Targeted Capacity Expansion:

Technology-Assisted Care(TCE-TAC)

RFA # TI-11-0023

CSAT QUARTERLY PROGRAMMATIC

REPORT

Program Reporting Period:

July-September, 2014 Program Reporting

TCE-Technology Assisted Care (TAC)
SAMHSA/CSAT
1 Choke Cherry Road, Room 5·1055
Rockville, MD 20850

1. Reporting Period: 1-1-2014/6-30-2014

2. RFA #: TI-11-0023

3. Grantee: 1H79TI023803-01

4. Provider Site(s):

Provider Site Name	Address	Contact Person	Phone/Email
Promesa Behavioral Health, Inc.	7475 N Palm, Ste 107 Fresno, CA 93711	Mandi Reed	559-439-5437 mreed@promesabehavioral.org
St. Agnes Holy Cross Center for Women	421 F Street Fresno, CA 93706	Sister Mary	559-237-3379
Visalia Recue Mission	322 NE 1st Avenue Visalia, CA 93291	Kirk Mills	559-733-2231
Project Director	7475 N Palm, Ste 107 Fresno, Ca 93711	Herbert A Cruz, M.D.	559-439-5437 hacruzmd@sbcglobal.net
Addiction Counselor	Visalia Rescue Mission Visalia, CA	Jessica Ramos-Taylor	559-283-9778 jtaylor@promesabehavioral.org

5. Project Director: Herbert A. Cruz, M.D. ; 559-439-5437; hacruzmd@sbcglobal.net

6. Evaluator: Carol L. Scroggins, Ed.D.

7. Evaluator Phone/Email: 559-439-5437/ cscroggins@promesabehavioral.org

8. Signature _____ 11-6-14

Project Director Signature Date

8. List any changes in key staff contact information here: No changes in staff occurred in this reporting period.

Staff Member	Add/Loss	Effective Date	Email	Phone

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BACKGROUND

Provide the abstract from your grant application. Specify all technologies being used in the project and any changes from the initial application.

TOADS (Telecare Outpatient Alcohol and Drug Services), the program services have operated from the main office of Promesa Behavioral Health's headquarters in Fresno, California. The local network encompasses a geographical area of Madera County to the north to Tulare County to the south, with the centralized data center supporting network connections to the project sites. Although this reflects the geographic extent of the local network, the catchment area for program is the entire State of California, as Promesa Behavioral Health presently receives client referrals from 35 of 58 California counties. Additional equipment was installed at the Fresno Promesa Data Center where all video and data circuits terminate, and from where the network is maintained. The network hub includes ISDN lines and secure high speed Internet connections so that Telepsychiatry services can be set up with off-net, non-direct connected locations. Project Director, Herbert A. Cruz, M.D. continues to supervise the telecare treatment services and conduct diagnostic interviews and ongoing medication management with clients.

TOADS is providing voluntary evaluation, assessment, intake and telecare treatment to individuals who are experiencing acute psychiatric distress related to substance abuse. Promesa has been providing telecare based treatment services since 2009, when we established its telecare services to provide telepsychiatry to clients who were outside our headquarters service area in Fresno, California. The intent of telecare was to eliminate the possibility of boundary concerns for an already sensitive population. Promesa has established bilingual/bicultural expertise in providing services to children and adolescents, transitional aged youth, LGBTQ, registered sex offenders, and the full spectrum of mental illness, including co-occurring disorders and substance abuse. The technology-based program reaches areas without direct mental health services, such as rural communities as well as those regions of the Central Valley from which travel represents a significant commitment in time. This project's aim is to provide innovative and secure videoconferencing technology that creates an interaction between families, clients, various judicial systems and the treatment facility to enhance treatment and reduced costs for all involved parties.

PROJECT IMPLEMENTATION

Project Goals and Objectives

Provide status reports of all current project goals and objectives, including lessons learned and best practices using the technologies.

Goal: *Increased availability of community resources for substance abuse and co-occurring disorders treatment through telecare counseling*
Status: Staff have provided presentations and in service trainings to community based organizations which have accelerated referrals for clients into the telecare program. As staff conducts presentations and increases the visibility of telecare throughout the community, referrals have also increased from a wider variety of community resources. We have established an interagency relationship with Hannah's House in Kings County.
Goal: *Increased knowledge of telecare as an option for treatment by community based organizations whose clients would benefit from substance abuse treatment*
Status: Staff has launched a web-based presentation of the overall benefits of the TOADS program, thus freeing up staff time that is consumed in presentation preparation, travel, setup, in-service training/presentations, and follow up. A virtual presentation enables staff to connect interested CBOs (community based organizations) to this time-saving resource, ensure consistent information is provided, with referral options. We have seen an substantial increase in questions through our website portal.
Goal: *Increased referrals from health care providers and community based organizations to telecare treatment for their clients*
Status: Client referrals from community based organizations are increasing. We have received referrals from the Community Regional Medical Centers, the Fresno County Department of Behavioral Health, Champions Recovery Alternative and we have added a residential treatment program for women in Kings County, Hannah's House; we are providing additional treatment services to their clients. Staff has observed a trend of self-referrals. These are coming from existing clients who discuss their excitement about telecare with family and friends. Additional self referrals are also resulting from client searches of Promesa's website which discusses TOADS and how to access services.
Goal: *Increased success of recovery for substance abusers through the use of telecare supported treatment as a result of more frequent sessions*

Status: We have conducted intakes on 106 clients to date.
Goal: *Increased number of community sites dedicated to providing telecare access points*
Status: Presently, we have 4 distal sites available to clients for telecare access points; clients with smartphones may opt to use their own device for accessing treatment. Staff has negotiated an additional distal location Kings County at Champions Recovery Alternative. Irrespective of the access point, clients are provided with an initial assessment of their personal technology assets (for example: do they own an iPhone, iPad or other smart device, what is the extent of their data plan, their comfort level with various types of messaging (texting, email, IM, voice). This technology overview allows the counseling staff to develop individualized training plans for each client in using their technology to access the Addiction Counselor. Clients are offered access to Technology 'how tos' on our website, which assists with equipment diagnostics and assessment, suggestions for software upgrades and improving their equipment's connectivity with the counseling staff. For clients who do not possess a "smart device" or laptop computer, then clients are encouraged to use the established distal sites to meet their telecare appointments. Staff ensures that each client learns how to use the distal equipment.
Goal**:** *Increased willingness of health care providers to refer clients with substance abuse to telecare for treatment*
Status: Staff has continued to build relationships with health care providers. Hannah's House staff have been very receptive to learning more about telecare substance abuse treatment, as well as engaging with our Addiction Counselors to ensure the enhanced services to their patients. Our primary Addiction Counselor, Jessica Ramos-Taylor, lives in Tulare County and often meets with clients from her home office, as does the registered intern, Georgina Crisanto who resides in Tulare County.
Goal: *Increased client participation in telecare treatment for substance abuse, resulting in reduced waiting lists for treatment, especially for isolated rural clients*
Status: our outreach to rural communities includes speaking with medical providers in rural communities (such as the Valley Health Team Clinics, United Health of the San Joaquin Valley), rural community based organizations (such as Centro la Familia Advocacy Services) and the Parent Engagement Centers of the County Office of Education as well as community colleges such as Fresno, Tulare and Merced Adult Schools. We are also listed in local '211' directories operated by local United Ways.

Goal *Increased client completion of treatment through telecare counseling*
Status: Of the active clients (31), 22 have not yet reached six months.
Goal: *Increased willingness of health care providers to refer clients with substance abuse to telecare for treatment*
Status: We have seen an increase in referrals from health care providers, particularly the largest medical provider in the region – Community Regional Medical Centers as well as Fresno County's Department of Behavioral Health, along with Champions and Hannah's House in Kings County
Goal: *Increased use of staff time for substance abuse providers through reduced travel time to meet the needs of isolated rural clients*
Telecare is working well for staff who meet with clients either through distal services or personal technology with few clients seen in on-site vis-à-vis counseling. Promesa's full time addiction staff provides 40 hours of telecare services each week; one part time staff along with 1 intern who provides from 10-20 hours of services each week.

Status Toward Goals

If you are falling short in meeting any project objectives, please explain and provide your plan for catching up. Include anticipated date of resolution.

At the present, we have not met the goals set forth in our original proposal. Currently, we are disappointed that we are not where we anticipated we would be in terms of client enrollments. We submitted a Post Award Change Request to reduce client numbers from the projected 240 annually to 160. TOADS management staff has sought TAC assistance to further this request. The agency will formally request a further reduction for Year 3. Our Program Manager, Mandi Reed is currently on medical leave. When she returns to duty in mid-November, 2014, we will formally make this request of our assigned Program Officer.

If you changed any project goals or objectives (including GPRA targets) during the reporting period, state the changes, the date changes were approved and how the approval was transmitted.

We requested changes to project goals in terms of the overall client load for the year. Pending discussion with SAMHSA staff on this request, we enacted no changes to the program's objectives during this reporting period.

If you intend to request approval of changes in any project goals or objectives during the next reporting period, state the changes and the reasons for wanting to make them. (Remember that you need prior approval from SAMHSA to make these changes.)

With Year Two completed, we have learned that our original, optimistic projections of client enrollments has not kept pace with the reality of client intakes. We requested a Post Award Change in January, 2013. In that request, we requested at 58% reduction in client intakes. That request is still pending. As Year Two has concluded, even though client intakes have been increasing (to an average of 3 per week), we will be requesting a Post Award Change dialogue with our Program Officer. The reason for this request is to bring our original estimate down to match the service level we are actually providing.

In Year 3, our intent is to focus upon sustainability of the program beyond the grant funding. We have taken several steps already to meet this objective. One is to adopt an agency-wide E H R program that will enable all staff to upgrade skills and recordkeeping, as well as be in alignment with meeting ACA requirements when those are fully implemented by 2016.

Along with that staff continues to evaluate every client for their eligibility for third party payment, either through MediCal, expanded MediCal or other public/private insurance.

ORGANIZATION AND MANAGEMENT

Personnel

List all positions supported by the grant, filled and vacant.

Position Title	Incumbent Name	Percent Time
Project Director	Herbert A Cruz, M.D.	50
Director, Substance Abuse Division	Tejal Patel, LMFT	5
Program Manager	Amanda Reed, M.S., LMFT	50
Addiction Counselor	Jessica Ramos-Taylor,M.S.	100
Addiction Counselor	Courtney Babcock	50
Technology Consultant	John Kasdorf	5
Evaluation Consultant	Carol Scroggins, Ed.D.	18
Counseling Intern	Georgina Cristano, M.S., MFT Intern	15

List staff additions or losses including contractors/consultants within the reporting period.

Staff/Contractor Position Title	FTE	Date Change Occurred	Addition or Loss

Discuss the impact of personnel changes on project progress and strategies for minimizing negative impact.

We made no staff changes during this reporting period.

Discuss obstacles encountered in filling vacancies (if any); strategies for filling vacancies and anticipated timeline for having positions filled.

Partnerships

List each of the partner organizations.

Partner
Community Regional Medical Centers, Fresno, California
Hannah's House, Hanford, California
Fresno County Department of Behavioral Health, Fresno California
St. Agnes Holy Cross Center for Women, Fresno, California
Visalia Rescue Mission, Visalia, California
Fresno American Indian Health Program, Fresno, California
Community Regional Medical Center
Valley Health Team, Kerman, California
St. Paul Newman Center, Fresno, California
Champions Recovery Alternative, Hanford, California

Describe significant changes in relationships and/or working arrangements and summarize the implications of the change**.**

TOADS staff continues to enhance its relationships with existing collaborative partners, while creating new partnerships. The only change in this reporting period was adding an additional organization to our partnerships –Hannah's House, a residential treatment center in Hanford, California in Kings County. Participants in that program can come from Kings, Tulare, or Kern Counties, but only those Medi-Cal beneficiaries from Kings County are eligible to receive services from the local Community Mental Health facility.

Training and Technical Assistance (TA)

Describe staff development activities, including orientation and training for this reporting period. Staff did not participate in any specific training for this reporting period.

Staff Development Activity	Date	Number of Participants	Training Provider

If you received technical assistance from a SAMHSA TA provider, describe it.

Type of TA Received	Date	Purpose of Assistance	TA Provider	Additional Assistance Planned for this Issue

If you plan any training or TA activities for the next reporting period, describe the topic and anticipated audience.

PERFORMANCE INFORMATION

GPRA Performance

As close to the last day of the reporting period as possible, check your official GPRA statistics on the SAIS webpage. Complete the table below. Enter the cumulative numbers (from beginning of the grant) from the SAIS reports.

Date on which reporting quarter data was obtained: September, 2014

	Target	Actual	%	Target	Actual	%
Intakes (Baseline)	*Example: 10* 560	*15* 105	*150%* 18.8	*0* *186*	*0* 11	*0%* .8%
6-Month Follow	*Example: 0* *22*	*0* *0*	*0%* 28%	*0* *22*	*0* *0*	*0%* 0

If your intake or follow-up percentages are below 80 percent, please explain and state your plan for reaching your targets.

Our plan to increase referrals, intakes and thus active clients includes adding three new approaches to our outreach plan.

One component of this plan remains our continued efforts to create closer ties with the jail system, drug courts and probation departments to provide services to potential clients in the justice system. We plan to continue to provide in-service training to the staff of both the Department of Social Services and the Department of Behavioral Health regarding the program and how it can continue to be of benefit to the clientele served by these Fresno County departments. Similar in-service trainings will be offered to staff of neighboring counties (Madera, Kings, Tulare and Mariposa). Staff is developing an online presentation to facilitate these trainings and alleviate the preparation and travel time to make these out calls. A presentation in Mariposa County, for example, would be an all day endeavor.

Two, staff and our technology consultant have developed and launched a web-based presentation for interested agencies and for clients, along with apps, a client portal and web-based meetings.

Three, TOADS staff decided to add virtual group counseling to our program offering. This was implemented in the Spring of 2014, to positive feedback from participants. A further improvement to the program included the purchase of 'HotSpots' to enhance connectivity for clients who do not have internet services. These hotspot devices will enable clients to participate in the program using their own technology and the hotspot device, available to clients on a 'check out' basis. The HotSpots ensure connectivity for clients in areas of weak broadband signaling.

If your count of the number of target or actual persons served (intakes) through your grant or your follow-up rates differ from those shown in your GPRA report, specify and account for the differences. Identify steps taken to seek assistance, if needed, to remedy the discrepancy.

We are not reporting differences with GPRA.

Evaluation

Describe evaluation activities, progress made/action steps, and changes during the reporting period.

Our evaluator, Dr. Scroggins, is highly involved in our program. She reviews the client files at intake, 6 month review and discharge. This approach enables insights into quality improvement and program direction in telecare as a treatment delivery system. She also provides ongoing insights into quality improvement.

For example, one insight offered during this reporting period is that the longer the intake 'takes' (that is, the more time a counselor dedicates to the client, establishing rapport in the intake), the more likely the client is to follow thorough for the initial six month duration of the program. Intakes that seem to occur quickly, the more likely the client is to drop out of the program quickly. Counseling staff has begun to document the length of time of intakes as well as the context of the intake (in person, by phone or by Web-Ex). Our intent is to gather information about the intake process and to see if there may be a connection between the intake process and commitment to treatment.

Note any changes to the evaluation plan for this period, and document that GPO approval was received prior to the implementation of the changes.

We made no changes to the evaluation plan.

Provide as an attachment the most recent documentation of evaluation findings outside GPRA reporting. Indicate if there are no new evaluation findings from last reporting period.

The year end evaluation report is attached.

Discuss any problems encountered in conducting the evaluation, the impact of these problems on the evaluation and on the overall project, and plans for resolving the problems.

We have had no difficulties in conducting evaluation.

Discuss how evaluation findings were used to improve the project.

We used information to offer an experimental virtual group session. It was very well received by clients. Additionally, evaluation information is integrated in our reflective practice during weekly staff meetings.

Attach any written evaluation reports received during the period. Indicate if there are no new evaluation reports from the last reporting period.

An evaluation report will be submitted in the next reporting period.

Interim Financial Status

Attach an updated program budget and any budget modifications.

Financial Status

Attach an updated program budget and any budget modifications.

Instructions for completing the following budget worksheet:

- Double click on the worksheet to activate the Excel function
- The spreadsheet has been pre-formulated, but you must first enter (1) your total grant award, (2) all direct costs, and (3) total indirect costs
- Once you have entered the requested fields, click outside of the spreadsheet to exit

Note:

- Please report total expenditures (not obligations) on the budget worksheet
- Include all expenses accrued since the last reporting period and cumulative expenses accrued over the course of the grant period
- In the 'Total Grant Award' cell, please enter the total amount of grant funding you have received since the initiation of the grant
- The 'Remaining Balance' cell will automatically subtract total cumulative expenditures to date from the total funding amount

Direct Costs:		
Staff Salaries	$ 24,617.12	$ 160,254.12
Fringe Benefits	$ 3,675.73	$ 29,216.73
Contracts	$ 21,210.00	$ 191,130.00
Equipment	$ -	$ -
Supplies	$ 153.66	$ 3,003.66
Travel	$ -	$ 7,679.00
Facilities	$ 5,992.82	$ 54,298.82
Other Direct Costs: (please identify below)		
	$ -	$ -
	$ -	$ -
	$ -	$ -
Total Direct Costs:	$ 55,649.33	$ 445,582.33
Total Indirect Costs:	$ 7,385.13	$ 44,503.13
Total Expenditures (Sum of Direct and Indirect Costs):	$ 63,034.46	$ 490,085.46
Remaining Balance (Based on Total Grant Award):		**$ 349,914.54**

Other Significant Project Activities

Discuss any notable project activities, events, or other issues that occurred during the reporting period not previously described. Describe any problems that emerged, the effect it had on the project and steps taken or planned to overcome the barrier.

No major activities occurred in this reporting period.

Attach a copy of the project's policies and procedures.

attached below

Attach copies of any publications in professional journals or presentations about your project during the reporting period. Indicate if there have been no publications or presentations since the last reporting period.

no publications occurred during the reporting period

LIST OF ATTACHMENTS

List each attachment separately here and attach to the back of this report.

Attachment 1: Policies and Procedures

Attachment 2: Cultural Competency Policy

Attachment 3:

Attachment 4:

Attachment 5:

Attachment 6:

Attachment 7:

Attachment 8:

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Attachment 9:

1. **Protect Participants and Staff from potential Risks**
   a) As with any delivery of human services there is risk of physical, psychological, social and legal action. Staff has been trained to identify these risks and to respond accordingly. There does not seem to be any risks related to this project in general, only the day to day risk of doing business as a substance abuse treatment provider.
   b) We have standard and accepted policies in place to maintain the integrity and safety of our participant's health and well being. Stall has been trained in non-violent intervention, 42 CFR policy and procedures, HIPAA compliance and crisis intervention. We take all of these issues various seriously and will not release any information related to any participant unless a signed authorization detailing the specific nature of the release is on file.
   c) We provide both written and face to face technical support to each person, individually, should there be an even related to these risks. In the event we are unable to resolve the issue, we refer our participants to a mediation and/or arbitration organization to assist our participants to come to an independent resolution.
   d) Promesa Behavioral Health has a strategic alliance with United Health Centers, a Federally Qualified Health Center, to address any physical and/or medical issues that might arise for our participants. We also have strategic alliances with the mental health departments of each of the counties included in the project (Kings, Tulare, Madera and Fresno) as well as independent mental health services agencies that will assist us if any psychological or social issues that arise which might become a barrier to the telecare treatment we are proposing to implement in this project.
   e) We take great pride in our relationships with the service providers in our communities and have active inter-agency referral networks.

2. **Fair Selection of Participants**
   a) This program is available to all adult residents in the Counties identified in the proposal who are seeking treatment for substance abuse issues.
   b) Participants must be a minimum of 18 years of age to enroll. There are no restrictions on gender or racial/ethnic background.
   c) Participants may be homeless, pregnant, or with disabling conditions.
   d) In general, participants with a prior history of violent or sex offenses may not be considered eligible for participation, however, these are evaluated on a case by case basis. For example, if currently a defendant in a case, a potential

participant may be referred to the telecare program by their attorney/public defender. Further eligibility would be determined by the District Attorneys' offices based on an assessment of potential benefit to the participant. Local Drug Court Coordinators may conduct a suitability interview that assesses family and community ties, employability, substance abuse history, mental status, compliance level and attitudes towards entering into telecare supported treatment.

e) Participants will be sought through referrals from local substance abuse treatment providers, mental health services agencies as well as local clinics and medical care facilities.
f) Information about the telecare project will also be broadcast to potential participants through local media outlets, including those that serve Spanish speaking audiences (such as Univision), Hmong language outlets and others.

3. Absence of Coercion

a) Participation in the program is voluntary, even if entering the program through a court order.
b) Each participant may remove themselves from program participation if they choose to do so.
c) Contingency Management is an adjunct to treatment that has proven effect in substance abuse and mental health treatment. Participants are rewarded for their positive behavior and general adherence to their treatment plan with an incentive value not to exceed the amount allowed by SAMHSA, presently valued at $20.00.
d) Each participant will be informed that there is zero discrimination and will be allowed services if they decide not to participate in the data collection portion of the project.

4. Data Collection

a) Promesa Behavioral Health will collect data from the participants themselves in a confidential, face to face, interview. This data is gathered and entered into a confidential database EPHI/EHR. The data is real time and available for review only by those directly involved in the project.
b) Participant data that is electronically gathered is encrypted, decipherable only by staff directly involved in the project.

c) Participant data that is in the form of paper files are stored in a triple locked facility (the filing cabinet is locked, the file storage room is locked and the facility in which the files are kept is locked and alarmed). Only staff with active caseloads are provided keys to the participant file room.
d) Promesa Behavioral Health randomly collects urine and/or saliva to ascertain substance use. If positive, we request that participants go to laboratories with which we have existing contracts and who specialize in collecting, testing and reporting on these samples. Participants sign waivers to permit us access to the results of these tests. If participants refuse to sign waivers, we forego requesting these laboratory tests. However, for participants who are court mandated (including participants on probation, parole or other restrictive conditions), the waivers are included in the order for treatment. In general, this type of sampling is used to support treatment plans by confronting continued drug/alcohol use, it is not generally used in a research context.
e) Data is collected through interviews, psychological assessments (such as the Addiction Severity Index), questionnaires, observations and electronic communication notes (texts, emails, tweets) exchanged between participant and counselor. Participants will be informed that Twitter communications may not be confidentially protected due to the public nature of twitter exchanges.
f) Data is collected in two formats – face to face interviews and secured electronic connections.

5. Privacy and Confidentiality

a) Our certificated Substance Abuse Counselors and Professionals and telecare counselors will gather data in a private office with only the participant present during the interview and data collection process.
b) The initial intake interview and follow up interviews take place in person. Telecare treatment and electronic interviews are conducted during telecare sessions.
c) During the initial intake interview, participants are provided an access code. This is their identifier for logging onto a session and for all electronic communication with their counselor or Promesa staff. Their name or other identifying information is never transmitted electronically.
d) Only the substance abuse counselors, telecare clinical staff and designated support staff will have access to the participant's information.

e) Participant privacy is an overriding agency principle. We keep all records secured, as noted in 4.c. Electronic records are encrypted and secured with passwords, which are only provided to staff directly assigned to the substance abuse division.
f) Participant files are coded, and the codes are only accessible to the substance abuse counseling staff directly assigned to telecare services.
g) We do not expect to include minors (those under age 18) as participants in the telecare project.

6. Adequate Consent Procedures

a) The data is shared only in cases involving court orders, if the participant is enrolled in the program at the request of a Defense Attorney, District Attorney, Drug Court Judge, Public Defender or other professional directly involved with the participant's treatment.
b) Substance abuse diagnoses and treatment plans are shared with the telecare treatment team, however, if any information is to be released, it is based upon specific written direction form the participant and a signed release of information is acquired by Promesa Behavioral Health.
    i. Provisos:
        1. All participants consent to treatment voluntarily. However, as with most court mandated treatment, the court can impose sanctions for non-compliance. This is in the domain of the court. Promesa allows participants to opt out of care, irrespective of court mandates.
        2. Participants are free to leave the telecare treatment program if they choose.
        3. Participants may voluntarily return to telecare treatment without prejudice after opting out.
c) Data is collected for the purpose of reporting to SAMHSA. However, these reports do not include participants' names, only demographics, outcomes and other specifics requested by SAMHSA.
d) Participants are provided a verbal overview of consent, release and waiver forms, encouraged to ask questions of what the forms contain and mean, then asked to sign these forms. Participants are provided copies of all forms they sign.

e) Cultural competency is a basic premise of Promesa Behavioral Health. Many participants and potential participants speak and read languages other than English. For participants who are non-English speaking, they are provided this verbal overview in their preferred language by our bilingual staff. All forms are translated into the preferred language of the participant, so that participants are fully informed of the program and of telecare.
f) Orientation into telecare and the process for accessing their counselor is also provided in a bilingual manner.

2. Risk/Benefit Discussion

a) The small amount of risk involved with telecare treatment is far outweighed by the opportunity for participants to make life changing strides in their lives through telecare supported treatment. Promesa believes that the small amount of risk is associated with the potential for breach of privacy yet, the rewards associated with expanded access to substance abuse counseling and the potential to live a clean and sober life are outweighed by this risk.
b) There is a risk associated with buprenorphine (including Suboxone) supported treatment for participants with prescription drug addiction. One risk comes from mixing buprenorphine with other medications, especially benzodiazepines (for example, Valium®*, Klonopin®†, or Xanax®‡), which can be dangerous. Other risks associated with this medical support for prescription drug addiction are also covered in the intake and consent interviews. Participants are informed of all known risks, including the potential for fatality. These cautions are thoroughly covered in the intake interview and consent reviews. Participants are advised that buprenorphine, especially if taken outside the care of a physician, using routes of administration other than sublingual or in higher than recommended therapeutic doses, can have negative consequences.
c) We expect that few telecare participants will be receiving buprenorphine supported telecare treatment.

- *Valium® is a registered trademark of Roche Products Inc.
- †Klonopin® is a registered trademark of Roche Laboratories Inc.
- ‡Xanax® is a registered trademark of Pharmacia & Upjohn Company

Promesa Behavioral Health

Cultural Competency Policies

Introduction

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Promesa Behavioral Health (PBH) places high importance on maintaining a network of culturally competent providers with whom we contract services as well as within our pool of staff. PBH conceptualizes cultural competency as the ability to deliver excellent mental health services that are culturally and linguistically appropriate. As such, the PBH Cultural Competency Committee was created to increase cultural competence across all staff, provider, and organizational levels. The Committee is comprised of staff members from within each of the agency's divisions – Foster Family, Adoptions, Group Homes and Substance Abuse. Meetings are held quarterly and independent consultants and provider representation are highly encouraged. The PBH Cultural Competency Committee recognizes that mental healthcare disparities exist across the many different strata that comprise "culture," such as language, ethnicity/race, religion, sexual orientation, sex/gender roles, socioeconomic status, and age. Our Committee also recognizes the influence that culture has on many issues related to mental health care, including barriers to service, attitudes towards recovery, beliefs about mental illness, and help-seeking behaviors (especially within the out-of-home placement youth who are our clients). Keeping these issues in mind, the Committee actively works towards fostering a robust network of culturally competent providers and staff by:

• Promoting cross-cultural awareness and respect.

• Assessing cultural competence.

• Training culturally competent providers.

• Promoting the recruitment of bilingual/bicultural staff of the prevalent secondary and tertiary languages of our region (i.e., Spanish and Hmong).

•Maintaining a pool of locally, culturally competent consultants who provide training, program oversight and guidance for our staff. Presently, these consultants are:

Herbert A. Cruz, M.D. (psychiatry, with addiction specialty)

Harold Seymour, Ph.D. (clinical psychology)

Within Promesa, the answer to the question "What is Cultural Competency?" is addressed with the following understanding: Cultural competency, on an individual level, evolves through changes in behaviors, attitudes, knowledge, and skills. On an organization level, it evolves through changes in policy, development of structure, and providing education to our staff. PBH recognizes that the incorporation of these two levels into a culture of competency for its staff, providers, and subcontractors assures quality services to our clients. PBH further defines cultural competency as follows:

Cultural competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations. 'Culture' refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic,

religious, or social groups. ‘Competence’ implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs present by consumers and their communities.

Cultural competence includes attaining the knowledge, skills, and attitudes to enable administrators and practitioners within systems of care to provide effective care for diverse populations. Recovery and rehabilitation are more likely to occur where systems, services, and providers have and utilize knowledge and skills that are culturally competent and compatible with the backgrounds of consumers, their families, and communities. Cultural competence acknowledges and incorporates variance in normative acceptable behaviors, beliefs, and values in determining an individual’s mental wellness/illness, and incorporating those variables into assessment and treatment. (SAMHSA)

Linguistic competence is the capacity of an agency to communicate effectively, and convey information in a manner that is easily understood by diverse audiences including persons of limited English proficiency, those who have low literacy skills or are not literate, individuals with disabilities, and those who are deaf or hard of hearing. (National Center for Cultural Competence)

Promesa Behavioral Health

Cultural Competency Program Description and Plan

Cultural Competency Standards:

PBH’s plan is based on the adoption of the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care published by the US Department of Health and Human Services’ Office of Minority Health in 2000. These standards are:

A. Assurance that clients receive from all providers effective, understandable, and respectful care that is provided in a manner compatible with their cultural beliefs and practices and preferred language.

1. Effective health care is care that successfully restores the client to the desired health status and takes steps to protect future health by incorporating health promotion, disease prevention, and wellness interventions. In order for health services to be effective, the clinician must accurately diagnose the illness, discern the correct treatment for that individual, and negotiate the treatment plan successfully with the client.

2. Understandable care focuses on the need for clients to fully comprehend questions, instructions, and explanations from clinical, administrative, and other staff. To be

understandable the concepts must make sense in the cultural framework of the client.

3. Respectful care includes taking into consideration the values, preferences, and expressed needs of the client and helps to create an environment in which clients from diverse backgrounds feel comfortable discussing their specific needs with any member of the staff.

B. Offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each client with limited English proficiency at all points of contact, in a timely manner during all hours of operation;

C. Provide to clients in their preferred language both verbal offers and written notices informing them of their right to receive language services;

D. Ensure the competence of language assistance provided to limited English proficient clients by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the client); and

E. Make available easily understood client-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.

F. Implement strategies to recruit, retain, and promote at all levels a diverse staff and leadership represents the demographic characteristics of the service area;

G. Ensure that staff at all levels and across all disciplines receive ongoing education in culturally appropriate service;

H. Develop, implement, and promote a written strategic plan that outline clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide culturally appropriate services;

I. Ensure that data on the individual client's race, ethnicity, and spoken/written language are collected in health records, and/or integrated into the management information systems and periodically updated;

J. Maintain a current demographic, cultural, and epidemiological profile of the community as well as a needs assessment to accurately plan for services that respond to the cultural characteristics of the service area;

K. Develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms, to facilitate community and client involvement in designing and implementing CLAS-related activities;

L. Ensure that conflict and grievance resolution processes are culturally sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by clients; and

M. Regularly make available to the public information about their progress and successful innovations implementing the CLAS Standards and to provide public notice in their communities about the availability of this information.

Cultural Competency Plan Authority, Structure, and Responsibility for the Integration and Implementation of the Plan

PBH's C.E.O. and its Division Managers have the authority and responsibility to integrate cultural competency throughout the PBH operation. The agency delegates the development and oversight of the plan to PBH's Human Resources Manager and the Cultural Competency committee. The Cultural Competency Committee is charged with implementing the Cultural Competency Plan. The Plan is required by the PBH's policy on cultural competency and is updated annually. Committee members include Division Managers, including the Director of the Substance Abuse Division. It also includes clients, former clients and provider representatives who have demonstrated cultural proficiency. The Committee meets quarterly to review progress toward meeting plan goals, to plan new initiatives, and to provide resources and technical assistance to other providers. The overall aim of the plan is to foster a robust network of culturally competent providers and staff by:

• Recognizing and honoring diversity in all forms;

• Assessing cultural competency on a frequent basis;

• Offering immediate access to culturally appropriate behavioral care for clients;

• Offering continuous, comprehensive cultural competency/diversity education and training for staff, consultants, and providers; and

• Promoting the recruitment of bilingual/bicultural staff of the prevalent secondary language/culture of our region (Spanish), along with others (Hmong, Lao, East Indian languages and dialects).

PBH's overall strategy has been, and will continue to be the following continuous looping sequence: (1) assess the extent to which PBH and our providers are meeting the needs of the culturally diverse populations we serve, (2) plan the necessary steps and interventions needed to address any deficiencies noted in the assessment and to build on the strengths identified, (3) implements the plans developed, and (4) evaluate effects of the implementation.

Overall Goal of the Culturally Competency Plan

To confront the problem of the disparities and barriers to service that exist across the many different aspects of "culture," including, language, ethnicity/race, religion, sexual orientation, sex/gender roles, socioeconomic status, and age, a Cultural Competency Plan has been developed that define our expectations with respect to providing culturally proficient services. The PBH policies require the plan to include:

•Development of specific goals;

•Specific strategies to meet those goals; and

•Measures of the extent to which the goals are met.

PBH expanded its cultural competency policies to cover the National CLAS Standards during 2013 strategic plan review, with the discreet elements listed below. In addition, the Committee may choose to establish further goals or assessment to ensure that the Plan is effective, and meeting the Standards.

Culturally Competent Care

Goal: Ensure clients are receiving culturally appropriate services.

Strategies:

1. Impact of culture is incorporated into the treatment planning process.

2. Recruitment of additional bilingual/bicultural staff; retain existing bilingual/bicultural staff.

3. Cultural Competency training for all providers. Establish a monthly training schedule, with topics relevant to the breadth of cultural competency (transgender concerns, for example).

Measures:

1. Chart audits, consumer satisfaction surveys.

2. Number and distribution of bilingual/bicultural staff, client load of each staff in the Substance Abuse Division.

3. Consultants are required to offer trainings on an annual basis.

Language Access Services:

Goal: Ensure clients receive linguistically appropriate services

Strategies:

1. Utilization of language translation services for clients whose language is not represented by staff skills (our staff speak Spanish, Lao, Hmong and American Sign Language).

2. Client materials are easily understood and available in language of choice.

Measures:

1. Semi-annual self-assessments by staff addressing their proficiency with accessing translation services. Random calls to clients and outside service providers to determine staff proficiency in accessing translation services.

2. Client materials and signage are reviewed annually by an external quality review organization.

Organizational Supports for Cultural Competence

Goal: Ensure clients have access to services that are sensitive to their cultural and linguistic needs.

Strategies:

1. Organizational and provider assessments of our clients, their unique cultural perspectives and services provided in the substance abuse treatment division.

2. Knowledge of service area demographic profiles of the various cultures, language communities, gay/lesbian/transgendered and other communities within our service region.

3. Provide relevant trainings to staff and service providers on a frequent basis.

Measures:

1. Annually PBH reviews progress toward its goals, grievances, and conduct formal bi-annual organizational self-assessments of staff and agency.

2. On a quarterly basis PBH reviews the demographic profiles of the covered area.

3. Number and types of staff receiving education in various areas of cultural competency.

The Core of the Cultural Competency

Promesa is implementing a federal substance abuse treatment program (Telecare Outreach Alcohol and Drug Services), which puts the agency in direct alignment with the CLAS standards. As noted above, our principal standard for cultural/linguistically appropriate services are:

To provide effective, e1uitable, 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.

Specifically, as detailed in the CLAS:

Governance, Leadership, Workforce

2. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices and allocated resources

•PBH's Board of Directors and Executive Leadership adhere to the CLAS standards.

3. Recruit, promote, and support culturally and linguistically diverse governance, leadership and workforce that are responsive to the population in the service area.

•PBH hires, promotes and supports a culturally, linguistically and representative staff. Staff include multicultural/ethnic staff, who speak a wide variety of languages. Moreover, staff also include gay and lesbian identified individuals.

4. Educate and training governance, leadership and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

•PBH conducts monthly trainings in various issues that arise in addressing the diversity of clients we serve. Staff, managers and Board members each attend trainings throughout the year.

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 facility timely access to all health care and services.

•PBH clients whose language is not English receive services in their language of choice. Clients are assigned to the caseload of those bilingual/bicultural staff whom the clients can identify with and communicate easily with.

•Clients needing language or communication services outside of those available internally are assisted to receive services using various interpreter or translation services available in the community.

6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.

•PBH staff provides both written and oral assistance to enable clients to be fully informed of the services available.

7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.

•PBH staff is professionally trained to provide services. All bilingual/bicultural staff are of the culture and language they are representing. Minors are never utilized as interpreters in our programs. Minors are not allowed to comingle with adults receiving services.

8. Provide easy to understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

•PBH's printed and multimedia materials are translated in to the most prevalent languages found in our service area --- Spanish, Hmong and Lao.

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.