PROGRAM INFORMATION:

Program Title: Support and Overnight Stay (SOS)
Program Description: Specialty MH Services and Case Management
Provider: WestCare California
MHP Work Plan: 1–Behavioral Health Integrated Access
4-Behavioral health clinical care
Choose an item.
Age Group Served 1: ADULT
Age Group Served 2: Choose an item.
Dates Of Operation: Click here to enter text.
Reporting Period: July 1, 2022 – June 30, 2023
Funding Source 1: Choose an item.
Funding Source 2: Innovations (MHSA)
Funding Source 3: Choose an item.
Other Funding: Medi-Cal SPMHS

FISCAL INFORMATION:

Program Budget Amount: $1,141,440
Program Actual Amount: $985,198
Number of Unique PSs Served During Time Period: 390
Number of Services Rendered During Time Period: 1349 services for a total of 77,440 units conducted by LPHA and Case Managers and recorded in Avatar. This does not include count of activities conducted by non-clinical staff such as transportation, hospital intake, program orientation and intake, supportive counseling that accounts for a count of 2468 non-billable services. Total count of services including SPMHS is 3817. Total units of service were down almost 10% owing to the general impact of COVID and severe staffing shortages in clinical and case management over the course of the fiscal year.
Actual Cost Per PS: $2526

CONTRACT INFORMATION:

Program Type:
Type of Program: Outpatient
Contract Term: January 2019 to June 2024
For Other: Bridge MH Services to facilitate linkage
Renewal Date: Click here to enter text.
Level of Care Information Age 18 & Over: Enhanced Outpatient Treatment (caseload 1:40)
Level of Care Information Age 0- 17: Choose an item.

TARGET POPULATION INFORMATION:

Target Population: Target population are adults presenting to area Emergency Departments for 5150 evaluation who do not need hospitalization but do require linkage or re-linkage to behavioral health services to reduce crisis recidivism

CORE CONCEPTS:

- **Community collaboration:** individuals, families, agencies, and businesses work together to accomplish a shared vision.
- **Cultural competence:** adopting behaviors, attitudes and policies that enable providers to work effectively in cross-cultural situations.
- **Individual/Family-Driven, Wellness/Recovery/Resiliency-Focused Services**: adult PSs and families of children and youth identify needs and preferences that result in the most effective services and supports.
- **Access to underserved communities:** Historically unserved and underserved communities are those groups that either have documented low levels of access and/or use of mental health services, face barriers to participation in the policy making process in public mental health, have low rates of insurance coverage for mental health care, and/or have been identified as priorities for mental health services.
- **Integrated service experiences:** services for PSs and families are seamless. PSs and families do not have to negotiate with multiple agencies and funding sources to meet their needs.

Please select core concepts embedded in services/ program:
(May select more than one)

Access to underserved communities

Integrated service experiences

Individual/Family-Driven, Wellness/Recovery/Resiliency-Focused Services

Community collaboration

Please describe how the selected concept (s) embedded :

Case management services endeavor to link consumers to needed MH services as well as other resources needed to stabilize them; case managers look at whole person and attempt to integrate all services necessary to support PS, keeping in mind the consumer's strengths, needs and preferences in linkage activities. Key to these efforts is strong collaboration with mental health treatment agencies to get consumers connected to ongoing support. Short term mental health services such as assessment, plan development, group and individual rehabilitation, psychotherapy and bridge medication when needed help ensure smooth linkages to the broader system of care for PSs reluctant to engage traditional services.

PROGRAM OUTCOME & GOALS

- **Must include each of these areas/domains: (1)** Effectiveness, **(2)** Efficiency, **(3)** Access, **(4)** Satisfaction & Feedback Of Persons Served & Stakeholder
- **Include the following components for documenting each goal: (1)** Indicator, **(2)** Who Applied, **(3)** Time of Measure, **(4)** Data Source, **(5)** Target Goal Expectancy

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NO.	GOAL	DOMAIN	INDICATOR	DATA SOURCE	Target
1	Program will respond to ED within 30 minutes of call	Efficiency Access	Time to arrive at ED	Data system	Less than 30 min
2	Placement time to facility	Efficiency Access	Time at ED before transport	Data system	Less than 30 min
3	Monitor crisis recidivism	Effectiveness	# of return crisis visits during SOS episode	Avatar	N/A
4	PSs will be linked to necessary services	Effectiveness Access	# of MH linkages by program	Data system	35%
5	PSs will receive services necessary to facilitate linkages	Efficiency	# of services provided	Data system	N/A
6	Track clinical outcomes by discharge status	Effectiveness	Discharge status	Data system	N/A
7	PSs will report satisfaction with services provided	Satisfaction	% of PSs reporting satisfaction with services	Consumer survey instrument	65% report satisfaction
8	PSs will receive an array of services to facilitate linkage (further elaborates on goal #5)	Effectiveness Efficiency	# and type of services provided	Data system	N/A

OUTCOME GOALS **OUTCOME DATA**

SOS PROGRAM GOAL 1: Contractor shall track response time to emergency departments/5150 facility by SOS team members. Response to Emergency Department is expected within 30 minutes or less.

SOS Program Outcome 1: FY 2022-2023 average response time from SOS facility to emergency department is *23.5 minutes* well under the expected goal of 30 minutes.

SOS PROGRAM GOAL 2: Contractor shall track the amount of time it takes to place consumers from the emergency department to the SOS facility. The average time spent at the emergency facility constitutes the data for this goal.

SOS Program Outcome 2: FY 2022-2023 average time from arrival at ED/5150 facility to departure to SOS facility was *15.3 minutes*; consistent with the time it takes to secure consent from the PS by staff to be transported as well as discharge information from hospital staff. Average total from time of first call to arrival at SOS was *52.9 minutes*. This increase in response time was also impacted by the staffing shortage at the MLK site as staff out with COVID leaving only one staff member for periods of time.

SOS PROGRAM GOAL 3: Contractor shall track PS with behavioral health disorders who are frequent users of hospital ED/5150 facilities and monitor recidivism of those PS

SOS Program Outcome 3: Data show 394 discharges for FY 2022-2023, up from 355 discharges last rating period. This is the result primarily of more PSs staying involved with services for longer periods this fiscal year (up to 180 days) instead of 90 days because of COVID challenges that restricted most SPMHS services, especially case management, to telephonic contact. Consumers are tracked from intake forward up to 180 days for revisits to the emergency room and/or subsequent hospitalizations. Data presented here are limited to information available in Avatar and does not, as a result, include repeat visits to CRMC, other EDs and/or inpatient psychiatric units. Data presented is data for revisits to Exodus only and as recorded/found when accessing Avatar at discharge.

As reported in Avatar, Of 394 recorded discharges, for 2022-2023, two hundred twenty-five (229) or 58% there was no identifiable return visit to Exodus during the SOS episode. Of those (194) who had repeat visits to Exodus, 67 persons discharged (17%) had one recorded return visit and 34 persons (8%) had two visits to Exodus. This suggests that 74% of all PS who were served and discharged by SOS did not have excessive repeat visits to the 5150 evaluation facility. Ninety discharged PS with a return ED visit (41%), had three to five return visits, compared to 21.6% for 2021-2022. Only two consumers (2%) with return visits to Exodus compared to 10.4% of consumers in 2021-2022. ED. Of course, this data is to be interpreted cautiously as

there is no information available for those consumers presenting at CRMC, St. Agnes and other area emergency departments.

It is still critically important that a method for obtaining accurate recidivism data be devised to enhance understanding of the overall effectiveness of SOS from this data point.

SOS PROGRAM GOAL 4: Contractor shall monitor report and track appropriate linkage successes and challenges.

SOS Program Outcome 4: The tables below shows discharge status for 394 persons discharged between July 1, 2022 and June 30, 2023. Please note that the total for discharge status exceeds the total number of discharges as some were linked to both MH and SUD programs. The table also includes comparison data (shown as percentage) by category for FY 2021-2022.

DISCHARGE STATUS	NUMBER	FY 2022-2023 %	FY 2021-2022 %
Successfully Linked	187	47%	22.9%
Linked but not known active at discharge	72	18%	5.6%
SUD program linkage * noted below	108	N/A	N/A
Declined services for linkage **	77	20%	46.6%
Unable to locate	34	9%	10%
Moved out of county	12	3%	2.7%
Incarcerated	0	0.0%	0.5%
Primary AOD issues	4	1%	6.6%
Conserved	0	0.0%	0.0%
Other /Unknown	8	2%	7.0%
TOTAL	502	100	100

NOTE re: Table for Program Outcomes #4 above:

*One hundred and six of 390 persons (27%) admitted were linked to SUD treatment, of whom were linked to residential treatment. Co-Occurring persons account for 86% or 390 of those admitted to SOS. Total persons linked to services, including mental health and SUD was 76%.

**While number of persons declining further services beyond intake increased, 39% were already open to FSP programs and participating at time of intake.

<u>Successes</u>: Almost 48% of individuals were successfully linked with one or more mental health services and 38 % of persons discharged were actively participating in a mental health service at time of discharge. This is in line with the percentage of PSs who were linked in FY 2022-2023, though there were three (18) percent fewer PSs actively participating at discharge. The increase of linkages to SUD treatment is also notable.

<u>Challenges</u>: Eighty-six (89) percent of consumers admitted to SOS were homeless at time of intake. Understandably, follow-up contact is very difficult, and many consumers get lost until the next visit to the ED or 5150 facility. Keeping consumers engaged in services is also a challenge, and once linkages have been made contact with SOS is less intensive as responsibility for engagement shifts to the mental health provider. The biggest challenge aside from COVID has been staff turnover, short staffing due to illnesses, including COVID and difficulty recruiting and retaining personnel, both clinical and non-clinical staff.

<u>The following table illustrates specific mental health linkages by agency</u>. One hundred-ninety one (246) include both MH and SUD programs. The SOS case managers also routinely link consumers to housing, SSI, DSS, physical health providers, payee services, DMV and the like. These additional linkages are necessary to obtaining other critical services that may help promote mental health stabilization. The table below identifies mental health and SUD linkages, but cannot capture much of the anecdotal stories of consumers with multiple ED contacts who by virtue of SOS persistence in case management demonstrate a reduction in ED visits and successful transitions into ongoing behavioral health care despite a history of treatment failure. Of those who declined further services, 24 were already linked to various behavioral health programs at intake and did not need additional case management.

AGENCY	NUMBER 2022-2023
DBH: Metro & Specialty Teams	49
DBH: UCWC	0
MHS Impact	12
Turning Point Vista	18
Turning Point: Rural	15
Turning Point: AB109	7
Central Star TAY	1
Turning Point Sunrise	14
DART	13
Substance Abuse Treatment Programs	108
Private Psychiatrist/Mental Health	7
Other MH Linkages	13
Unknown	21
TOTAL	278

Note: About half of PSs linked to SUD programs were concurrently referred and linked to mental health services.

SOS PROGRAM GOAL 5: Contractor shall track, report and monitor follow-up contacts with consumers by case managers. These include the following types of services: linkage to mental health, case management, supportive counseling, family support and education and active efforts to contact consumers for follow-up. Services for FY 2019-2020 are further summarized under program goal number eight later in this report.

SOS Outcome 5: Since all case management services, including linkage to mental health and other ancillary services are now recorded in Avatar as a "billable" service, it is not possible any longer to track contact attempts and activities in the manner described in Program Goal 5 above.

SOS PROGRAM GOAL 6: Contractor shall track clinical outcomes by discharge placement.

SOS Outcome 6: Clinical outcomes by discharge placement are summarized below and are based on data presented in Program Goal 4:

Clinical Outcome 1: Thirty (18) percent (72) of consumers were linked to services.
At least 39 percent of PSs (153) presenting for intake were open to DBH cost centers at time of intake. Forty-three (26) percent were open to community based FSP providers and 13% were open to various DBH programs, 4% to medication only services. Data was not recorded for 34 consumers.

Clinical Outcome 2: Those consumers *successfully linked and active at discharge* (187) exhibit the following characteristics: they are linked to an identifiably appropriate mental health service; they are able to take an active role in their services, hospitalizations are minimized and returns to the ED are minimal; homeless consumers have been able to take advantage of housing opportunities.

Clinical Outcome 3: Consumers *linked but not active at discharge* (72) exhibit the following clinical outcomes; they are linked to an appropriate individual mental health service; they are familiarized with the range of options available to them; when stabilized homeless consumers can take advantage of housing opportunities and they are offered further supportive services should linkages fail.

Clinical Outcome 4: Consumers who *declined further services* (77) exhibit the following characteristics: they do not consider themselves to be mentally ill or in need of services; they exhibit a high level of denial and poor insight, and many have co-occurring substance use disorders they are unwilling to address. They tend to recidivate to area ED/5150 facilities when experiencing a transient crisis.

Clinical Outcome 5: Consumers who *cannot be contacted* (34) represent 8% of all consumers with discharge data; and exhibit the following characteristics: high levels of denial and poor insight, mostly homeless, are in a constant state of transition and avoid services, except when in a transient crisis; these consumers are more likely to recidivate to are ED/5150 facilities.

Clinical Outcome 6: Those consumers who were identified as *primary substance abusers* in need of linkage to residential and/or outpatient substance use services (4) represent seven (1%) percent of consumers served at SOS, though co-occurring mental health disorders are highly prevalent across the board for SOS consumers (about 86%). During FY 2022-2023, a total of 106 persons with substance abuse disorders were linked directly to substance abuse services, primarily residential. In many cases consumers were also linked to Full Service Partnerships and provided care coordination services to effectively bridge the two service systems.

SOS PROGRAM GOAL 7: Contractor will develop a satisfaction survey, approved by DBH that complies with mandated state performance outcome and quality improvement reports. At a minimum, eight percent of PS will report satisfaction with program services.

SOS Outcome 7:. Fiscal year FY2022-2023-year surveys were obtained. This year produced 213 surveys or almost 56% response rate. Satisfaction with SOS was very high, and comments suggest that PS experienced the program staff as hospitable, compassionate, and sensitive to their needs. Ninety-seven (98) percent of surveys are highly positive about the services that were provided.

Questions on the survey include the following: 1) I was welcomed to the program and services were explained to me; 2) SOS staff treated me with dignity and respect; 3)The SOS facility was clean and I feel sage there; 4) I had access to showers, meals and a comfortable bed; 5) Before my stay ended I met again with staff and was provided a business care so that I could follow up with needed services; and 6) Overall, my experience with SOS was a positive one. Obtaining surveys at the conclusion of an episode is not fruitful as so many PS are lost to follow-up due to homelessness and lack of contact numbers. There is no reason to believe that FY 2021-2022 would produce a very dissimilar response.

SOS PROGRAM GOAL 8: Contractor will identify services provided to each Person Served.

SOS Outcome 8: Personnel Service Coordinators and Peer Support Specialists provide a range of services that includes transportation, screening at the ED, intake activities at the overnight facility, monitoring PS, assisting with hygiene and laundry, preparing quick meals as well as offering support and encouragement. These persons are responsible for the 24-hour operation of the overnight site. These activities traditionally account for approximately 3000 activities. The count of non-clinical activities has remained relatively stable across fiscal years.

Two mental health clinicians and three case managers provide specialty mental health services which are documented in Avatar and are detailed for FY 2022-2023 in the following table. Unsuccessful contact attempts were previously tracked but since moving into Avatar this specific data is no longer collected. Contact attempts generally involve field visits and outreach efforts, coordination with other mental health providers, Fresno County Jail inmate locater and extended family contact when that information is known. It is important to note that for most of the fiscal year SOS was down a full-time clinician and one case manager (some months two CM). Clinician and case manager turnover as well as COVID issues account for the significant drop-in clinical services.

The chart below shows services entered into Avatar between 07/01/2022 and June 30, 2023, by MHRS staff and the LPHA.

Service	Units	Count
Assessment	9709	81
Plan Development	7474	93
Case Management	32654	587
Rehab Individual	15989	266
Individual Therapy	1288	19
Group Rehab	0	0
Group Therapy	0	0
Collateral	5071	98
Crisis Intervention	122	2
*Chart Note 956/958	5143	20

TOTAL SPMHS	77440	1349

*Services provided prior to assessment and plan of care development at initial SOS contact. While all PSs with Medi-Cal are referred for assessment, case management services begin typically the next morning following intake to the SOS facility.

ADDITIONAL INFORMATION

Due to COVID capacity restrictions lodge, and other housing resources bed capacity was affected during this fiscal year. All totaled there were 1976 "bed days" available. When admissions (390), revisits (229) and "layovers" (301) are totaled (920) 47% of available beds were occupied. PSs are allowed to "layover" for up to five days when necessary to achieve effective linkage to behavioral health services.

Three hundred ninety (390) unique consumers were served in FY 2022-2023 comparable to FY 2021-2022 when 346 unique PSs were served, after increasing of approximately 44 PS from the previous six years when typically, 650 PSs were served year to year. The continued decrease in referrals seemed to coincide with the opening of CRT, the Lodge and increased housing and shelter programs for homeless persons. The destabilizing effects of COVID over the past two years has also dealt a blow. SOS is wholly dependent on the referrals it receives from local hospitals and Exodus.

Eighty-eight (88) percent reported homeless at intake, an increase of two percentage points from FY 2021-2022. At discharge only 21% were recorded to be homeless though 37% were unknown as to discharge living arrangement. At admission only thee PS was housed in "other-dependent," typically board and care facilities, while 8 or 2 percent of PS had been linked to these facilities at time of discharge. There were major increases in all other categories of housed (11 at intake versus 203 at discharge) as illustrated by the table below. One hundred ninety-six PSs were NOT homeless at discharge demonstrating SOS unique success in housing/shelter advocacy.

LIVING ARRANGEMENT	INTAKE	DISCHARGE

Homeless	346	203
Alone/Independent	4	9
Friend/Relative	18	21
Other Dependent (B & C)	3	11
Shelter/Mission	2	15
Residential SUD	2	46
Unknown	15	85
TOTAL	390	390

PSs with co-occurring diagnoses number 337 of 390 admissions or 86% of total admissions. Seventy-four percent of these used meth alone or in combination with other substances, 32% alcohol, 33% cannabis and only 12% identified heroin/opiates used alone or in combination with other substances. Other two (2) percent report any use of cocaine. Twenty nine percent of PSs report polysubstance use of three or more substances.

Males outnumbered females. Sixty-eight (70) percent males and 29% female, as well as two males to female transgender and one female to male.

Twenty-two (22) percent of PSs were between the ages of 18 to 29, 74% between 30 and 59 and 4% were 60 and older.

Ethnic breakdown included 43.5% Hispanic, 26.7% Caucasian, 21% African-American, 3.5% Native American, 3% Asian and 2.3% who identified as mixed race or other ethnicity.

Fifty-two (53) percent of persons served were diagnosed with psychotic disorders including schizophrenia, schizoaffective disorder, and psychotic disorder unspecified (203 persons), a 2.5% increase. Bipolar diagnoses comprised 7% of referrals and Mood disorder unspecified was 8%. Depressive disorders accounted for 21% of referrals and only two persons were identified at referral as drug-induced symptoms.

Seven (7) percent of PSs had miscellaneous disorders such as ADHD, Anxiety, PTSD, Adjustment Disorder, and other "unspecified" diagnosis. No diagnosis was recorded in Avatar for 16 persons or 4%.

Referrals predominantly come from Exodus (47%). thirteen (13) percent come from CRMC, 7% from Clovis Community, 8% CBHC. Twelve (16) percent came from St. Agnes and just 9% are referrals from Kaiser or other hospitals out of the area. For nine persons served there was no referral source documented.

DEPARTMENT RECOMMENDATION(S):

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