FRESNO COUNTY DEPARTMENT OF BEHAVIORAL HEALTH — OUTCOMES REPORT- Attachment A

PROGRAM INFORMATION:

Program Title:	Central Star Youth Psychiatric Health Facility (PHF)	**Provider:**	Central Star Behavioral Health, Inc.
Program Description:	Acute Inpatient Care for Adolescents	**MHP Work Plan:**	4-Behavioral health clinical care
Age Group Served 1:	CHILDREN	**Dates Of Operation:**	April 20, 2015 - present
Age Group Served 2:	Choose an item.	**Reporting Period:**	July 1, 2015 - June 30, 2016
Funding Source 1:	Medical FFP	**Funding Source 3:**	Other, please specify below
Funding Source 2:	Realignment	**Other Funding:**	Private Insurance

FISCAL INFORMATION:

Program Budget Amount:	$3,502,840, Fresno County	**Program Actual Amount:**	$2,131,914 Fresno County Clients ($2,635,902.75 – Total Cost)

Number of Unique Clients Served During Time Period: 290 Fresno County clients.

Number of Services Rendered During Time Period: 2,671 Fresno County bed days

Actual Cost Per Client: Average $7,351.20 per client

CONTRACT INFORMATION:

Program Type:	Contract-Operated	**Type of Program:**	PHF/Inpatient
Contract Term:	Jan 2015 – Jun 2020 (01/01/2015 to 06/30/2018 plus two optional twelve-month periods)	**For Other:**	Click here to enter text.
		Renewal Date:	07/01/2020

Level of Care Information Age 18 & Over: Choose an item.

Level of Care Information Age 0- 17: Choose an item.

The levels of care shown above do not apply. This program provides acute inpatient psychiatric services for adolescents.

TARGET POPULATION INFORMATION:

Target Population: Adolescents, ages 12 to 18 in acute mental health distress who present a threat of harm to self, and/or to others and/or grave disability (severe personal disorganization and inability for self-care and/or functioning safely in the community). Clients include Medi-Cal beneficiaries, Medicare and Medicare/Medi-Cal beneficiaries, and indigent/uninsured clients who are referred by DBH, other County departments, a contract provider with the DBH, a hospital emergency room, Juvenile Hall, and other agencies.

MHSA CORE CONCEPTS:

Please select MHSA core concepts embedded in services/ program: *(May select more than one)*	**Please describe how the selected concept (s) embedded** :
Recovery/Resiliency Orientation Cultural Competence Orientation Community Collaboration Client/Family Driven Program	Recovery and resiliency are fully infused via our selection of practice models that include WRAP, and multiple other hope, strength-based, skill building and wellness focused programming and curricula. Cultural attunement is a strong, long held framework requiring active bi-annual planning with program specific projects and an explicit focus of staff recruitment and trainings (formal plan also provided to county). Learning and working with the communities we serve, our varied agency partners, and the resources/services available for discharge/aftercare is mission critical to program success and discussed vis a vis our evaluation data in Form C. Very much client/family driven! Please request to see our Handbooks for clients and families, visit during our family night groups and inclusive treatment team meetings, and peruse our consumer input via surveys. Finally, regarding integrated care, we completed the COMPASS assessment this past year, have identified key areas to move forward on regarding substance abuse, already integrated Seeking Safety units (for co-occuring trauma and substance abuse) into milieu programming, and are currently actively searching for additional pertinent health teaching modules. Note: overall our Core Practice training curricula engages staff in discussion and mastery across all the MHSA core concept areas.

PROGRAM OUTCOME GOALS:

REQUIRED: 1) Short amount of time between client referral and admission to the PHF; 2) Effective discharge planning as demonstrated by referral and linkage to other DBH programs, community providers and other community resources; 3) Collaborative approaches and treatment strategies to reduce readmission of clients with frequent readmissions to the facility; and, 4) Low denial rate related to those who do not meet Medi-Cal medical necessity criteria per DBH's utilization review. OPTIONAL: 1) Reduced incidence of involuntary hospitalization and incarcerations (Post Discharge); 2) Reduced frequency and severity of crisis in the community (Post Discharge); 3) Increased acquisition of community living, coping and communication skills; and 4) Reduction in high risk behavior.

PROGRAM OUTCOME DATA/INDICATORS:

Evaluation currently encompasses: 1) SBHG EMR data entered by program staff regarding client registry, service utilization; and, risk behavior incidents. 2) Survey methodologies to capture additional information and perspectives from clients, families and/or agency partners. 3) System of Care Dataset Analyses to assess patterns (including repeat use) of crisis/hospital and other high end services vis a vis available community services and supports among clients before, during and after their PHF service episodes. The latter will require collaboration and access to county datasets on individuals served by the PHF, TBD.

For a psychiatric hospital in a county without recent prior adolescent inpatient treatment capacity, a key measure of effectiveness is achieving, sustaining and managing utilization so that people in the community have a safe, structured and secure setting to send youth during acute crises. During FY 15-16 (Jul-Jun) there were 481 unduplicated clients served during 629 episodes of care across all counties served by the PHF. Lengths of stay ranged from 1 to 24 days, and averaged 5.7 days (75% exited within 7 days). The average daily census (calculated over a month) was 10, and ranged from 7 to 13. Since opening, the facility served 544 unduplicated youth during 713 episodes, with an average length of stay of 6.6 (75% exiting within 7 days). And, since opening, the average daily census was also 10 with same range as above. While the daily census fluctuates, it averages out similarly, and LOS is down, for the recently closed FY compared to the first few months of initial operations.

Regarding Fresno County clients only, since opening, the facility served 400 unduplicated Fresno County youth during 551 episodes, with an average length of stay of 5.9 days (75% exiting within 7 days). During FY 15-16, there were 342 unduplicated clients served during 476 episodes of care.[1] Lengths of stay ranged from 1 to 29 days, and averaged 5.3 days (75% exited within 6 days). Please see table #3 for more information about Fresno youth's readmissions.

We wish to draw your attention to our efforts to understand and address the key performance indicator of repeat admissions which is a current program focus. The majority (83%) of clients had only one episode since the facility opened. The historical average episode count per client is 1.3, with a range of 1 to 9. Analyses, incl. multivariate regression, reveals there have been three outlier clients, with 7, 8 & 9 episodes each. There is a cluster (16% of all clients) with episode counts between 2 to 5 each. The drivers of higher repeat episodes appear to be: Longer First Episodes (N= 203; p<.000, Importance .244) and County Social Services Referral Source (N= 18; p<.000, Importance .092). Ethnicity (African Americans, Asian Americans and Other/Mixed), is also predictive, but is not as statistically significant (N=80; p<.034, Importance .024). The average episode counts of those with above median First Episode Lengths (over 5 days) and those referred from County Social Services is 1.6. Also, there is a strong linear relationship between First Episode Lengths and PHF recidivism (ANOVA F = 47, p<.000). The two driving factors (longer first episodes, social services referrals) may be proxy variables for uncertainty and difficulties in effecting solid, stable discharge arrangements among the subset of clients with child welfare involvements, and/or other complicating factors affecting their discharge ease (in the short term) and their family/home life and placement circumstances (in the longer term). Additional analyses are planned to further understand and address the pertinent factors driving repeat use of the PHF. Other program results and data

[1] Please note the EMR dataset shows missing Fresno County unique identifier numbers on 91 youth due to identifiers not being available at the time of admission. Thus, there is likely an over count in this section (episode data were matched on last name, first name and date of birth to yield unduplicated client counts) – note the fiscal information above from the reported 290 unduplicated clients served in FY 15-16, tallied across monthly invoices . We will continue to investigate, clarify inconsistencies in our tracking systems, and report improved figures if we we can locate the missing information.

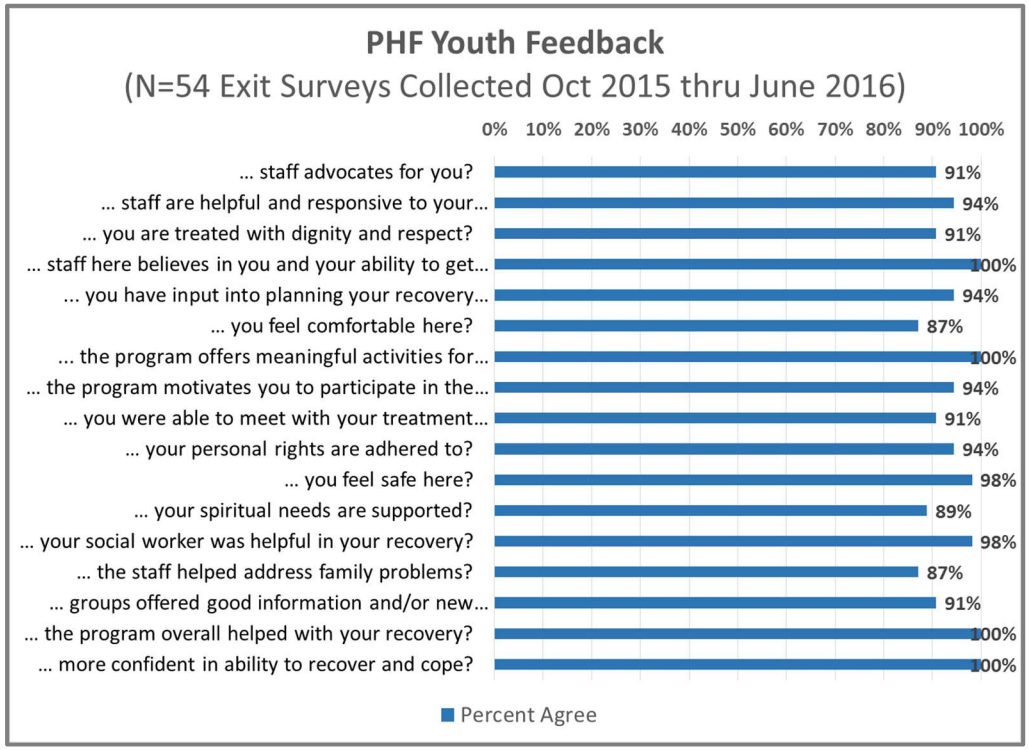
are presented in the table below.

REQUIRED	1. The time between client referral and admission to the PHF	• Data QI progress since last year = Time stamps added to admissions in the EMR. • Data QI need: referral date/time tracking in analyzable format. Currently insufficient data available to report; • There were no distinctive situations impacting admissions this year; program managers report that most admissions occur within 48 hours of referrals, and on occasion may take up to 3 days. • We are currently investigating (unidentified) agency partner assertions of difficulties effecting timely admissions. The investigation is led by our company president, as we take this very seriously.
	2. Effectiveness of discharge planning as demonstrated by the referral and linkage to other Department of Behavioral Health programs, community providers and other community resources	From PHF aftercare module in EMR, discharge summaries manually examined on N=265 discharges during FY 15-16 (across all counties served), below: Data QI Needed: Dataset lacks County of Residence. <u>Discharge Settings:</u> *222 (84%) discharged to family home* 21 (8%) discharged to group home 9 (3%) discharged to foster home 7 (3%) discharged to CPS protection 5 (2%) discharged to law enforcement <u>Recovery Potential</u> (staff ratings, with notes for collaboration and follow-through re: aftercare): *169 (65%) Good Rehabilitation Potential* *87 (34%) Fair Rehabilitation Potential* 3 (1%) Poor Rehabilitation Potential • Data QI progress since last year = Discharge summaries captured on form in EMR and routinely completed • Data QI needed: a) Conduct inter-rater reliability testing on recovery potential ratings; b) Automate using data codes and extracts to facilitate analyses of all records, not just a sample; and, c) consider survey protocols (see below).

	3. Collaborative approach and treatment strategies to reduce readmission of clients with frequent readmissions to the facility	Fresno County Youth's Readmission Data: Among episodes during FY 15-16, 21% represent a readmission (youth seen before in the facility, one or more times, including prior to FY 15-16). Over all time, on average, Fresno youth experienced 1.4 PHF admissions each. The majority (81%) had one admission since the facility opened. The majority of those returning (18% out of 19%) had 2 to 5 episodes each. A sizable percentage (43%) of readmissions occur within 30 days. • Continued Program Focus: Bring family and allied professionals into aftercare planning as early as possible for clients with historically high use. • Continue to support all high users and their families with a written WRAP by discharge. • Program QI: Examine feasibility, assignments to implement Follow-Up Linkage & Referral Phone Calls. • Access and evaluate county datasets on PHF clients' subsequent enrollment in community based services.
	4. Denial rate for PHF that do not meet Medi-Cal medical necessity criteria as determined by the utilization review performed by Fresno County MH Plan	• Approval rate improved to 97% by Jan 2016, maintained at a high level (97% overall for the year), with 100% achieved in June 2016.
OPTIONAL (PART OF SBHG EVALU PLAN)	5. Reduce incidence of involuntary hospitalization and incarcerations (Post Discharge)	• Data QI: Explore feasibility with county and implement planned System of Care Dataset Analyses
	6. Reduce frequency and severity of crisis in the community (Post Discharge)	• Data QI: Explore feasibility with county and implement planned System of Care Dataset Analyses
	7. Increased acquisition of community living, coping and communication skills	• Data QI Progress. Youth surveys implemented. See graphic following table. • Data QI Needed: Examine feasibility of surveying family members, agency partners working with clients post discharge.

	8. Reduction in high risk behavior (e.g. aggression, self-harm, substance abuse, high risk sexual activity, etc.)	Behavioral Risks While In Setting: ○ There were 155 incidents in the facility this past fiscal year. ○ The most common types of incidents are client crisis (e.g., aggression, out-of-control behavior) (58%) and contraband and property damage (13%). Client injuries occurred in 6% of all incidents; and staff injuries 2%. ○ There were *no occasions* where injuries were serious enough to warrant external medical attention. There were *no suicides or fatalities* from other causes during enrollments since the program opened. Use of Restrictive Interventions: ○ The team managed risk behavior incidents with low use of restrictive interventions. On average *in a quarter*, emergency medications are used 8.3 times, involuntary seclusion 4.3 times; and behavioral restraints 7.3 times. Since program began, these (all types combined) compute to 26 uses of restrictive interventions per 1,000 patient days; 25 during recent FY. ○ Most (60%) behavioral restraints last for under 40 mins. (range 3 mins. to 3 hrs.). Most (75%) seclusions last for under 40 minutes (range 7 mins. to 3 hrs.). Any restraint or seclusion of an adolescent lasting over 2 hours requires reauthorization by the physician (this occurred with just one client once in recent FY). Behavioral Risks Post Discharge: ○ PHF clients' diagnoses include 86% with internalizing conditions, including 59% with severe symptoms involving mood and emotional dysregulation, and 57% with a history of attempts and/or ideation about suicide. These are the greatest behavioral risks for discharging clients, and necessitate careful discharge planning and much attention and close-in monitoring by next-on providers. • Data QI Progress: The agency has a new incident module in the EMR, which will facilitate within client data analyses and streamline routine reporting on aggregate data such as above. • Data QI Needed: Examine criteria and usage of "client crisis" category. • Data QI Needed: Explore feasibility of Follow-Up Linkage & Referral Phone Interview protocol.

	9. Increased linkage to and utilization of community resources and natural supports to foster ongoing wellness and recovery – as defined by participant	• Data QI Progress. Youth surveys implemented. Please see graph following table. • Data QI Needed: Examine feasibility of surveying family members, agency partners working with clients post discharge.
	10. Discharge to a stable living situation	• Data QI Progress. Data field added to EMR Aftercare Plan, discharge summary (see Item #2 above for settings). • Data QI Needed: Explore interviewing returning youth in more depth regarding their family and living situations to understand (codify) the kinds of issues and challenges occurring between admissions.
	11. Return to or linkage to outpatient mental health services	• Implement planned System of Care Dataset Analyses
	12. Establishing a permanent relationship with one or more caring support person	• Data QI Progress. Youth surveys implemented. See graphic following table. • Aggressively pursue permanency focus as part of Aftercare planning. • Data QI Needed: Examine feasibility of surveying family members, agency partners working with clients post discharge.



DEPARTMENT RECOMMENDATION(S):

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