FRESNO COUNTY MENTAL HEALTH PLAN OUTCOMES REPORT- Attachment A

PROGRAM INFORMATION:

Program Title:	Support and Overnight Stay (SOS)	**Provider:**	Westcare California
Program Description:	Case Management	**MHP Work Plan:**	4-Behavioral health clinical care 1–Behavioral Health Integrated Access Choose an item.
Age Group Served 1:	ADULT	**Dates Of Operation:**	July 2012 to present
Age Group Served 2:		**Reporting Period:**	July 1, 2018 - June 30, 2019
Funding Source 1:		**Funding Source 3:**	Early Intervention (MHSA)
Funding Source 2:	Early Intervention (MHSA)	**Other Funding:**	

FISCAL INFORMATION:

Program Budget Amount:	$866,729	**Program Actual Amount:**	$814,552
Number of Unique Clients Served During Time Period:	447		
Number of Services Rendered During Time Period:	7923		
Actual Cost Per Client:	$1822.00		

CONTRACT INFORMATION:

Program Type:		**Type of Program:**	Outpatient
Contract Term:	May 2012 to June 2024	**For Other:**	Case Management
		Renewal Date:	Contract was renewed as of January 1, 2019 but specialty mental health services did not begin until after June 30, 2019

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: Adults presenting to area EDs for 5150 evaluation who do not require hospitalization but do require linkage to mental health and other services to reduce crisis recidivism

CORE CONCEPTS:

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

Access to underserved communities

Integrated service experiences

Community collaboration

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

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 client, 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 clients 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

Click here to enter text.

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	Clients will be linked to necessary services	Effectiveness Access	# of MH linkages by program	Data system	35%
5	Clients 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	Clients will report satisfaction with services provided	Satisfaction	% of clients reporting satisfaction with services	Consumer survey instrument	65% report satisfaction
8	Clients 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 2018-2019 average response time from SOS facility to emergency department is *16.7 minutes* well below 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 2017-18 average time from arrival at ED/5150 facility to departure to SOS facility was *16.3 minutes*; consistent with the time it take to secure consent from the client to be transported as well as discharge information from hospital staff. Average total from time of first call to arrival at SOS was *52 minutes*.

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

SOS Program Outcome 3: Data show 484 discharges for FY 2018-19. 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 484 recorded discharges, 240 (49.5%) there was no identifiable return visit to Exodus during the SOS episode. Of those (244) who had repeat visits to Exodus, 81 persons discharged (16.7%) had one recorded return visit. Eight percent (8%) had two visits to Exodus. This suggests that 75% of persons who were served and discharged by SOS did not have excessive repeat visits to the 5150 evaluation facility. One hundred eighteen (118) of 484 discharged consumers with a return ED visit or 24%, had three to five return visits. Only one (1) percent of consumers, five in total had 10-11 return visits to the ED. Six consumers of 484 discharged had greater than 21 revisits to Exodus with a range of 21 to 43, representing 20% of the 945 recorded revisits to Exodus even though they only account for 1.2% of total discharged. 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 department

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 484 individuals who discharged between July 1, 2018 and June 30, 2019. The table also includes comparison data (shown as percentage) by category for FY 2017-2018.

DISCHARGE STATUS	NUMBER	FY 2017-2018 %	FY 2018-2019 %
Successfully Linked	154	31.8%	28.2%
Linked but not known active at discharge	50	10.4%	11.1%
Declined services for linkage	37	7.6%	12.04%
Unable to locate	138	28.5%	35.8%
Moved out of county	10	2.0%	3.7%
Incarcerated	0	0.0%	3.5%
Primary AOD problem	8	1.7%	1.06%
Not SMI	1	0.2%	0.5%
Conserved	0	0.0%	2.6%
Other/Unknown Linkage	86	17.8%	1.5%
TOTAL	484	100	100

Successes: Forty-two (42.2%) percent of individuals were successfully linked with one or more mental health services and at least 32% of persons discharged were actively participating in a mental health service at time of discharge. Both the percentage of persons linked and the percentage of those linked who were actively participating at discharge INCREASED by almost three percentage points. Fewer persons refused service linkage this reporting period (a decrease of more than five percent from FY 2017-2018.

Challenges: Eighty-one (81) 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. Additionally, the program declined to collect discharge reason data for 86 consumers or almost 18%; This impacts the accuracy of the above detailed data. Still data suggests that fewer consumers are declining services and fewer consumers were unable to be located from intake to discharge down from 36% to 29% from last reporting period.

The following table illustrates specific mental health linkages by agency. Two hundred forty-eight (248) recorded linkages were made for consumers during FY 2018-2019. This number is only ten fewer than for FY 2017-2018 (258), however it also represents an increase in overall linkages because there were also fewer discharges for comparison (484 in FY18.19 to 656 in FY17.18). These linkages represent ONLY mental health linkages. 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 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 mental health care despite a history of treatment failure.

AGENCY	**NUMBER 2018-2019**	**PERCENTAGE**
DBH: Specialty Programs Older Adult, RISE, SHINE. First Onset, IOP, Medium and High Intensity, TAY	6	2.4%
DBH: Metro	82	33.0%
DBH: UCWC	20	8.1%
MHS Impact	29	11.7%
Turning Point Vista	56	22.6%
Turning Point: TAY	5	2.0%
Turning Point: Rural	10	4.0%
Substance Abuse Treatment Program	40	16.2%
TOTAL	248	100

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 2018-2019 are further summarized under program goal number eight later in this report.

SOS Outcome 5: Data for FY 2018-2019 show that activities were logged by case managers in efforts to get consumers linked to on-going mental health services after initial orientation and intake.

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: Forty-one (41.2) percent (248) of consumers were linked to services. Thirty percent of clients presenting for intake were or had been, linked to various county programs

Clinical Outcome 2: Those consumers *successfully linked and active at discharge* (154) 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* (50) 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* (37) 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* (138) represent 28.5% 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 are identified as *primary substance abusers* in need of linkage to residential and/or outpatient substance use services (8) represent only two (2%) percent of consumers served at SOS, though co-occurring mental health disorders are highly prevalent across the board for SOS consumers (about 88%). During FY 2018-2019, a total of 40 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 consumers will report satisfaction with program services.

SOS Outcome 7: Four hundred sixty (460) consumer surveys were completed the day following admission. This is an 80% response rate overall. Satisfaction with SOS is very high and comments suggest that consumers experience the program staff as hospitable, compassionate and sensitive to their needs. Ninety-seven (97) 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 consumers are lost to follow-up due to homelessness and lack of contact numbers.

SOS PROGRAM GOAL 8: Contractor will identify services provided to each consumer

SOS Outcome 8: For FY 2018-2019 SOS provided a total of 5412 activities for consumers. The following information reflected in Category two does not include case management activities for Case Mangers for late May through June 2019 as they began entering their services in Avatar instead of WestCare's Clinical Data Base. It Activities are displayed in two categories. Category One (3145 services) includes intake activities performed by Personal Service Coordinators and Peer Support Specialists. Category Two (2267 services) includes various support activities provided by case managers in efforts to get consumers linked to appropriate mental health services.

Contact attempts 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.

Category One: Non Case Management	**Number**	**Category Two: Case Management**	**Number**
Hospital Intake	1030	Case Management	793
Intake at SOS facility	1065	Contact Attempt	543
Transportation	1050	Family Support	54
		Mental Health Linkage	209
		Supportive Counseling	668
TOTAL CATEGORY ONE	3145	TOTAL CATEGORY TWO	2267

During startup of clinical services in June 2019, case managers recorded their activities by "note to chart" as assessments and plans of care needed to be completed for all new and existing consumers. The program continued to provide the usual services and documented them in Avatar, notwithstanding various challenges of learning to "bill" differently and in a new health record.

The chart below shows services entered into Avatar between 5/15/19 and 6/30/19 by MHRS staff and the LPHA. Specialty mental health services are new services added to the SOS contract and will be included in ongoing annual reports.

Service	Units	Number	
Assessment	3871	30	
Plan Development	1251	21	
Case Management	1306	31	Notes to charts included here
Rehab Individual	173	4	
Individual Therapy	105	1	
TOTAL SPMHS	6533	77	

ADDITIONAL INFORMATION

Four hundred forty-seven unique consumers were served in FY 2018-2019 compared to six hundred and fifty-six unique (648) persons in FY 2017-2018, a decrease of 209 consumers from FY2017-2018. The steep decrease in referrals is of concern and needs to be researched. It may be that the CRT program has drawn some clients away or that there has been an increase in persons requiring hospitalization.

Eighty-one (81) percent reported homeless at intake, an increase of four percentage points from FY 2017-2018.

There were 1246 bed days logged for the fiscal year, which included 577 unique individuals and 670 total “revisits” which are repeat visits to the ED and/or lay-overs by persons still active in their SOS episodes. This is an average of four clients utilizing beds on any given day or 106 bed days per month.

Clients with co-occurring diagnoses number 339 unique individuals or 76% of total clients. Thirty-eight (38) percent of clients report a chronic or serious health condition as well.

Males outnumbered females. Sixty-four (64) percent males and 35% female, as well as three transgender females.

Ethnic breakdown included 36% Hispanic, 33% Caucasian, 20% African-American, 4% Native American, 2.5% Asian and 3.25% who identified as mixed race.

Fifty-six (56) percent of clients served were between the ages of 20 to 39. Range of ages served was 18-78 years of age. Twenty-one (21) percent were age 40-49.

Thirty-nine (39) percent of persons served were diagnosed with psychotic disorders including schizophrenia, schizoaffective disorder and psychotic disorder unspecified (72 persons). Bipolar diagnoses comprised 8% of referrals and Mood disorder unspecified was 10%. Depressive disorders accounted for 22% of referrals and only three persons were found to have a primary substance use disorder. Five percent of clients had miscellaneous disorders such as ADHD, Anxiety, PTSD, Adjustment and Autism and six percent had no diagnosis recorded in Avatar.

Referrals predominantly come from Exodus (50%). Thirty-five (35) percent come from CRMC and St. Agnes while 14% are post hospitalization referrals from various psychiatric hospitals Fresno County contracts with. The drop in referrals, and thereby opportunities to serve consumers, is of concern. Two hundred fewer consumers were served in FY18-19; Six hundred forty-eight were served in 2017-2018 and only four hundred forty-seven for this period. That said, only ten fewer clients were linked or re-linked than for the previous period.

DEPARTMENT RECOMMENDATION(S):

Click here to enter text.