
FY 2018-2019

Annual Report



SANTA BARBARA COUNTY
DEPARTMENT OF
Behavioral Wellness
A System of Care and Recovery

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(805) 681-5220 ♦ Alice Gleghorn, Ph.D., Director

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From the Director

I am pleased to present the Fiscal Year 2018-2019 Annual Report for the Santa Barbara County Department of Behavioral Wellness.

Over the past year, the Department has accomplished many achievements and faced many challenges. I would like to acknowledge the important work our staff do every day, diligence in consistently maximizing opportunities to expand housing, crisis services and the ongoing aim to provide the highest quality in service delivery practices. In addition, the department continues to be present to provide support during times of community crisis.

Important achievements this year included the launch of our Drug Medi-Cal Organized Delivery System (DMC-ODS), fully integrating the Access line for Substance Use Disorder and Specialty Mental Health Service needs; launching of a medication management clinic at a Recovery Learning Center; completion of a robust cultural competency needs assessment used to steer service delivery and practices; expansion of housing services; expansion of crisis services including expanded co-response with law enforcement, medication assisted treatment, opening of a third Crisis Residential Treatment Program (Agnes), development of a forensic focused Crisis Residential Facility in Santa Maria and launch of the Children's Crisis Triage program. This year also found a tremendous number of audits of the department taking place. As a result of success throughout these many audits, this is the first year the departmental audits have been listed in the low risk category of the County of Santa Barbara Auditor-Controller's *External Monitoring Report*.

Our annual reports provide ongoing updates and data on our continued progress. In a similar quality improvement effort, the County has launched the Renew '22 initiative. The Department is an active Renew '22 participant; key initiatives appear in the department's FY18-20 Strategic Plan which can be accessed on the Behavioral Wellness website.

We are proud of the many contributions staff have made to the health and well-being of Santa Barbara County both during daily service delivery and during community disasters and traumatic events.

We appreciate your interest in the Department of Behavioral Wellness, and hope you enjoy our Annual Report.

Sincerely,

Alice Gleghorn, Ph.D.
Director

Mission, Vision and Guiding Principles

Mission

The mission of the Department of Behavioral Wellness is to promote the prevention of and recovery from addiction and mental illness among individuals, families and communities, by providing effective leadership and delivering state-of-the-art, culturally competent services.

Values

- ♦ Quality services for persons of all ages with mental illness and/or substance abuse
- ♦ Integrity in individual and organizational actions
- ♦ Dignity, respect, and compassion for all persons
- ♦ Active involvement of clients and families in treatment, recovery, and policy development
- ♦ Diversity throughout our organization and cultural competency in service delivery
- ♦ A system of care and recovery that is clearly defined and promotes recovery and resiliency
- ♦ Emphasis on prevention and treatment
- ♦ Teamwork among department employees in an atmosphere that is respectful and creative
- ♦ Continuous quality improvement in service delivery and administration
- ♦ Wellness modeled for our clients at all levels; i.e., staff who regularly arrive at the workplace healthy, energetic and resilient
- ♦ Safety for everyone

Guiding Principles

Client- and family-driven system of care: Individuals and families participate in decision making at all levels, empowering clients to drive their own recovery.

Partnership Culture: We develop partnerships with clients, family members, leaders, advocates, agencies, and businesses. We welcome individuals with complex needs, spanning behavioral health, physical health, and substance use disorders, and strive to provide the best possible care.

Peer employment: Client and family employees are trained, valued, and budgeted- for in ever-increasing numbers as part of a well-trained workforce.

Integrated service experiences: Client-driven services are holistic, easily accessible, and provide consistent and seamless communication and coordination across the entire continuum of care delivery providers, agencies and organizations.

Cultural competence, diversity and inclusivity: Our culturally diverse workforce represents this community. We work effectively in cross-cultural situations, consistently adopting behaviors, attitudes and policies that enable staff and providers to communicate with people of all ethnicities, genders, sexual orientations, religious beliefs, and abilities.

Focus on wellness, recovery and resilience: We believe that people with psychiatric and/or substance use disorders are able to recover, live, work, learn and participate fully in their communities.

Strengths-based perspective: Recovery is facilitated by focusing on strengths more than weaknesses, both in ourselves and in our clients.

Fiscal responsibility: We efficiently leverage finite resources to provide the highest quality care to our clients, including those who are indigent.

Transparency and accountability: There are no secrets. We do what we say we will do, or we explain why we can't.

Continuous quality improvement: We reliably collect and consistently use data on outcomes in our system of clients and other pertinent populations (such as incarcerated and homeless), as well as data related to perceptions of families, employees, and community-based organizations, to fuel a continuous quality improvement process.

About Behavioral Wellness



Founded in 1962, the Santa Barbara County Department of Behavioral Wellness promotes the prevention of, and recovery from, addiction and mental illness among individuals, families and communities, by providing effective leadership and delivering state-of-the-art, culturally competent services.

An array of services is provided countywide for adults, children and transition-age youth. Services are provided on an inpatient, outpatient and crisis basis. During FY 2018-19 the Department of Behavioral Wellness served 8,645 mental health clients and 3,901 Alcohol and Drug Program clients.

As of June of 2019, Behavioral Wellness employed 437 persons. Behavioral Wellness also contracts with a number of community-based alcohol, drug and mental health providers, as well as with individual practitioners called "network providers" to offer additional services countywide including newly expanded substance use disorder residential services.

Behavioral Wellness is presently focusing on the Santa Barbara County Renew 2022 (Renew '22) transformation initiative which aims to address financial and organizational challenges and make decisions that will transform the County for success well into the future. In January 2018, the Board of Supervisors approved more than 100 initiatives generated by employee subcommittees focused on these five components of Renew '22:

- Re-Vision Our Organization
- Re-Design How We Work, Re-Balance Our Resources
- Respond To Residents and Customers
- Retain High Performing Employees
- Prepare the Next Generation of Leaders.



RENEW '22 has allowed Behavioral Wellness to establish system goals which:

- Create a common vocabulary and adhere to a vision of excellence
- Take ownership and accountability for quality, essential services and outcomes through employee engagement and leadership-led empowerment
- Brainstorm new ideas, take calculated risks, think outside of the box at all levels
- Innovate and adapt to modern expectations and future needs, which includes agile systems and processes that support desired outcomes
- Make effective decisions using accurate data analysis and metrics, and evaluate programs using performance indicators to establish a stronger and more vibrant organization
- Share our success stories, case studies, best practices and celebrate our progress

This annual report is organized around the core areas of Clinical, Business and Fiscal Operations of the Department and key accomplishments within each.

Clinical operations focus on inpatient and outpatient service delivery systems, the crisis system of care and contracted community-based organization (CBO) services.

Alcohol and Drug System of Care

The Drug Medi-Cal Organized Delivery system (DMC-ODS) was established during this fiscal year. The entire substance use disorder (SUD) treatment field has been transformed. Services have been expanded to include individual counseling, case management, recovery services and non-perinatal residential treatment services. At any given time there are approximately seventy five (75) clients in residential treatment, and clients in all levels of care are receiving a host of wrap around services to ensure treatment success. Harm reduction models have been adopted to engage more clients in treatment.

We have established medication assisted treatment (MAT) throughout every region. SUD treatment programs, the jail, Behavioral Wellness mental health clinics and partner agencies are engaged in prescribing and monitoring FDA approved medications to help clients recover from opioid and alcohol use disorders. Behavioral Wellness collaborated with the Sheriff's Department to secure a MAT in Criminal Justice Settings grant to provide medications within the jails and then link clients receiving those medications to out-of-custody treatment services. A MAT Access Points grant was awarded to Behavioral Wellness to create a buprenorphine induction clinic for clients entering our CSU who need opioid use medications.

Through a Proposition 47 grant, the Behavioral Wellness Alcohol and Drug Program will be facilitating and managing the establishment of a sobering center adjacent to our South County Crisis Stabilization Unit (CSU). The sobering center will receive individuals who need alcohol and other drug interventions rather than unnecessary incarceration or hospitalization. The sobering center promises to reduce recidivism into the criminal justice and acute system of care, and will also include step-down housing for those clients who are homeless.

Change Agents and Action Teams

As result of our Department's commitment to excellence, many systemic improvements and change process have continued through the leadership of Action Teams and the Change Agents over the past year. Although supervisors and regional managers support the PDSA (Plan-Do-Study-Act) process, there has been an increase in line staff participation with Change Agents this year with line staff suggesting the major process changes to be made within the clinics/programs. Highlights from our system Action Teams, including the Housing Action Team (H.E.A.R.T.), Forensic Action Team, Crisis Action Team, Cultural Competency and Diversity Action Team, Peer Action Team, and the Children's System of Care Action Team are noted throughout this report. Action Teams continue to serve as important venues to encourage communication, planning and coordination throughout the system.

Cultural Competency and Diversity

Recent Accomplishments

- ✓ The Department revised their Three- year Cultural Competency Plan (CCP) that includes a Language Access Plan and a Cultural Competency Training Plan. The plan also demonstrates ongoing efforts, strategies, and interventions to reduce health disparities and increase outreach, engagement, and retention of diverse communities. The plan covers Department trainings, and other core activities over a three-year period.
- ✓ The Department measured the quality of cultural and linguistic services through a Cultural Competency Needs Assessment. In 2019, through funds coordinated by the Southern California Regional Partnership, the Department consulted with Dr. Jonathan Martinez with the California State University at Northridge (CSUN) to conduct a cultural competence needs assessment of the county-wide behavioral health system of care. The information obtained in the report was used to inform ongoing and future cultural competence initiatives for the Department.
- ✓ In collaboration with sponsoring organizations, the Department participated in various outreach and engagement events. During 2019, the Department reached over 5,260 diverse community members through presentations, workshops, and tabling events. Community members received information on available services and how to access care.
- ✓ New in-person training opportunities were coordinated for Behavioral Wellness and contracted provider staff. These trainings included Implicit Bias and Cultural Humility in Working with Diverse Families in Community Based Mental Health Settings.

Current and Future Focus

- ✓ In collaboration with the new Workforce Training Manager, CCDAT will focus on developing recruitment and retention recommendations to support a more diverse and culturally attuned workforce.
- ✓ On Jan 15, 2020 the Santa Barbara Department staff was provided the Use of a Healthcare Interpreter training which was very successful. Two additional regional trainings are planned and will be recorded for future trainings to be part of the foundational cultural competency trainings on an ongoing basis.
- ✓ CCDAT will continue to research and develop appropriate language access recommendations for all who need linguistic services.

Crisis System Improvements

Recent Accomplishments

Co-Response Teams. Launching last year as a pilot project with the Sheriff's Department and initially providing services one day per week have expanded greatly. Co-Response now operates two teams, one with the Sheriff's Department and one with the Santa Barbara Police Department, and provides services 4 days per week on each team. In addition, the County of Santa Barbara was awarded a Prop 47 grant which among other things will fund an additional Co-Response team in the South County. The Sheriff's Department was awarded a Byrne Jag grant which will fund two Co-Response teams, one in the north County and one in the South. We are also working with the Santa Maria Police Department to start a pilot Co-Response team which will operate 40 hours per week.

Children's Triage Program. Behavioral Wellness was awarded funding through the Mental Health Services Act Oversight and Accountability Commission (MHSOAC) for the Children's Triage program. This program consists of two teams – one in Santa Maria and one in Santa Barbara. Each team has one full-time licensed mental health clinician and one half-time Parent Partner (Recovery Assistant). In addition to Santa Maria and Santa Barbara response, either team can be quickly deployed to Lompoc Valley Hospital if there is a youth in crisis in their Emergency Department. The goal of the program is to prevent inpatient psychiatric hospitalization of youth by providing intensive mental health services to youth placed on involuntary holds and awaiting psychiatric hospitalizations. The team works closely with the hospital staff, the client and the client's caregivers to de-escalate the crisis, develop sound safety plans and rescind the hold.

Medication Assisted Treatment. Behavioral Wellness has received funding for a Medication Assisted Treatment (MAT) Access Point at the South County Crisis Services (SCCS) Hub. Behavioral Wellness clients or those in contact with a Behavioral Wellness crisis team who have an opiate addiction and are interested in treatment can begin MAT treatment at SCCS. Individuals screened who are needing methadone treatment will be linked to Aegis Treatment Center in Santa Barbara. Individuals screened appropriate for other MAT treatment (Vivacrol, Suboxone, etc) can begin the induction process at SCCS and receive their first dose of MAT treatment. Individuals will then be connected to ongoing MAT treatment providers either within Behavioral Wellness or with a community treatment providers.

Current and Future Focus

- A new referral form allows information from 5150 Holds to be entered into hospital electronic medical records for better coordination of care.
- Through law enforcement drop offs at the Crisis Hubs and walk in capacity at the Crisis Stabilization Unit, MAT Access Point and soon to be operating Sobering Center, those experiencing urgent or crisis psychiatric medical needs can receive help right away.

Key Initiatives at the Psychiatric Health Facility

Pharmacy Improvements

- Opening an inpatient pharmacy
- Installing a medication dispensing machine (Pyxis)
- Working collaboratively with Public Health on the purchase of medications

Administrative Improvements

- Approving 101 Policies and Procedures
- Seeing the positive result of its process improvement efforts reflected in the PHF Patient Survey response
- Continued progress with the Quality Assessment and Performance Improvement (QAPI) program and indicator tracking system
- Continued focus of attention on environment of care
- Improved infection control practices

Emergency Preparedness Efforts

- Conversion of unit to generator power capability
- Adopting an Emergency Preparedness Plan
- Participation in multiple emergency preparedness drills

Strengthening Community Outreach and Engagement

Behavioral Wellness continues with leadership of the Community Wellness Team which has been active in multiple community traumatic events, natural disasters and mass casualties providing emotional support and healing for members of the community. Co-facilitating by the Institute for Collective Trauma and Growth, the team remains active with over a dozen organizational providers actively engaged in community response needs.

Behavioral Wellness continues to provide critical incident debriefings for first responders and other groups impacted by traumatic events, as well as providing support for schools following unplanned deaths or other traumatic events impacting campuses.

System Training

During the FY18-19, Behavioral Wellness offered 36 live training on evidence-based practices for Mental Health Providers. Some of our newest and innovative were:

- Trauma Informed Care Special Topics: PTSD; Eating Disorders; and Substance Abuse
- Community Resilience Model
- Trauma Resilience Model
- Peer Employee Career Development Series: Peer Support & Recovery; Self-Care and Stress Management; Effective Communication with Management; and Surviving and Thriving
- Cultural Humility in Working with Diverse Families in Community-Based Mental Health Settings
- Two Day Conference on Harm Reduction and Medication-Assisted Treatment for Substance Use Disorders

Compliance - Audits

It was a successful year for audits for the Department despite what felt like the constant treadmill of audit preparation. In what was a tremendous success, in December of 2018 the Department had its “readiness review” for the Drug-Medi-Cal organized delivery system with the State Department of Health Care Services (DHCS). The State visit was to determine whether the Department’s Alcohol and Drug Program was prepared to launch a system that would enable Medi-Cal beneficiaries to receive specified alcohol and drug program services that would be paid for by Medi-Cal. Although DHCS scheduled three-days for the review, the Department was able to wrap up in only one day, due to the extensive preparation and detailed program conceptualization of the Alcohol and Drug Program staff. With only a few modifications recommended by DHCS, the Department launched the Drug-Medi-Cal program in January 2019. DHCS came back for a re-review in May 2019. Again, some program modifications and updates were required by DHCS, but changes were made in short order, and the Drug-Medi-Cal program continues to offer an expansive program.

Similarly, the Department’s Psychiatric Health Facility (PHF) experienced a high level of success in its DHCS Triennial Review, an audit which covered the years 2016-2018. For the first time in many years, the PHF had minimal disallowances that resulted in having to pay back money to DHCS for patient charts that were out of compliance. DHCS issued a short corrective action plan that required the PHF to make modifications primarily to the forms that it uses for its inpatient services. The corrections were easily made and the PHF celebrated this significant achievement in demonstrating its dedication to high-quality inpatient care.

As a result of these successful audit outcomes, and others not mentioned here, this is the first year that all of the Department’s audits have been listed in the low risk category of the Auditor-Controller’s *External Monitoring Report* to the Board of Supervisors (in the January 28, 2020 Board of Supervisors Agenda).



Fiscal activities focus on capacity and performance in regard to budgeting, the revenue cycle, Medi-Cal cost recovery and broader financial resources management.

Recent Accomplishments

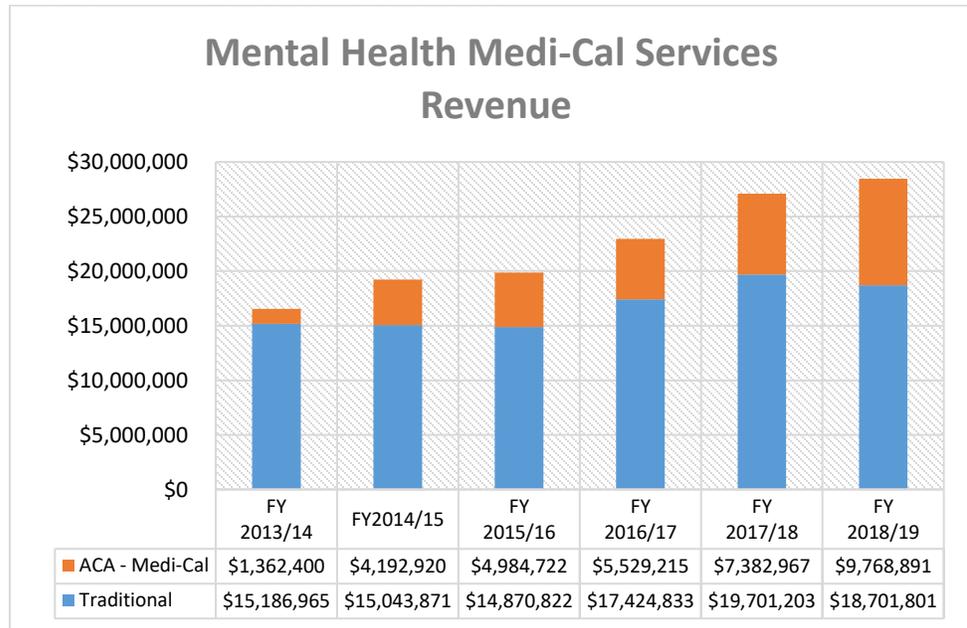
- ✓ Adoption of a balanced departmental budget for FY 2019-20 (\$143M) with no service level reductions.
- ✓ Successfully developed and implemented a new billing and payments system infrastructure to comply with the Drug Medi-Cal Organized Delivery System claiming requirements.
- ✓ Signed a contract to automate the eligibility verification and claims of Private Insurance clients.
- ✓ Started Quarterly CBOs meeting to help CBOs to train and assist them with Billing and Revenue.
- ✓ Patient Representatives Restructure to better serve the clinical operations and service delivery to clients.
- ✓ Started Quarterly CBOs meeting to help CBOs to train and assist them with Billing and Revenue.
- ✓ Provide fiscal oversight, including executing payments, collecting revenues, and/or monitoring compliance with fiscal contract terms for approximately 200 contracts, leases, and/or other legal agreements.
- ✓ Performed fiscal monitoring and settled approximately 37 major subcontracts totaling \$36M.
- ✓ Completed and submitted the Mental Health Service Act Revenue and Expenditure Report on time.



Left-to-Right: Anthony Villa, Christie Boyer, Susan Goodman, Chris Ribeiro, Miyoung Cogswell, Tor Hargens, Kimberley Matthews, David Meza, Josue Sanchez, Ralph Meza, Kathleen Mansell, Max Davis, Katrina Liu, Deidre Baker, Sam Bottrose, Dipak Neupane, Dessi Mladenova

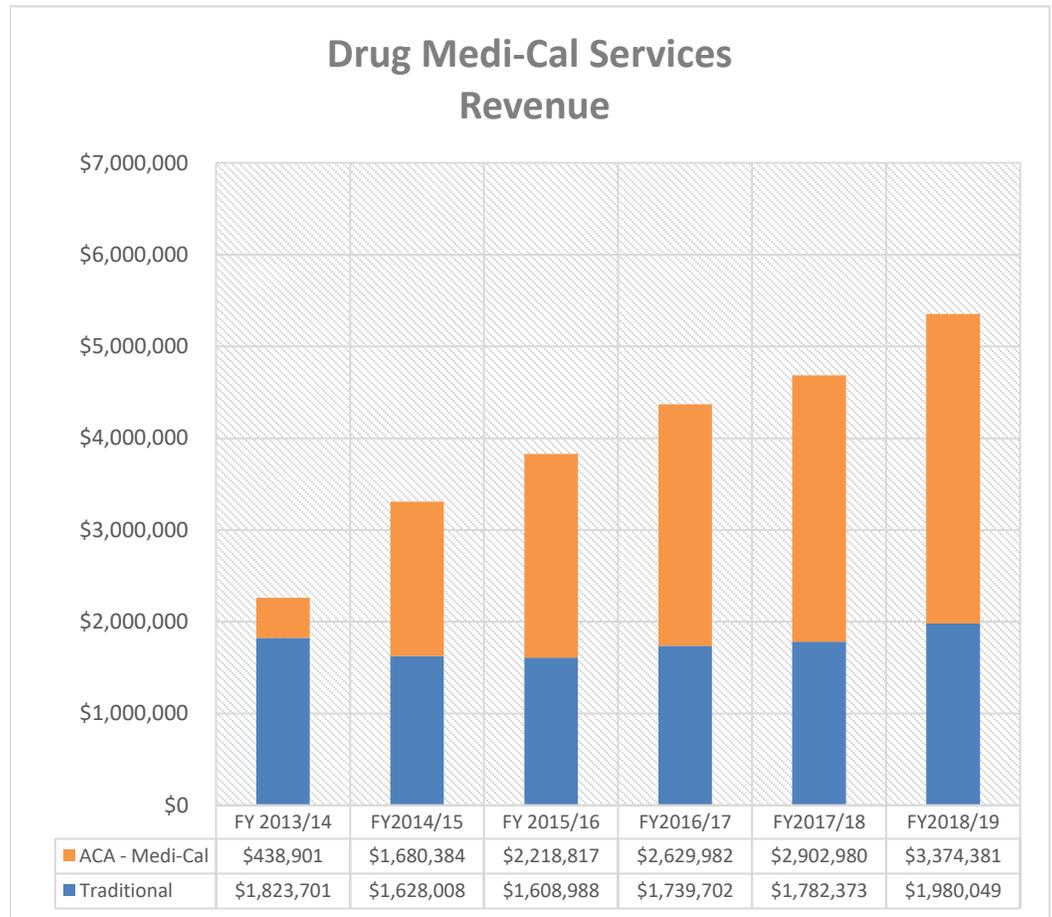
Within Mental Health Medi-Cal-funded programs, revenue from services provided to clients enrolled in the Affordable Care Act (ACA) Medicaid Expansion has increased significantly each year since the inception of this coverage on January 1, 2014. In FY 2018-19 Medi-Cal revenues from clients covered by ACA Medi-Cal increased by 32.3% as compared to FY 2017-18. Medi-Cal revenues from clients covered by Traditional Medi-Cal decreased by 5.1% in FY 2018-19 as compared to FY 2017-18. ACA Medi-Cal revenue made up \$9.8M (32%) of the total FY 2018-19 Medi-Cal revenue \$28.5M.

Table 2: MH Medi-Cal Services Revenue



Within Drug Medi-Cal (DMC) funded programs for Alcohol and Drug treatment, revenue for clients enrolled due to ACA has increased significantly each year, while revenue from clients covered by Traditional Medi-Cal has grown at a much slower pace. Overall DMC revenue increased by \$0.7M (14%) in FY 2018-19 as compared to FY 2017-18. ACA Medi-Cal revenue made up \$3.4M, or 63% of the almost \$5.4M revenue collected for FY 2018-19 services. This is an increase of \$0.4M (16%), over FY 2017-18. The Organized Delivery System (ODS) became effective December 2018, and is the primary factor driving the overall increase in FY 2018-19 Drug Medi-Cal revenue. We expect to see this trend to continue into FY 2019-20.

Table 3: Drug Medi-Cal Services FFP Revenue



Current and Future Efforts

- ✓ Refine rate setting process for Organized Delivery System (ODS), to ensure that billable rates meet full cost recovery, and are in alignment with final cost reporting requirements.
- ✓ Long Term Institute for Mental Disease (IMD), including state Hospital costs continue to be an area of significant concern. Expenditures have increased by over 500% in the last five years and continue to rise, outpacing revenue growth. The Department continues to explore alternative service models to leverage additional funding and improve efficiencies to mitigate fiscal impact of continued rising IMD service demands.
- ✓ Forensic MHRC, \$3.1M (funded in CCP Budget) to provide secure MH treatment for justice involved clients. Site selected as of fall 2019, and preliminary construction planning underway.

Santa Barbara County Department of Behavioral Wellness

Annual Data Report FY 2018/19

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SANTA BARBARA COUNTY
DEPARTMENT OF
Behavioral Wellness
A System of Care and Recovery

January 2020

Santa Barbara County Department of Behavioral Wellness

The Santa Barbara County Department of Behavioral Wellness aims to continuously improve programs, practices and policies. We recognize that we cannot improve what we do not measure; it is, therefore, important to thoughtfully collect and analyze data. As a part of our larger system change efforts, we are working to change our culture to be more data-driven, in order to make better decisions (such as adjusting practices or altering resource allocation) and to increase our impact and effectiveness. Efforts to become more data driven, including this report, reflect our commitment to accountable stewardship of public resources, to continuous evaluation and improvement, and most importantly, to delivering on our mission, vision, and values.

In February 2016, the Board of Supervisors approved the Annual Metrics Report, which includes specific, thoughtfully chosen measures. This annual report for fiscal year 18/19 includes all of those key performance measures, as well as a few additional analyses. It provides data on: who was served and where; crisis and inpatient services; access to and timeliness of services; child and adult outcomes including client satisfaction and system performance; and comparisons to the previous fiscal year. Many of these variables are also required data elements that the Department reports to the California Department of Health Care Services.

Client Demographics

In fiscal year 18/19, the Department served over twelve thousand unique clients; a 6% decrease in total clients from last fiscal year. The Mental Health (MH) System served more than twice as many unique clients as the Alcohol and Drug Program (ADP) (about 8,645 in MH and 3,901 in ADP), as is usually the case.

Understanding Key Terms: “Unique Clients” vs. “Program Admissions”

Clients and services may be counted in different ways.

- A **unique client** is a single, unduplicated person. They may be unique to the system, or unique to the program.
- A **program admission** is counted each time a client is opened to a new program or service.
 - Ex: A client is open in an outpatient clinic, has one mobile crisis encounter, and has one inpatient hospital stay. She has three program admissions.
 - Ex: A client is in outpatient services, discharges, and then later returns to outpatient services in the same fiscal year. He has two program admissions.

By Age Group

While fewer clients were served by ADP and MH systems than last year, both MH and ADP served more adults compared to youth, and MH served a greater proportion of youth (36% youth in MH and 8% youth in ADP). There are several possible explanations for the decreases in unique clients served. For example, there have been increased efforts to move clients along the continuum of MH services and step them down to, appropriate, lower levels of care (e.g. The Holman Group, Neighborhood Clinics, and other primary care providers), which may partially explain the slightly lower MH numbers. The total number of unique MH clients decreased slightly (5% decrease) as did the total services billed (3% decrease).

Additionally, recent legislative and practice changes have meant fewer youth and adults are mandated and referred to participate in substance use disorder (SUD) treatment. There are also more options available for SUD clients outside of the Department’s continuum of care. Efforts were made to determine whether the decrease in unique clients served by ADP services (9% decrease) was associated with a higher volume of services per client. However, DMC-ODS was launched midyear and there were many changes in billing and data collection, making these analyses not possible at this time.

Unique Clients by System of Care 2018/19

	ADP			MH			TOTAL**
	Child	Adult	Total*	Child	Adult	Total*	Unique clients
FY 17 / 18	367	3,932	4,300	3,127	5,957	9,100	13,400
FY 18 / 19	299	3,599	3,901	3,085	5,552	8,645	12,546
% Change	-18.5%	-8.5%	-9.3%	-1.3%	-6.8%	-5.0%	-6.4%

*Note. Clients missing date of birth were included in total but not classified as adult or child.

**Note. If a client was open to both ADP and MH, they are duplicated (not all unique clients) in this total count.

By Region

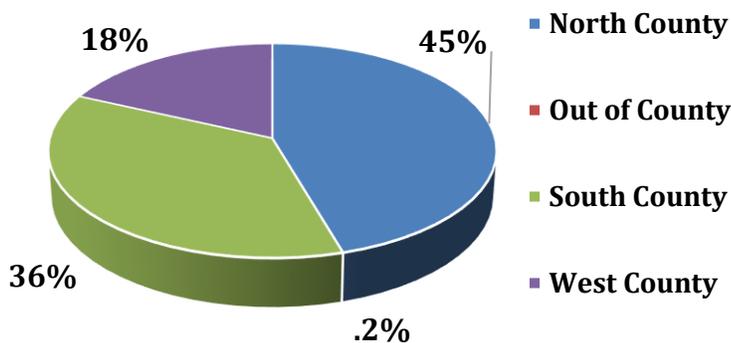
The table below displays the number of unduplicated clients served in each region with at least one or more program admissions during the fiscal year. A client may be counted in multiple regions. For example, if a client is seen by mobile crisis in North County and then admitted to the PHF in South County, they are admitted to both programs and consequently counted in both regions. Fewer clients were served across all regions and both systems of care (ADP and MH).

Unique Clients by Region of Service 2018/19

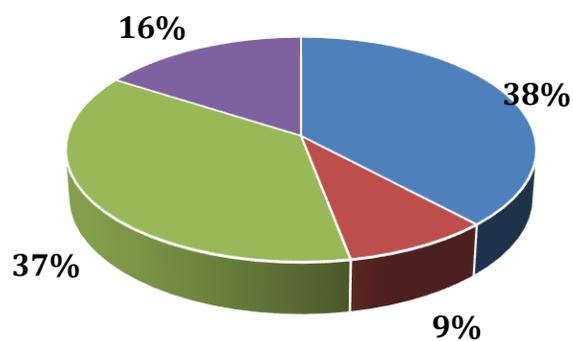
	ADP				MH			
	South	West	North	O of C	South	West	North	O of C
FY 17 / 18	1576	835	2,045	0	4,132	1,714	3,943	980
FY 18 / 19	1488	729	1,855	8	3,719	1,646	3,867	923
% Change	-5.6%	-12.7%	-9.3%	100.0%	-10.0%	-4.0%	-1.9%	-5.8%

About the same proportion of mental health clients were served in North (38%) and South (37%) County. More ADP clients were served in North County (45%), compared to South County (36%). West county rates of service were similar for ADP (16%) and MH (18%).

ADP Region of Service FY 18/19



MH Region of Service FY 18/19



Alcohol & Drug Programs (ADP)

In FY 2018/19, 3,901 unique clients were open to ADP: 92% adults and 8% youth. Among both adults and youth, about 64% of ADP clients were male. The ratios of age group and client gender are similar to FY 17/18.

Alcohol and Drug Unique Client Demographics FY 18/19

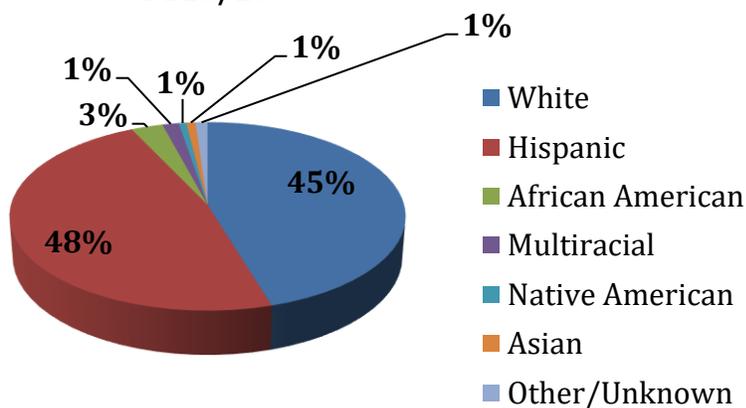
	ALL Adult & Youth		Adult		Youth		Missing DOB
	N	%	N	%	N	%	N
Male	2,477	63%	2,285	63%	191	64%	*
Female	1,412	36%	1,304	36%	108	36%	*
Missing/Other	12	0%	10	0%	0	0%	*
<i>Total</i>	3,901		3,599	92%	299	8%	3
Race/Ethnicity							
White	1,678	43%	1,632	45%	45	15%	*
Hispanic	1,953	50%	1,713	48%	240	80%	*
African American	111	3%	105	3%	6	2%	*
Multiracial	59	2%	54	2%	5	2%	*
Native American	26	1%	25	1%	1	0%	*
Asian**	31	1%	30	1%	1	0%	*
Other/Unknown**	43	1%	40	1%	1	0%	*
<i>Total</i>	3,901		3,599		299		3

*Number not included due to small sample size

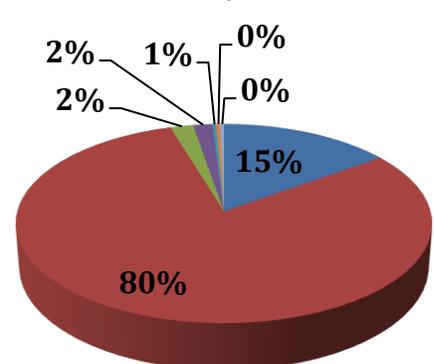
**Note. Combined small sample sizes into a larger ethnic group for protection of client privacy

Half (50%) of all ADP clients served were Hispanic and 43% were White. Whereas among adult ADP clients ethnicity was more equally divided between Whites (45%) and Hispanics (48%), this was not the case among ADP youth: 80% were Hispanic and 15% were White. The adult and youth ADP system of care served proportionally dissimilar ethnic populations, which is consistent with last fiscal year's data.

**ADP ADULT Client Ethnicity
FY18/19**



**ADP YOUTH Client Ethnicity
FY18/19**



Mental Health System

In FY 2018/19, 8,645 unique clients were open to the Mental Health system. Two-thirds were adults (5,550; 64%) and one-third were youth (3,085; 36%). Half (50%) of all MH clients were female. The ratios of age group and client gender are similar to FY 17/18.

Mental Health Unique Client Demographics FY 18/19

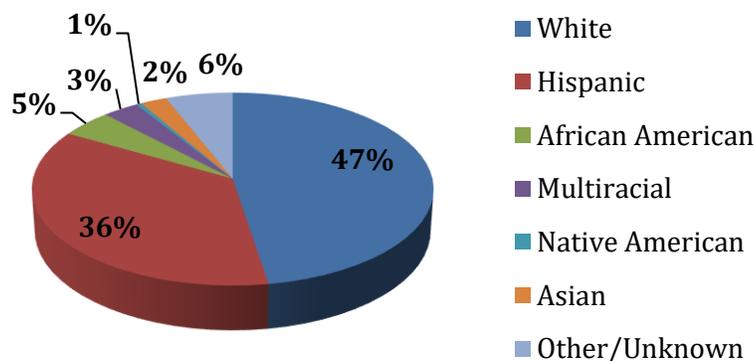
	ALL Adult & Youth		Adult		Youth		Missing DOB
	N	%	N	%	N	%	N
Male	4,232	49%	2,710	49%	1,519	49%	*
Female	4,327	50%	2,788	50%	1,536	50%	*
Missing/Other	90	1%	54	1%	30	1%	*
<i>Total</i>	8,649		5,552		3,085		12
Race/Ethnicity							
White	3,270	38%	2,632	47%	636	21%	*
Hispanic	3,968	46%	1,991	36%	1,977	64%	*
African American	322	4%	258	5%	64	2%	*
Multiracial	237	3%	178	3%	59	2%	*
Native American	32	0%	26	0%	6	0%	*
Asian	145	2%	132	2%	13	0%	*
Other/Unknown	675	8%	333	6%	330	11%	*
<i>Total</i>	8,649		5,550		3,085		14

*Number not included due to small sample size

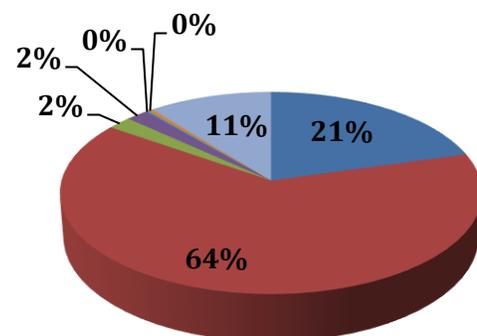
**Note. Combined small sample sizes into a larger ethnic group for protection of client privacy

The ethnicity of MH clients differed by age group: 47% of adults were White and 36% were Hispanic; 21% of youth MH clients were White and 64% were Hispanic. Consistent with the population served by ADP, the adult and youth MH systems of care served proportionally dissimilar ethnic populations.

**MH ADULT Client Ethnicity
FY18/19**



**MH YOUTH Client Ethnicity
FY18/19**



Client Service Settings

Behavioral Wellness and its partner agencies provide a variety of services in both inpatient and outpatient settings. Though most clients receive services in Santa Barbara County, due to limited in-County capacity (in number or kind), some clients are served at inpatient and residential facilities outside of the County. Clients may receive more than one service type during the fiscal year. For example, depending on individual treatment needs, a client may receive services in a Behavioral Wellness clinic and might also receive additional services from a crisis team or a partner organization in the community.

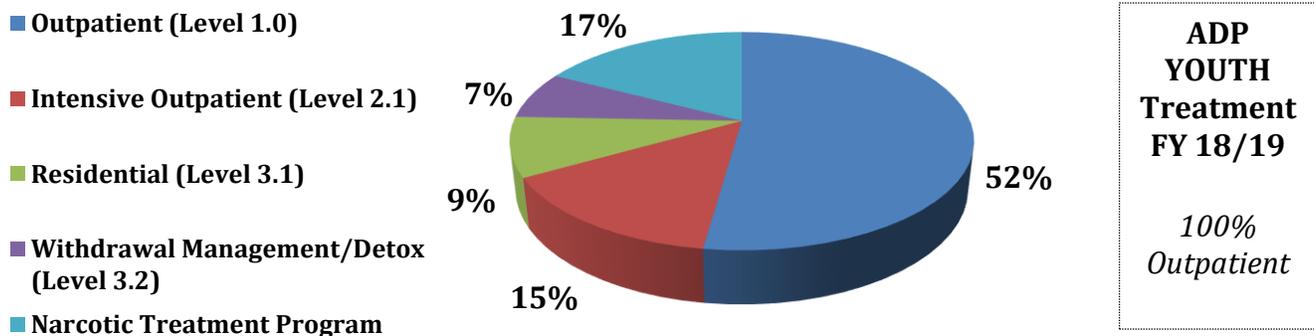
Alcohol & Drug Programs (ADP)

In 2015, the California Department of Health Care Services (DHCS) initiated an innovative pilot program called the Drug Medi-Cal Organized Delivery System (DMC-ODS). The program reorganized specialty substance use disorder (SUD) treatment in the state using the American Society of Addiction Medicine (ASAM) Criteria for SUD treatment. The ASAM is a multidimensional assessment of a client's needs and strengths and the results inform treatment placement and planning. The DMC-ODS pilot adds and expands DMC coverage of residential treatment services, case management, and recovery support services, enables selective provider contracting, supports coordination with managed care health plans, facilitates quality improvement, utilization management, evidence-based practices, and promotes use of a licensed workforce.¹

Santa Barbara County went "live" with the DMC-ODS on December 1, 2018. The Access line experienced a significant increase in callers requesting SUD services; in particular newly covered services such as residential treatment. Clients had to be administratively discharged and re-admitted to programs when ODS went "live"; the pie chart below reflects the level of care that clients were admitted to after December 1, 2018 (seven months of services rather than the full year).

Behavioral Wellness contracts with community-based organizations to deliver alcohol and other drug prevention and treatment services. About half (52%) of adult substance abuse treatment services were provided in outpatient settings (level 1.0); another 17% were outpatient Narcotic Treatment Program (NTP) (methadone) services. Comparing this year to last fiscal year, there was a reduction in the number of NTP clients served. This may reflect the increased availability of Medication Assisted Treatment (MAT) within the county in various treatment settings (both within and outside of our ADP systems of care). Intensive outpatient services (level 2.1) accounted for 15% of all services, 9% were residential treatment services (level 3.1), and 7% were withdrawal management services (level 3.2). All youth substance abuse treatment services were provided in outpatient settings.

ADP Adult Level of Care Admissions FY18/19
12/1/18-6/30/19



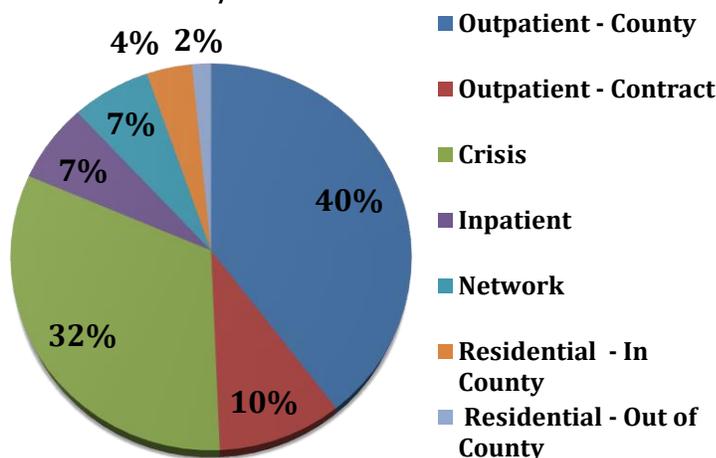
¹ Source: Urada, D., Teruya, C., Antonini, V. P., Joshi, V., Padwa, H., Huang, D., Lee, A.B., Castro-Moino, K., & Tran, E. (2018). California Drug Medi-Cal Organized Delivery System, 2018 Evaluation Report. Los Angeles, CA: UCLA Integrated Substance Abuse Programs.

Mental Health System

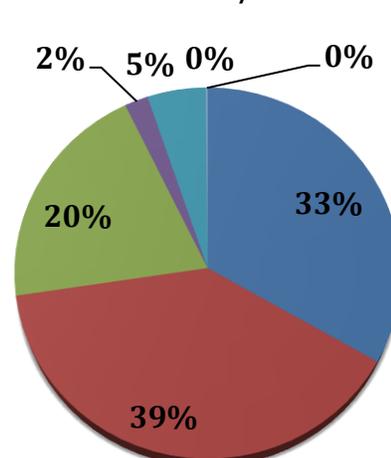
As seen in the pie charts below, 40% of mental health services for adults and 33% for youth are delivered by the county in outpatient settings. There are a few (10%) contracted outpatient services for adults, while 39% of all youth services are provided by contracted outpatient providers.

The next largest service “setting” for both adults and youth are crisis services, which are most frequently delivered by mobile crisis teams in hospitals, an office or phone, or in the field. Adults had a greater proportion of crisis care (32%) than youth (20%), though it should be noted that these numbers have decreased from the last fiscal year (adult crisis care decreased from 34% in FY 17/18 to 32% in FY 18/19 and youth crisis care decreased from 23% in FY 17/18 to 20% in FY 18/19). Residential treatment programs and inpatient care are less frequent treatment settings (utilized by clients who need higher levels of care) (13% of all adult services and 2% of all youth services). For youth, no residential services are available in county, and fewer than 10% of adult clients received residential services out of county.

**Mental Health ADULT Services
FY18/19**



**Mental Health CHILD Services
FY18/19**



In prior years, Santa Barbara County had separate triage and mobile crisis teams. At the beginning of the 18/19 fiscal year, North and South County programs were restructured to form regional County Crisis Services teams; West County had separate mobile and triage teams. The table below displays West County crisis teams combined in order to compare across regions. The locations of services varied by region, reflecting the unique needs of the geographically diverse areas. However, Office/Phone was the most common across all three regions.

Location of Crisis Services, FY 18/19

	North	South	West
Hospital	36%	19%	18%
Office/Phone	44%	55%	66%
Community	18%	17%	15%
Other	1%	9%	1%

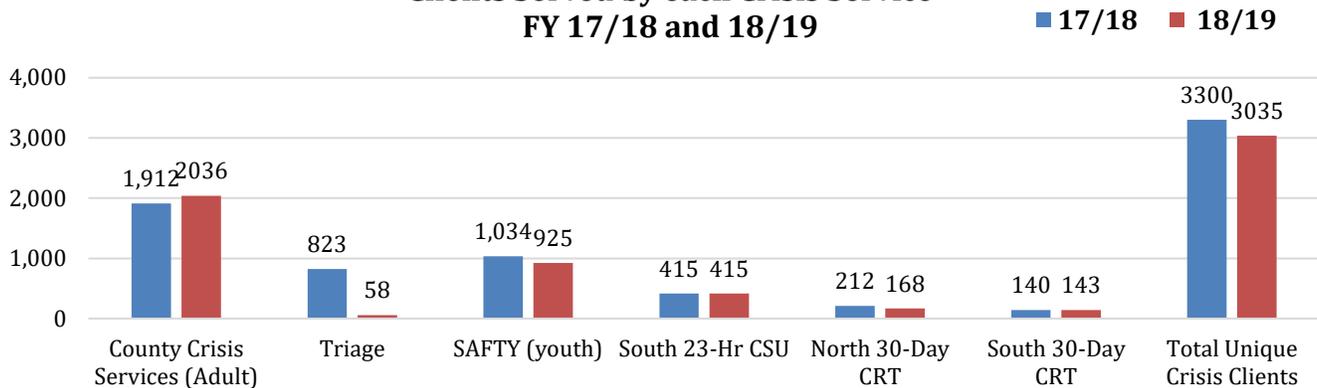
While office/phone was still the most common crisis location, it was only 44% of services in North County and 55% in South County. In North County, 36% of crisis services were also delivered in a hospital, while this was half as common in West County (18%), as well as South County (19%). Each region had similar proportions of crisis services delivered in the community.

Clients Served

In FY 18/19, about 8% fewer unique clients required a crisis service compared to last year (3,035 unique clients were served), whereas there was 4% fewer last year compared to the year prior. There have been some administrative changes that have impacted these numbers. Triage integrated with mobile crisis (now called North, South, and West County Crisis Services); therefore, many of the clients who may have been duplicated under mobile crisis/county crisis services and triage in past years are now only counted under one program. Furthermore, because the organization that operated both CRTs went out of business in May 2019 and new providers were brought in to operate the sites, census numbers were impacted.

Looking across the types of services, about one hundred fewer youth were seen by SAFTY and 44 fewer adults were served at the North County CRT, while the total unique clients remained consistent at the CSU and South County CRT. It should be noted that these numbers reflect crisis services provided, and therefore include out of county and non-MediCal residents who accessed crisis services. There are several factors that may have contributed to the decreased number of youth seen by SAFTY and adults served at the North County CRT. For example, the children crisis triage grant shifted some of the responsibility of youth 5150 holds away from SAFTY to BeWell staff. The transition from Anka Behavioral Health, Inc to Telecare also caused a temporary reduction of available beds and downtime within the North County CRT site, which impacted the number of adults served.

**Clients Served by each Crisis Service
FY 17/18 and 18/19**

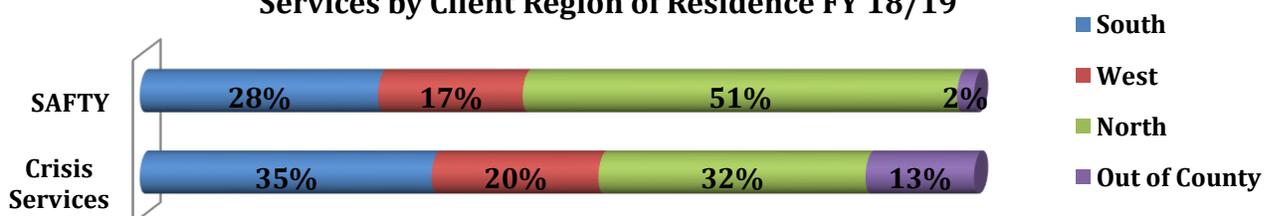


Additionally, in September 2018 a co-response pilot project between the Sheriff's Department and Behavioral Wellness was launched in Santa Barbara. One full time mobile crisis staff spends 40 hours a week with a field Sheriff Deputy, riding along and responding to community need. When not responding to crisis calls, the co-response team is able to provide outreach and engagement services. From September 2018 through June 2019 there were 394 calls (911 calls that are identified to dispatch as potential mental health issues) and 405 proactive engagement calls.

By Region

Of those served by crisis services, there were some regional differences in clients' region of residence. Between 2-13% of clients served by each crisis service were out of county residents (often transient individuals or students). About half (51%) of SAFTY's services were provided to North County residents, which is consistent with the larger proportion of child clients in North County. Crisis services saw a similar proportion of clients from North and South County..

Services by Client Region of Residence FY 18/19



Stabilization Rates

Crisis programs continued to be successful in stabilizing clients and preventing hospitalizations:

- ✓ **99%** of clients served by the **Crisis Stabilization Unit** were stabilized (did not need hospitalization) within 24 hours of CSU service.
- ✓ **92%** of clients discharged from the **Crisis Stabilization Unit** remained stabilized (did not need hospitalization) within 30 days of discharge.
- ✓ **85%** of clients served by the **Crisis Residential Treatment (CRT)** Programs were stabilized (did not need hospitalization) within 30 days of discharge; this is lower than the 92% that were stabilized in FY 17/18. This may be due to the organizational transition from Anka Behavioral Health, Inc, to Crestwood Behavioral Health.

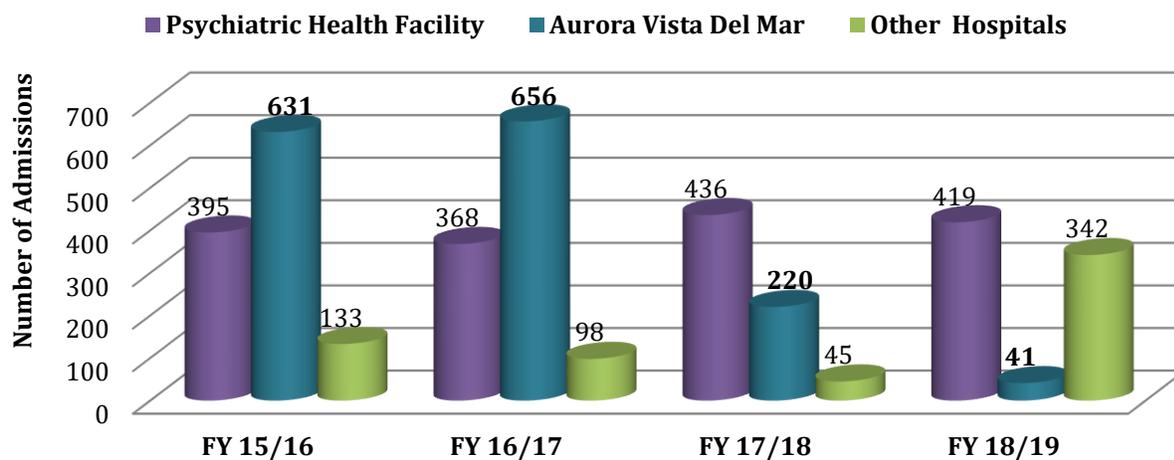
Inpatient Utilization

Behavioral Wellness monitors inpatient services closely in order to assess and address utilization, client care, and fiscal impact. The department routinely tracks the number of inpatient psychiatric hospital admissions by age group, ethnicity, and region of the county. Hospital admission data are available for the County's Psychiatric Health Facility (PHF) and all other out-of-county hospitals that report admissions to the department. Through fiscal year 16/17, acute inpatient hospital admissions were steadily increasing and this was attributed to increased court-mandated defendants who were declared "incompetent to stand trial".

Admissions

Following three years of consistently having 1,100-1,200 psychiatric hospital admissions, there were 802 admissions in FY 18/19; this was a bit higher than the significant drop that was experienced in FY 17/18 (701 psychiatric hospital admissions; a reduction of 38% from the year prior) in part because Vista Del Mar lost two buildings in the Thomas Fire in December 2017. While youth continue to access inpatient services at Aurora Vista del Mar, the county has begun sending adults to Aurora Las Encinas hospital instead of Aurora Vista del Mar, accounting for the increase in "other hospitals."

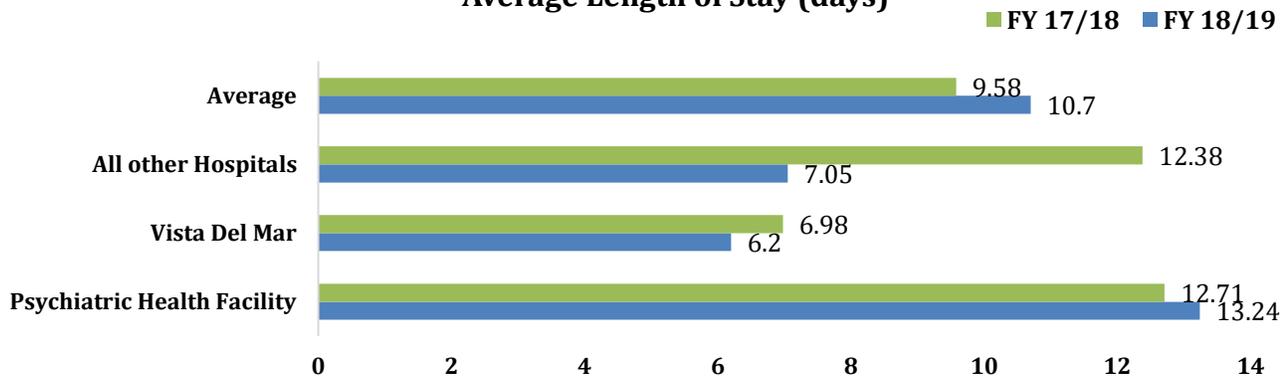
Psychiatric Hospital Admissions



Length of Stay

Across all hospitals, clients had an average length of stay of 10.7 days. The Psychiatric Health Facility had the longest average length of stay (n = 419; LOS = 13.2 days), which includes both short-term psychiatric clients and longer term conserved or IST clients, while Vista Del Mar had the shortest (n = 41; LOS = 6.2 days).

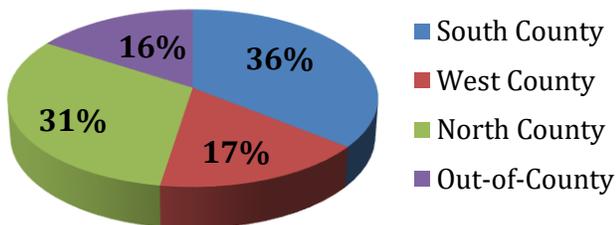
Average Length of Stay (days)



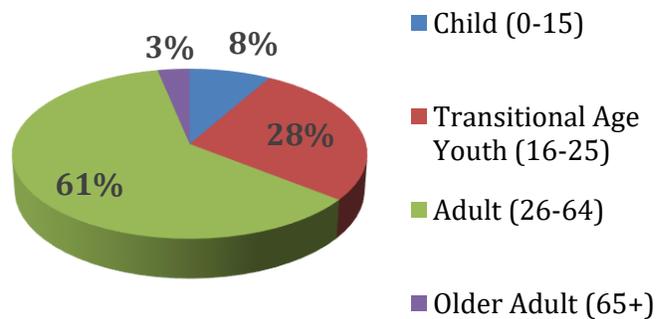
Demographics

The largest percentage (36%) of clients hospitalized lived in South County. Most (61%) were adults aged 26-64, followed by 28% that were Transitional Age Youth (TAY; 16-25); only 8% were 15 or younger and 3% over 65 years of age.

Clients Hospitalized by Region of Residence, FY 18/19

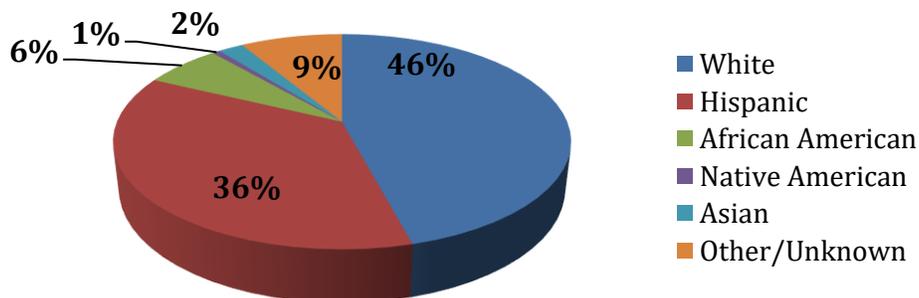


Clients Hospitalized by Age Group, FY 18/19



Just under half (46%) of hospitalized clients were White and a third (36%) were Hispanic. These demographics are similar to last year.

Clients Hospitalized by Ethnicity, FY 18/19



Timeliness of Care

In adherence with regulatory requirements, and to support system improvement efforts, Behavioral Wellness monitors numerous metrics related to timeliness of care. Ensuring that clients discharged from hospitals, for example, are connected to outpatient services, is an important component of continuity of care and reducing hospital readmissions. Likewise, responding in a timely manner to Access Line calls, particularly those designated as *crisis* or *urgent*, can help stabilize clients, meet their mental health needs and aid in avoiding hospitalization.

Access Call Type

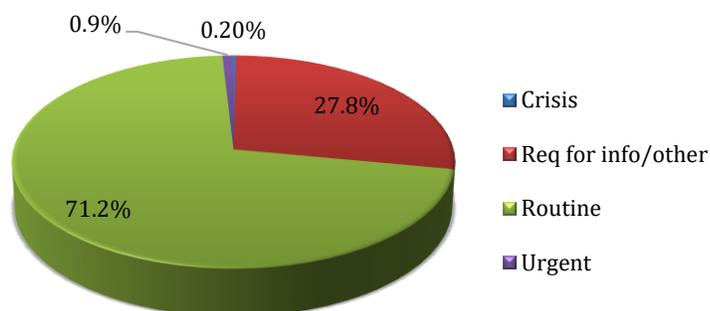
In FY15/16, the Department recognized the opportunity to improve the functioning of the Access line and the specificity of data collection. The electronic data collection form was redesigned and improved, and in October of 2016, Access staffing was centralized within Quality Care Management (QCM). Access calls/entries are categorized as follows:

- **Crisis** calls/clients: Those who are at immediate risk of hospitalization (because they pose a danger to themselves or another).
- **Urgent** calls/clients: Those who, without assistance, would likely need inpatient hospitalization within 24 hours.
- **Routine** calls/clients: Those who are neither crisis nor urgent, but rather are seeking outpatient services. Callers typically received an assessment on the phone and are given an appointment with an appropriate clinic.
- **Information/Other** calls/clients: Those seeking information about services or referrals but not seeking an intake.

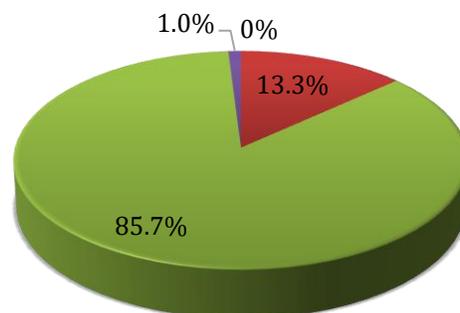
ADP Access Calls

ADP ODS was launched on December 1, 2018. Since that time the large majority (71% of adult calls and 86% of youth calls) of the total 2,454 SUD Access calls were routine and 27% of adult and 13% of youth calls were for other/information. One percent of adult and youth calls were urgent and less than 1% of adult calls and no youth calls were crisis.

**ADP Adult Access Calls by Type
FY 18/19**

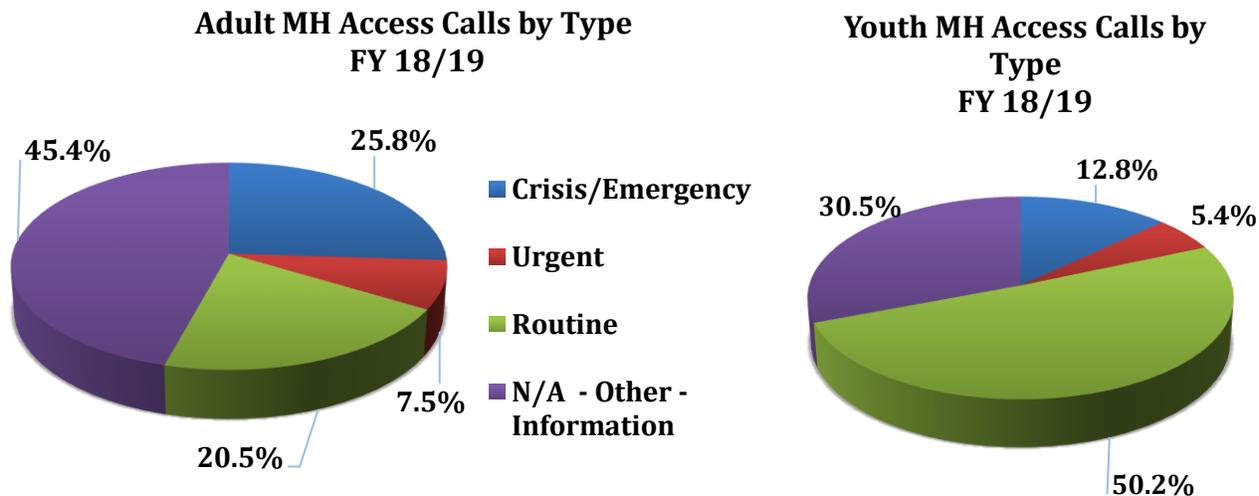


**ADP Youth Access Calls by Type
FY 18/19**



Mental Health Access Calls

In FY 18/19, there were 8,724 total Mental Health (MH) calls/entries, an average of 727 calls per month, close to last fiscal year’s average of 743 calls per month. Nearly half of all calls (46%) were to request information or “other”. About one-fifth of all calls were classified as crisis/emergencies (22%), another 7% were urgent calls. Routine calls were about one-quarter of all calls (24%). These are similar proportions to last fiscal year. Calls are displayed below by age and type².



While almost half of adult calls were to request information, half of youth calls were “routine.” A quarter of adult calls were considered crises (26%) and half (13%) as many among youth.

ADP Timeliness [New]

ADP ODS was launched on December 1, 2018; therefore, data from Q3 and Q4 is only available for this annual report. There were 2,454 calls during this time period; of those, 653 calls were for information/other and no appointment was requested or offered. The average number of days from Access call to offered appointment is calculated based on the remaining 1,870 adult and youth callers, which includes routine, urgent, and crisis calls.

ADP Access Timeliness, FY 18/19

	Adult	Youth
AVG # Days: Access Call to Offered Appt	5 days	5 days
% w/in 10 Days: Access Call to Offered Appt	83%	84%
AVG # Days: Urgent Call to Actual Appt	3.8 days	*

* Number not included due to small sample size, n < 10

² Date of birth was missing for 72 callers so they were not included in the charts above. Seventy-seven percent of callers who were missing date of birth called to request information and 22% were routine calls.

Mental Health Timeliness

Timeliness, from contact with the 24-hour Access Line to services, serves as a critical set of metrics for the Department. It is important to note that the Access Line structure, staffing, and data collection tools changed in October 2016, and that the State changed reporting requirements and regulations. Therefore, this year's data is only comparable to data collected after October 2016. It is expected that the accuracy of these indicators will continue to improve as the Department further refines data collection tools and processes. This year, the metrics were examined by adults and children in order to more fully understand the differences between groups.

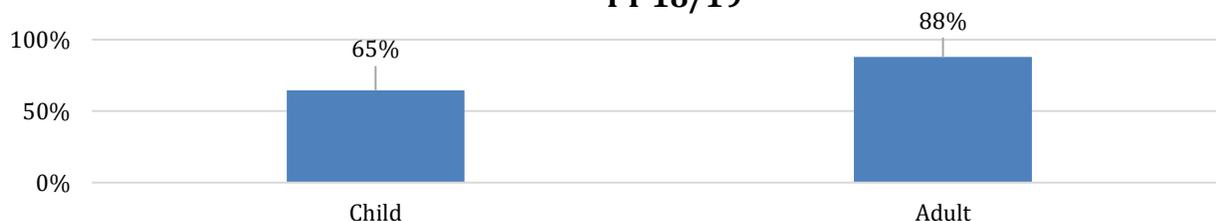
Mental Health Access Timeliness		FY 18/19	
		Adult	Youth
Routine	offered an appointment within 10 business days	92%	91%
Urgent	offered an appointment within same/next day	96%	57%
Crisis	offered an appointment within same/next day	99%	97%

The data are displayed slightly differently this year; last year we looked at this data by quarter because Access was still new. This year we are able to provide an overview for the entire year, by adult and child. Compared to last fiscal year, these metrics have improved substantially. Last year, *routine* calls were offered an appointment within 10 business days between 73-87%; this year, the average was 91% for youth and 92% for adults. For *urgent* calls, the range last year was between 72-91% for everyone; this year the average for adults was 96% and an average of 57% for youth. The low percentages for *urgent* calls to youth highlight an area for timeliness improvement that was not identifiable when both age groups were examined together. It is valuable to note that this figure was based on a small N, which allowed screeners to review classification and timeliness, and also led to immediate training for access screeners about the definition of an urgent call and the timeliness standards. Finally, calls designated as *crisis* improved in timeliness from 86-98% within same/next day last fiscal year to an average of 99% for adults and 97% for youth this fiscal year.

Outpatient Aftercare

Behavioral Wellness tracks the percent of clients receiving a Specialty Mental Health Service (SMHS) after a psychiatric hospital discharge. In past years, we reported the percent of all clients who were hospitalized, rather than the percent of clients hospitalized who ever received subsequent SMHS from Behavioral Wellness. Many clients who are hospitalized may have a follow up appointment with a private insurance or other non-MediCal-funded provider, or may be transient and leave town following hospitalization, and we do not have access to their subsequent mental health services. Clients may also choose not to attend any scheduled follow up SMHS, even though scheduled upon discharge. Therefore, in previous reports, we underreported our success in seeing clients at Behavioral Wellness in a timely manner. We corrected this to specifically look at timeliness for clients ever subsequently served by Behavioral Wellness. Also, the timeliness goal changed from SMHS within 10 days of discharge to within 7 days of discharge. Both of these changes make it difficult to make past year comparisons.

Specialty Mental Health Service within 7 days of Hospital Discharge FY 18/19



In FY 18/19, the average time from PHF discharge to a SMHS appointment was **5.0 days**. In FY 17/18, the average was **3.6 days** from PHF discharge to a SMHS. Thus, the time to SMHS appointment increased by almost one and a half days from last year, though more clients were seen within 7 days of discharge.

Psychiatry

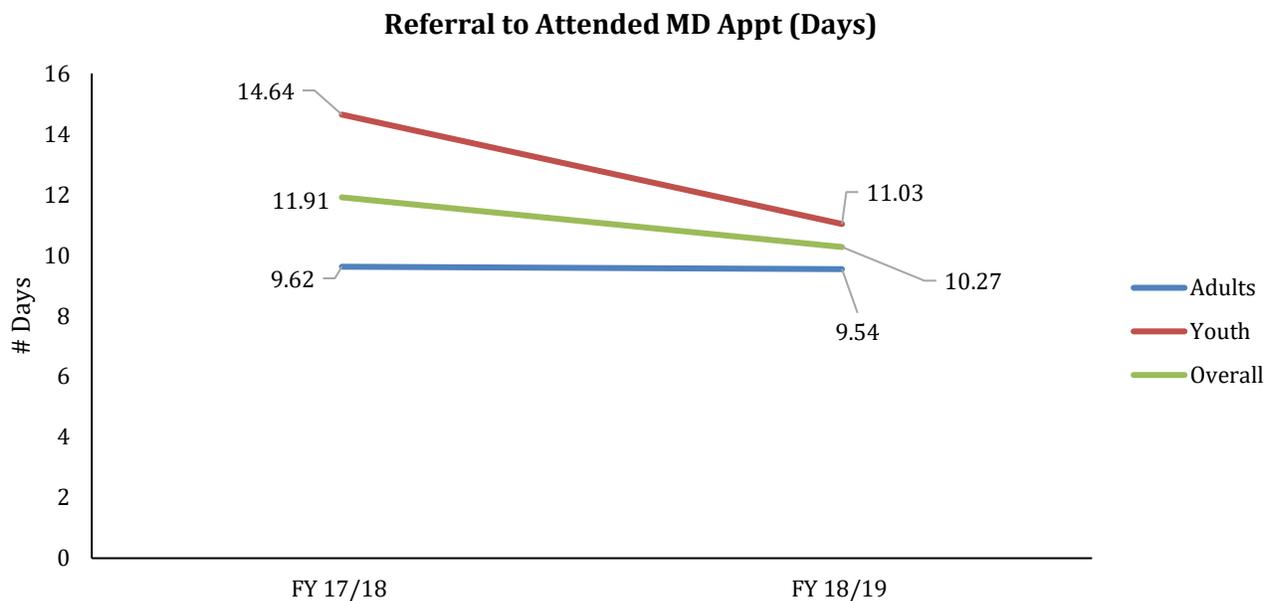
Due to limited resources, psychiatric appointments must be prioritized. For example, adults with urgent medication needs are seen more quickly than routine appointments. Similarly, youth with urgent needs are scheduled with a psychiatrist after an assessment, whereas others might have several therapeutic sessions before they are referred to a psychiatrist (and some may never need to see a psychiatrist). From the point of psychiatry referral to psychiatry appointment:

Psychiatry Timeliness FY 18/19

	Unique Adults (n = 195)	Unique Youth (n = 179)	Total Unique (n = 374)
Referral to Offered			
Offered appt. within 15 calendar days*	83%	58%	71%
Average days to offered	10.14 days	12.9 days	11.47 days
Referral to Attended			
Attended appt. within 15 calendar days*	87%	73%	80%
Average days to attended	9.54 days	11.03 days	10.27 days

*Note. Clients whose offered and attended dates were not recorded due to cancellation, no show, or not recording were counted as not within the 15-day window.

On average, 71% of clients were **offered** a psychiatry/MD appointment within 15 calendar days of referral, and 80% of clients **attended** a psychiatric/MD appointment within that time frame. The lower percentage of offered is likely due to the offered appointment not being recorded, or being cancelled, while this data was not missing for attended appointments. Adults had slightly shorter wait times than youth, (9.54 days to attended appointment for adults and 11.03 days to attended appointment for youth). The longer wait time for youth is partially a provider availability issue; there are fewer child psychiatrists and thus longer wait times. These wait times reflect an improvement compared to last fiscal year (see below).



Child Outcomes

Child and Adolescent Needs and Strengths (CANS)

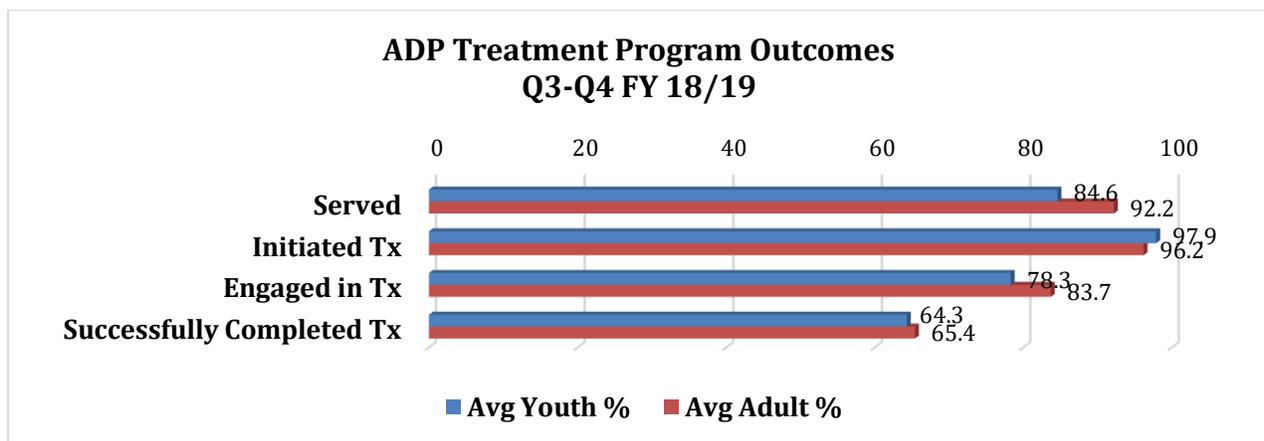
The CANS is a multi-purpose tool developed for children’s service professionals to identify current needs and strengths of the child and family, to support treatment planning, facilitate quality improvement and to monitor outcomes.

Due to a State mandated change, Santa Barbara County had to begin using a different version of the CANS in July 2018. This change in instrumentation made all existing CANS reports (such as compliance and outcomes) obsolete. Due to the analytic complexity of the CANS and the desire for clinicians and supervisors to be able to review their client strengths and needs over time, Santa Barbara County is in the process of contracting with a CANS and PSC software provider. This annual report data chapter will be updated with the CANS Outcome data as soon as it is available.

Adult Outcomes

ADP

ODS went live in the middle of Q2 and clients had to be administratively closed and re-opened into the electronic health record at that time. For this reason, complete data were only available and this report reflects Q3 and Q4. On average, 93% of client admissions were served; of those, on average, 96% initiated treatment. On average, 6% of admissions dropped (did not return) for treatment. On average 88% engaged in treatment. The average successful completion of treatment was high, and exceeded our goals at 64%.



The average lengths of stay (LOS) in days from January to June 2019 (Q3 & Q4) are as follows:

Level of Care	LOS all (in days)	LOS open (in days)	LOS closed (in days)
Outpatient (1.0)	99.2	153.7	84.7
Intensive Outpatient (2.1)	68.1	107.9	60.2
Residential (3.1)	40.5	76.2	37.3
Intensive Residential (3.5)	30.0	-	30.0
Withdrawal Management (3.2)	7.0	8.3	7.0

We expect that for any given episode of treatment, some clients will have several admissions, at different levels of care – this is both appropriate and positive. For example, a client might initially be admitted to withdrawal management, then to residential and later to outpatient treatment. To that end, 35% of clients were readmitted within 14 days after discharge, suggesting substantial utilization (step up or down) along the continuum of SUD care.

Mental Health System

Milestones of Recovery Scale (MORS)

The MORS is an 8-item tool for identifying stage of recovery. The MORS can be used to assign clients to appropriate levels of care, based on a person-centered assessment of where they are in their recovery process, and can also be used to measure progress towards recovery. Scores of 1-3 indicate extreme risk to high risk; 4-5 indicate poor coping; and, 6-8 indicate coping/rehabilitating and early or advanced recovery.

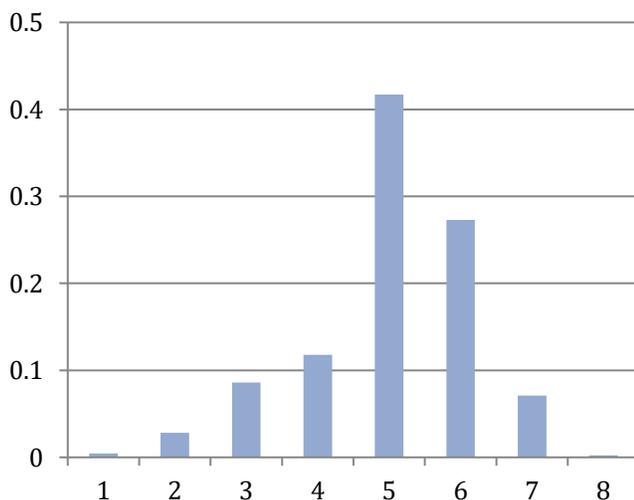
Risk/Need	MORS Scale
Highest	1 Extreme Risk
	2 High Risk / Not Engaged
	3 High Risk / Engaged
Moderate	4 Poorly Coping / Not Engaged
	5 Poorly Coping / <i>Engaged</i>
Least	6 Coping / Rehabilitating
	7 Early Recovery
	8 Advanced Recovery

Improvement on the MORS (higher number) indicates that clients have increased their level of engagement, coping skills, and stage of recovery. Decreased scores indicate that clients have not improved and are less engaged (at increased risk). Results of MORS data analyses are reported here, separately, for Transitional Age Youth (TAY) programs, Adult Outpatient, and Assertive Community Treatment (ACT). TAY and adult outpatient MORS are administered every 6 months, while adult FP/ACT clients are administered monthly. These analyses include clients with open admissions in FY 18/19, who had an intake/baseline MORS as well as MORS scores at 6- and 12-months.

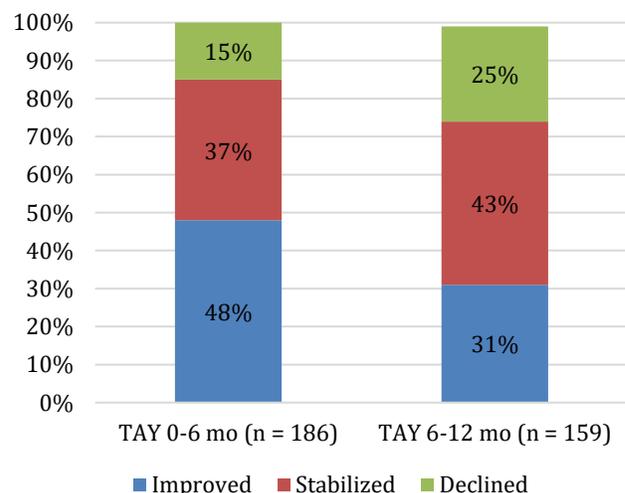
Transitional Age Youth Programs

Of all open TAY (n=333), 71.5% had a baseline MORS score (n=238). Of those, over two-thirds (71%) had a baseline MORS score of five or six – poorly coping and engaged to coping and rehabilitating. Between baseline and 6 months, 48% improved, 37% stabilized (no change in score), and 15% declined in functioning (n = 186). Between 6 and 12 months, 31% improved, 43% stabilized, and 25% of clients declined (n = 159). Thus, in the first six months of treatment, 85% of TAY improved or stabilized, and in the next six months of treatment, 74% improved or stabilized. These results represent an improvement compared to FY 17/18.

TAY Baseline MORS



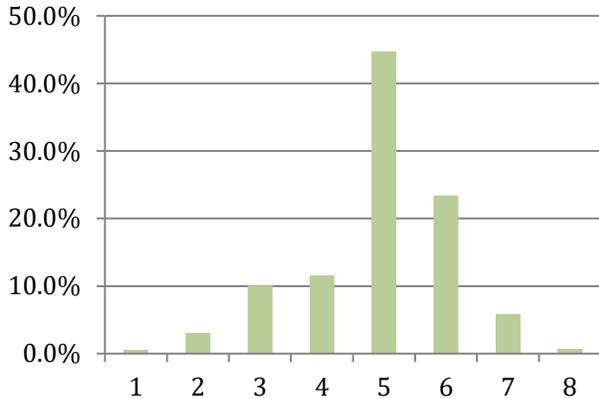
TAY MORS Change



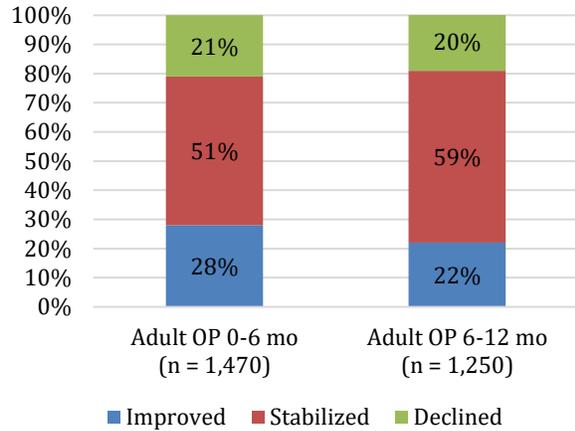
Adult Outpatient Programs

Of all open adult outpatient clients (n=2,485), 73% had a baseline MORS score (n=1,803). Of those, the majority (68%) had a baseline MORS score of five or six – poorly coping and engaged to coping and rehabilitating. Between baseline and 6 months, 28% improved, 51% stabilized (no change in score), and 21% declined in functioning (n = 1,470). Between 6 and 12 months, 22% improved, 59% stabilized, and 20% of clients declined (n = 1,250). Thus, in the first six months of treatment, 79% of adult outpatient clients improved or stabilized, and in the next six months of treatment, 81% improved or stabilized. These results represent an improvement compared to FY 17/18.

Adult Outpatient Baseline MORS



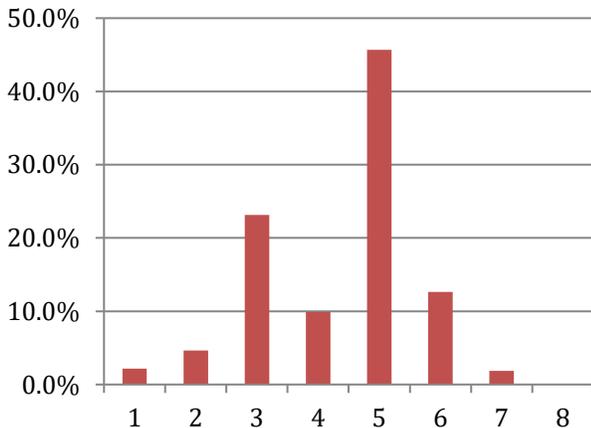
Adult OP MORS Change



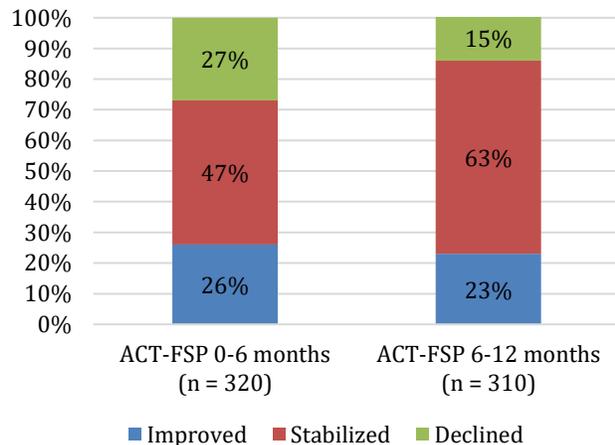
Assertive Community Treatment Programs

Of all open Assertive Community Treatment (ACT) program clients (n =324), 100% had a baseline MORS score (n =324). As we might expect, the vast majority (79%) had a baseline MORS score of three to five, lower than TAY and other adult outpatient clients. Between baseline and 6 months, 26% improved, 47% stabilized (no change in score), and 27% declined in functioning (n = 320). Between 6 and 12 months, 23% improved, 63% stabilized, and 15% of clients declined (n = 310). Thus, in the first six months of treatment, 73% of ACT clients improved or stabilized, and in the next six months of treatment, 86% improved or stabilized. These results represent an improvement compared to FY 17/18.

ACT-FSP Baseline MORS



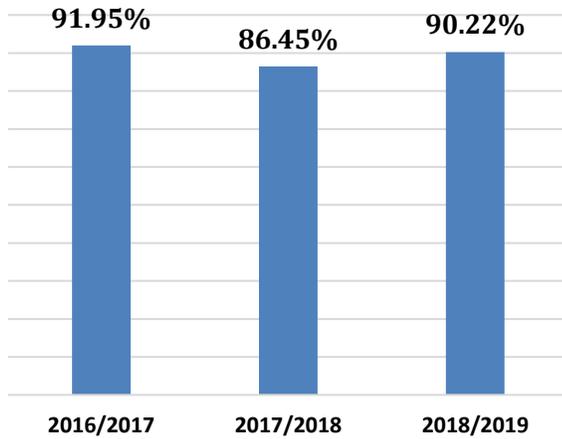
ACT-FSP MORS Change



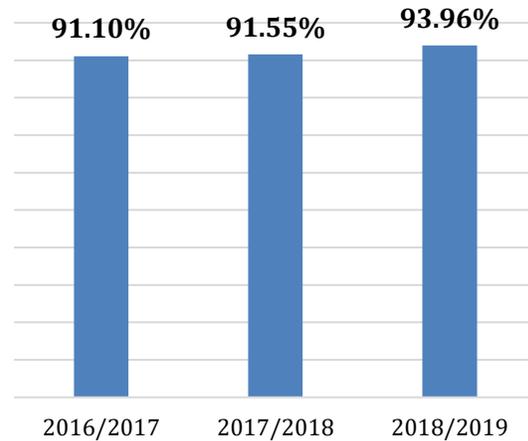
CPS – Client Satisfaction

The Consumer Perception Survey is administered to a sample of outpatient mental health (not ADP) clients in May and November of every year, including clients served in County operated programs and those served by our community-based partners. There are separate, but similar, surveys given to adults, older adults, youth, and parents/guardians. Clients report on their satisfaction with services. The graphs below indicate the percent of clients who **agree to strongly agree** that, “Overall, I am satisfied with the services I/my child received,” or “I like the services that I receive here”. The average satisfaction ratings per fiscal year are presented below. Average satisfaction ratings were high and relatively stable with small (2%) fluctuations over time.

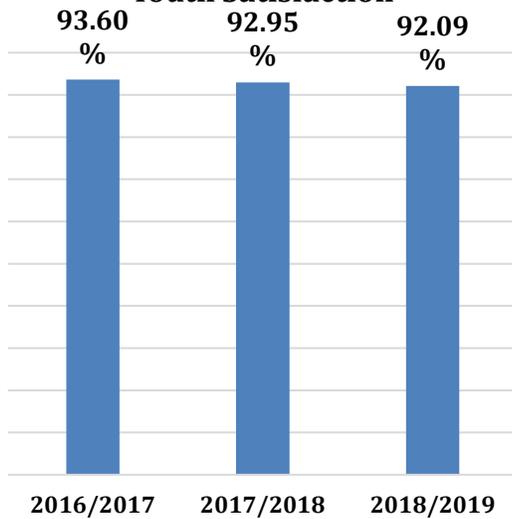
Adult Satisfaction



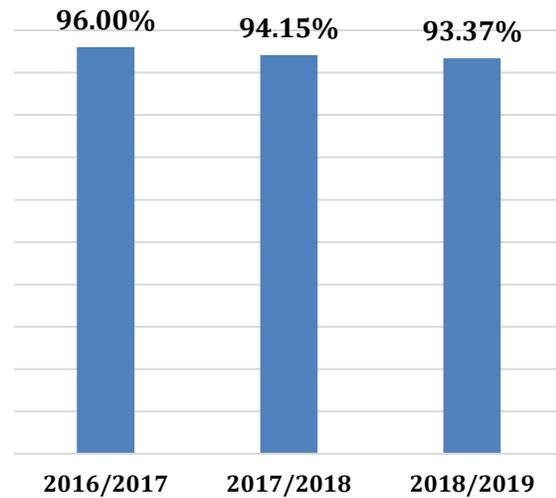
Older Adult Satisfaction



Youth Satisfaction



Family Satisfaction



Staff Activity

The Department designed a new report for managers and supervisors in order to help them monitor and support higher levels of client engagement. Data are drawn from employee's timesheets and the report provides both the number and percentage of time recorded on different types of activities, such as time spent in trainings, meetings and providing services. The total is the sum of direct and non-direct services, training and meeting hours. The Managed Care Final Rule has necessitated some changes in how staff code and complete timecards. As more training is provided for staff and timecards are more accurately completed, we expect that documented staff activities will increase.

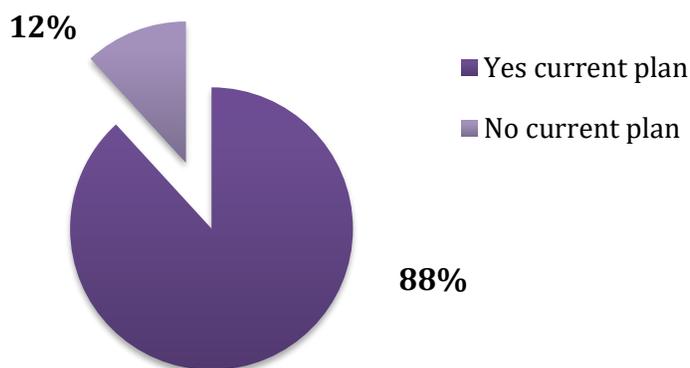
The total average documented time for staff of outpatient clinics was 47.6%; for Crisis staff, it was 26.5%. Crisis numbers are expected to be lower because their work is responsive to demand, not scheduled, as in outpatient settings. Only finalized notes are included; that is, pending and draft notes are not accounted for in direct services.

	% Meetings/Training	% Direct/Client Support	% Total
Outpatient Clinics	13.1%	34.5%	47.6%
Crisis/Triage Services	8.0%	18.5%	26.5%

Current Treatment Plans

An important indicator of our performance as a system is the extent to which we have current clinical treatment/care plans for clients. As part of Quality Improvement (QI) efforts, reports were developed to monitor this indicator, and staff have been using this data to update and complete treatment plans as required.

**Client Treatment Plan FY 18/19
Average across Sites**



For FY 18/19, treatment plans were current for 88% of clients (similar to last year). It should be noted that this is a “snapshot” from 6/30/19, and clients with “no current plan” includes both clients whose plans are expired and clients who just had an intake and are still in the process of assessment. For clients who had their intake appointment less than 60 days ago, their treatment plan may still be in development (and is in compliance with standards of care), yet would be reflected in these numbers as “no current plan.” Therefore, the 12% of clients with no current plan does not mean that these clients necessarily have expired treatment plans.

In addition to pulling system-wide data Quality Care Management Coordinators perform randomly selected internal chart audits. In FY 18/19, 180 charts were reviewed and 179 of those (99.4%) had a current treatment plan.