

**Summary of El Dorado County Mental Health Service Challenges
Identified in the May 2021 I.D.E.A. Consulting Behavioral Health
System Analysis, Evaluation, and Recommendations Report
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The following items are organized by recommendation. The recommendations to address these challenges can be found in the report.

Recommendation 1

- Inconsistent management and staffing
- Limited teamwork communication and collaboration

Recommendation 2

- Unorganized crisis services
- High number of individuals in crisis services
- Delays in crisis response

Recommendation 3

- Inefficient access to children's services
- No standardized referral method
- Insufficient access to child/youth specialty mental health services
- Limited services in the schools and community
- High number of children in crisis services

Recommendation 4

- Insufficient access to routine adult specialty services

Recommendation 5

- Limited timely and coordinated mental health response
- Limited crisis services across the county including South Lake Tahoe

Recommendation 6

- Poor coordination and communication across access system
- After hours crisis answering services does not operate during business hours

Recommendation 7

- Limited benefit enrollment activities to ensure completion and resolution of issues.

Recommendation 8

- Limited cultural and linguistic competency
- Limited outreach to underserved populations

Recommendation 9

- Fragmented children's system of care
- Limited oversight and coordination across services and providers
- Unclear medical necessity criteria

Recommendation 10

- Fragmented adult system of care
- Limited oversight and coordination
- Limited outpatient clinical services
- Limited integrated services for dual diagnosis clients
- Limited peer run services, respite, supported housing, and Board and Care resources.

Recommendation 11

- Fragmented outpatient services
- Few outpatient services for the majority of adult clients
- Limited additional resources in the community

Recommendation 12 and 13

- Insufficient oversight of intensive/inpatient services
- High number of administrative days in the Psychiatric Health Facility
- High number of conservatorships
- Limited systemic response to those discharged
- Limited ongoing case management

Recommendation 14

- Inconsistent use of evidence based treatment models
- Limited data on outcomes

Recommendations 15 and 16

- Limited employment of persons with lived experience

Recommendation 17

- Cultural Competency Plan not updated in several years
- Staff not trained on cultural responsiveness to different populations

Recommendation 18

- Outpatient clinics are not welcoming

Recommendation 19

- Limited involvement of clients and families in the delivery system

Recommendation 20

- Limited/unclear communication with psychiatrists

Recommendation 21

- Limited effective and efficient referral processes

Recommendation 22

- Insufficient quality management system
- Insufficient outpatient service authorizations and utilization review
- Insufficient inpatient/intensive service authorizations and utilization review
- Limited timely data at Quality Improvement committees
- Limited cultural/linguistic responsiveness across the delivery system
- Insufficient monitoring of fiscal expenditures and monitoring cost effectiveness
- Quality Improvement programs' roles and functions are not clear
- No structure to obtain feedback from clients, families and providers
- Need to restructure Quality Improvement to include a continuous Quality Improvement process