BEHAVIORAL HEALTH SERVICES

CULTURAL COMPETENCE PLAN

FY 2016—18 UPDATE

Rev: June 1, 2017

Table of Contents

ATTACHMENTS

1. About Madera County
2. Madera County Penetration Report 2017
   *See separate attachment

I. Commitment to Cultural Competence

Madera County Behavioral Health Services (MCBHS) believes the pursuit of health equality must be in the forefront of our all our efforts. MCBHS places high importance on providing high quality services that accommodate the unique needs of individuals and families whose cultural perspectives and linguistic differences are significantly dissimilar from the main stream United States culture.

Cultural sensitivity and inclusiveness is embedded at all levels of MCBHS as exemplified in the Department's mission, core values, patient advocacy efforts, code of conduct, program planning and everyday practices.

Mission

To promote the prevention of and recovery from mental illness and substance abuse for the individuals, families, and communities we serve by providing accessible, caring, and culturally competent services.

Core Values

We, the employees of Madera County Behavioral Health Services, value:

- The promotion of wellness and recovery.
- The integrity of individual and organizational actions.
- The dignity, worth, and diversity of all people.
- The importance of human relationships.
- The contribution of each employee.

Organizational Code of Conduct, Ethics and Compliance (CCEC)

The workforce CCEC addresses cultural sensitivity in its standards of conduct. Below are the relevant excerpts from the Code.

- Quality of Care:
  1) Provide culturally competent services and programs treating clients and constituents in a culturally sensitive manner appropriate to their background, culture, language, religion and heritage and are mindful of individual differences.

- Staff Client Relationships:
  1) We are committed to providing services by qualified staff members that are compassionate, courteous, culturally competent, fiscally responsible and ethical.
  2) Respect the basic rights, dignity and value of clients and their families demonstrating courtesy and sensitivity to clients of all cultural and linguistic backgrounds.
  3) As treatment providers, we have a professional concern for clients within the bounds of professional responsibilities, so as to safeguard the welfare of the client, both during and after treatment. Set clear, appropriate, and culturally sensitive boundaries.

II. CLAS Standards

MCBHS has adopted the enhanced National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care as the blueprint for cultural competence planning.

Principal Standard:

1. Provide effective, equitable, understandable, and respectful quality care and services 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 equality through policy, practices, and allocated resources.
3. Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce 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 with 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 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 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 and complaints.
15. Communicate the organization's progress in implementing and sustaining CLS to all stakeholders, constituents, and the general public.

III. Governance, Leadership and Workforce

A. Governance
The Director, Senior Management Team and the BHS Advisory Board have the authority and responsibility to integrate cultural competency throughout the MCBHS operation.

B. Ethnic Services Manager (ESM)
The Director has delegated the development and oversight of cultural competence to the Division Manager of the Quality Management Program who also serves as the ESM.

C. The ESM works closely with the Director and is a member of the Executive Management Team. In this high level administrative capacity, the ESM is instrumentally involved in the long range strategic and operational planning and implementation of all MCBHS services and activities. Thus, the ESM is critically positioned to ensure the diverse needs of the county's racial, ethnic, cultural and linguistic populations are infused into all management planning and decisions.

D. Planning Process
The QMC, under the direction of the ESM, is responsible for the cultural competence planning process. The QMC meets quarterly and has the following membership:

E. MCBHS Staff:
- Director
- Assistant Director
- 3 Division Managers
- QMC Program Supervisor
- SUD Program Supervisor
- Intake Program Supervisor
- Medical Records/Front Desk Supervisor
- Compliance Officer
- Client Advocate
- Community Service Liaison (peer worker)

Community Representatives:
- Hope House Wellness Center, Program Director
- Hope House Resources Coordinator
- BHS Board Representative/Family Member

IV. Planning Framework

A. Annual Plan

1. Purpose
   The Cultural Competence Plan is dedicated to advancing and documenting the Department's overall cultural responsiveness to the community and its client's. The plan is updated annually.

2. Short Term Goals
   Do a few things well! Goal criteria:
   - Realistically doable with available resources;
   - Can be completed within a 12 month time frame; and
   - Have relevant and practical applications for immediate improvement.

3. Long Term Goals
   The long range goal is to continuously improve MCBHS effectiveness in meeting the CLAS principle standard of providing high quality culturally competent services to persons with diverse cultural health beliefs, practices and languages.

   A 5-year strategic plan is pending direction and priorities from the California Department of Health Care Services.

B. Comprehensive Behavioral Health Services CC Plan
   MCBHS is an integrated agency at all levels serving all ages of both the seriously mentally ill (SMI/SED) and substance use disorder (SUD). Therefore, the CC Annual Plans addresses all activities, programs and clients regardless of diagnosis with the exception of penetration rate statistics which includes only mental health.

C. Threshold Language
   Spanish and English are the threshold languages in Madera County.

VI. County Demographics

Table 1: Madera County Demographics Compared to California: 2016

Demographics	Madera County	California	Disparity
July 1, 2016 Population Estimate	154,697	39,250,017	NA
	%	%	%
2010 to 2016 Growth	2.6	5.4	-2.8
Foreign Born	21.6	27.0	-5.4
Persons In Poverty	22.6	15.3	+7.3
Gender			
Female	51.7	50.3	+1.4
Male	48.2	49.7	-1.5
Age			
Persons under 5	7.5	6.3	+ 1.2
Persons 6—17	27.5	23.2	+4.3
Persons 18-64	51.8	56.9	- 5.4
Persons 65+	13.5	13.6	- 0.1
Race/Ethnicity (a)(b)			
White/Caucasian Not Hispanic	34.7	37.7	- 3.0
Latino/Hispanic	56.7	38.9	+17.8
African American	4.2	6.5	- 2.3
Native American	4.4	1.7	+ 2.7
Asian	2.6	14.8	-12.2
Native Hawaiian/Pacific Islander	0.3	0.5	- 0.2
Multi-race/Other	2.5	3.7	- 1.2
Language Other than English spoken at home age 5+ (2011-2015)	44.7	43.8	+0.9

US Census Bureau, QuickFacts, Madera, California

A. County / State notable differences:
- Madera County has 7.3% more persons in poverty than the State. This is up 1.4% from 2015—2016. .
- Madera County has 17.8% more Latino/Hispanic persons than the State.
- Madera County has 12.2% fewer Asians than the State.

Table 2: Madera County Race/Ethnicity Changes 2014 to 2016

RACE/ETHNICITY	2014%	2015%	*Diff*	2015%	2016%	*Diff*
White/Caucasian Not Hispanic	30.5	29.2	***- 1.3***	29.2	34.7	***+5.5***
Latino/Hispanic	55.7	56.7	***+1.0***	56.7	57.4	***+0.7***
African American	4.0	4.3	***+ .3***	4.3	4.2	***-0.1***
Native American	4.6	4.5	***- .1***	4.5	4.4	***-0.1***
Asian	2.5	2.6	***+ .1***	2.6	2.4	***-0.2***
Native Hawaiian/Pacific Islander	0.3	0.3	***0***	0.3	0.3	***0***
Multi-race/Other	2.4	2.4	***0***	2.4	2.5	***+0.1***

US Census Bureau, QuickFacts, Madera, California, 2016

B. County race/ethnicity changes from 2015 to 2016
- An increase in of 5.5% in Whites/Caucasians Not Hispanics
- An increase in 0.7% of Latinos/Hispanics
- Other differences are negligible.

V. Penetration Rates

Table 3: Penetration Rate of Total Medi-Cal Beneficiaries with SMI 2016-17

Overall Prevalence SMI/SED Madera County[1]	MMEF Eligibles[2]	Estimated Medi-Cal Beneficiaries w/ SMI/SED	Medi-Cal Beneficiaries Served	Penetration Rate
7.37%	66,505	4,901	3,707	75.6%

Table 4: Penetration Rate of Hispanic Medi-Cal Beneficiaries with SMI 2016-17

Overall Prevalence SMI/SED Hispanic[1]	MMEF Eligibles[2]	Estimated Hispanic Medi-Cal Beneficiaries w/ SMI/SED	Medi-Cal Beneficiaries Served	Penetration Rate
8.49%	45,059	3,826	1,585	41.4%

1. DHCS California Behavioral Health Prevalence Rates by County. DHCS report in consultation with Charles Holzer and group. SMI for total population of Madera County.
2. Eligibles from Kings View Madera County Penetration Report FY 2017; based on monthly Medi-Cal Eligibility File (MMEF) and reflects the monthly average

Also, see Attachment 2 Madera County Penetration Report FY 2017

For Charles Holzer prevalence rates of SMI/SED applied in report use link–
http://www.dhcs.ca.gov/provgovpart/Documents/CaliforniaPrevalenceEstimates.pdf

Table 1: Workforce Ethnicity & Spanish Speakers by Job Class–4 Year Trend

Race/Ethnicity By Job Class	2013		2014		2015		2016		2017	
	#	%	#	%	#	%	#	%	#	%
Clinical	69	63	82	65	78	62	78	55	89	62
White	29	43	34	41	25	32	20	26	24	27
Hispanic	31	45	36	44	43	55	46	59	53	60
African Am	3	4	4	5	4	5	5	6	5	6
Asian	3	4	3	4	3	4	4	5	4	4
Other	3	4	5	6	3	4	2	3	3	3
Spanish Speakers	15	22*	27	33*	34	46*	35	45	40	45
Peer/VAD	3	3	7	5	9	7	10	7	9	6
White	2	67	0	0	3	33	3	30	5	56
Hispanic	1	33	4	57	5	56	7	70	4	44
African Am	0	0	3	43	0	0	0	0	0	0
Asian	0	0	0	0	0	0	0	0	0	0
Other	0	0	0	0	1	11	0	0	0	0
Spanish Speakers	1	33*	4	57*	2	22*	3	30	2	22
Non-Clinical	37	34	38	30	39	31	54	38	46	32
White	16	43	16	42	15	38	22	41	14	30
Hispanic	15	41	15	39	17	44	23	43	25	54
African Am	3	8	3	8	3	8	4	7	3	7
Asian	0	0	0	0	0	0	0	0	0	0
Other	3	8	4	11	4	10	5	9	4	9
Spanish Speakers	14	38*	13	34*	14	36*	20	37	22	48
All Staff	109	100	127	100	126	100	142	100	144	100
White	47	43	50	40	43	34	45	32	43	30
Hispanic	47	43	55	43	65	52	76	53	82	57
African Am	6	6	10	8	7	6	9	6	8	6
Asian	3	2	3	2	3	2	4	3	4	3
Other	6	6	9	7	8	6	7	5	7	5
Spanish Speakers	30	28	44	35	50	40	58	41	64	44

*Percent of Job Class

Summary of Staff Changes from 2013 to 2017

- Clinical Staff
  –Hispanic clinicians grew from 31 (45%) to 53 (60%) – +14%
  –Spanish speakers increased from 22% to 45%

–Clinical supervisors (not shown in table):
- Total: 8 clinical supervisors
- 2 (25%) are Hispanic and also speak Spanish
- 1 (13%) is African American
- 1 (13%) is Armenian and speaks Armenian.

- Paid Peer Support Staff
  –Trend data is erratic and unreliable due to the small number in this job class (≤10)
  Total client staff: nine
  Four (44%) are Hispanic
  Two (22%) speak Spanish

- Non-Clinical/Administrative Staff
  – Hispanics increased slightly from 15 (41%) to 25 (54%) – +13%
  – Spanish speakers increased from 14 (38%) to 22 (48%) – +10%

- All Staff
  –Total staff increased from 109 to 144 – +33%
  –Hispanic employees increased from 47 (43%) to 82 (57%) – +14%
  –Spanish speakers grew from 30 (28%) to 64 (44%) – +16%
  –African American staff was stable over the 4 year period ranging from 6-8%

VII. 2016-17 Cultural Competence Goals & Outcomes

A. CLAS Standard 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.

Goal A1:

Develop and train staff on a standardized method for classifying the race/ethnicity of clients and community contacts.

Outcome:

The prevention services supervisors were provided a brief training on the race and ethnicity categories used by the federal government. The training included the definitions of each main category and its subcategories. These definitions were also added to the data collector for quick reference and to ensure accurate information. In addition, staff were directed to only pick one category, to reduce duplicated counts of individuals. The intake staff for treatment services are provided with a list of race and ethnicity categories to choose from, when providing services to the clients they serve. The clients are asked to disclose a category and the intake staff reports the client's response.

Prevention and Early Intervention Services: The Prevention add Early Intervention services funded by MHSA will use the U.S. Office of Management and Budget (OMB) standards on race and ethnicity which are listed below:

Race

White – A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

Black or African American – A person having origins in any of the Black racial groups of Africa.

American Indian or Alaska Native – A person having origins in any of the original peoples of North and South America (including Central America) and who maintains tribal affiliation or community attachment.

Asian – A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

Native Hawaiian or Other Pacific Islander – A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

Ethnicity

Hispanic or Latino - A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin.

The MCBHS PEI staff and MHP Program Supervisor developed consulted and then chose the categories above.

Treatment Services: The following race and ethnicity categories are used for clients served by treatment services:

Ethnicity*
1. Not Hispanic
2. Mexican / Mexican American
3. Cuban
4. Puerto Rican
5. Other Hispanic / Latino

Race*
1. Asian – Other
2. Black / African American
3. Cambodian
4. Chinese
5. Eskimo / Alaskan Native
6. Filipino
7. Guamanian
8. Hawaiian Native
9. Asian Indian
10. Japanese
11. Korean
12. Laotian
13. Mien
14. Native American
15. Non-White – Other
16. Pacific Islander – Other
17. Hmong
18. Multiple
19. Samoan
20. Vietnamese
21. White
22. Unknown / Not Reported

*Definitions not provided for these categories.

B. CLAS Standard 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.

Goal B1: Develop and implement a plan to provide outreach services to the older adults in Madera County.

Goal B2 : Routinely monitor and conduct annual audits of BHS facility ADA compliance and implement identified needed corrections and improvements.

During FY 16-17, outreach services were provided to the Madera Senior Center with a prevention staff person attending the facility three times a week. Mental Health First Aid along with other mental health topics of interest were presented to the senior population attending the facility.

During FY 16-17, the BHS facilities were inspected once every six months to determine if they continued to meet ADA compliance. Any needed corrections would have been made if found.

C. CLAS Standard 9:
Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.

Goal C1:
Restructure the QMC planning process to better integrate cultural competence planning throughout the department.

Outcome:
Reschedule to 2017-20 to focus limited resources on Goal D.

D. CLAS 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.

Goal D1: Provide training to clerical staff to respond to clients/family members in a culturally appropriate manner as they are the first individuals a client/family member will encounter in the system.

Outcome:
Two culturally competent customer service trainings were provided:

1. Culturally Competent Customer Service Training
   Participants: All clerical staff

This training included an overview of the concepts and terminology of culturally competent customer service trainings to include answering the phone or dealing with someone walking in for services in Spanish and English or utilizing a translation service as necessary. Provide cultural appropriate tools to enable participants to meaningfully incorporate these critical components into their work. Participants learned: how to create a welcoming environment in health care settings.

Goal D2: Ensure that the MHP's contracted providers have cultural competency training to provide interpreter or other support services to beneficiaries.

Outcome:
Since over 90% of the MHP's contract providers are large institutions, e.g., group homes, hospitals, etc., outside of Madera County, it would be impossible to have all of the contractor's staff come to Madera County for cultural competency training. In order to comply with this mandate as part of the State DHCS protocol, the MHP had the following placed in their contracts starting FY 17-18, that upon request, the contractor would provide cultural competency training and send to the MHP, the sign-in sheets of the cultural competency training that was offered to staff.

Goal D3: Ensure that all staff complete their mandatory four hour sexual harassment training.

Outcome:
All staff completed their mandatory four hour sexual harassment training.

E. **CLAS 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.

Goal E1:
Use peer staff training in Promatores de Salud, parenting classes, Whole Health workshop, CASRA curriculum, Mental Health First Aid, etc., to provide outreach and education to targeted community individuals and groups.

Outcome:
The services below were provided by peer staff trained to provide the services under MHSA PEI during FY 16-17.

Prevention Education and Outreach

Hope House – 492 - Unduplicated

Duplicated Count for Race Ethnicity

- 3,231 - White
- 843 - African America
- 119 – Native American
- 226 – Asian
- 7 - Native Hawaiian and OPI
- 12 - Two or More Races
- 1 – Other
- 6,079 - Hispanic/Latino
- 4 - Non-Hispanic or Non-Latino

Mountain Wellness Center – 413 - Unduplicated

Duplicated Count for Race Ethnicity

- 883 – White
- 1 - Native American
- 4 – Hispanic/Latino
- 967 – Unknown/Decline to Answer
- 1 – Non-Hispanic

CalWORKs - 42 (MHFA) - Unduplicated

Unduplicated

- 14 - White
- 28 – Hispanic/Latino

Mental Health Educator (Duplicated) – 2915 - Outreach and 325 – Training

Duplicated Count for Race Ethnicity

- 245 – White
- 11 - African American
- 30 – Native American
- 5 – Asian
- 2 - Native Hawaiian/OPI
- 7 – Two or More Races
- 7 – Other Race
- 933 – Hispanic/Latino
- 21 – Non-Hispanic/Non-Latino

Community Health Worker (Duplicated)

Duplicated Count for Race Ethnicity

- 26 – White
- 19 – African American
- 9 - Native American
- 1 – Asian
- 232 – Hispanic/Latino
- 1 - More Than One Ethnicity

Youth Empowerment Program - Unduplicated - 91

Duplicated Count for Race Ethnicity

- 19 – White
- 1 – Black
- 6 – Native American
- 11 – Asian
- 82 – Hispanic
- 1 - Non-Hispanic or Non-Latino
- 1 - Other Non-Hispanic or Non-Latino

VIII. 2017-18 Cultural Competence Goals

A. CLAS 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.

Goal A1: Increase the Latino penetration rate by targeting outreach and education programs to Latinos aimed 1) increasing awareness of BHS services and 2) building trust to seek services.

Goal A2: Provide two cultural competence trainings for staff including:
–Training in Promotores De Salud for peer staff and other topics aimed at assisting staff to more effective serve the Latino population.
–Training on culture of persons with disabilities.

Goal A3: Place taglines for mandated languages on all the MHP brochures, etc., per the MHP contract during FY 17-18. Have all of the MHP brochures and other mandated documents in font size 12 and 18.

F. CLAS Standard 9:

Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.

Goal B1:

Restructure the QMC planning process and membership to better integrate cultural competence planning throughout the department.

G. CLAS Standard 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.

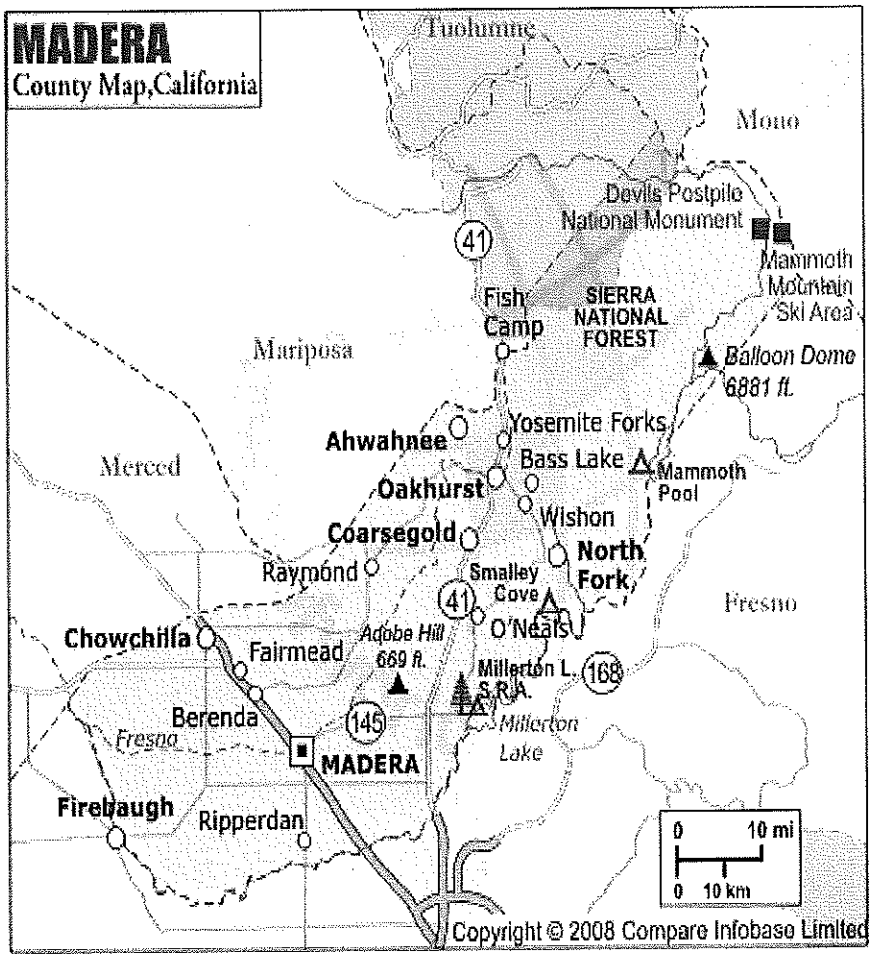
Goal C1: Develop and implement a plan to provide outreach services to the older adults in Madera County.

Goal C2 : Routinely monitor and conduct annual audits of BHS facility ADA compliance and implement identified needed corrections and improvements.

ATTACHMENT 1

ABOUT MADERA COUNTY

ABOUT MADERA COUNTY



1. Urban and rural centers
   - The County has no statistical metropolitan areas.
   - There are two incorporated cities in Madera County—Madera and Chowchilla.

2. Terrain and Distances
   - Madera County covers 2,138 square miles and is located in the exact center of California in the heart of the San Joaquin Valley.
   - The small rural county stretches from the San Joaquin Valley to the crest of the Sierra Nevada, the highest mountains in the continuous United States.
   - Bordered on the north by the Chowchilla River and on the south by the San Joaquin River, the county includes some of the richest agricultural land in the world.
   - Surrounding counties include Fresno to the south, Mariposa and Merced to the north and northwest, Mono and Tuolumne to the northeast.

3. Main Transportation Routes and Public Transportation
   Most of the industrial and residential activity is positioned along Highway 99 which links the county with the entire state. Highway 99 and State Route 145 transect the City of Madera. State Highway 41 serves the eastern portion (Mountain Area) of the county. Two key traffic arteries serving the Mountain Region are State Highways 49 and 41. The primary means of transportation is privately owned vehicles with very limited public transportation which is a major barrier to accessing services in a county so geographically large.

   Greyhound Bus Lines serve Madera; Atchison, Topeka & Santa Fe and Southern Pacific railroads served the valley area with Amtrak stopping in Madera. Madera City has a local Senior Citizens bus, taxi and Dial-A-Ride services.

4. Service Delivery Regions
   For service planning, MCBHS divides the county into 3 service regions based on differences in demographics.

   - Madera City and Surrounding Area
     Madera City is the county seat and is transected by Freeway 99. It is 20 miles away from the nearest metropolitan area of Fresno. This area consists of farming and industrial land on the valley floor.

   - Chowchilla City and Surrounding Area
     Chowchilla is the second of the two incorporated cities in Madera County. It is about 157 square miles and is transected by Highway 99. Both the Central California Women's Facility and the Valley State Prison are located in this region.

   - Mountain Area
     Eastern Madera County is the gateway to Yosemite National Park. It covers the portion of Madera County from the base of the foothills at Route 145 to the High Sierra Mountains–1,379 square miles. It includes the unincorporated areas of Ahwahnee, Bass Lake, Coarsegold, Fish Camp, North Fork, Oakhurst, O'Neals, Raymond and Wishon. These towns range in population from 310 to 11,676. Oakhurst is the commercial and residential center of this region. Recreation is big in this area which includes part of Yosemite National Park and many lakes.

5. Socioeconomic Characteristics

   - Economics
     - Primary Economic Support
       On the valley floor of western Madera County, agriculture is the largest industry accounting for 30% of the employment. Government, another significant sector, accounts for 20% and Services make up 17%. The Children's Hospital of Central California is a large employer located in the southern part of the county near the Fresno County line. By contrast, the economy of eastern Madera County is built around recreation and tourism.

- Unemployment (2014):
  Madera County 10.3 % California 7.5%
- Median Household Income:
  Madera County $45,490 California $61,489
- Persons In Poverty (2014):
  Madera County 22.3% California 16.4%

➢ Education
- Schools in Madera Unified School District:
  –27 High Schools
  –13 Middle Schools
  –36 Elementary Schools
- 10 private schools
- High school graduation rate:
  Madera County 86% California: 83%

➢ Health
- Hospitals w/ ERs
  – Children's Hospital of Central California
  – Madera Community Hospital (General Acute Care; 106 beds)
- Health Care Providers
  – 2,175 primary care physicians
  – 2,309 dentists
  – 815 mental health providers
- Ranks 43 of 58 counties in health outcomes*
- Ranks 49 out of 58 counties in health behaviors (smoking, obesity, excessive drinking, etc.)*
  *County Health Rankings & Roadmaps a Robert Wood Johnson program.

ATTACHMENT 2

MADERA COUNTY PENETRATION REPORT
FY 2016-17

See separate attachment.