PROGRAM INFORMATION:

Program Title:	Supervised Overnight Stay Program (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, 2021 – June 30, 2022
Funding Source 1:	Other, please specify below	**Funding Source 3:**	Choose an item.
Funding Source 2:	Early Intervention (MHSA)	**Other Funding:**	Medi-Cal SPMHS

FISCAL INFORMATION:

Program Budget Amount: $1,141,440 **Program Actual Amount:** $906,302

Number of Unique Clients Served During Time Period: 346

Number of Services Rendered During Time Period: 1172 services for a total of 85,133 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 3302 non-billable services. Total count of services including SPMHS is 4474. Total count of billable services and units of service was down almost 60% 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 Client: $2,619

CONTRACT INFORMATION:

Program Type:		**Type of Program:**	Outpatient
Contract Term:	January 1, 2019 through June 30, 2024	**For Other:**	Bridge MH Services to facilitate linkage
		Renewal Date:	January 1, 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: 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**: adults 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 individuals 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 individuals 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 persons served, keeping in mind the individual's strengths, needs and preferences in linkage activities. Key to these efforts is strong collaboration with mental health treatment agencies to get individuals 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	Individuals 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 individuals 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 2021/2022 average response time from SOS facility to emergency department is *58 minutes* well in excess of the expected goal of 30 minutes. This increase in response time was 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 2: Contractor shall track the amount of time it takes to place individuals 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 *18 minutes*; consistent with the time it takes to secure consent from the person served 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 *90 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 individuals with behavioral health disorders who are frequent users of hospital ED/5150 facilities and monitor recidivism of those persons served.

SOS Program Outcome 3: Data show 410 discharges for FY 2020-2021, up from 355 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. Persons served 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 410 recorded discharges, for 2021-2022, two hundred twenty-five (225) or 54.9% there was no identifiable return visit to Exodus during the SOS episode. Of those (185) who had repeat visits to Exodus, 40 persons discharged (21.6%) had one recorded return visit and 31 persons (16.8%) had two visits to Exodus. This suggests that 72% of all persons who were served and discharged by SOS did not have excessive repeat visits to the 5150 evaluation facility. Ninety discharged individuals with a return ED visit (48.6%), had three to five return visits, compared to 25% for 2020-2021. Only two individuals (1.08%) with return visits to Exodus had

ten or more visits (one person had 10 and one person 19) compared to 10.4% of individuals in 2020-2022. ED. Of course, this data is to be interpreted cautiously as there is no information available for those individuals 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 show discharge status for 410 persons discharged between July 1, 2021 and June 30, 2022. 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 2020-2021.

DISCHARGE STATUS	NUMBER	FY 2021-2022 %	FY 2020-2021 %
Successfully Linked	94	22.9%	23.9%
Linked but not known active at discharge	23	5.6%	9%
SUD program linkage *	76	N/A	N/A
Declined services for linkage **	191	46.6%	31.3%
Unable to locate	41	10%	14.4%
Moved out of county	11	2.7%	2.5%
Incarcerated	2	0.5%	0.6%
Primary AOD issues	27	6.6%	6.2%
Conserved	0	0.0%	1.7%
Other /Unknown	8	7.0%	10.4%
TOTAL	410	100	100

NOTE re: Table for Program Outcomes #4 above:

*****Seventy-six of 410 persons (18.5%) admitted were linked to SUD treatment, 50 of whom were linked to residential treatment. Co-Occurring persons account for 83.4% or 342 of those admitted to SOS. Total persons linked to services, including mental health and SUD was 51%.

**While number of persons declining further services beyond intake increased, 13% were already open to FSP programs and participating at time of intake.

Successes: Almost 30% of individuals were successfully linked with one or more mental health services and 23 % of persons discharged were actively participating in a mental health service at time of discharge. This is in line with the percentage of persons served who were linked in FY 2020-2021, though there were three (3) percent fewer individuals actively participating at discharge. The increase of linkages to SUD treatment is also notable

Challenges: Eighty-six (86) percent of individuals admitted to SOS were homeless at time of intake. Understandably, follow-up contact is very difficult, and many individuals get lost until the next visit to the ED or 5150 facility. Keeping individuals 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.

The following table illustrates specific mental health linkages by agency. One hundred-ninety-one (191) include both MH and SUD programs. The SOS case managers also routinely link persons served 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 individuals 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 2021-2022
DBH: Metro & Specialty Teams	15
DBH: UCWC	8
MHS Impact	6
Turning Point Vista	8
Turning Point: TAY	6
Turning Point: Rural	1
Turning Point Co-occurring	3
Turning Point: AB109	1
Central Star TAY	6
Sunrise	13

DART	12
Substance Abuse Treatment Programs	76
Private Psychiatrist/Mental Health	3
Other MH Linkages	4
Unknown	29
TOTAL	191

Note: About half of individuals 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 individuals 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 individuals 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 (30) percent (130) of individuals were linked to services.
At least 24 percent of persons served (100) presenting for intake were open to DBH cost centers at time of intake. Forty-three (43) percent were open to community based FSP providers and 57% were open to various DBH programs, 12% to medication only services. Data was not recorded for 42 individuals.

Clinical Outcome 2: Those individuals *successfully linked and active at discharge* (94) 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 individuals have been able to take advantage of housing opportunities.

Clinical Outcome 3: Individuals *linked but not active at discharge* (23) 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 individuals can take advantage of housing opportunities and they are offered further supportive services should linkages fail.

Clinical Outcome 4: Individuals who *declined further services* (191) 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: Individuals who *cannot be contacted* (41) represent 10% of all individuals 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 individuals are more likely to recidivate to are ED/5150 facilities.

Clinical Outcome 6: Those individuals who were identified as *primary substance abusers* in need of linkage to residential and/or outpatient substance use services (27) represent seven (7%) percent of individuals served at SOS, though co-occurring mental health disorders are highly prevalent across the board for SOS individuals (about 83%). During FY 2021-2022, a total of 76 persons with substance abuse disorders were linked directly to substance abuse services, primarily residential. In many cases individuals 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 individuals will report satisfaction with program services.

SOS Outcome 7: There is no data for this program goal. Fiscal year FY2018-2019 was the last year that surveys were obtained. That year produced 460 surveys or almost 80% response rate. Satisfaction with SOS was very high, and comments suggest that individuals experienced 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. COVID restrictions and other factors, including staffing shortage contributed to this failure. Fiscal year 2021-2022 31 surveys were obtained. Ninety-eight (98) percent of surveys are highly positive about the services provided. Satisfaction with SOS was very high, and persons served continue to regard SOS staff as compassionate.

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 persons served 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 individuals, 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 2021-2022 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 Avatar between 07/01/2021 and June 30, 2022, by MHRS staff and the LPHA.

Service	Units	Count
Assessment	19012	161
Plan Development	11638	175
Case Management	33460	442
Rehab Individual	10581	110
Individual Therapy	1467	87
Group Rehab	0	0
Group Therapy	0	0
Collateral	167	4
Crisis Intervention	354	4
*Chart Note 956/958	8454	189
TOTAL SPMHS	85133	1172

*Services provided prior to assessment and plan of care development at initial SOS contact. While all persons served 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 only five beds were allowed filled instead of full capacity of nine, from July 1, 2021, through April 2022. For the month of March 2022 six beds were open for occupancy and in June 2022, SOS returned to its full nine bed capacity. All totaled there were 1976 "bed days" available. When admissions (410) and "layovers" (534) are totaled (944) 47.8% of available beds were occupied. Individuals are allowed to "layover" for up to five days when necessary to achieve effective linkage to behavioral health services.

Three hundred forty-six (346) unique individuals were served in FY 2021-2022 comparable to FY 2020-2021 when 355 unique individuals were served, after suffering a decrease of approximately 210 individuals from the previous six years when typically, 650 individuals 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-six (86) percent reported homeless at intake, an increase of two percentage points from FY 2021-2022. At discharge only 19% were recorded to be homeless though 33% were unknown as to discharge living arrangement. At admission only one individual was housed in "other-dependent," typically board and care facilities, while 44 or 10.7 percent of persons served had been linked to these facilities at time of discharge. There were major increases in all other categories of housed (54 at intake versus 196 at discharge) as illustrated by the table below. One hundred ninety-six individuals were NOT homeless at discharge demonstrating SOS unique success in housing/shelter advocacy.

LIVING ARRANGEMENT	INTAKE	DISCHARGE
Homeless	353	78
Alone/Independent	7	16
Friend/Relative	33	64
Other Dependent (B & C)	1	44
Shelter/Mission	0	22
Residential SUD	0	50
Unknown	13	136

TOTAL	410	410

Persons served with co-occurring diagnoses number 342 of 410 admissions or 83.4% of total admissions. Seventy-four percent of these used meth alone or in combination with other substances, 35% alcohol, 32% cannabis and only 8% identified heroin/opiates used alone or in combination with other substances. Other three (3) percent report any use of cocaine. Twenty percent of persons served report polysubstance use of three or more substances.

Males outnumbered females. Sixty-eight (68) percent males and 32% female, as well as two males to female transgender and one female to male.

Eighteen (18.8) percent of persons served were between the ages of 18 to 29, 55. % between 30 and 59 and 3.4% were 60 and older.

Ethnic breakdown included 39% Hispanic, 33% Caucasian, 20% African American, 1.7 % Native American, 3% Asian and 2.9% who identified as mixed race or other ethnicity.

Forty-one (50.5) percent of persons served were diagnosed with psychotic disorders including schizophrenia, schizoaffective disorder and psychotic disorder unspecified (207 persons), a 9% increase. Bipolar diagnoses comprised 9.3% of referrals and Mood disorder unspecified was 9.8%. Depressive disorders accounted for 19.3% of referrals and only two persons were identified at referral as drug-induced symptoms. Seven (7.3) percent of individuals had miscellaneous disorders such as ADHD, Anxiety, PTSD, Adjustment Disorder, and other “unspecified” diagnosis. No diagnosis was recorded in Avatar for 14 persons or 3.4%.

Referrals predominantly come from Exodus (50%). Fifteen (15) percent come from CRMC, 9.5% from Clovis Community, 9.3% CBHC. Twelve (12) percent came from St. Agnes and just 1.7% are referrals from Kaiser or other hospitals out of the area. For nine persons served there was no referral source documented.

DEPARTMENT RECOMMENDATION(S):

Click here to enter text.