at other intervals specified by the State.	• Admin Support Staff • Front Desk Staff • Consumers / Family of Consumers (for children) • Organizational Providers • UR Coordinator	• Consumer Perception Survey issued by DHCS, supported by CIBHS or other contracted vendor	November 2018 / May 2019, or per the timeline set by the State.
b. MHP shall inform service providers of the results of beneficiary/family satisfaction activities	MHD will report results of Consumer Perception Surveys to MHD staff and contracted organizational providers	• Admin Support Staff • UR Coordinator • QI Program Manager	• All-Staff meeting minutes • CBO meeting minutes • Emails	Generally twice per year, after the data from the previous Consumer Perception Survey becomes available and is analyzed

QI Directive	Goal	Responsible parties	Auditing Tool	Goal Assessment Date
c. MHP shall evaluate beneficiary Grievances, Appeals, Expedited Appeals, State Hearings, Expedited State Hearings, and change of provider requests	MHD will track and trend programmatic or staffing issues identified in Grievances, Appeals, Expedited Appeals, State Hearings, Expedited State Hearings, and Requests for Change of Provider, identifying and correcting any indications of poor quality of care.	• UR Coordinator • Patients' Rights Advocate • MHSA Coordinator • Management Team	• Tracking logs • QIC Minutes • Management Team Minutes • Mental Health Commission minutes	Ongoing through June 2019

8. Service Delivery System and Clinical Issues Affecting Consumers

QI Directive	Goal	Responsible parties	Auditing Tool	Goal Assessment Date
a. MHP shall implement mechanisms to monitor safety and effectiveness of medication practices	MHD will develop a Med Monitoring Committee which will be charged with oversight of the safety and effectiveness of outpatient medication practices	• MH Medical Director • Assistant Director of Health Services • Community Public Health Nursing Division Manager • QI Program Manager • UR Coordinator	• Med Monitoring Committee minutes	Ongoing (quarterly meetings) through June 2019
b. MHP shall conduct performance outcome monitoring activities.	MHD has selected the CANS and ANSA as the instruments to measure treatment outcomes. Use will begin when the tool have been built into AVATAR.	• UR Coordinator • Avatar System Specialist • QI Program Manager • MHP Leadership Team	• AVATAR report comparing baseline data to data collected at regular intervals	Ongoing through June 2019
c. MHP shall ensure that progress notes are timely.	MHD's standard for note completion: by end of business, the day following delivery of the service. GOAL: standard will be met 80% of the time.	• UR Coordinator • Avatar System Specialist • QI Program Manager • MHP Leadership Team	• AVATAR timeliness report	Ongoing through June 2019

QI Directive	Goal	Responsible parties	Auditing Tool	Goal Assessment Date
d. MHP shall monitor clinical issues affecting consumers	Continue to develop AB 109 program, targeting MH consumers involved in the criminal justice system. GOAL: Improvement in MH recovery and decrease in criminal justice system recidivism	• AB 109 Manager, Program Coordinator and Clinical Staff	• QIC meeting minutes	Ongoing through June 2019

9. Interface with Physical Health Care

QI Directive	Goal	Responsible Parties	Auditing Tool	Goal Assessment Date
a. MHP shall make clinical consultation and training available to beneficiaries' primary care providers (PCP)	MHD will provide training to PCPs at the FQHC on an as requested basis. MHD will also develop a protocol for standardizing and tracking psychiatric/PCP consultation.	• MH Medical Director • Assistant Director of Health Services • FQHC Medical Director • QI Program Manager • UR Coordinator	• Training sign-in sheet and outline/handouts	Ongoing through June 2019

10. Utilization Management

QI Directive	Goal	Responsible Parties	Auditing Tool	Goal Assessment Date
a. MHP shall evaluate inpatient medical necessity appropriateness and efficiency of services provided to beneficiaries prospectively and retrospectively	100% of all out-of-county Hospital Treatment Authorization Requests (TAR) shall be completed within 14 days of receipt of request.	• UR Coordinator • Admin Support Staff • QI Program Manager • Crisis Clinicians	• TAR Log • Crisis Assessment Report	Ongoing through June 2019

QI Directive	Goal	Responsible Parties	Auditing Tool	Goal Assessment Date
b. MHP shall evaluate medical necessity appropriateness and efficiency of outpatient services provided to beneficiaries prospectively and retrospectively.	At the time of authorization or re-authorization of services with contracted organizational providers, the MHP will assure medical necessity is established 100% of the time for Specialty MH services. At the time of annual Treatment Plan renewal, the MHD will assure medical necessity is established in MHD-served consumers 100% of the time before approving the Treatment Plan.	• UR Clinical Staff • QI Program Manager • MH Program Coordinators • UR Coordinator • Avatar System Specialist	• Avatar reports; assessment reviews; service authorization requests	Ongoing through June 2019
c. MHP shall comply with timeliness when processing of submitting authorization requests for children in foster care or Kin-Gap living outside county of origin	100% of authorizations for Out-of-County children shall be completed within 3 calendar days from the receipt of the original Service Authorization Request (SAR). If complete additional information is requested and not received within 14 days from the date of receipt of the original SAR, the MHD shall complete the SAR within 3 business days from the date the complete additional requested information is received.	• UR Clinical Staff • QI Program Manager • UR Coordinator	• Managed Care Authorization Binder	Ongoing through June 2019

11. Provider Relations

QI Directive	Goal	Responsible parties	Auditing Tool	Goal Assessment Date
a. MHP has ongoing monitoring system in place that ensures contracted providers sites are certified and recertified as per Title 9 regulations	MHD will certify and re-certify all contracted provider sites meeting 100% compliance in the following manner: • Within state required time frames of a new contracted provider or if current contracted provider changes/adds locations, certifications will be performed as needed to maintain compliance with current state requirements. • Re-certify every 3 years thereafter.	• Fiscal Staff	• Certification Protocol from DHCS	Ongoing through June 2019
b. Monitor Provider Satisfaction	MHD will conduct as-needed meetings of MHD senior management and Contract Provider Management.	• MH Director • Assistant Director of Health Services • QI Program Manager • UR Coordinator	• CBO meeting minutes	Ongoing through June 2019
c. Monitor FSP Reporting	100% reported timely.	• FSP Report Monitors • UR Coordinator	• State website • Tracking document	Ongoing through June 2019
d. Monitor Provider Appeals	MHD will track and trend issues identified in Provider Appeals.	• UR Coordinator • MHSA Coordinator • Management Team	• Tracking Logs • QIC Minutes • Meeting Minutes	Ongoing through June 2019