

## FRESNO COUNTY MENTAL HEALTH PLAN

## OUTCOMES REPORT- Attachment A

### PROGRAM INFORMATION:

<b>Program Title:</b>	Primary Care Integration	<b>Provider:</b>	Clinica Sierra Vista
<b>Program Description:</b>	The SMI/SED service component aims to provide services to clients with SMI/SED diagnoses, utilizing recognized evidence - based practices and outcome-informed therapy targeted to address and treat mental health concerns and diagnoses on a case by case basis. Clinica Sierra Vista aims to integrate primary care with specialty mental health services for SMI/SED population, in accordance to individualized treatment plans. Individuals experiencing early manifestations of a mental health concern or illness shall receive early intervention services to prevent the illness or concern from worsening. Clinica has also been working diligently this past year to develop and grow the current SUD program within the BH sites.	<b>MHP Work Plan:</b>	1-Behavioral Health Integrated Access 2-Wellness, recovery, and resiliency support 3-Culturally and community defined practices
<b>Age Group Served 1:</b>	ADULT	<b>Dates Of Operation:</b>	07/01/2018-present
<b>Age Group Served 2:</b>	CHILDREN	<b>Reporting Period:</b>	July 1, 2020 - June 30, 2021
<b>Funding Source 1:</b>	Medical FFP	<b>Funding Source 3:</b>	Prevention (MHSA)
<b>Funding Source 2:</b>	Com Services & Supports (MHSA)	<b>Other Funding:</b>	Click here to enter text.

### FISCAL INFORMATION:

<b>Program Budget Amount:</b>	SED Contract Budget = \$1,944,763 SMI Contract Budget = \$1,964,447 PCI:SUD Contract Budget = \$688,892 PEI Contract Budget=\$92,089	<b>Program Actual Amount:</b>	Program Expenses for SED = \$1,130,198 Program Expenses for SMI = \$1,409,443 Program Expenses for PCI:SUD = \$257,694 Program Expenses for PEI: \$10,224
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<b>Number of Unique Clients Served During Time Period:</b>	SMI: 643, SED: 271, SUD: 27, PEI: 0
<b>Number of Services Rendered During Time Period:</b>	SMI: 18,907, SED: 12,664, PCI-SUD: 188, PEI: 0
<b>Actual Cost Per Client:</b>	SMI: \$2192 SED: \$4,171, PCI SUD: \$9545, PEI: \$0

**CONTRACT INFORMATION:**

<b>Program Type:</b>	<a href="#">Contract-Operated</a>	<b>Type of Program:</b>	<a href="#">Outpatient</a>
<b>Contract Term:</b>	<a href="#">07/01/2020-06/30/2021</a>	<b>For Other:</b>	<a href="#">Click here to enter text.</a>
		<b>Renewal Date:</b>	<a href="#">6/30/2022</a>
<b>Level of Care Information Age 18 &amp; Over:</b>	<a href="#">Traditional Outpatient Treatment (caseload 1:80)</a>		
<b>Level of Care Information Age 0- 17:</b>	<a href="#">Outpatient Treatment</a>		

**TARGET POPULATION INFORMATION:**

**Target Population:** [The Target population will include residents of Fresno County including children, youth, adolescents, adults, perinatal women, and older adults. Additionally, target populations include indigent, uninsured, underserved, special needs, cultural populations, migrant, and seasonal farmworkers and other person of limited access. Specific target areas include eastern foothills, south central, other rural regions and metropolitan areas of Fresno County, as well as underservice cultural, ethnic, racial and linguistic populations. Integrated mental health: Severely and mentally ill \(SMI\) and severely emotionally disturbed \(SED\); and substance use disorder treatment services for children, families, and adults at community primary care clinics and behavioral health clinics within the county of Fresno's development of a broad continuum at various levels of care](#)

**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 clients 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 clients and families are seamless. Clients 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)*

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

Access to underserved communities

Integrated service experiences

Cultural Competency

**Please describe how the selected concept (s) embedded :**

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

CSV provides each person served with a Joint Commission accredited assessment and individualized plan of care to meet the their needs. The plan will outline their present mental health concerns as well as coordinating resources to meet their needs. Changes to the plan of care may be developed throughout the year based on the family and persons' served needs, achievement of goals, and treatment teams coordinated approach.

Cultural Competency:

Cultural Competency is addressed within each site by ensuring each staff member completes the required cultural competency training (7.5 hrs). Families' cultural expectations and inclusiveness is supported by ensuring families receive services in their language of preference. Staff is trained to partner with the appropriate community based organizations that support the families' needs. Focus populations include Latino, Southeast Asian, African American and Native American cultures as well as serving the families that that limited means for payment. CSV goals are to support the needs for any individual/family regardless of race, color, or culture background.

Access to underserved communities:

Each site has been strategically incorporated within the community CSV is seeking to service. Each site provides a full range of services to families that may have reservations of beginning services due to

limited means. CSV also strives to offer care and support to the inner city, the rural, and isolated, those of low, moderate and fixed incomes and families from an array of cultural backgrounds who speak several languages. CSV strives to serve individuals from underserved and uninsured populations that typically experience disproportionately higher rates of untreated mental health concerns and illnesses due to a number of factors, including stigma, cultural and linguistic barriers to services, poverty, distrust, geographic isolation and transportation.

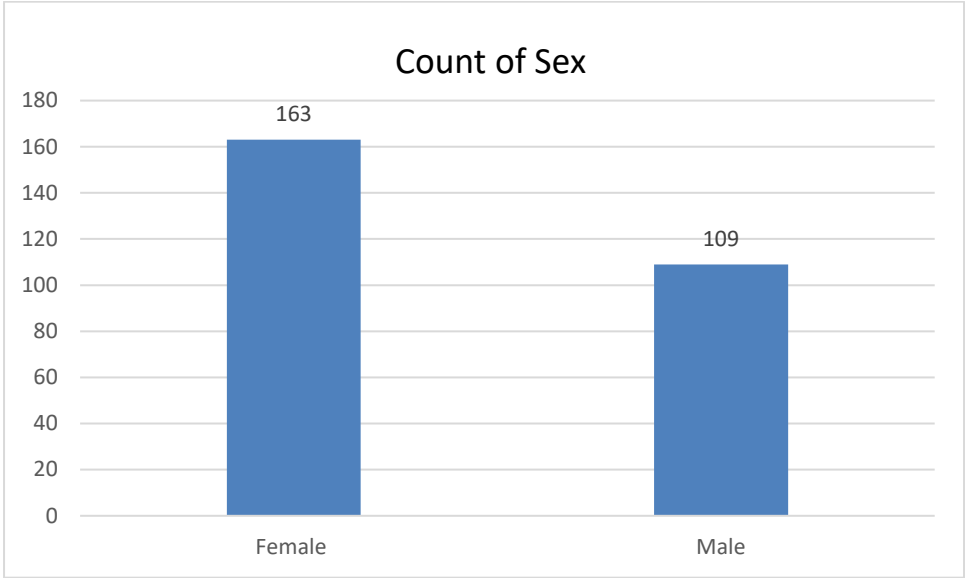
#### Integrated Service Experience:

Treatment teams collaborate to develop an individualized plan of care for every individual that requests services. Families are encouraged to participate and partnerships within the community assist to develop supportive networks for each person served. The goal for every person served is to develop their supportive network within the community as well develop their own personal skills based on their beliefs, languages and values with the ultimate goal of safety, stabilization and overall recovery for each client served.

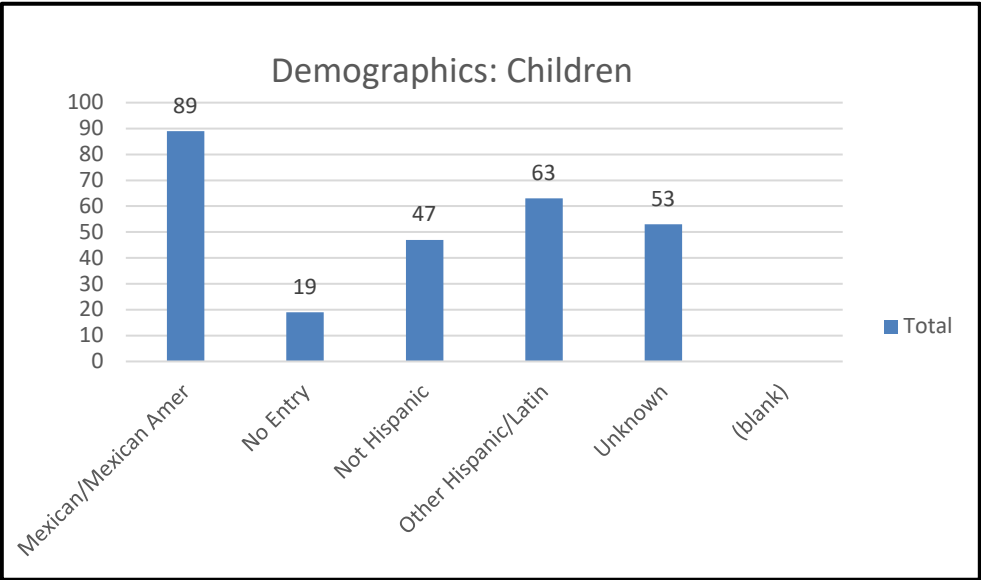
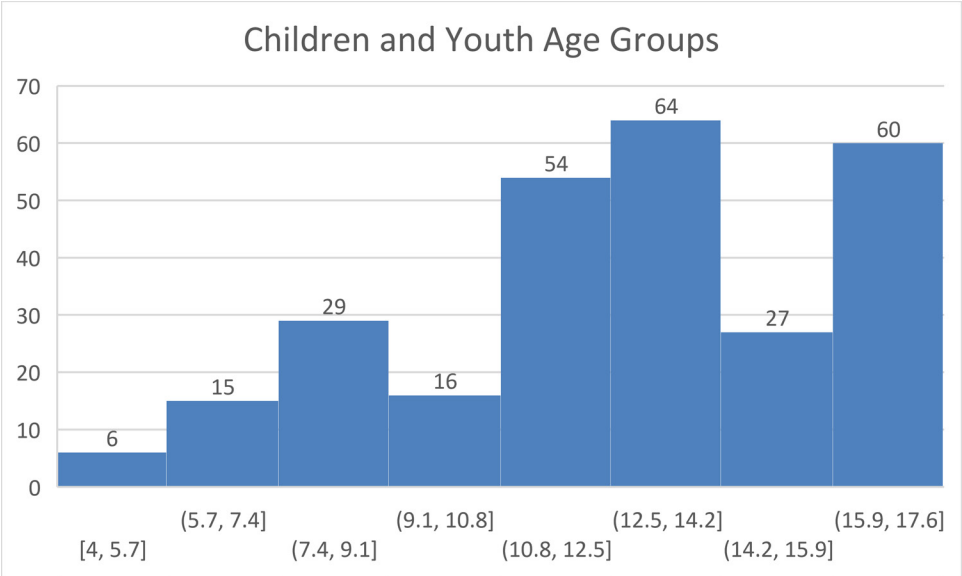
#### PROGRAM OUTCOME & GOALS

- **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

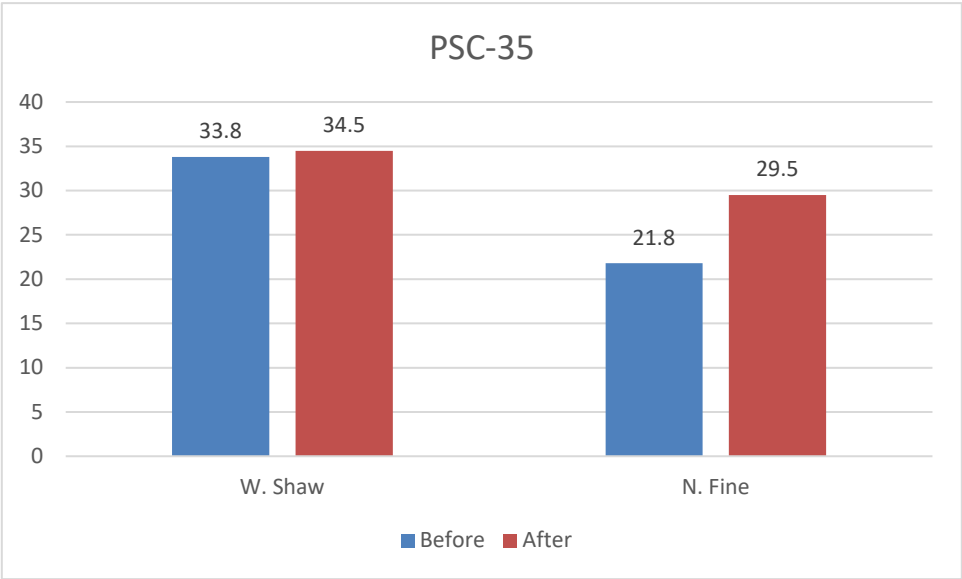
1. Effectiveness: Our program has utilized the PSC-35 (children) and PHQ-9 (adults) to track the outcomes of persons served. We utilized our Quality Improvement staff to assist in tracking the accountability of our program and provided consistent reporting to our staff. Consistent reporting supported the staff in monitoring the results of the persons served and addressing where needed. For our children's program, we served 271 SED individuals (60% female, 40% male).



Age		
Category	N	%
0-5	6	2.2%
6-12	114	42%
13-17	151	55.7%
Total	271	100%

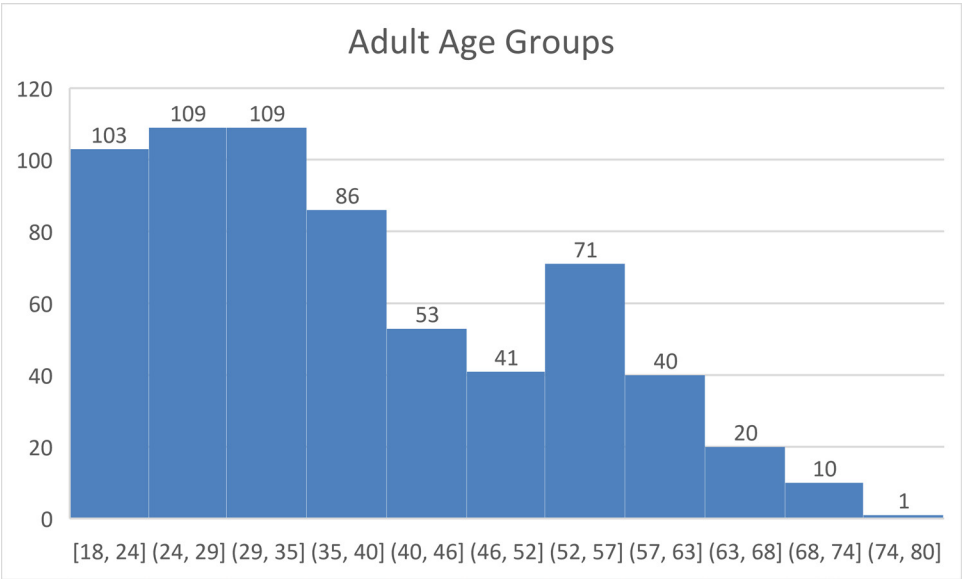
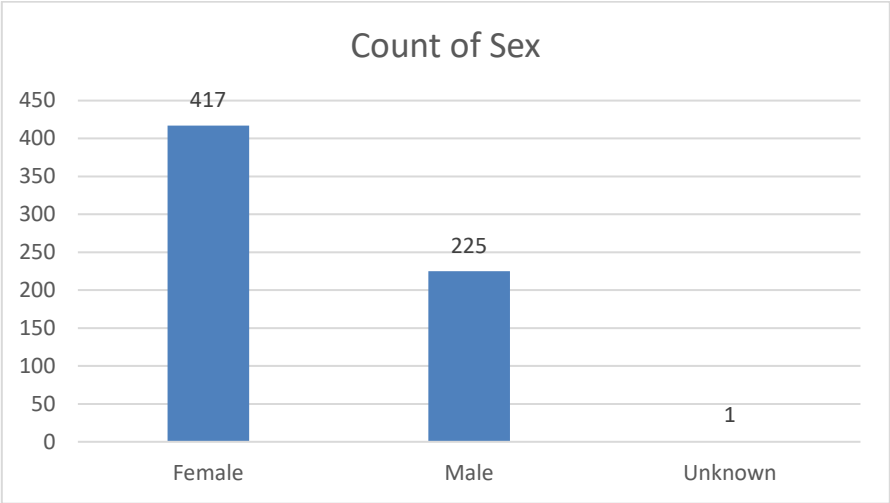


In the below charts, for the individuals seen in the SED program, the average pre-score for PSC-35 was 27.8 and upon discharge, the score averaged an increase of 15%. In light of the current mandates and increasing changes for school expectations, treatment expectations, and COVID mandates, we have seen many clients show deterioration in their mental state. The graph shows that persons’ served have increased in their behaviors within the PSC-35. We have created a plan to collaborate more with schools and provide more support to families to ensure persons’ served needs are being addressed and support their transition back to school as well as having face to face services.



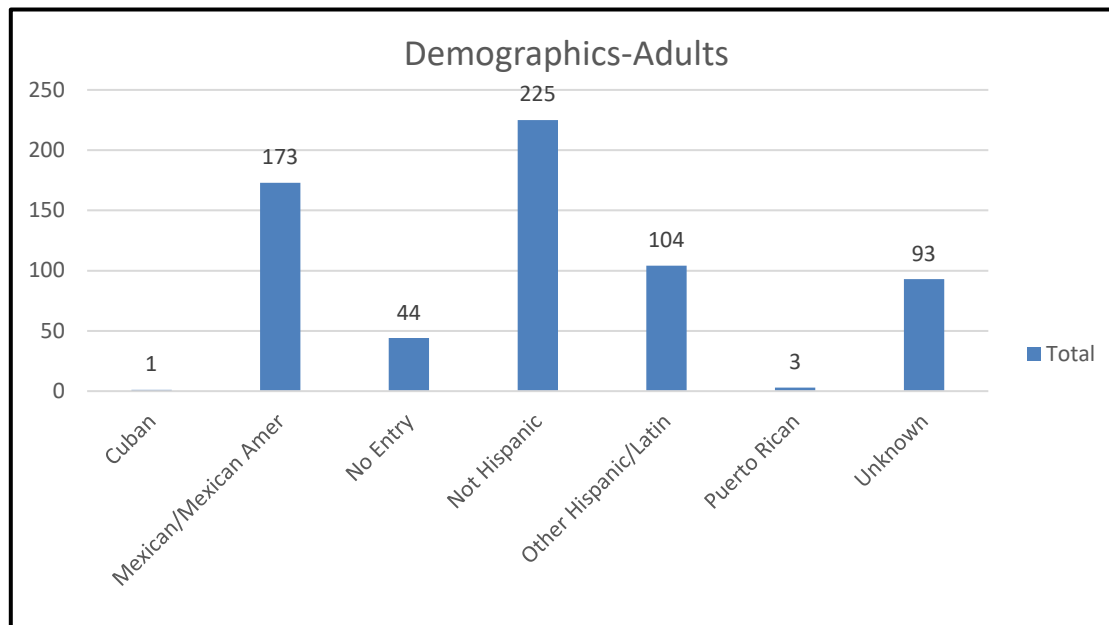
The graph is depicting the scores from both W. Shaw and N. Fine.

For our Adult programs, we served 643 individuals (64.8% female, 34.9% Male).

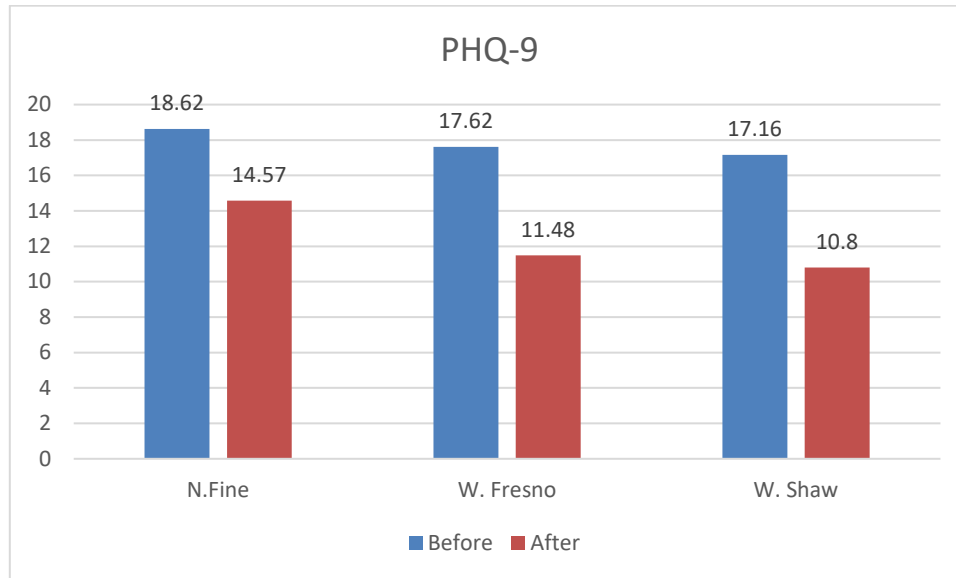




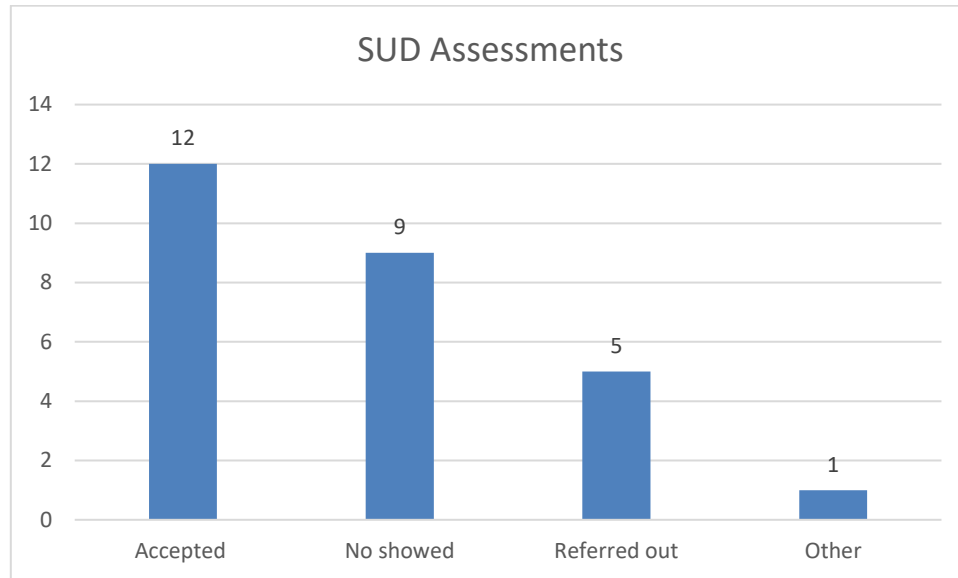
Age		
Category	N	%
18-24	103	16%
25-62	509	79.1%
63+	31	4.8%
Total	643	100%



The program utilized PHQ-9 as an outcome measurement tool and were able to track progress for adult clients. As shown in the graph below, persons served averaged a 31% reduction in their symptoms upon discharge.



For the SUD program, the program has had a difficult start with minimal referrals. Since the start of the program, the staff has been active in community outreach, attending health fairs, meeting with community partners and building relationships. The staff has conducted presentations to community partners and has developed a good working relationship with the Dept. of Human Services to acquire ongoing referrals. Although, the program has only had 27 clients, we have conducted 188 services to clients in efforts to engage clients and keep them engaged. We have conducted weekly groups for our clients via Teams to ensure clients were able to maintain contact with their treatment team, in light of the COVID mandates. All clients have been scheduled to receive 3 group sessions per week, 2 individual sessions per week and one random UA per month.



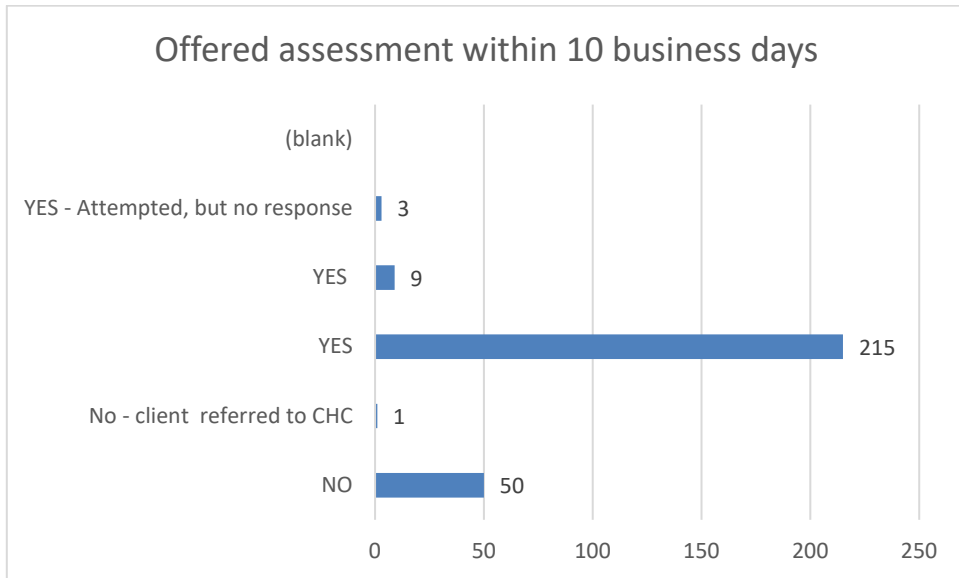
2. Efficiency: Clinica voluntarily participates in The Joint Commission on Accreditation of Healthcare Organizations. The Joint Commission performs a formal assessment of service utilization, quality of services delivered, and persons served outcomes on a tri-annual basis with receiving a review this year (2021) in July. This accreditation has had a significant impact on quality improvement processes within Clinica. Specific areas of impact include utilizing an active corporate-wide quality improvement committee; a focus on safety of the work environment; an internal carefully monitored, incident reporting process, leadership/management training for supervisors, and measures for quantifying increases in staff core area of competency. The Clinica senior leadership team selects important components of the total program (e.g., clinical, managerial, administrative, facility, and process related) that have the potential to impact the persons served outcomes, directly or indirectly. For each of these components, specific indicators are developed or selected, measured and monitored on a continuing basis. The QI/QA program tracks these activities, as well as all resulting improvement activities. Data gathered from checklists by QI/QA staff are used to identify trends annually. Data trends are then used to identify system issues for proactive adjustments. In addition, the QI/QA system allows Clinica to operate on a "flat" authority structure in which anyone, no matter their rank or status within the organization, can suggest improvements, call out problems, and innovate on the go. This has been key to keeping costs down and quality up. Peer reviews have been implemented to ensure the competency and effectiveness of clinicians' treatment. Within the past year, the clinical team has shown a 12% increase in their performance. Changes this year included an update to the nutrition screening to include assessing for potential eating disorders as well as a new assessment form was developed to assess for potential exploitation within persons served. Additionally, trauma will also be further addressed in which there will be an increased focus in treatment planning for persons served that have identified trauma within their assessments. Furthermore, each site will be conducting

suicide risk assessments on a quarterly basis to ensure sites are safe for persons served and any concerns are being addressed. By utilizing the results of the JC audit, we are able improve the assessment process, tailor the treatment plans to the their needs and ensure our facilities are safe for our persons served. The assessment processes implemented within the Specialty BH sites have also been incorporated within our CHC sites.

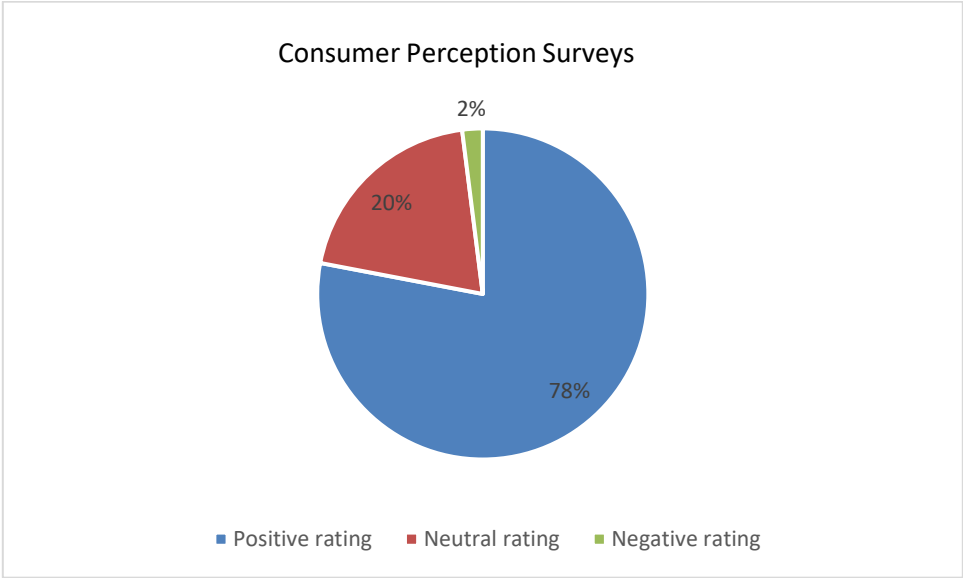
Within the past year, the pandemic and continued isolation has taken a significant toll among our clients. As a result of an increase in completed suicides and attempted suicides, CSV collaborated with several BH teams to develop a Suicide prevention program. The program reviewed cases of clients that had completed suicide as well as attempted suicides and explored areas of opportunity to improve our clinical work. After 2 days of intensive review and collaboration with clinical supervisors, psychiatrists and WRAP therapists, a program was developed to provide all clinical staff structure on how to respond to individuals in need with suicidal ideation. A clinical decision tree was developed to provide direction. A means counseling form was created to assess a individual's plan and how to respond in ensuring individual's safety. Finally, a crisis checklist was developed to ensure the staff was collaborating with appropriate personnel in monitoring persons' served safety as well as collaboration in the continuity of care. The program was tested for 30 days and has since been rolled out the entire BH teams, specialty and CHCs. Since the rollout (April 2020), there have been zero completed suicides and an improvement in the use of outcome measurement tools, the use of CSSR-S to assess for suicide risk, increase in family services and increase in case consultation.

Additionally, CSV has implemented quarterly trainings for the clinical staff to improve areas of concern among the team. The trainings conducted have focused on Safety planning for suicidal clients, Family engagement, Case management, Clinical interventions and coordination of care. The trainings has supported the staff in developing their clinical skills and improving confidence when responding to clients' needs.

3. Access: Within the past year, persons' served access to care has continued to improve. We have assessed 281 individuals for the year and 83% were able to begin services within 10 business days. This showed a 23% increase over last year for access to care. The average number of days for clients wait is 13. In the past year, each site improved focus on access to care by providing a consistent number of assessments per week, while also scheduling back up clinicians for overflow. Each site reviewed the demand for assessment and developed a schedule that would dedicate a specific number of slots per week as well as assigning an assessment clinician each day. Implementation of the structured schedule has shown marked improvements in the timely access to care for clients. During the year, staffing played a role in not meeting our goal of 90% or better, however, we anticipate fiscal year 21-22 to meet the goal of 95% or better in timely access to care with an average of 10 business days or less.



4. Satisfaction& Feedback of persons served: Within this past year, CSV has continued to face many challenges and changes (as most sites), the most significant challenge has been transitioning individuals from face to face services to virtual services. The virtual platform was difficult to manage and engaging persons served among our SED individuals, which resulted in a significant drop in the census and deterioration in many persons' served behaviors. A Consumer Perception survey was administered to persons served and the response was minimal. As a result, CSV has implemented a supplemental survey that will be conducted on a quarterly basis to review individual's involvement in treatment and their perception of safety within treatment. (Survey Attached)



**DEPARTMENT RECOMMENDATION(S):**

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