PROGRAM INFORMATION:

Program Title:	Support and Overnight Stay (SOS)	**Provider:**	WestCare California
Program Description:	Specialty MH Services and Case Management	**MHP Work Plan:**	1–Behavioral Health Integrated Access 4-Behavioral health clinical care Choose an item.
Age Group Served 1:	ADULT	**Dates Of Operation:**	Click here to enter text.
Age Group Served 2:	Choose an item.	**Reporting Period:**	July 1, 2020 - June 30, 2021
Funding Source 1:	Choose an item.	**Funding Source 3:**	Choose an item.
Funding Source 2:	Innovations (MHSA)	**Other Funding:**	Medi-Cal SPMHS

FISCAL INFORMATION:

Program Budget Amount: $1,141,440 **Program Actual Amount:** $1,039,133

Number of Unique Persons Served During Time Period: 393

Number of Services Rendered During Time Period: 2789 services for a total of 144,528 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 3627 non-billable services. Total services including SPMHS is 6416.

Actual Cost Per Person Served: $2644

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 persons served 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 persons served and families are seamless. Persons served 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 individuals, 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 individuals 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	Persons served will be linked to necessary services	Effectiveness Access	# of MH linkages by program	Data system	35%
5	Individuals 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	Individuals will report satisfaction with services provided	Satisfaction	% of persons served reporting satisfaction with services	Consumer survey instrument	65% report satisfaction
8	Individuals 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 2020-2021 average response time from SOS facility to emergency department is *20.6 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 2020-2021 average time from arrival at ED/5150 facility to departure to SOS facility was *15.4 minutes*; consistent with the time it take to secure consent from the individual to be transported as well as discharge information from hospital staff. Average total from time of first call to arrival at SOS was *45 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 355 discharges for FY 2020-2021, down from 525 discharges last rating period. This is the result primarily of more individuals 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 355 recorded discharges, for 221 (62%) there was no identifiable return visit to Exodus during the SOS episode. Of those (134) who had repeat visits to Exodus, 52 persons discharged (39%) had one recorded return visit and 18 persons (13.4%) had two visits to Exodus. This suggests that slightly greater than half of persons who were served and discharged by SOS did not have excessive repeat visits to the 5150 evaluation facility. Thirty-two discharged consumers with a return ED visit (24%), had three to five return visits. Ten percent (10.4%), of consumers had 10-20 return visits to the ED but represent fully one third of the total return visits (176 of 527) by SOS consumers. Only one consumer of 355 discharged had 20 total return visits to Exodus. 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 355 discharges between July 1, 2020 and June 30, 2021. The table also includes comparison data (shown as percentage) by category for FY 2019-2020.

DISCHARGE STATUS	NUMBER	FY 2020-2021 %	FY 2019-2020 %
Successfully Linked	85	23.9%	25.3%
Linked but not known active at discharge	32	9.0%	13.3%
Declined services for linkage	111	31.3%	25.5%
Unable to locate	51	14.4%	17.9%
Moved out of county	9	2.5%	2.7%
Incarcerated	2	0.6%	0.4%
Primary AOD issues	22	6.2%	2.3%
Conserved	6	1.7%	0.4%
Other /Unknown	37	10.4%	12.2%
TOTAL	355	100	100

Successes: Thirty-three (32.9) percent of individuals were successfully linked with one or more behavioral health services and at least 23% of persons discharged were actively participating in a mental health service at time of discharge. Number of persons who were linked declined by almost six percentage points from FY

19-20 but should not be considered unexpected given COVID restrictions on both capacity of the program and challenges of facilitating service linkage when most behavioral health services were not provided face-to-face for 11 months.

Challenges: Eighty-six (86%) 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. Tracking individuals became even more difficulty during COVID as the day center was closed to drop-in visits, 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 behavioral health provider. Linkages and overall participation in behavioral health services was undoubtably impacted by the limitations of COVID for 11 months of the reporting period.

The following table illustrates specific mental health linkages by agency. One hundred thirty seven (137) recorded linkages were made for consumers during FY 2020-2021. These linkages represent ONLY behavioral 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 2012-2021	PERCENTAGE
DBH: Metro, UCWC, Specialty Teams	37	27%
MHS Impact	9	6.6%
MHS Dart West	11	8.1%
Turning Point Vista	18	13.1%
Turning Point: TAY	4	2.9%
Turning Point: Rural	3	2.2%

Turning Point: AB109	4	2.9%
Turning Point: Sunrise	13	9.5%
Central Star TAY	5	3.6%
Substance Use D/O Treatment Programs	20	14.6%
Other Linkages	13	9.5%
TOTAL	137	100

Note: About on third of persons served 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-three (33) percent (137) of consumers were linked to services. One hundred six (106) or 27% of persons served were open to DBH cost centers at time of intake compared to 29% for FY19-20. Fifty-four (54) of 106 were open to various community based FSP programs and 45 to DBH Metro and other county programs. Of the individuals open to DBH programs, 30% were medication only individuals.

Clinical Outcome 2: Those consumers *successfully linked and active at discharge* (85) 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* (32) 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* (111) 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* (51) represent 14.4% 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 (22) represent only six (6%) 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 2020-2021, a total of 20 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: No consumer satisfaction surveys were obtained for FY20-21.

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. There is no reason to believe that FY 2019-2020 would produce a very dissimaler respone

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

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 persons served, 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. They producted approximately 3726 non-clinical services on behalf of persons served.

Two mental health clinicians and three case managers provide specialty mental health services which are documented in Avatar and are detailed for FY 2020-2021 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.

The chart below shows services entered into Avatar between 07/01/2020 and 6/30/21 by MHRS staff and the LPHA.

Service	Count	Units
Assessment	161	30233
Plan Development	174	10251
Case Management	721	36188
Rehab Individual	446	25290
Individual Therapy	237	12760
Group Rehab	0	0
Group Therapy	0	0
Collateral	33	347
Crisis Intervention	11	836
*Chart Note 956/958	1025	28623
TOTAL SPMHS	2789	144,528

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

ADDITIONAL INFORMATION

Three hundred ninety-three (393) unique consumers were served in FY 2020-2021 compared to FY 2019-2020 when 452 unique consumers were served. The decrease in persons served were likely affected by COVID peculiarities, but also possibly by the expansion in housing supports for homeless mentally ill. The opening of the Lodge in January 2021 and the lack of clarity about the interface of SOS and the Lodge when we provide similar services may be a factor as well.

Eighty-one (83) percent or 332 persons reported homeless at intake. At discharge only 101 were known to be homeless. At admission only two percent of persons served were housed in “other-dependent,” typically board and care facilities, while 16 percent of persons served had been linked to these facilities at time of

discharge. Slightly less than two percent (1.8) were in shelters at time of intake and 7.3% were linked to shelters by discharge. The numbers living with family/friends/extended family also improved from intake to discharge. These figures need to be interpreted carefully as there were more persons whose living arrangements at time of discharge were unknown (24%).

Individuals with co-occurring diagnoses number 343 of 388 admissions or 88% of total admissions.

Males outnumbered females. Sixty-eight (68) percent males and 31% female, four male to female transgender and two female to male transgender

Ethnic breakdown included 44% Hispanic, 32% Caucasian, 17% African-American, 2.1% Native American, 3.6% Asian and 1.5% who identified as mixed race or other ethnicity.

Forty-two (51.8) percent of persons served were diagnosed with psychotic disorders including schizophrenia, schizoaffective disorder and psychotic disorder unspecified (201 persons). This is an increase of 10 percentage points from last fiscal year, Bipolar diagnoses comprised six (6) percentage of referrals and Mood disorder unspecified was 10.3%. Depressive disorders accounted for 13% of referrals and only nine persons (2.3%) were found to have drug-induced psychotic or mood symptoms. Eight (7.9) percent of persons served had miscellaneous disorders such as ADHD, Anxiety, PTSD, Adjustment Disorder, and other "unspecified" diagnosis. No diagnosis was recorded in Avatar for 34 persons or 9%.

Referrals predominantly come from Exodus (59%). Twenty-six (27) percent come from CRMC/Clovis/CBHC. Twelve (12) percent came from St. Agnes and just 2.6% are from other emergency departments.

Bed capacity at SOS was reduced from nine to five on advice of Susan Holt due to COVID precautions. In addition to 388 admissions or revisits to SOS, two hundred thirty-eight (328) persons served were granted "layovers" of two or more days in order to facilitate linkages to programs, including mental health, substance use treatment and housing options for a total of 552 additional bed days.

DEPARTMENT RECOMMENDATION(S):

Click here to enter text.