El Dorado County

Health and Human Services Agency

Behavioral Health Division

CULTURAL COMPETENCE PLAN

Fiscal Year 2025-26

"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

Substance Use Disorder Services (SUDS) Office and Clinic
929 Spring Street
Placerville, CA 95667
Phone (530) 621-6290
Fax (530) 295-2596

South Lake Tahoe Mental Health Office and Clinic
1900 Lake Tahoe Boulevard
South Lake Tahoe, CA 96150
Phone: (530) 573-7970
Fax: (530) 543-6873

West Slope Mental Health Office and Clinic
768 Pleasant Valley Road, Suite 201
Diamond Springs, CA 95619
Phone: (530) 621-6290
Fax: (530) 295-2565

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 (CLAS) 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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Introduction

The Cultural Competence Plan (CCP) Requirements, as detailed in Department of Mental Health (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. Please note that El Dorado County Behavioral Health Services includes both Mental Health (MH) and Substance Use Disorder Services (SUDS). As we move forward with a more integrated Behavioral Health System, we are including both MH and SUDS in this and subsequent years CCP updates.

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 Behavioral 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.

A. Copies of the following documents to ensure the commitment to cultural and linguistic competence services are reflected throughout the entire system:

1. Mission Statement

   HHSA

   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.

   Behavioral Health

   To deliver coordinated, timely, trauma-informed, culturally-responsive mental health and substance use disorder treatment services that promote wellness, recovery, resiliency, and positive outcomes.

2. Statements of Philosophy – in lieu of a Statement of Philosophy, our department and division Vision Statements are as follows.

   HHSA

   Transforming lives and improving futures

   Behavioral Health

   To provide exemplary community-based mental health and substance use disorder treatment, in collaboration with the Public Guardian, and other partner agencies, within a coordinated, cost-effective system of care.

3. Strategic Plans

   The HHSA Strategic Plan can be found online at: https://www.edcgov.us/Government/hhsa/Pages/strategic_planning.aspx.

4. Policy and Procedure Manuals

   See Appendix B

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 current MHSA Three-Year Program and Expenditure Plan and the County's respective MHSA Annual Updates can be found online on the BHD's MHSA Page at: https://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.

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, queer, intersex, pansexual, two-spirit (2S), androgynous and asexual (LGBTQQIP2SAA) 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.

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 current Community Planning Process is included in the current MHSA Plan and 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

As a part of El Dorado County, Behavioral Health's commitment to the ongoing improvement of culturally competent services, the division's cultural competence committee formalized its Charter. The committee meets quarterly to review data, identify needs, and plan initiatives to develop an increasingly culturally competent network to ensure the perspective, participation and inclusion of individuals, parents, caregivers, and families across the lifespan, who are members of diverse racial, ethnic, SOGI and cultural communities are significant factors in all EDC Behavioral Health decisions and recommendations.

One of El Dorado's most vulnerable populations, LGBTQ+ youth and adults, often suffer as a result of non-supportive or even hostile environments in their homes, schools and communities. Research demonstrates that LGBTQ+ individuals who do not have access to LGBTQ+-affirming community environments are at higher risk for negative outcomes, including early high-school dropout, homelessness, negative mental health symptoms, increased substance use, suicide and physical, emotional and/or sexual abuse. To create a more LGBTQ+ affirming space and services, El Dorado staff from Behavioral Health attended a "Train the Training" sexual orientation, gender identity, and expression (SOGIE) training in October 2022, after which, staff worked with Care TA to develop a comprehensive training curriculum for El Dorado County. SOGIE trainings will be provided to all Behavioral Health staff and contracted provider staff over multiple trainings.

Throughout the year, Behavioral Health staff may also 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
- Continuum of Care

- El Dorado County Commission on Aging
- Community Mental and Behavioral Health Cooperative
- Stepping Up Initiative
- Practicing Cultural Competency – Mental Health & Substance Use Disorder Treatments for Native

C. Share lessons learned on efforts made on the items B and C 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.

All County Contractors and subcontractors are required by law and held accountable by signed contract to comply with Federal Equal Opportunity Requirements and non-discrimination laws.

In addition, El Dorado County implemented Drug Medi-Cal Organized Delivery System (DMC-ODS) services June 1, 2019. The DMC-ODS system provides a continuum of care modeled after the American Society of Addiction Medicines (ASAM) Criteria for substance use disorder treatment. This service system enables more local control of services provisions to tailor them to more closely meet the diverse needs of our community. This service system enables more local control of service provisions to tailor services to more closely meet the diverse needs of our clients. Additionally, this system provides greater administrative oversight, creates utilization controls to improve care and efficient use of resources, implements evidenced-based practices in substance abuse treatment, and coordinates with other systems of care.

In recognition of the importance of cultural and linguistic competence within the DMC-ODS system, El Dorado County SUDS requires all network providers to:

- Ensure their policies, procedures, and practices are consistent with the principles outlined and are embedded in the organizational structure, as well as being upheld in day-to-day operations.
- Translation services shall be available for beneficiaries, as needed.

- Ensure equal access to quality care by diverse populations, each service provider receiving funds shall adopt the federal Office of Minority Health Culturally and Linguistically Appropriate Service (CLAS) national standards and comply with 42 CFR 438.206(c)(2).
- Ensure that the Client's primary spoken language and self-identified race and ethnicity are included in the CalOMS AVATAR system, the Provider's management information system, as well as any Client records used by provider staff.

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 a Manager of Mental Health Programs 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.

The CC/ESM is part of our Cultural Competence Team collectively working towards establishing an official division Cultural Competence Committee.

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 25/26 Budget**
Interpreter*	$4,500
Latino Outreach	$340,000
Wennem Wadati - A Native Path to Healing	$97,750
Community Stigma Reduction Project	$85,000
Veterans Outreach	$146,625

* 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).

In addition, BHD training funds are available for cultural competence trainings.

Criterion 2, Updated Assessment of Services Needs

I. General Population

Based on the 2023 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 2023 estimated demographic data, the County's current population is 194,425.

Race	Number	Percent of Total Population
American Indian or Alaska Native	2039	1.05%
Asian	9,947	5.12%
Black or African American	1,407	0.72%
Native Hawaiian or Other Pacific Islander	288	0.15%
White or Caucasian	146,113	75.15%
Multiracial	24,571	12.64%
Other Race	10,060	5.17%

Ethnicity	Number	Percent of Total Population
Hispanic or Latino	28,176	14.49%
Non-Hispanic or Latino	166,249	85.51%

Language Spoken in the Home (over the age of 5 only)	Number	Percent of Total Population
English Only	162,553	87.56%
Spanish	12,167	6.55%
Other Indo-European Languages	4,633	2.50%
Asian and Pacific Island Languages	5,514	2.97%
Other Languages	786	0.42%

Age	Number	Percent of Total Population
Under 5 years	8,772	4.51%
5 to 9 years	9,627	4.95%
10 to 14 years	11,070	5.69%
15 to 17 years	7,114	3.66%
18 to 20 years	6,356	3.27%
21 to 24 years	8,216	4.23%
25 to 34 years	19,100	9.82%
35 to 44 years	22,145	11.39%
45 to 54 years	23,396	12.03%
55 to 64 years	31,887	16.40%
65 to 74 years	29,244	15.04%
75 to 84 years	12,751	6.56%
85+ years	4,747	2.44%

Gender	Number	Percent of Total Population
Female	97,757	50.28%
Male	96,668	49.72%

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

Please note that unless specifically referenced as “SUDS” or “includes SUDS”, the data refers to MH only.

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 MH client utilization data**

El Dorado County Medi-Cal Approved Claims Data - Calendar Year 2017				
	Average Number of Eligibles per Month	**Number of Beneficiaries Served per Year**	**El Dorado County Penetration Rate**	**Statewide Penetration Rate**
Total	37,339	1,311	3.51%	4.86%
Age group				
0-5	4,011	35	0.87%	2.23%
6-17	8,726	402	4.61%	6.88%
18-59	19,563	797	4.07%	5.06%
60 +	5,041	77	1.53%	2.90%
Gender				
Female	19,464	647	3.32%	4.48%
Male	17,876	664	3.71%	5.31%
Race/Ethnicity				
White	22,452	876	3.90%	6.73%
Hispanic	7,097	157	2.21%	4.08%
African-American	309	21	6.80%	8.49%
Asian/Pacific Islander	1,004	10	1.00%	2.26%
Native American	269	16	5.95%	7.50%
Other	6,210	231	3.72%	5.01%
Eligibility Categories				
Disabled	4,204	353	8.40%	15.29%
Foster Care	356	130	36.52%	51.91%
Other Child	8,348	272	3.26%	5.20%
Family Adult	5,539	177	3.20%	3.31%
Other Adult	3,574	20	0.56%	0.74%
MCHIP	4,108	86	2.09%	4.43%

ACA	11,764	362	3.08%	4.30%

3. County's DMC-ODS Utilization Data

DMC-ODS Table 1: Penetration Rates by Age, CY 2020

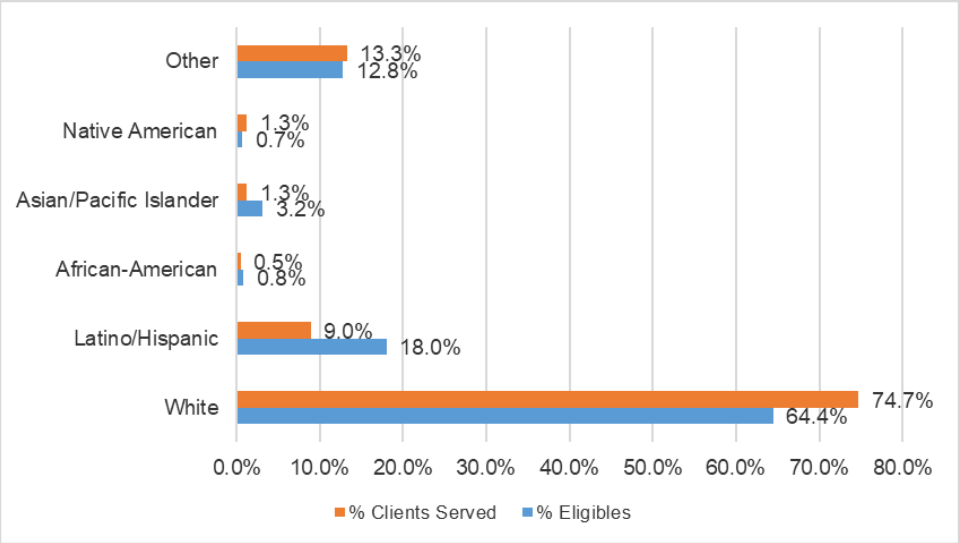
El Dorado				Small Counties	Statewide
Age Groups	Average # of Eligibles per Month	# of Beneficiaries Served	Penetration Rate	Penetration Rate	Penetration Rate
Ages 12-17	4,504	*	n/a	0.23%	0.25%
Ages 18-64	22,286	361	1.62%	1.01%	1.26%
Ages 65+	3,110	*	n/a	0.37%	0.77%
TOTAL	**29,900**	**391**	**1.31%**	**0.81%**	**1.03%**

DMC-ODS Table 2: Penetration Rates by Race/Ethnicity, CY 2020

El Dorado				Small Counties	Statewide
Race/Ethnicity Groups	Average # of Eligibles per Month	# of Clients Served	Penetration Rate	Penetration Rate	Penetration Rate
White	19,263	292	1.52%	1.14%	1.96%
Latino/Hispanic	5,383	35	0.65%	0.56%	0.69%
African American	254	*	n/a	0.78%	1.34%
Asian/Pacific Islander	951	*	n/a	0.16%	0.17%
Native American	221	*	n/a	0.70%	1.84%

Other	3,830	52	1.36%	0.73%	1.41%
TOTAL	**29,902**	**391**	**1.31%**	**0.81%**	**1.03%**

DMC-ODS Table 3: Percentage of Eligibles and Beneficiaries Served by Race/Ethnicity, CY 2020



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

Age Group

Mental Health Services

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. Additionally, the County's Mental Health Services Act (MHSA) Plan and Annual Updates maintain a Prevention and Early Intervention (PEI) program for "Children age 0-5 and their Families" with an organization that specializes in providing services to the young. As such, services provided through that organization would not be reflected through Medi-Cal claim data.

Consistent with Statewide findings, the highest penetration rates occur for beneficiaries age 6 through 59.

The El Dorado County penetration rate for ages 6-17 is lower than the Statewide average, however the County has introduced a new access point for high school students through the use of school-based community partner for the West Slope. The South Lake Tahoe high school also has developed its own school-based model. Additionally, the County has become a partner in the "Unite Us" referral system in South Lake Tahoe, and it is anticipated that referrals for youth may increase through this community-based referral system.

Beneficiaries age 18-59 represent the great number of beneficiaries in the county and the penetration rate is slightly lower than statewide average. The County continues to explore the reasoning for this, but some impacts are the result of:

- Strong primary care providers with a behavioral health unit (e.g., Shingle Springs Health and Wellness, El Dorado County Community Health Center, Barton Clinic); and

- Rural nature of much of El Dorado County without public transport.

Beneficiaries age 60+ also have a penetration rate lower than State average. To help ensure access to services for this group, the MHSA Plan and Annual Updates include an Innovation program to partner with the Senior Nutrition program to engage older adults who utilize the home-delivered meal program or the congregate meal sites and a PEI program to engage older adults. The start of this program has been on hold as a result of the federal and State COVID-19 precaution mandates since two key program activities - services in the home and at congregate meal sites - have been severely impacted by the precautions. Congregate meals are not being served at this time, and social distancing has been strongly encouraged for all individuals.

This lower penetration rate for older adults could also be due to historic concerns as noted in 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%

Substance Use Disorder Services

El Dorado County DMC-ODS served 391 beneficiaries in CY 2020. El Dorado's penetration rates were higher than small-sized counties and statewide averages. The overall penetration rate of 1.31 percent was higher than small-sized counties (0.81 percent) and the Statewide average (1.03 percent). Penetration rates for Age Group 12-17 and 65+ were unable to be calculated due to suppression of the data in accordance with HIPAA guidelines. The need to suppress data, however, indicates rates far lower than the 18-64 age range.

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	19,464	647	3.32%	4.48%
Male	17,876	664	3.71%	5.31%

Race/Ethnicity

Mental Health Services

Consistent with Statewide findings, the access of the Latino population is lower than white Medi-Cal beneficiaries in El Dorado County.

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 (2019)	*unknown*	*unknown*	4.08%	*unknown*	6.73%	0.61
EDC (2019)	37,339	157	2.21%	876	3.90%	0.57
EDC (2018)	38,329	160	2.22%	934	4.03%	0.55
EDC (2017)	39,331	142	1.95%	860	3.53%	0.55
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
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

[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 (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. However, the County continues to work towards developing a contract for Specialty Mental Health Services with the local Tribal provider, Shingle Springs Health and Wellness.

Substance Use Disorder Services

DMC-ODS Tables 2 displays penetration rates by race/ethnicity compared to counties of like size and statewide rates. Based on CY 2020 data, penetration rates for Latin/Hispanic beneficiaries at 0.65% were far lower than the county's rates for White beneficiaries 1.52%. The County's penetration rates for Latino/Hispanic beneficiaries were higher than the average of small counties at 0.56% but lower that the Statewide average of 0.69%. The number of clients served for African American, Asian/Pacific Islander, and Native American were small and suppression rules applied.

Eligibility Categories

Mental Health Services

It is difficult to determine why the El Dorado County and Statewide penetration rate varies so significantly 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" rather than through a referral to County Mental Health.

Additionally, clients who participate in MHSA PEI activities are generally not included in CAEQRO data. In El Dorado County, PEI 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.

Further, with the implementation of the Affordable Care Act, many individuals seek mental health services through their primary care provider and/or their Managed Care Plan rather than through the County. This is evidenced by the reduction in the number

of requests for services annually since the expansion of Medi-Cal eligibility in 2014 until FY 2019-20, when the referrals began increasing again.

It is suspected that the reason for the increase in the number of referrals starting in FY 2019-20 is due to a number of factors, including implementation of Student Wellness Centers, increased collaboration with Child Welfare Services, and increased referrals from other healthcare providers. Although COVID precautions were implemented in quarter 4 of FY 2019-20, there was not a significant impact (reduction in referrals) immediately as a result of those precautions.

The decrease in the number of referrals in FY 2020-21 is believed to be a direct result of COVID-19 impacts. During the height of the quarantine from July 2020 and into 2021, individuals were not seeking services at the same levels as the previous year.

Fiscal Year (FY)	Number of Requests for Services	Percent Change from Prior Year
2014-15	1,852	--
2015-16	1,607	-13.2%
2016-17	1,406	-12.5%
2017-18	1,337	-4.9%
2018-19	1,322	-1.1%
2019-20	1,593	20.5%
2020-21	1,478	-7.2%
2021-22	1,642	11.1%

The County continues to monitor potential reasons for this decrease.

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	2,107	1.1%
Asian	8,533	4.5%
Black or African American	1,902	1%
Native Hawaiian and Other Pacific Islander	368	0.19%
White or Caucasian	160,312	84%
Multiracial	8,590	4.5%
Other Race	8,269	4.3%

Ethnicity	Number	Percent of Total Population
Hispanic or Latino	24,951	13.1%
Non-Hispanic or Latino	165,130	869%

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

Age	Total	Percent of County
Under 5	8,998	4.69%
5 to 9	9,669	5.04%
10 to 14	11,261	5.87%
15 to 17	7,425	3.87%
18 to 20	6,715	3.50%

Age	Total	Percent of County
35 to 44	20,413	10.64%
45 to 54	25,593	13.34%
55 to 64	33,746	17.59%
65 to 74	25,094	13.08%
75 to 84	10,379	5.41%

21 to 24	8,844	4.61%
25 to 34	19,473	10.15%

85 and Over	4,221	2.20%

Children 0 to 20 comprise 22.97% of the population and adults age 65 and over comprise 20.69% 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

El Dorado County Average Median Income	$83,377

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 Outpatient Clinic Client Utilization FY 2020-21	**Countywide Population[3]** (regardless of Medi-Cal eligibility)	**Penetration Rate** (not Medi-Cal specific)
Age Group			
Child and Youth (0-17)	270	36,982	0.7%
Transitional Age Youth (18-24)	96	14,939	0.6%
Adult (25-64)	458	98,222	0.5%
Older Adult (65+)	21	43,508	0.0%
Race			
American Indian or Alaska Native	17	2,108	0.8%
Asian	6	9,468	0.1%
Black or African American	23	1,936	1.2%
Native Hawaiian or Other Pacific Islander	--	376	--
White	461	162,337	0.3%
Unknown / Other / Multiracial	507	17,426	2.9%
Ethnicity			
Hispanic or Latino	107	26,116	0.4%
Non-Hispanic or Latino	592	167,535	0.4%

[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. April 2013.

[3] https://www.welldorado.org/demographicdata?id=246&sectionId=942, Demographics information provided by Claritas, updated January 2021.

Unknown/Declined to State	286	--	--
Primary Language[4]			
English	871	161,410	0.5%
Spanish	11	15,152	0.1%
Other/Declined to State	103	8,167	1.3%

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

By age group, the MHSA CSS penetration rate for children (aged 0 to 17 years) continues to be the highest among all age groups, however the CSS programs are only one of several programs that provide services to children and youth in El Dorado 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, once implemented, will provide mobile outreach, with services 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 8.2% of the language preference in the County for individuals above age 5. However, the penetration rate for individuals identifying as Hispanic or Latino is higher than the penetration rate for those who are not Hispanic or Latino.

[4] Ages 5+ who speak language at home.

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, queer, intersex, pansexual, two-spirit (2S), androgynous and asexual (LGBTQQIP2SAA) 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.

- 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.

- "Student Wellness Centers and Mental Health Supports at El Dorado Union High School District Sites," is a collaboration with school district psychological and nursing staff and other community-based organizations, to provide students with greater access to mental health services.

- "Outreach and Engagement Services" includes a program in the South Lake Tahoe area to assist homeless individuals with a serious mental illness to engage in services and secure housing, funded through the federal program "Projects for Assistance in Transition from Homelessness" or "PATH".

Criterion 3, Strategies and Efforts For Reducing Racial, Ethnic, Cultural and Linguistic Behavioral 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 (either the parents or the children)	x	x	x	x
Untreated mental illness leading to academic failure	x	x		x
Stressed families	x	x		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		x
Insufficient numbers of bilingual, bicultural Spanish-speaking providers and peers	x	x	x	x
Unstable housing		x		x
Native American Population:				
Lack of cultural awareness from providers	x	x	x	x
Lack of trust of governmental agencies	x	x	x	x

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		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	x
Transportation challenges		x		x
Stigma	x	x	x	x
Not receiving the FSP level of care	x	x		
Transition Age Youth:				
Newly found independence	x	x		
Stigma	x	x	x	x
Co-occurring disorders	x	x	x	x
Limited mental health service engagement	x	x		
Unstable housing		x		
Older Adults:				
Transportation	x	x		x
Cost	x	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		x
LGBTQQIP2SAA population:				
Lack of local culturally specific resources	x	x	x	x
Co-occurring disorders	x	x		x
Stigma	x	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		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.

Disparity	Strategies
Untreated mental illness leading to academic failure	The CSS projects, Full Service Partnership and Student Wellness Centers, along with the PEI projects of Student Wellness Centers, Children 0-5 and Their Families, Mentoring, Parenting Skills, Primary Intervention Project (PIP), and Juvenile Justice Services 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, Full Service Partnership, and Wennem Wadati focus on strengthening family resiliency and reducing family stresses.
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 eligible individuals.

Disparity	Strategies
Native American Population:	
Lack of cultural awareness from providers	PEI Wennem Wadati - A Native Path to Healing and the Workforce Education and raining projects address this issue.
Lack of trust of governmental agencies	The PEI project Wennem Wadati - A Native Path to Healing address this issue.
Foster Care Youth:	
At risk of out of home placement or higher level of placement	The CSS Full Service Partnership, and Transitional Age Youth Services, as well as the PEI Foster Care Continuum address these issues.
Disproportionately at risk of homelessness and criminal justice involvement	The CSS Full Service Partnership, Transitional Age Youth Services, the PEI Foster Care Continuum Training and the Juvenile Justice Services 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 Services, as well as the PEI Foster Care Continuum 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 Services, as well as the PEI Foster Care Continuum 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 and Mentoring for Youth programs 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 receiving the FSP level of care	The CSS Full Service Partnership program addresses the need for 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, 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), as well as Outreach and Engagement, reach out to those with limited engagement.
Unstable housing	The CSS projects 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. Additionally, PEI Older Adult programs utilizing the Mobility Van to assist with transportation.
Cost	PEI Older Adults programs address 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 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 include providing information to providers of physical healthcare services.

Disparity	Strategies
Provider issues	PEI, CSS and Innovation projects 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 Latino Outreach Workforce Education and Training
Isolation	The PEI, CSS and Innovation projects, including Adult Full Service Partnership, Outreach and Engagement Services, Community Based Mental Health Services, Assisted Outpatient Treatment, PEI Older Adult Programs, and Senior Nutrition Collaboration all address the issue of isolation.
LGBTQQIP2SAA population:	
Lack of local culturally specific resources	The PEI project Community Stigma Reduction Project addresses this issue.
Co-occurring disorders	The PEI project Community Stigma Reduction Project 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 Community Stigma Reduction Project addresses the additional stigma the LGBTQQIP2SAA community experiences.
Parents:	
Their own mental health needs	The PEI projects of Community Outreach and Linkage, Mental Health First Aid, Community Stigma Reduction Project, and Community Outreach and Linkage address these issues.
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.

Disparity	Strategies
Lack of education regarding mental health	PEI Parenting Skills, Mental Health First Aid, Community Stigma Reduction Project, 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 and MHSA Housing address housing for those at risk.
Homeless individuals/families:	
Homeless / unstable housing	CSS Outreach and Engagement program, including PATH, provides linkage to available housing options. This includes CSS programs, MHSA Housing and transitional housing for eligible individuals.
Co-occurring disorders	PEI Community Outreach and Linkage, and service integration with Substance Use Disorder Services, 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.
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.

Both the SUDS and MH Quality Improvement Work Plans include 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.

- The collaboration between Mental Health and Child Welfare Services has significantly improved, and a member of the County's Access Team attends collaborative meetings regularly to ensure timely access to Mental Health services.

- 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 entire State has experienced difficulty in hiring Clinicians, 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 and ratified a new MOU for the Local 1 union that the majority of MH and SUDs employees are part of. This included salary increases and increased geographical differential pay. This 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 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 Behavioral 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 has a group of 5 staff that meet monthly regarding Cultural Competence matters. The group completed a committee charter and begun holding committee meetings in August 2023.

The Cultural Competence Committee meets at least 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 serves 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 Quality Improvement Committee (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 Behavioral Health Commission.

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 or attended by BHD staff include:

- The Immigrant Experience Ethnicity and Families
- Exploring Cultural Awareness Sensitivity and Competence
- The Influence of Culture and Society on Mental Health

Cultural competence training for BHD staff will continue to cover the seven required areas on a rotating basis.

Additionally, the Cultural Competence Group is exploring options for Sexual Orientation and Gender Identity Expression (SOGIE) training in order for the BHD's staff to gain the skills to better communicate this type of information requests to clients. The BHD worked with Care TA to develop a comprehensive two part training curriculum.

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.**

Cultural Competence Training FY 2024-2025
for Current Staff of Behavioral Health Division
(Substance Use Disorder Services and Mental Health)

Training Event	Description of Training	# of Hours	Attendance by Staff Function	# of Attendees	Date of Training	Training Organization
Counseling Lesbian Gay, Bisexual and Transgender (LGBT) Clients v.2	This course utilizes information from the American Counseling Association, the American Psychological Association, as well as research by well-known and respected professionals in the fields of counseling and psychology. This course is designed as a beginners experience in learning about Lesbian, Gay, Bisexual, and Transgender clients and in no way is considered to be the summative of all knowledge in working with this population.	**1**	Direct Services: 7	**7**	*various dates*	myLearningPointe.com
Cultural Competence: The Immigrant Experience, The Impact of Migration on Families	Latinos in the United States constitute a significant and sizable population that mental health professionals must serve appropriately. In her book, Latino Families in Therapy, our speaker in this interview, Dr. Celia Falicov, writes that, "Even when freely chosen, the transition of migration is replete with loss and disarray –there is loss of language, separation from loved ones, the intangible emotional vacuum left in the space where "home" used to be, the loss of community, and lack of understanding of how jobs, schools, banks, or hospitals work. Immigrants are rendered vulnerable, isolated, and susceptible to individual and family distress." She states that it is impossible to do cross-cultural work without critical cultural and sociopolitical self-awareness on the part of the practitioner, and refers to the term, "Cultural Humility" to describe what this takes.	**1**	Administration: 7 Direct Services: 10	**17**	*various dates*	myLearningPointe.com
Cultural Competence: The Immigrant Experience, The Legal Hoops of	Family reunification has stood as a central pillar of the US Immigration system. However, immigration laws have implications that go well beyond actual admissions. These laws not only determine who is allowed to immigrate and through which channels, but they also shape the composition of immigrant families and, by doing so, they affect immigrant	**1**	Administration: 4 Direct Services: 8	**12**	*various dates*	myLearningPointe.com

Immigration	households' economic opportunities and their ability to integrate into American society. In principle, our immigration law recognizes the right of US citizens and lawful permanent residents to be reunited with close family members born abroad. However, a closer look at the actual impact of current immigration laws on families reveals that many legal provisions of the laws threaten this reunification.					
Crisis Response Strategies for Adult Individuals with Intellectual and/or Developmental Disabilities (I/DD)	**Part 1** builds a foundation by defining I/DD, exploring common co-occurring conditions, and examining how crisis may present across diverse identities, communication styles, and cultural contexts. Learners will gain trauma-informed and culturally responsive assessment strategies to promote calm, safety, and connection. **Part 2** deepens this foundation with practical tools to support children, youth, and families with I/DD throughout a crisis. The course highlights identity-specific and intersectional approaches, and concludes with best practices for stabilization, care coordination, and mobile crisis follow-up	**2**	Direct Services: 4	**4**	*various dates*	Medi-Cal Mobile Crisis Technical Assistance Center
Crisis Response Strategies for Children, Youth, and Families, Including Intellectual/Developmental Disabilities (I/DD)	This is a recording of the fifth and final training in M-TAC's five-part series designed to support mobile crisis teams in delivering culturally appropriate care to California's diverse communities. Focusing on children, youth, and families, this training video equips mobile crisis responders with essential tools and strategies for supporting young people and their caregivers during mental health crises. Drawing on deep community experience and subject matter expertise, the session recording emphasizes family systems, culturally responsive communication, and family-centered approaches to care.	**2.5**	Direct Services: 5	**5**	*various dates*	Medi-Cal Mobile Crisis Technical Assistance Center

Collaborative, Culturally Responsive Crisis Safety Planning	This training introduces the essential components of person-centered crisis safety planning for mobile crisis team members. Participants will learn to use the M-TAC Safety Planning tool to co-create safety plans that are personalized, culturally relevant, and actionable. Through seven structured steps, this course emphasizes trauma-informed and collaborative approaches that support individuals in crisis to exercise voice and choice, reduce access to lethal means, and identify meaningful reasons for living.	**3**	Direct Services: 12	12	*various dates*	Medi-Cal Mobile Crisis Technical Assistance Center
Introduction to Culturally Responsive Crisis Care for Tribal and Urban Indian People	This course supports mobile crisis teams and supervisors to employ culturally responsive interventions when working with Tribal and Urban Indian people across California. Participants will increase their knowledge of culturally responsive crisis intervention and de-escalation techniques and practice applying this knowledge through case study scenarios. The course delves into the complexities of how to deliver mobile crisis services in a community that has been colonized and oppressed for generations. It provides an overview of the systemic and historical factors unique to these communities and highlights the importance of integrating Native perspectives, structures, and traditions with mobile crisis services. Participants will learn to apply National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Tribal and Urban Indian communities.	**2**	Direct Services: 9	9	*various dates*	Medi-Cal Mobile Crisis Technical Assistance Center

Introduction to Culturally Responsive Crisis Care for Diverse Communities	This training will provide mobile crisis team members with knowledge and practical skills on culturally responsive intervention and de-escalation skills with community members from a wide range of cultural, and socioeconomic backgrounds, racial and ethnic identities, gender identities, and abilities, etc. Culturally responsive crisis response is not only best practice but an ethical imperative, especially critical in consideration of the richly diverse communities of California. Topics include how the intersectionality of race, class, gender, culture, and community history can result in social inequality and complex crisis engagement; role of cultural identities in the presentation of crisis response symptoms; application of culturally and linguistically appropriate services (CLAS) standards and culturally responsive techniques in mobile crisis response; and skill development in culturally responsive and strength-based crisis intervention and de-escalation strategies.		Administration: 1 Direct Services: 10	11	*various dates*	Medi-Cal Mobile Crisis Technical Assistance Center

Cultural Competence: The Immigrant Experience, Ethnicity and Families	The domain of clinical practice currently faces a crisis of competence and conscience in the treatment of those clients whose ethnicity, race, or class renders them minority groups in American society. Even with the best of intentions and belief in our own objectivity/impartiality, we unwittingly, even unconsciously impose presumptuous interpretations and interventions on clients' lives. So, we shouldn't be shocked to learn that ethnic minority groups are the smallest users of mental health services. Furthermore, when these groups do use treatment, they show the highest premature termination rate of any social group. Something is wrong here! Our clinical training programs need to step up to this challenge. Latinos in the United States constitute a significant and sizable population that mental health professionals must serve appropriately. In her book, Latino Families in Therapy, our speaker in this interview, Dr. Celia Falicov, writes that, "Even when freely chosen, the transition of migration is replete with loss and disarray –there is loss of language, separation from loved ones, the intangible emotional vacuum left in the space where "home" used to be, the loss of community, and lack of understanding of how jobs, schools, banks, or hospitals work. Immigrants are rendered vulnerable, isolated, and susceptible to individual and family distress."	**1**	Administration: 5 Direct Services: 8	**13**	*various dates*	myLearningPointe.com

Culture Counts: Mental Health Care	Culture, Race and Ethnicity was written as a supplement to Mental Health: A Report of the Surgeon General (U.S. Department of Health and	**2**	Direct Services: 7 Administration: 2	**9**	*various dates*	myLearningPointe.com

for African Americans	Human Services [DHHS], 1999). It documents the existence of striking disparities for minorities in mental health services and the underlying knowledge base. Racial and ethnic minorities have less access to mental health services than do whites. They are less likely to receive needed care. When they receive care, it is more likely to be poor in quality.					

Culture Counts: Mental Health Care for Asian Americans and Pacific Islanders	Culture, Race and Ethnicity was written as a supplement to Mental Health: A Report of the Surgeon General (U.S. Department of Health and Human Services [DHHS], 1999). It documents the existence of striking disparities for minorities in mental health services and the underlying knowledge base. Racial and ethnic minorities have less access to mental health services than do whites. They are less likely to receive needed care. When they receive care, it is more likely to be poor in quality.	**2**	Direct Services: 5 Administration: 1	**6**	*various dates*	myLearningPointe.com
Culture Counts: Mental Health Care for Hispanic Americans	Culture, Race and Ethnicity was written as a supplement to Mental Health: A Report of the Surgeon General (U.S. Department of Health and Human Services [DHHS], 1999). It documents the existence of striking disparities for minorities in mental health services and the underlying knowledge base. Racial and ethnic minorities have less access to mental health services than do whites. They are less likely to receive needed care. When they receive care, it is more likely to be poor in quality.	**2**	Administration: 2 Direct Services: 4	**6**	*various dates*	myLearningPointe.com
Culture Counts: The Influence of	This course documents the existence of striking disparities for minorities in mental health services	**2**	Administration: 7 Direct Services: 14	**21**	*various dates*	myLearningPointe.com

Culture and Society on Mental Health	and the underlying knowledge base. To better understand what happens inside the clinical setting, this chapter looks outside to reveal the diverse effects of culture and society on mental health, mental illness, and mental health services. This understanding is key in developing mental health services that are more responsive to the cultural and social contexts of racial and ethnic minorities.					
Culture Counts: Mental Health Care for American Indians and Alaska Natives	Culture, Race and Ethnicity was written as a supplement to Mental Health: A Report of the Surgeon General (U.S. Department of Health and Human Services [DHHS], 1999). It documents the existence of striking disparities for minorities in mental health services and the underlying knowledge base. Racial and ethnic minorities have less access to mental health services than do whites. They are less likely to receive needed care. When they receive care, it is more likely to be poor in quality.	**2**	Administration: 3 Direct Services: 13	**16**	*various dates*	myLearningPointe.com

Diversity in the Workplace	This course is about diversity in our workplace. With a global economy and living in a multiethnic state, you will have diversity within your organization and among your clients. This course is designed to help you recognize diversities in your work environment. Some diversity issues or categories are protected by the Federal laws such as the Civil Rights Act, the Age Discrimination in Employment Act, the Americans with Disabilities Act, and others. Some diversity issues are not necessarily specified by law but do fall under ethical behavior within the workplace. This course is not about you requiring you to change your values and morals, rather it is about	**1**	Administration: 5 Direct Services: 9	**14**	*various dates*	myLearningPointe.com

	helping you see where you can act to make your workplace an accepting place to for everyone and celebrate each person's diversity.					
Improving Cultural Competency for Behavioral Health Professionals	Participants will be able to Describe how culture, cultural identity, and intersectionality are related to behavioral health and behavioral health care. Describe the principles of cultural competency and cultural humility. Discuss how our bias, power, and privilege can affect the therapeutic relationship. Discuss ways to learn more about a client's cultural identity. Describe how stereotypes and microaggressions can affect the therapeutic relationship. Explain how culture and stigma can influence help-seeking behaviors. Describe how communication styles can differ across cultures. Identify strategies to reduce bias during assessment and diagnosis. Explain how to elicit a client's explanatory model.	**5**	Direct Services: 11	**11**	*various dates*	U.S. Department of Health & Human Services

LGBTQ+ Identities 201: Going Beyond Understanding to Empowering	This training expands on LGBTQ+ terminology and improves skills in cultivating welcoming spaces. Participants will learn how to more profoundly support the LGBTQ+ individuals. This training discusses how you can move beyond simply understanding LGBTQ+ identities and experiences to actively dispelling myths, undoing harm and empowering LGBTQ+ individuals and communities.	**1**	Administration: 3 Direct Services: 2	**5**	September 10, 2024	National Council on Mental Wellbeing
Military Culture Part 1: An	This is the first of four modules giving you an introduction to working with current and former	**1**	Administration: 1	**1**	June 19,	myLearningPointe.com

Introduction to the United States Armed Forces	United States military members. Many civilians have a preconceived notion of what the mindset is of persons in the military. When working with veterans or current military members you must work to understand where they are at with their values, ideals, and experiences. This module informs you about the basic mentality of those who serve as members of the military as a whole and also the mission, creed, motto, ethos and values of each branch of the military. This course is intended for any professional who will be working with veterans, current military members, or military family members.				2025	
Military Culture Part 2: Formalities of the Military	Module 2 of the Military Culture course acquaints you with the hierarchy of the military organization and the types of duties or jobs a person might have in the military. It is helpful when working with veterans or active duty military personnel to understand the hierarchy. All branches of the military are steeped in traditions. These include customs, courtesies, and ceremonies. While each branch has its own traditions, this module discusses some of the common traditions for all branches that you may see expressed by your clients or their families.	**1**	Administration: 1	**1**	June 27, 205	myLearningPointe.com
Military Culture Part 4: Providing Help	In this module we discuss why many in the military are reluctant to seek treatment and resources available to them through the military organization. To assist behavioral health professionals in working with service members, we review "Cultural Vital Signs," a publication of the Department of Defense (DoD) and the Department of Veterans Affairs (VA) which provides direction	**1**	Direct Services: 2	**2**	*various dates*	myLearningPointe.com

	for eliciting information from your military clients. This module also provides an overview of the guidance available from the DoD, the VA, and the Substance Abuse and Mental Health Services Administration (SAMHSA) for best practices and evidence-based programs and practices.					
What is Cultural Humility? The Basics.	Cultural humility is a practice of self-reflection on how one's own background and the background of others, impact teaching, learning, research, creative activity, engagement, leadership, etc.	**1.5**	Administration: 8 Direct Servies: 10	**18**	*various dates*	myLearningPointe.com

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

Staff recruitment and retention is a key component of the BHD's WET component. The MHP is participating in the Central Region's partnership for implementation of the California Department of Health Care Access and Information WET program, with the County's primary focus on Loan Repayment and Retention.

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 contracts 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).

- 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 which resulted in a slight salary increase, but the County's salary schedule remains lower than surrounding counties.

The County continues to offer a bilingual differential of $1.00 per hour for staff who are certified in Spanish, and included the following message on recruitments for Behavioral Health:

> *The ability to speak and read Spanish in addition to English would be an asset and preferred in this position, but is not required. Applicants for English/Spanish bilingual designated positions must take and pass the bilingual proficiency examination administered by the County of El Dorado and, if successful, become eligible for a pay differential of $1.00 per hour. The differential is defined by the Memorandum of Understanding between the County of El Dorado and the Bargaining Unit representing this job classification.*

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 four Behavioral Health 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 $4,500.

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.

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 "Beneficiary Handbook", offered 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. This document is also available on the BHD's website and in the clinic lobbies.

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 slightly increased the salary of many classifications.

- Some LEP clients may have limited or poor reading skills, thus the BHD is exploring the use of videos or screen reader capability through Adobe 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.

III. 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.
- The BHD contracts with language line providers to assist clients with any interpreter needs at no charge to the clients.

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 may 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. In the event bilingual staff are unable to provide translation, contracted providers may be used to translate documents.

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 continues the ongoing process of reviewing written materials to ensure materials are at an appropriate reading level.

Criterion 8, County Behavioral 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

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: Community Stigma Reduction Project

This project supports differences, builds 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 and will be implemented once COVID precautions are lifted or reduced.

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: Community-Based Outreach and Linkage, including the Psychiatric Emergency Response Team (PERT) and South Tahoe Area Collaborative Services (STACS)

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.

Similarly, STACS operates in the South Lake Tahoe area and is a collaborative between Behavioral Health staff, law enforcement, other first responders, medical providers, community-based organizations, and schools to provide field-based services when necessary to address urgent needs in the community.

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 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 Behavioral 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.

Additionally, Behavioral Health maintains a list of hotlines and warmlines for community members should they wish to speak with someone who better aligns with their needs. The resource list can be accessed at https://edcgov.us/Government/MentalHealth/behavioral-health-resources.

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	South Lake Tahoe, Tahoma

Behavioral Health offices are in Diamond Springs and South Lake Tahoe. 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

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