Independent Expert Review
Final Report

Sacramento County
Adult Mental Health Service Delivery System

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TABLE OF CONTENTS

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We hope this Report provides a blueprint for understanding the current adult mental health service delivery system in Sacramento County, and gives a foundation for moving forward to create a strong, cost-effective, person-centered, recovery-focused system that gives voice and promotes wellness for all persons receiving mental health services.

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EXECUTIVE SUMMARY

The Sacramento County mental health system has a unique opportunity to restructure and redesign the adult service delivery system. This transformation will strengthen the outpatient system and help reduce the high cost of inpatient and other intensive sub-acute residential services. By delivering person-centered, recovery-based, quality-driven services in the community, a greater proportion of people will have the supports needed to reduce crises and hospitalizations. This Independent Expert Review was initiated to review the adult mental health system and make recommendations on redesigning the system to best meet the needs of persons who require mental health services. The review activities included one to two day on-site reviews at all contract and county adult mental health outpatient providers. In addition, interviews were held with key stakeholders; focus groups were conducted with persons who receive services; and a consumer survey was collected. Data was analyzed to understand the number of persons served, hours of services delivered, and utilization of inpatient services.

This review process culminated in the development of recommendations for strengthening the outpatient service delivery system in Sacramento County. Some of the recommendations in this Report can be implemented immediately. Others will require developing and redesigning programs that will better serve clients in the community in order to maximize positive outcomes. Restructuring and redesigning the service delivery system will strengthen the outpatient system and help reduce the high cost of inpatient and sub-acute residential services. By delivering recovery-based, person-centered, and culturally-sensitive services in the community, the system can be successful at keeping people out of the hospitals and reducing other high-cost, intensive services. As the system implements these recommendations, the county is encouraged to evaluate programs to ensure that services reflect the goals of the system transformation and meet the needs of clients.

The goal of this Report is to describe the current Sacramento County adult mental health system, providing an overview of the number of clients and units of service for all components of the adult mental health system. Data has been used, whenever possible, to provide a better understanding of the current service delivery system. Each component of the system will be discussed, and the way in which current practices and policies impact access, service utilization, and outcomes. Methods for creating quality services that are responsive to the needs of individuals will be presented, as well as strategies for developing an accountable, cost-effective system for persons qualified for services. The Report identifies evidenced-based and promising practices, recommendations for strengthening services, and opportunities to transform the system, while maximizing county and federal dollars.

The first critical step in transforming the mental health system is for leaders from both the county and outpatient providers, along with persons with lived experience, to come together to discuss the following recommendations, prioritize them, and develop an implementation plan. What is most important is for people to collaborate and plan together to achieve a system that provides person-centered, recovery-oriented, quality-driven services.

"How wonderful it is that nobody need wait a single moment before starting to improve the world." - Anne Frank

Summary of Transformation Recommendations for the Sacramento County Adult Mental Health System

This section provides a summary of the transformation recommendations from the Independent Expert Review Team's Report. The first step in implementing these recommendations is for managers from the county and the outpatient providers to come together, review the recommendations, and begin planning how to transform the system. It is important to include persons with lived experience in these planning discussions.

These recommendations should be prioritized and developed into a plan. Some of these recommendations will be easier to implement than others, which may take years to fully implement. What is most important is for people to collaborate and plan together to achieve a system that provides person-centered, recovery-oriented, quality-driven services.

For the complete recommendations, including relevant discussions and promising practices, please see Chapter 1.2, Chapter 2.2, Chapter 3, and Chapter 4. A list of acronyms and terms used in this Report is included in Appendix A.

Recommendation: Develop a Response Team to strengthen the access system. It is recommended that the county develop a 24/7 Response Team to ensure that individuals have easy and timely access to services. The Response Team utilizes a well-known, centralized phone number that the community can call when requesting mental health services and/or experiencing a mental health crisis. The Response Team provides a skilled telephone response to all callers, supplying information and linking them to the appropriate service in the community. The Response Team provides several services, including:

- Performing the functions of the existing "Access Team," by screening requests for mental health services and linking callers to services;
- Responding to calls from persons experiencing a mental health crisis and working with them to resolve the crisis;
- Conducting evaluations for meeting 5150 criteria at local Emergency Departments;
- Performing the functions of the current Intensive Placement Team to authorize sub-acute residential placement, as well as helping to discharge individuals from these higher levels of care; and
- Conducting Utilization Reviews for all services, authorizing and reauthorizing services.

The Response Team creates a welcoming, fluid, and flexible system that provides information and links people to services. Persons needing outpatient mental health services may also access services at the individual provider level.

Recommendation: Providers conduct intake assessments for easy access to services. To ensure easy access to mental health services, individuals seeking mental health services can call or walk into any mental health provider. (The client is no longer required to make a phone call to the Access Team for an initial authorization.) Mental health providers are required to maintain an Access Log that tracks all requests for services and the outcomes of those requests; the providers are required to submit the Access Log to the Response Team on a monthly basis. The provider welcomes the person, and completes a brief

screening and a clinical assessment. If the provider determines that the person does not qualify for specialty mental health services, they provide referrals to community-based services, including FQHC providers, substance abuse providers, and the Wellness and Recovery Centers (for non-Medi-cal billed services). If the provider determines that the person qualifies for mental health services, they send a copy of the assessment and treatment authorization request to the county Utilization Review for authorization. If the assessment indicates the need for Level IV services, the provider also completes the LOCUS and submits it with the initial paperwork to county Utilization Review.

Recommendation: Redesign Crisis Response and Crisis Intervention Services at the county and provider level.

County Responsibility: The 9-1-1 dispatch forwards all mental health-related calls to the Response Team, except 9-1-1 calls involving safety issues. These safety issues are immediately linked to the police/sheriff. The Response Team handles all Sacramento County calls from the 9-1-1 dispatch related to crisis situations. In addition, Sacramento County Mental Health has one (1) county mental health phone number, well publicized, to provide a first response to all mental health crisis calls. The Response Team goes to the Emergency Department and conducts 5150 evaluations.

Provider Responsibilities: Each provider has an individual assigned to respond to crisis situations during business hours. This "responder of the day" talks with individuals on the phone, is available to see them, and coordinates services with the county Response Team. The providers also develop the capacity to respond to crisis situations by phone 24/7, provide information on current clients, and assist the Response Team in de-escalating crisis situations. If a client needs a 5150 evaluation, on-call staff notifies the county Response Team and arranges for clients to be transported to an Emergency Department.

Recommendation: Develop a Welcoming Line to offer consumer support 24/7. To provide a supportive phone service to individuals who need someone to talk to, it is recommended that a Welcoming Line (also called a Warm Line) be developed. The Welcoming Line is staffed by persons with lived experience and trained in this specific task. It is also recommended that the Welcoming Line be co-located at the Wellness and Recovery Centers, so that individuals answering the phone can have support from other mental health staff. The Universal Language Line is used to interpret, as needed. If the person calling is Asian/Pacific Islander, he/she is referred to the Transcultural 24/7 Response Line.

Recommendation: Redesign the regional outpatient system to offer a continuum of services at each provider. Each regional outpatient provider develops a continuum of recovery-focused services, with the flexibility to serve clients with all outpatient levels of need (Levels II - IV). Providers that offer different levels of services combine services, and staff, to develop a continuum of services (i.e., Turning Point Northgate and Pathways). MHSA FSP services continue to be offered and are available across all providers.

Each provider has the capacity to designate a level of service for a client that is based on need, not based on the specific provider delivering the services. The Response Team will authorize

Level II and III services, with reauthorization required every two years. For persons identified as Level IV, the provider documents the need for Level IV services and submits a request to Utilization Review. The Response Team Utilization Reviewer reviews the request for Level IV services (FSP), and authorizes up to one year of service. Each provider has access to MHSA flex funds, as needed, to support the goals of persons designated as FSP. All providers also have expectations for maximizing Medi-Cal revenue, whenever possible.

Contracts are modified to remove the specific expectations of one visit per month for Level II services and four visits per month for Level IV FSP services. Contracts have service standards for the total number of hours per year, rather than a specific number of contacts per person per year. Key outcome measures are also used to measure performance.

Recommendation: Improve notification of inpatient and MHTC admissions and coordinate discharge planning. The Response Team is aware of all inpatient admissions and will notify the outpatient providers when the provider has a client who is admitted to an inpatient hospital or the MHTC. This process informs providers of admissions so that they can coordinate services and support a timely discharge from the hospital or MHTC. Response Team staff also tracks the admissions to ensure that provider staff have made contact with the hospitals. For clients who are not linked, the Response Team is responsible for coordinating discharges and making outpatient referrals to the appropriate provider.

Recommendation: Develop Intensive Outpatient Services (IOS) program(s) to help persons discharged from sub-acute residential placements successfully return to the community. The county utilizes existing providers to develop intensive outpatient program(s) targeted to serve persons discharged from higher levels of care, including Mental Health Rehabilitation Centers and the State Hospital. Each IOS serves at least 12 people coming out of higher levels of care and will offer daily programs and deliver supportive services. The IOS offers weekend services, as needed (e.g., medication support services in the person's home). The provider works closely with the person's identified support persons to problem solve issues in a timely manner. The county closely monitors the planning and implementation of the IOS to provide technical assistance and to ensure that the provider successfully helps the individual live in the community.

Recommendation: Consolidate the two county outpatient clinics and plan how the remaining staff can best support the system transformation. It is recommended that the county combine the two county outpatient clinics and review staffing and function requirements to achieve positive outcomes in the system. These staff may offer additional support to the Response Team. For example, for persons who are indigent, these staff could conduct face-to-face assessments for persons who are new to the system; meet with individuals at the Emergency Department and/or private inpatient setting to link them to a provider; provide urgent outpatient care; and coordinate with the psychiatrist.

Recommendation: Create wellness and recovery-focused services in a welcoming environment at each provider. All providers are encouraged to visit the Wellness and Recovery Centers, especially the Marconi site, to experience a welcoming environment that promotes a recovery-oriented, person-centered program. The Marconi Center

creates an environment that helps people realize that they can achieve their goals and feel empowered to make them a reality. Each provider is encouraged to visit the Center and use it to stimulate ideas for modifying their own facility to make it more inviting, friendly, and wellness and recovery-focused (for example, home-like décor, plants, comfortable seating, etc). All providers are encouraged to warmly greet individuals as soon as they walk in the door, as this helps individuals to feel comfortable and welcomed. It is also recommended that staff receive trainings on nonverbal communication and the way it can influence whether a person feels welcomed when he/she walks in the door.

Recommendation: Hire Peer Support Specialists for volunteer and paid service delivery positions. It is recommended that the county fund positions for Peer Support Specialists, to deliver services within each provider's service delivery system. Providers work closely with the Wellness and Recovery Centers to develop job descriptions and skills, train new hires, and provide ongoing support to Peer Support Specialists. Providers also utilize training from Wellness and Recovery staff to help them promote wellness and recovery principles throughout their system and understand how to integrate Peer Support Specialists throughout the service delivery system.

Recommendation: Provide Wellness and Recovery Training. It is recommended that the county develop a contract with an organization to deliver training to Peer Support Specialists. This training provides a Wellness and Recovery certification for working within the mental health system, as well as developing core skills for supporting clients. This organization also provides a training for provider and county staff to learn wellness and recovery principles and how to integrate Peer Support Specialists into the service delivery team.

In addition, it is recommended that the county contract with a local organization to provide ongoing monthly mentoring/training groups to support and monitor all Peer Support Specialists hired across the county. This training is offered periodically throughout the year.

Recommendation: Identify innovative evidence-based practices and provide training, supervision, and ongoing feedback to integrate these new skills throughout services. Providers have the flexibility to use a range of practices to improve the quality of services. Service delivery staff are trained and supervised to provide evidence-based and promising practices, which focus on improving quality of care and core client outcomes, including: stability in housing, employment, education, and developing positive social supports. Suggestions for training include: Motivational Interviewing, Supported Employment, Cognitive Behavioral Therapy, Trauma Informed CBT, and/or Dialectical Behavioral Therapy. Training could be funded with MHSA funds, and delivered to all county and provider staff. There are also effective web-based training sites that offer courses on a wide range of topics and allow clinical staff to earn continuing education units (CEUs), as well as information for clients and family members. In addition to providing training on evidence-based and promising practices, it is important that the training is practiced and integrated into services; supervisors mentor staff to effectively implement the new skills as they deliver services.

It is also recommended that the county host a monthly meeting to allow providers to share and discuss their experiences with implementing evidence-based and promising practice models

through a case presentation format. This strategy helps showcase services and allows providers to share experiences about what they have found to be most effective in helping clients achieve measurable outcomes.

Recommendation: Implement a training program that facilitates communication between consumers and psychiatrists. The county is encouraged to identify, contract, and implement an innovative training program to promote and facilitate communication between consumers and psychiatrists. This program helps clients prepare for their appointment with the psychiatrist and make decisions for their treatment and recovery. Train-the-trainer models have been found to be cost-effective and efficient ways to develop skills across all staff in the system.

Recommendation: Identify evidence-based practices and provide training for staff on the treatment of co-occurring disorders. Training on the treatment of individuals with co-occurring disorders would improve outcomes for clients with co-occurring diagnoses. Motivational Interviewing has proven to be effective in working with individuals who have co-occurring disorders. The county is also encouraged to offer training in other evidence-based practices that have been found to be effective for persons with co-occurring disorders.

Recommendation: Develop a training program to train UC Davis Residents to integrate clients' voice in treatment. It is recommended that UC Davis Residents receive training from persons with lived experience to learn about integrating client voice and choice to empower clients and support wellness and recovery. Prior to starting a rotation at the outpatient clinic or MHTC, the Residents receive training from persons with lived experience. This training provides a consumer's perspective to the Resident about listening and valuing the individual's voice, and the importance of supporting wellness and recovery. At the MHTC, persons with lived experience share the impact of a hospitalization on an individual's recovery, the importance of involving family in the treatment and discharge planning, and the value of treating a client with respect and dignity to promote recovery.

Recommendation: Integrate persons with lived experience as part of the MHTC service delivery team to ensure communication. It is recommended that persons with lived experience are active members of the MHTC Treatment Team. These individuals provide support and information to the individual hospitalized, as well as offering support services to the client's family during the hospitalization. As employees of the MHTC, they are active partners in service delivery and part of the Discharge Planning Committee to promote recovery, wellness, and linkage to outside resources that would facilitate a timely and successful discharge.

Recommendation: Develop an expedited process for helping individuals qualify for Medi-Cal benefits. The mental health program is encouraged to use the Guest House model of expedited access to services and benefits as an example for developing similar programs at the outpatient clinics. Each person who is in crisis, and/or hospitalized, costs the county several thousand dollars in services. If clients were quickly enrolled in the Medi-Cal program, the expedited team would pay for the cost of staff by saving

county dollars in reduced inpatient and service costs. This expedited benefits process enhances the county's ability to obtain federal matching dollars for mental health services.

For many people, Medi-Cal billing is seen as a "medical model" that does not promote wellness and recovery. The State has recently adopted a new State Plan Amendment which expanded the definition of many of the Medi-Cal reimbursable services to include wellness and recovery services. This development enhanced staff's ability to bill for services to support a person's functioning and recovery; it also helps programs obtain federal reimbursement and sustain these important outpatient programs.

Recommendation: Maximize billing for services that are eligible for Medi-Cal reimbursement. Program and county quality management staff begin or continue to monitor the percent of Medi-Cal services billed on a monthly basis. In addition to tracking staff productivity (the amount of time staff spend delivering Medi-Cal eligible services), programs also track the percent of services provided that are eligible for Medi-Cal reimbursement. Staff billing practices need to be reviewed during supervision to make sure that they understand the types of services that can be billed to Medi-Cal. County Utilization Review staff continue to provide training to programs on ways to document services that are wellness-focused and eligible for Medi-Cal reimbursement.

Recommendation: Expand Crisis Residential programs. It is recommended that Sacramento County develop additional crisis residential programs in other parts of the county. Crisis residential programs are effective at de-escalating a crisis situation and helping clients return to the community within thirty (30) days. The crisis residential programs are eligible for Medi-Cal reimbursement and produce federal revenue to support the cost of the program.

Recommendation: Expand PHF Services. It is recommended that Sacramento County expand the number of available inpatient beds by contracting with other local organizations that have a 16-bed PHF, when available. PHFs with 16 beds are eligible for Medi-Cal reimbursement and are an important resource for people who need inpatient services in Sacramento County. The county is encouraged to develop additional 16-bed PHFs in the county to help reduce the cost of inpatient services.

Recommendation: Develop a county Crisis Stabilization Unit. It is recommended that the county develop a 23-hour Crisis Stabilization Unit (CSU), that is eligible for Medi-Cal reimbursement, and has strict admission criteria. For example, individuals would only be admitted if they have been medically cleared by a hospital Emergency Department. The CSU provides support to the Response Team to help de-escalate clients and prevent hospitalizations. Close collaboration with other providers is needed to ensure that there is the capacity in the community to admit individuals to inpatient facilities within the 23-hour requirement.

Recommendation: Develop Crisis Respite Services. Crisis Respite services are non-medical alternative programs that offer a non-judgmental environment for persons who are experiencing a mental health crisis. These programs are often run by persons

with lived experience. Crisis Respite services are similar to crisis stabilization programs and are often located in a home-like environment. The county is currently discussing the development of crisis respite programs with the MHSA Oversight Committee.

△ **Recommendation: Reduce the number of MHTC beds.** The MHTC provides an important function in the county and serves difficult-to-place clients. However, the MHTC is an expensive resource. The county is encouraged to identify other options for this facility and to develop opportunities to redirect funds to maximize Medi-Cal reimbursement. Whenever possible, any savings would be used to expand the outpatient service delivery system to enhance wellness and recovery.

△ **Recommendation: Reduce the use of private Psychiatric Hospitals.** It is recommended that the county reduce utilization of private psychiatric hospitals, whenever possible. The county works with the outpatient provider network to de-escalate persons in crisis, and potentially avoid hospitalizations by providing community support to help clients remain in the community. If a hospitalization is unavoidable, the hospital staff communicate with the outpatient providers to share clinical information during the hospital stay and facilitate a timely planned discharge back to the community. County management reviews data on all inpatient admissions, by hospital and providers, to identify gaps and opportunities to improve the service delivery system. Individual providers review all clients who were hospitalized from their teams to discuss possible improvements in crisis response and ongoing services.

△ **Recommendation: Reduce the use of Mental Health Rehabilitation Centers and State Hospital.** It is recommended that the county reduce utilization of the Mental Health Rehabilitation Centers and the State Hospital, whenever possible. The Intensive Placement Team staff, who are recommended to be part of the Response Team, actively works with all sub-acute residential facilities to identify clients who are able to move back to the community. These clients are discharged to the Intensive Outpatient Services Programs, and receive support services to ensure a successful transition back to the community.

△ **Recommendation: County leadership adopts a continuous quality improvement process to use data to inform system-level decisions.** It is key to the system transformation to develop a continuous quality improvement process to use data to guide the implementation of system reform and ongoing management of the continuum of services. This quality improvement process creates a feedback loop to systematically track and manage the key outcomes for the system. A continuous feedback loop is used to:

- Set goals for improving client outcomes and system performance
- Collect and produce client outcome and system performance data to measure progress in meeting the identified goals
- Review and discuss data at monthly managers meeting on the identified goals and potential barriers to achieving those goals
- Identify and discuss changes to the system to potentially improve client outcomes
- Produce and share data reports to measure changes to outcomes over time

Recommendation: Develop the capacity to systematically produce accurate data reports. It is crucial to develop the capacity to produce accurate and timely data reports, and create decision-support tools to measure client outcomes and system performance. This Independent Expert Review Report provides a good foundation of baseline data for managers to use to identify priority outcomes and set goals for system improvement. Decision-support tools can be developed to track the priority outcomes over time (monthly). Once the decision-support model is developed, staff can be trained to produce consistent, quality data reports each month for management review.

Recommendation: Develop an Outcomes Leadership Group comprised of managers from the county and providers, as well as clients, to work together to use data to measure client and performance outcomes, identify gaps, and develop strategies to improve outcomes. Key managers and clients are selected to form an Outcomes Leadership Group. This group meets monthly to review outpatient and higher level of care data, using the decision-support tools developed. Following a review of the data, the group identifies areas of success, areas for improvement, and discusses strategies to modify the system to improve outcomes. This approach promotes a supportive learning environment which can use data to:

- Celebrate successes,
- Identify training and technical assistance needs to improve outcomes, and
- Examine policies and practices to ensure the system can accomplish the identified performance goals and outcomes.

Reducing inpatient utilization is recommended as one of the first outcomes to measure. Examples of the data produced for the Outcomes Leadership Group may include:

- Number of inpatient admissions
- Number of inpatient bed days, by hospital; MHTC
- Number of inpatient admissions that had an outpatient service within 24 hours before the admission
- Number of inpatient admissions that had an outpatient service within 24 hours after discharge
- Number of clients with two inpatient admissions within six months; one year
- Number of clients with three of more inpatient admissions within six months; one year
- Number of clients with two or more inpatient admissions without an outpatient service between inpatient admissions

Summary – Fiscal Analysis of Transformation Recommendations

Mike Geiss, Fiscal Consultant, provided an estimate of the fiscal impact of the proposed recommendations. All amounts shown in this section are in thousands (000's) of dollars.

The proposed recommendations, based on the assumptions outlined in Chapter 3, result in the estimated impact shown in Table 1, below. The estimated total cost represents the net increase in costs as a result of the proposed recommendations. Estimated total cost is shown by the recommendations to the outpatient system transformation and the crisis residential, inpatient and sub-acute residential system transformation. The three primary funding sources are Medi-Cal Federal Financial Participation (FFP), county funding (sales tax and vehicle license fees referred to as realignment), and Mental Health Services Act (MHSA) funds.

Table 1
Estimated Fiscal Impact of Proposed Recommendations
(Dollars in Thousands)

	Year 1	Year 2	On-Going
Estimated Total Cost			
Outpatient	$2,650	$5,200	$5,000
Crisis Res., Inpatient and Sub-Acute	$1,840	$6,750	$5,700
Total	$4,490	$11,950	$10,700
Estimated Funding			
Medi-Cal FFP	$2,980	$7,730	$8,510
County*	$450	$2,475	$605
MHSA	$1,060	$1,745	$1,585
Total	$4,490	$11,950	$10,700

* County includes realignment and other county discretionary funding.

As shown by Table 1, the estimated total on-going costs of the recommendations are $10.7 million. These additional costs are estimated to be funded primarily with Medi-Cal FFP and little cost to the county. Medi-Cal is a reimbursement program whereby the Federal Government reimburses the county (through the State) a percentage of the county's actual costs. In California, the percentage reimbursement has typically been 50 percent and that is what is assumed for this fiscal analysis. Thus, the county must incur the full expenditure in order to receive the 50 percent reimbursement. This may cause cash flow issues in years in which the State budget is late or when claims processing system changes result in delayed Medi-Cal FFP payments to the county.

Table 1 also shows that truly transforming the system requires an up-front investment by the county with realignment revenues in the first two years. After that initial investment, the on-going costs unreimbursed costs to the county are approximately $2.2 million which could be

funded primarily with MHSA resources. The county has a prudent reserve of approximately $14 million in MHSA funds as well as additional unspent MHSA funds which could be used to fund the initial costs and on-going costs. It is recommended that future increases in MHSA funding be directed towards the system transformation.

Additional details of the fiscal analysis, including assumptions, are provided in Chapter 3 of this Report.

Summary – System Transformation

There are many opportunities to strengthen and transform the adult mental health service delivery system in Sacramento County. County managers, provider staff, and clients must collaborate together to successfully transform the system. The fiscal analysis supports the recommendations and transformation of the system. As shown, it is more cost-effective to deliver services in the community, whenever feasible.

One of the responsibilities of the county leadership is to provide oversight and management of the outpatient mental health programs. As the system implements these recommendations, the county is encouraged to evaluate each provider and county program to ensure that services are delivered in a manner that reflects the goals of the system transformation and meets the needs of clients.

The system must be flexible in how services are funded. For example, if the mental health programs are effective at reducing crises and inpatient services, and discharging people from higher levels of sub-acute residential care, the savings in dollars can be used to support the intensive outpatient services in the community, as well as other innovative, person-centered, recovery-oriented services to support healthy outcomes.

With leadership, a clear vision, and close collaboration with all persons involved in the mental health system, Sacramento County can successfully create an exemplary person-centered, recovery-oriented, quality-driven adult mental health system. This system transformation will also positively impact other community partners, including law enforcement, jails, and hospitals. Collaboration and coordination will be key factors to the success of the system transformation.

INDEPENDENT EXPERT REVIEW METHODS

Sacramento County's efforts to restructure the adult mental health outpatient system led to a lawsuit and federal court injunction. Following facilitated discussions, the two parties were unable to reach a settlement. However, there was an agreement to have an independent expert review of the system to answer the following question:

> *"What is the best way to design the adult outpatient mental health system, which shall include crisis residential, but exclude inpatient and sub-acute, to best suit the needs of mental health consumers and how best to transition to that system?"*

In further discussions, the parties agreed that an outside, impartial expert would be retained to review the adult mental health outpatient system and issue a report that would be the basis for resolving the issues in the best interests of the clients served. The scope of activities of the Independent Expert Review included an assessment of the current system's responsiveness to community needs, quality of care, and administrative functioning. The independent expert was also expected to assess the feasibility of alternative adult outpatient mental health service delivery modalities, to identify the fiscal impacts of any alternatives that may be recommended, and to assess any transition issues involved in implementing the proposed system.

Following an initial review of the data, the Review Team requested permission to expand the review to include the Mental Health Services Act (MHSA) Full Service Partnership (FSP) programs. Over half of the adult outpatient services are provided through these programs. This request was granted to allow the Review Team to fully understand the service delivery system and how it relates to client outcomes. In addition, data on inpatient and higher levels of care was analyzed to provide additional information for the analysis of the adult mental health system.

Overview of the Independent Expert Review Activities

The Review Team is comprised of I.D.E.A. Consulting staff and contractors, including specialists in evidence-based practices and outcomes, mental health organizational analysis, and quality of mental health services. An individual with lived experience was also a valued and active member of the team to ensure that a consumer-based value orientation informed both the review and the recommendations.

This review consisted of the following:

- Analysis of the clients served by the adult mental health outpatient programs.
- Analysis of the services delivered by the adult mental health outpatient programs, the quality of care, service utilization patterns, and the way that clients are supported across the county system of care.
- Analysis of organizational structures (agencies/programs) and the community systems that are in place to deliver services.
- Development of recommendations for alternative models for delivering adult outpatient mental health services in Sacramento County.

- Analysis of the fiscal impacts of the recommendations and costs associated with the transformation provided by Mike Geiss.

A sample of the Independent Expert Review materials is provided in Appendix B. Also included in Appendix B is detailed information on interviews, site visits, and focus groups that were conducted as a component of the review.

Initial Review Team Methodology

The Review Team utilized a number of different methods to develop an understanding of the existing system and develop recommendations for alternative models for implementation. These methods included the following:

- Review of existing documents, reports, and contracts related to the county and individual provider organizations.

- Analysis of data available for Calendar Year (CY) 2010. Fiscal Year (FY) 2009/10 data is available upon request.

- Thirty (30) interviews with leaders and representatives from various county, city, stakeholder, and provider agencies.
  - Provider and stakeholder organizations interviewed:
    - American Medical Response
    - The Effort
    - Homeless Coalition/Steps Forward
    - Hospital Council
    - Mental Health Contractor's Association: President
    - National Alliance on Mental Illness (NAMI)
    - Northern California Health Care Systems
    - Sacramento City Police
    - Sacramento County Sheriff
    - Sacramento Metro Fire Department
    - University of California, Davis, Department of Psychiatry
    - University of California, Davis, Department of Psychiatry – Jail Services
    - University of California, Davis, Medical Center Emergency Department
    - Mental Health Board:
      - Current Chair: Terence Imai
      - Past Chair: Chad Thompson
      - Board Members: Langley Kreuze, Frank Topping, Michael Hansen, Jane Fowler, Susan McCrea, Lois Cunningham

  - Sacramento County Department of Health and Human Services staff interviewed:
    - Ann Edwards, MFT, Director
    - Tracy Herbert, Ph.D., Deputy Director, Financial and Administrative Services
    - Mary Ann Bennett, Mental Health Director

- Dorian Kittrell, MFT, Executive Director, Mental Health Treatment Center; Interim Chief, Adult Services
- Jeff King, Sr. Administrative Analyst, Behavioral Health Services
- Uma Zykofsky, LCSW, Program Manager, Quality Management, Behavioral Health Services
- Rod Kennedy, MFT, Program Manager, Adult Mental Health Services, Contracted Services
- JoAnn Johnson, Program Manager, Cultural Competence and Ethnic Services
- Kelli Weaver, MSW, Acting Program Manager, Adult Mental Health Services, County-Operated Programs
- Stacy Starr, LCSW, Program Coordinator
- Cosette Telesford, LCSW, Program Coordinator, Access Team
- Jody Hoyt-Dunning, MFT, Senior Mental Health Counselor
- Angela Zolow, MFT, Senior Mental Health Counselor
- Takeshi Abe, MFT, Senior Mental Health Counselor
- Mike Waldron, Administrative Services Officer II, Adult Mental Health Services
- Evan Miller, Mental Health Counselor, Sacramento County Mental Health Treatment Center
- Sandy Damiano, Ph.D., Deputy Director, Primary Health Services Division
- Maria Morfin, Division Manager, Alcohol and Drug Services Program
- Marguerite Story-Baker, Program Manager, Alcohol and Drug Services Program

- On-site reviews for eighteen (18) sites, including two (2) county clinics and sixteen (16) contract programs. The Review Team met with program administrators, adult program managers, clinical staff, quality management staff, case managers, and consumer staff. A total of 157 county and provider staff participated in the on-site reviews. Clinical care was reviewed through 104 chart reviews and 50 case presentations using a performance-based review process.

- Four (4) focus groups of clients and family members, with a total of 45 participants.

- Review of each organization's delivery of culturally sensitive services.

- Surveys on individuals' perception of access and quality of services were received from 577 persons.

Definitions – Acronyms and Terms used in this Report

A list of acronyms and terms used in this Report is provided in Appendix A.

OVERVIEW - SACRAMENTO COUNTY ADULT MENTAL HEALTH SERVICES

The adult mental health system in Sacramento County is a complex system of outpatient services, crisis residential, psychiatric inpatient, and other higher levels of residential services, including the State Hospital. Each component of the system is interdependent upon other components. This interdependence creates the need to understand the role and function of each component, and the impact it has on the other components of the system. The design and implementation of a system has a direct impact on the lives and health of the individuals receiving services.

The data in this Report utilizes data for Calendar Year (CY) 2010. Several of the programs were funded in late 2009 or early 2010. As a result, the CY 2010 data provides the most consistent time period for analyzing the client, service, and cost data across all outpatient providers.

DATA NOTE: The data used for this Report is for CALENDAR YEAR 2010 (January 1, 2010 – December 31, 2010). The data was provided by the Research and Evaluation Unit of the Division of Behavioral Health Services, Mental Health Treatment Center staff, and the Budget Officer of the Division of Behavioral Health Services. Data was generated from the AVATAR system, as requested and outlined by the Expert Review Team. Calendar Year data was selected for this Report because some of the programs in the adult system only began delivering services in late 2009 or early 2010.

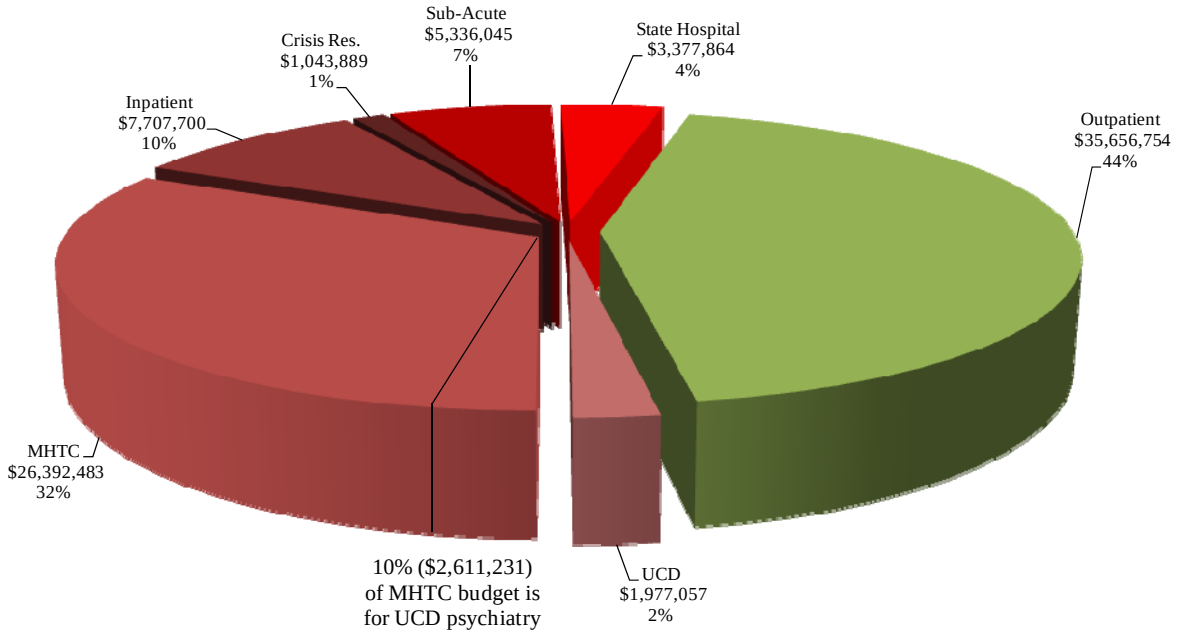
Using the most recent fiscal year (FY09/10) provides only a few months of services for these new providers. As a result, the Review Team chose to use CY 2010 data. This approach provides a common 12-month time frame to understand the similarities and differences in all outpatient programs. FY09/10 data is available upon request.

The AVATAR system is still in the development and transition stage required of a new Management Information System. The Review Team conducted numerous quality checks on the data. However, there may still be differences in the data compared to data from other reports. The Research, Evaluation, and Performance Outcomes Team and the County Management Team are encouraged to continue analyzing data and refining methodologies used for analyzing this important information. Data can only be improved if used and reviewed in a continuous quality improvement manner.

Figure 1 shows the total funding for the Sacramento County mental health services reviewed for this Report, by each component of the system (data provided by the Budget Officer of the Division of Behavioral Health Services). Administrative costs have not been included as many administrative functions include management of children's programs and other program components.

The total services budget for CY 2010 is $81,491,792. Outpatient services comprise 44% of the service dollars; University of California, Davis (UC Davis) Psychiatry is 2%; crisis residential is 1%; and inpatient and other higher levels of care (e.g., inpatient services, Mental Health Treatment Center, MHRC, IMD, and State Hospital) are 53% of the dollars.

Figure 1
Sacramento County Adult Mental Health
Estimated CY 2010 Service Budget
Total = $81,491,792
(Data from the Budget Officer of the Division of Behavioral Health Services)



Placement in inpatient and other higher levels of care is used when services in the community are not able to promote positive outcomes for persons with a serious mental illness. The system is spending 46% of the dollars on outpatient services (including UC Davis) on the majority of clients. Fifty-three percent (53%) of the dollars are spent on higher levels of care for a small number of clients.

This financial data shows that there is a large part of the budget spent on inpatient and other higher levels of care (MHTC, MHRC, State Hospital).

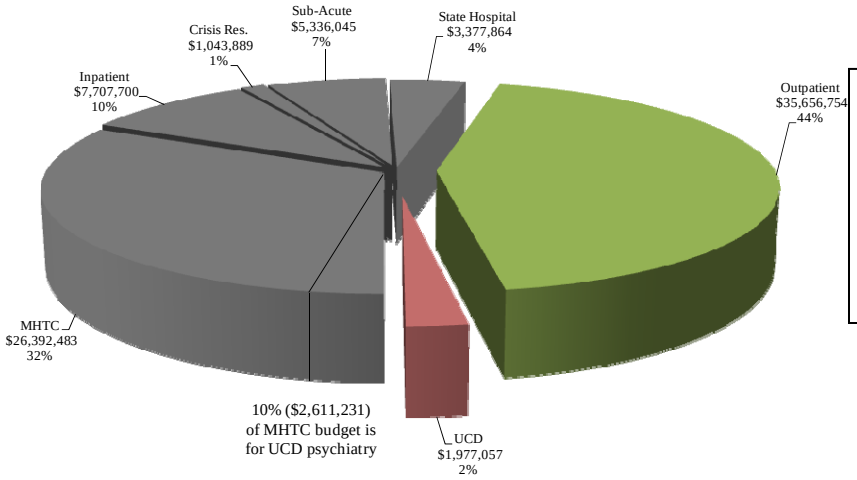
The outpatient system has high case loads and many of the services focus primarily on symptom management rather than wellness, recovery, and health. Crisis response is left to the discretion of law enforcement, Emergency Medical Services, and hospital Emergency Departments*, rather

than utilizing mental health professionals to de-escalate and manage crises in the community. As a result, a number of hospitalizations possibly could have been averted if clients were managed in the community by a mental health professional.

The restructuring and redesign of the adult service delivery system will strengthen the outpatient system and help reduce the high cost of inpatient and other intensive residential services. By delivering recovery-based, person-centered, and culturally sensitive services in the community, the system can be successful at keeping people out of the hospitals and reducing other high-cost, restrictive services.

**Note: This Report uses the term Emergency Department, rather than Emergency Room. This term is typically used by the hospitals and physicians.*

CHAPTER 1.1: ADULT OUTPATIENT SERVICES – CURRENT SYSTEM



Outpatient and UC Davis Component

CY 2010 Budget: $37,633,811 (46%)

The Sacramento County Adult Mental Health System served 10,328 persons in the outpatient programs in CY 2010. The total outpatient budget was $37,633,811, including $1,977,057 for UC Davis Department of Psychiatry expenses. This $37.6 million represents 46% of the service dollars expended by the Sacramento County Adult Mental Health System.

The Adult Mental Health System is a complex combination of outpatient services, provided by both contract providers and county-operated clinics. The first half of Chapter 1 provides an overview of these programs and the services that they deliver. Data is provided to show the number of clients and the types and amounts of services delivered in CY 2010. The second half of Chapter 1 discusses the key issues in the Adult outpatient system and provides Discussions and Recommendations for enhancing services to better meet the needs of individuals and help them achieve positive outcomes. A few Promising Practices are highlighted to provide examples of services or programs that reflect wellness and recovery.

Overview of Outpatient Services

Sacramento County mental health managers utilize a "level of care" system that offers services through programs designed to serve specific levels of care. This level system was created in 2008 to outline a continuum of service needs of clients over time. It outlines the basic model for identifying client strengths, achieving core outcomes, and determining the level of service needed. The model also includes details on the client's support system and involvement in daily activities. The model has four outpatient mental health service levels (I-IV). The complete Level of Care Model is provided in Appendix C.

Each of the providers will be discussed by the level of care program that they are contracted to provide. Data is used to show the number of clients served and a description of services. In addition, system-level issues will be discussed, including client voice and choice, integration of

persons with lived experience in the system, and opportunities to strengthen services and support wellness and recovery.

▪ Access to Services

The County Access Team is the primary entry point for most clients requesting specialty mental health services. In addition, El Hogar's Guest House is an entry point for persons who are homeless. El Hogar's Guest House access point for homeless will be discussed later in this Report.

The County Access Team is comprised of clinicians who answer the Access Line between 8 a.m. and 5 p.m., Monday through Friday. When all clinicians are busy, the person calling the Access Line is asked to leave their name and phone number. The Access Team calls back, typically within one business day. If the caller does not have their own phone (for example, they are using a friend's phone, or calling from a provider), they may miss the return call and have to call back at another time. There are no face-to-face assessments conducted by the Access Team.

Once the caller is connected to the Access Team, a clinician interviews the person over the phone to determine medical necessity and collect demographic and financial information.

At the end of the phone interview, which lasts approximately 20 minutes, the clinician determines the level of care needed and identifies the appropriate county or contract provider. The clinician gives the client the name and phone number of the assigned provider and tells them to call the provider directly for an appointment. In addition, the provider may look at the Avatar Census report and call the individual. The referral information is entered into the computer system, AVATAR, and the client's name immediately appears on the provider's new referral list. However, the person is told to wait at least one day to call the provider to ensure that their information shows up on the provider's computer.

Target Population. The Access Team uses a target population criteria for authorizing clients into the county adult mental health outpatient system. This target population is as follows:

- Adults, ages 18 and older
- Individuals with severe disabling conditions that require mental health services
- Target conditions/diagnoses:
  - Major depression (recurrent), with or without psychotic features
  - Bipolar Disorders
  - Schizophrenia; Schizophrenic Disorders
  - Psychotic Disorder NOS (re-evaluation and change within 3-6 months)
  - Borderline Personality Disorder
  - Post-Traumatic Stress Disorder (PTSD)

Medical Necessity. In addition, each individual must meet the criteria for medical necessity. Medical necessity is the criteria that identifies service need based on the inclusion of specific signs, symptoms, behaviors, and conditions, as well as proposed services associated with mental illness treatment. Medical necessity is based on:

- A covered diagnosis;
- An established level of function impairment

- An expectation that specialty mental health services is necessary to address the condition; and,
- An indication that the condition would not be responsive to physical health care-based treatment.

Level I Services

Individuals who qualify for Level I services are described as "individuals who are managing their symptoms and need ongoing psychiatric medication and occasional case management and linkage." Persons who meet Level I criteria are not eligible for county mental health services, but are referred to the County Primary Care Clinic and/or a local Federally Qualified Health Center (FQHC).

These facilities offer medical, mental health, and addiction services. The County Primary Care Clinic and the Effort also provide a number of different mental health services, including psychiatric evaluation, medication management, and counseling services for all ages. Other FQHCs in the county are also available to deliver physical, substance abuse, and mental health care.

Level II Services

Individuals who need Level II services require a low intensity of mental health services, primarily medication support, case management, and mental health services (social rehabilitation, collateral services, support groups, etc.). Individuals who meet Level II criteria are eligible for county mental health services.

Level II is the lowest level of care delivered by the mental health outpatient providers in Sacramento County. Clients may receive services for a short period of time, or for several years, to help them remain stable and living in the community. Level II providers have large case loads, with a staff to client ratio of 1:80, or higher. By contract, each Level II provider is responsible for ensuring that services are provided to not more than 900 unduplicated clients at any given point in the year. Of these 900 clients, the provider may serve up to 50 persons who meet Level III criteria. Typically, clients receive one contact per month, but the contract allows Level II providers to increase or decrease the number of contacts based on clinical need.

The Level II providers include four Regional Support Teams and two county-operated outpatient clinics:

- Regional Support Teams (RST)
  - El Hogar
  - Human Resources Consultants (HRC)
  - Northgate Point
  - Visions
- County Adult Psychiatric Support Services (APSS)
  - Aftercare Clinic
  - APSS Clinic

▪ Level III Services

Individuals who meet the Level III criteria need ongoing mental health support and services, and often require additional assistance to maintain their living situation and engage in services. Level III provides a higher level of care for clients, with a staff to client ratio of 1:20 to 1:25. Originally, HRC TCORE was designed to provide Level III services, but with their current funding level and caseloads, TCORE staff reported that their services are more "Level II.5."

▪ Mental Health Services Act (MHSA) Full Service Partnership (FSP) and Level IV Services

Level IV services are designed to provide the highest level of community-based outpatient services. These services are for persons who require intensive community/outpatient supports to live successfully in the community. These persons may be at imminent risk of involuntary treatment, or may not be discharged from an acute care or sub-acute care setting without the availability of intensive community support. Level IV services are offered to persons who are discharged from a locked inpatient placement, if these persons require intensive community support services. Providers complete a LOCUS and submit it with an authorization request for this level of service.

Level IV services include medication support, 24/7 response, intensive rehabilitation and case management, and linking to benefits. Supported housing is available, and the focus of the treatment is to engage the individual in services that will help them stabilize in a community setting. The California Mental Health Services Act (MHSA) has funded a number of programs to meet specialized needs in the county through Level IV Full Service Partnership (FSP) programs. Each of the FSP programs in Sacramento County are uniquely designed and offer a different array of services, depending on the population served and the level of funding.

MHSA FSP and Level IV services were designed to provide individualized therapy, as needed; services for co-occurring disorders (mental health and substance abuse disorders); assistance in developing wellness and recovery plans (WRAP); and support to participate at the Wellness and Recovery Centers. All Level IV providers receive MHSA flexible funds for "whatever it takes." These funds offer flexibility in helping an individual obtain housing, pay for first and last month's rent, pay for medications that are not covered by Medi-Cal, and/or purchase basic needs for setting up an apartment. The Level IV providers also have a higher staff to client ratio (1:10 to 1:15).

The following providers are funded through the MHSA funds. Each provider's services were designed to serve a specialized population, as shown below. The majority of these programs also deliver Full Service Partnership (FSP) services funded through MHSA. These providers include:

Program Name	Program Population Served
El Hogar Guest House	Access & Outreach to the Homeless
TLCS New Direction	Housing for Homeless & FSP
Turning Point Pathways	Homeless & FSP
APCC Transcultural Wellness Center	Asian Pacific Populations & FSP
El Hogar Sierra Elder Wellness	Older Adults & FSP
Turning Point Integrated Service Agency (ISA)	High-need, at risk of higher levels of care & FSP
Telecare SOAR	High-need, at risk of higher levels of care & FSP

▪ Wellness and Recovery Centers

There are two Wellness and Recovery Centers (North and South). These centers are multi-service community programs that promote wellness and recovery through the delivery of meaningful activities and community involvement. These centers are consumer and family-directed and operated. The centers now offer medication support services and bill Medi-Cal for some services, at the county's direction. These programs are considered Level II providers. The uniqueness of these centers, and the importance of integrating wellness and recovery services across all county mental health programs, will be discussed later in this chapter.

▪ University of California, Davis (UC Davis) Psychiatry Services

The county contracts with UC Davis to provide psychiatric services at the two county outpatient clinics and the Mental Health Treatment Center. In addition to UC Davis providing Residents to work in these settings, all full-time psychiatric staff are employees of UC Davis. This arrangement benefits both UC Davis and the county. UC Davis Department of Psychiatry provides excellent training to Residents by delivering treatment to county clients. Similarly, the county benefits through the availability of psychiatrists to work in the county programs. A discussion of this program and the impact on clients is provided later in this chapter.

▪ Crisis Response and Crisis Intervention Services

Crisis response and crisis intervention services are important components of the array of services available in a mental health system. A crisis is an unplanned event or situation that results in a person's need for an immediate mental health intervention, and which may include a variety of interventions and services that prevent a dramatic deterioration of functioning. The situation may be urgent or emergent (see definitions below). Crisis services in Sacramento County may be delivered in a clinic, in the field, in the community, or in an Emergency Department. The services must be delivered by a mental health staff or individuals with training and skills to perform such interventions and services.

Definition of Urgent Condition. A situation experienced by an individual that, without timely intervention, is certain to result in an immediate emergency psychiatric condition.

Definition of Emergency Condition. As a result of a mental disorder, the individual is a danger to self or others, or gravely disabled.

The outpatient providers can respond to a crisis event during regular business hours, or after business hours, by providing intervention and supportive services to de-escalate the crisis. Only Full Service Partnerships (FSPs) are required to have the capability to have a 24/7 after-hours capability to respond to their own enrolled FSP clients. Other outpatient providers do not have this requirement and may rely on the MHTC's 24/7 response system. This 24/7 toll-free after-hours line that responds to any caller, assesses the call, and provides crisis or other supportive information. In addition, the 24/7 Intake and Referral Team responds to calls from Emergency Department staff. The Intake and Referral Team provides necessary treatment information, consultation, and other essential information regarding clients who present at the hospitals or Emergency Departments. This line is also provides consultation to law enforcement when they call for information.

Despite the capacity of the mental health system to respond to a crisis situation, in Sacramento County, when a person calls 9-1-1 regarding a mental health crisis, the 9-1-1 dispatch operator typically calls law enforcement to respond to the mental health related crisis situations. In the majority of these situations, law enforcement conducts the evaluation for an involuntary commitment (W&I Code 5150) and transports the person to the Emergency Department. Mental health providers are typically not called in by law enforcement to be involved in this process. A discussion of crisis response and intervention services, and the impact on clients, is provided later in this chapter.

Array of Outpatient Services across Sacramento County

To understand the array of adult outpatient mental health services, a data model has been developed using data from AVATAR to show the number of adults receiving outpatient mental health services, the number of hours of service received, the types of service, and the average hours per client. This data model provides valuable information that is helpful in understanding the service delivery system, the types of services received, and the frequency of services delivered to clients. This data model is complex, but provides important information on the array of outpatient services and highlights differences between providers. This data model is used throughout this document to provide information on the levels of services and the service delivery patterns by different providers. In the outpatient system, clients receive one or more services from the following:

- Clinical Assessments
- Individual Rehabilitation/Therapy
- Group Services
- Case Management
- Medication Support
- Crisis Intervention (discussed later in the chapter)

The data model will be described in detail, to help the reader understand the information in the document. All data used in this model was generated from the AVATAR data system.

The first graphic (Figure 2) shows the total number of adult clients served by Sacramento County mental health outpatient programs in CY 2010 across Levels II-IV. There were 10,328 adult clients served in CY 2010. These adults received 318,190 hours of outpatient services, which calculates into an average number of 30.81 hours per client.

Also shown on the top section of Figure 2, on the left, is the unduplicated* number of adult mental health clients (10,328), the county adult population (2009 Census) of 1,039,397, and the county adult Penetration Rate of 0.99%. The Penetration Rate shows that approximately 1% of all Sacramento County adult residents receive outpatient mental health services.

** Note: Unduplicated means that each client is only counted once in the year, regardless of the number of services received.*

DATA NOTE: **Penetration Rate**: The Penetration Rate provides information on the proportion of adult persons who received one or more mental health services in the year, out of the county adult population. It also allows comparisons to other county and/or state mental health data to help understand access to mental health services. The Penetration Rate is only one component of understanding access to services. The amount of services the person received is also important, as well as outcomes of services.

Formula:

Number of unduplicated adults clients (ages 18 and older) who received at least one outpatient mental health service in the Calendar Year (divided by)
The total number of Sacramento County adults (ages 18 and older)

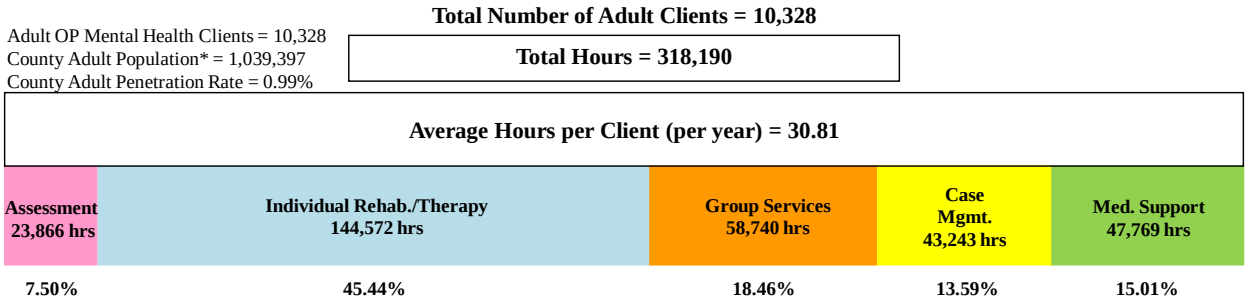
There are also other methods for calculating Penetration Rate. A second method uses the average monthly eligible count of Medi-Cal Beneficiaries in the year, instead of using the county adult population. A third method uses 200% of adult poverty population in the county. Each of these calculations provides a benchmark for access.

We chose to utilize the county population formula in this Report because the county adult population data was easily available and is an accepted method for calculating mental health penetration rates.

The color bar in Figure 2 (next page) also shows the breakdown of different outpatient services and the number of service hours for each service type. In addition, the proportion of hours for each service out of the total hours is provided. For example, there were 23,866 assessment hours delivered in CY 2010. This is 7.50% of the total 318,190 hours of service delivered. Individual rehab/therapy hours represent 45.44% of all services, group services represent 18.46%, case management hours represent 13.59%, and medication support hours represent 15.01% of all service hours.

The color bar is calibrated to 100% of service hours and visually shows the proportion of hours for each type of service. For example, assessments reported 7.50% of all service hours, so it is visually "smaller." Individual rehab/therapy has comprised 45.44% of all outpatient service hours so it proportionally "larger." This model helps the reader, at a glance, understand the proportion of services delivered by the service provider.

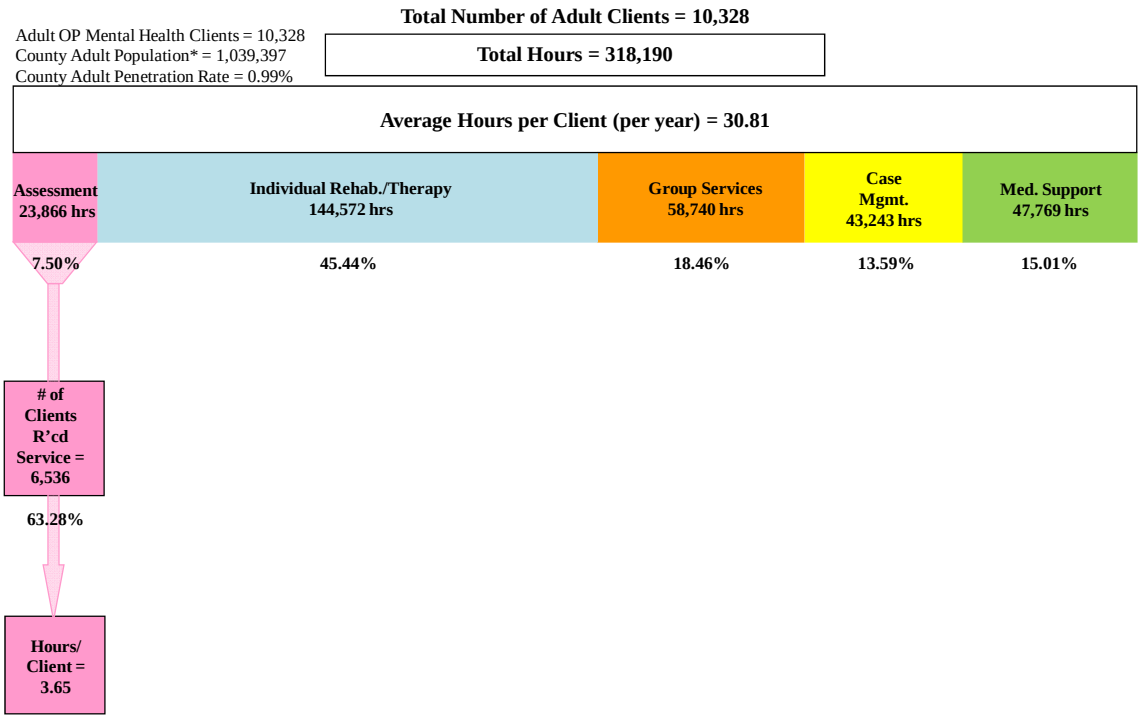
Figure 2
Adult Outpatient Mental Health Services Color Bar
Sacramento County Total
CY 2010
(Data from AVATAR)



* Source: U.S. Census Bureau, 2009 Population Estimates. Adults include those 18 years of age and older.

Figure 3 shows the same information described in Figure 2. In addition, it provides more information on assessment services, which were delivered across all outpatient service providers. Of the 23,866 hours of assessment services, there were 6,536 clients who received assessments (63.28% of all outpatient clients). Dividing the total number of assessment hours by the number of unique clients who received an assessment produces an average number of assessment hours per assessment client. As shown in Figure 3, each client averaged 3.65 hours of assessment services in the year.

Figure 3
Adult Outpatient Mental Health Services Color Bar and One Service
Sacramento County Total
CY 2010
(Data from AVATAR)



* Source: U.S. Census Bureau, 2009 Population Estimates. Adults include those 18 years of age and older.

Figure 4 (next page) shows the full graphic display of the adult services, building upon the information shown in Figures 2 and 3. Following assessment services, the next column of data shows information on individual rehab/therapy services. There were 144,572 hours of individual rehab/therapy services delivered. These services represent 45.44% of all outpatient services. There were 7,663 clients who received individual rehab/therapy. This shows that 74.20% of all clients who received adult services received individual rehab/therapy. Each client who received an individual rehab/therapy service averaged 18.87 hours of service in the year.

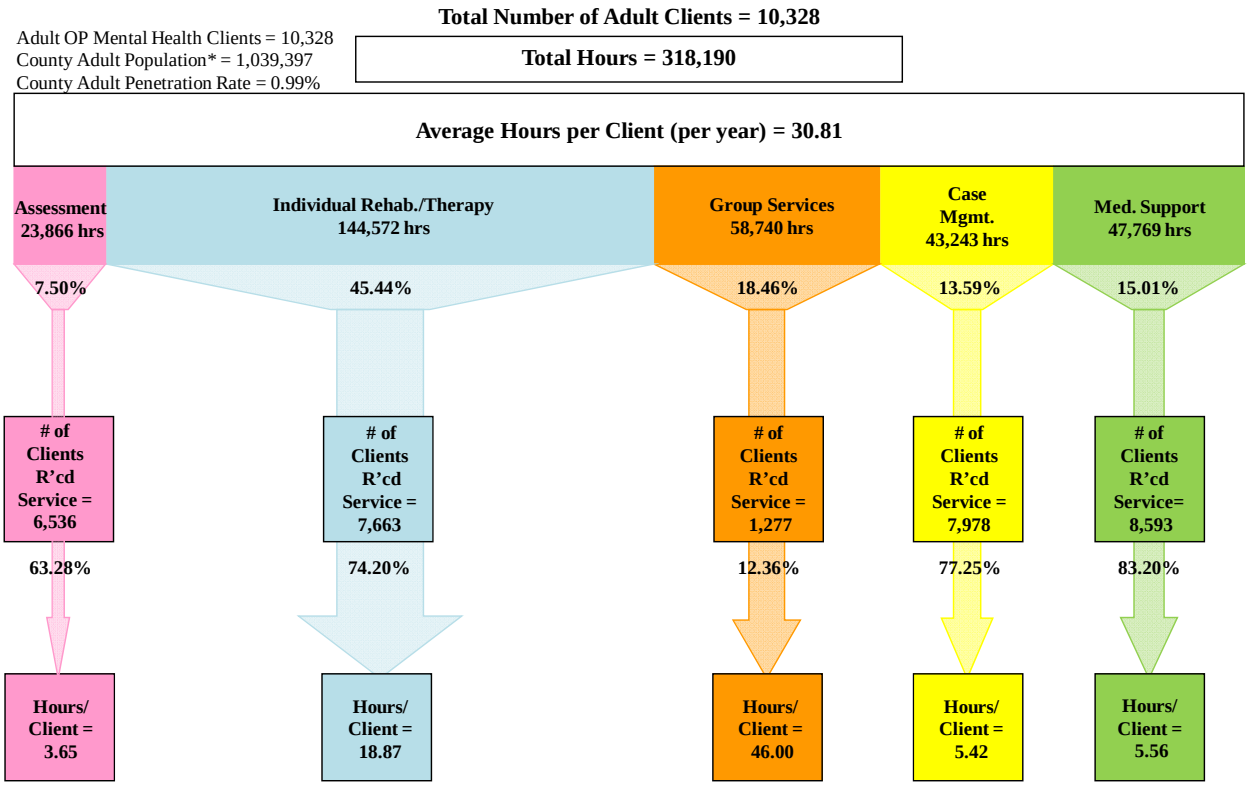
NOTE: One client can receive more than one type of service in a year. As a result, the count of clients across the services is duplicated, so the number of clients in the middle "boxes" will be higher than the total number of unduplicated clients. The total unduplicated count of clients across all services is shown at the top of the figure (10,328 clients).

The next column of data in Figure 4 shows group services. There were 58,740 hours of service delivered. These group services represent 18.46% of all adult outpatient services. There were 1,277 clients who received group services. This represents 12.36% of clients receiving outpatient services. The average client who received group services averaged 46 hours of service.

Case management services are also shown in Figure 4. There were 43,243 hours of case management services (13.59% of all outpatient hours). There were 7,978 clients who received case management services. This was 77.25% of all clients. Each client who received case management services averaged 5.42 hours of service in the year.

Medication support services are also shown in Figure 4. There were 47,769 hours of medication support delivered in CY 2010. This was 15.01% of all outpatient service hours. There were 8,593 clients who received medication support (83.20%). Each client who received medication support averaged 5.56 hours of service.

Figure 4
Adult Outpatient Mental Health Services
Sacramento County Total
CY 2010
(Data from AVATAR)



* Source: U.S. Census Bureau, 2009 Population Estimates. Adults include those 18 years of age and older.

The data on all adult clients provides valuable information on the number of clients receiving services, the amount of services received, and the types and intensity of services. Overall, the adult mental health system is serving approximately 1% of the county adult population. The majority of clients (83.20%) received medication services. The average client received about the same number of hours of medication services in the year (5.56 hours) as case management services (5.42 hours per year).

Throughout this Report, each of the providers will be described individually using this data model.

Levels of Care In Depth

The following section provides additional information on each level of service (Levels II, III, and IV). Note that data for Level I is not available and will not be discussed in this Report. (As noted previously, individuals with Level I needs do not qualify for county mental health services.)

Each program within a level of service will be described, as well as data showing the number of clients and array of services for each provider. In addition, a discussion of the Wellness and Recovery Centers and crisis response services is provided, as well as the results of the adult consumer survey collected as a component of the Independent Expert Review.

Level II Services

Level II services are primarily clinic-based services, with the majority of clients receiving medication support services. The array of services are consistent across providers. Level II services are provided by the four Regional Support Team (RST) providers (El Hogar, Human Resources Consultants, Northgate, and Visions). The two county clinics, Aftercare and APSS, also deliver Level II services.

In CY 2010, the allocated budget for each RST was $2,184,351. The allocated budget for each of the two county clinics was $2,161,003.

Level II Clients and Service Utilization

During CY 2010, the two county clinics were changing site locations and in the process of expanding and developing programs. As a result, the two clinics were not fully implemented until July 2010. These changes may have influenced the county data shown in the figures below.

Data on the number of clients and hours of services delivered by the four Regional Support Teams (RSTs) and two county clinics is shown in Figure 5. The data for the four RSTs will be discussed, and then the data for the two county-operated clinics will be discussed.

The RSTs served approximately the same number of clients in the calendar year. The hours of services were similar for three RSTs (El Hogar, HRC, Northgate), with each offering over 20,000 hours of services. Visions delivered approximately 9,000 more hours of outpatient service compared to the other three RSTs. This difference is also reflected in the hours per client per year, with the average client at Visions receiving 30.10 hours per year, compared to approximately 22 hours per year for clients at the other three RSTs.

Figure 5
Adult Outpatient Mental Health Services: Level II
Clients, Hours, and Hours per Client
CY 2010
(Data from AVATAR)

Level II			
	# of Clients	**# of Hours**	**Annual Hrs/Clt**
El Hogar RST	911	20,438.58	**22.44**
Human Resources Consultants RST	902	20,228.34	**22.43**
Northgate RST	943	20,586.52	**21.83**
Visions RST	971	29,228.68	**30.10**
County Aftercare Clinic	974	7,112.72	**7.30**
County APSS Clinic	1,326	10,876.56	**8.20**
Total Level II	5,644	144,063.98	**20.10**

Figure 5 also shows data for the two county outpatient clinics, Aftercare and APSS. Aftercare served a comparable number of clients (N=974) to the RSTs during the calendar year. APSS served over 350 more clients (N=1,326). However, the total number of hours of services for the two county clinics is lower, compared to the RSTs. This is also reflected in the hours per client, with 7.3 hours per client per year for Aftercare and 8.2 hours per year for APSS.

In summary, the number of clients and services are similar across the RSTs. The two county clinics delivered less than half the number of hours of service. As a result, the average hours per client was 2-3 times lower for the county clinics, showing that clients at the two county clinics received fewer hours of services in the year.

Proportion of Clients with Medi-Cal (Level II)
The contracts between the county and the RSTs estimate that each provider will produce a high rate of Medi-Cal billing, which will result in an estimated federal reimbursement of approximately 50% of their budget. The county estimates that the Medi-Cal billing for these four providers is close to this target.

Data was analyzed to determine if a high number of persons who are indigent were receiving services at the county clinics. If there are a high number of persons without Medi-Cal at any provider, this could negatively impact the provider's ability to bill Medi-Cal. CY 2010 data showed that approximately 97% of the RST clients are Medi-Cal. For the county clinics, 87.37% of Aftercare's clients and 83.86% of APSS's clients were Medi-Cal (see Figure 6).

Figure 6
Adult Outpatient Mental Health Services: Level II
Number and Percent of Clients by Funding Source
CY 2010
(Data from AVATAR)

Level II					
	Medi-Cal		Non Medi-Cal		Total
	# of Clients	% of Clients	# of Clients	% of Clients	# of Clients
El Hogar RST	887	97.37%	24	2.63%	911
Human Resources Consultants RST	887	98.34%	15	1.66%	902
Northgate RST	923	97.88%	20	2.12%	943
Visions RST	968	99.69%	3	0.31%	971
County Aftercare Clinic	851	87.37%	123	12.63%	974
County APSS Clinic	1,112	83.86%	214	16.14%	1,326

It would be expected that the proportion of Medi-Cal billing would be similar across RSTs. It is lower for the county clinics because of the larger number of clients without Medi-Cal. Billing Medi-Cal is an important part of outpatient mental health services. If Medi-Cal is maximized, there are more dollars available to deliver and strengthen services.

Array of Level II Services

Regional Support Teams and County-Operated Adult Psychiatric Support Services Clinics
The four Regional Support Teams (RSTs) are operated by contracted agencies in four geographical areas of the county. The county-operated clinics are in two sites. The four RSTs (El Hogar, Human Resources Consultants, Northgate, and Visions) and the two county clinics (referred to as Aftercare Clinic and APSS Clinic) provide services to clients whose needs have been determined to be at Level II. The following basic information applies to all of these programs. Many of the RST programs also operate other programs for the county, such as homeless outreach and Level IV services. These additional programs will be noted in this section and explained in more detail later in the Report.

Access/Intake. Access to any of these programs is determined by the county Access Team staff. Once they have determined that a person needs Level II services, they assign the individual to a

specific provider and instruct the individual to call the provider directly. The authorization is then entered into the AVATAR database. This information is sent to the provider to notify them of the new referral.

Services. All of the Level II providers offer a range of services, including medication support, case management, individual rehabilitation/therapy, and group services. All Level II providers are expected to run SACPort groups, which is a program that will be discussed later in this document. Specific data on the level of these services is displayed in the data model diagram following the information on each provider. In most of the Level II programs, very few substance abuse or dual diagnosis services were offered. Staff tend to refer individuals to Alcoholics Anonymous, Narcotics Anonymous, community providers, or county AOD services. The SACPort program contains a substance abuse module which all of the programs reported offering at times.

Service Delivery. In each of the Level II programs, all clients have a Personal Services Coordinator who develops a service plan with the client and directly provides services to that client. They may also refer the client to other services and groups. The caseload size averages 1:80. Staff are expected to provide at least one service to every client each month. For the RSTs, this is a contract requirement. However, the contracts also allow the provider to increase or decrease the number of contacts based on clinical need. Each of the programs serve about 900 clients annually, except the APSS Clinic, which serves more clients. These numbers are included in the data model information for each provider. If staff feel that a client needs more services than can be provided by a Level II agency, they will submit a request to the Access Team. If this request is for a Level IV service, staff will also complete a LOCUS.

Crisis Response/Coordination with Inpatient Providers. Level II programs do not have on-call capacity in the evenings or on weekends. All programs reported having the capacity to schedule clients on an emergency basis with psychiatrists when needed. The MHTC has created the capacity for Level II staff to see their clients at the MHTC by having staff from each provider verified through California Live Scan. Having Level II staff in treatment meetings at the MHTC is valuable in coordinating discharge and transitioning clients back into the community.

Cultural/Language Issues. All of the programs have some bilingual/bicultural staff. For other language needs, providers use the Universal Language Line, the Assisted Access providers such as Southeast Asian Assistance Center, and or other local resources. All programs have access to information and forms translated into the county's threshold languages.

Staff with Lived Experience. Some of the providers hire persons with lived experience to work on the service delivery teams and reported that these staff members are an important part of services and invaluable in working individuals to help them meet their goals. Other providers have hired persons with lived experience, but do not disclose this information to their clients. Some providers do not have persons with lived experience on staff.

Training. All programs reported sending staff to county-led trainings on documentation and Medi-Cal billing, as well as clinical trainings. Nearly every provider noted the need for more staff training.

El Hogar RST

El Hogar operates the following county-funded programs:

- Regional Support Team (RST)
- Guest House, a program that offers homeless outreach services
- Sierra Elder Wellness, an MHSA-funded Full Service Partnership (FSP) program serving older adults

Access/Intake. Staff at the RST will check the AVATAR system to determine if new clients have been authorized for services and contact the individuals if they have not yet called for an appointment. They estimate that 25% of the people scheduled for an intake do not show up for the appointment. A Personal Services Coordinator (PSC) completes the initial assessment and develops a service plan.

Service Delivery. Services are primarily delivered in the clinic. Staff have access to two vehicles and provide transportation when clients need community-based services. The Review Team saw evidence of a recovery-based approach in the leadership team and strong clinical supervision, especially during the case presentations.

The diversity of programs offered, and the quality of staff that continuously look for new ways to diversify programs and services, creates a strong team that is willing to learn and change. Staff development is supported through weekly individual and group team meetings and supervision. The agency strives to support individuals in achieving their goals, not just managing their symptoms. This dedication provides high-quality treatment for clients.

Crisis Response/Coordination with Inpatient Providers. Staff will respond to crisis situations during business hours and are able to go into the community to respond, if necessary. They indicated that they are usually notified when a client has been admitted to the MHTC, but are not routinely contacted by private hospitals when one of their clients has been hospitalized. They work with discharge staff at the inpatient facilities to schedule appointments for clients being discharged. After hours, clients call 9-1-1 when they are in crisis.

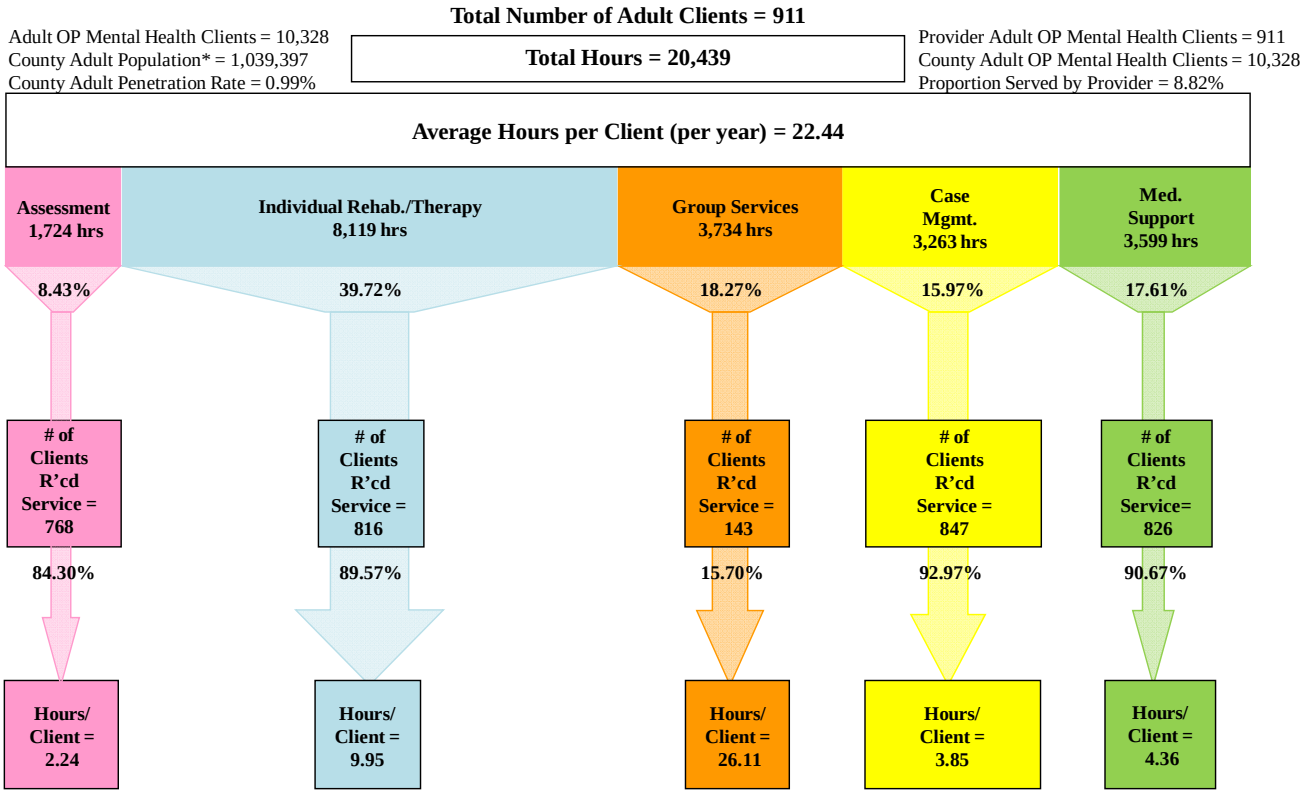
Cultural/Language Issues. The RST does have a few bilingual Spanish-speaking staff who offer services to clients. For other languages, they have contracts with local agencies such as Language World or Southeast Asian Assistance Center to provide interpretation services.

Staff with Lived Experience. The El Hogar RST Team have hired several staff with lived experience. These staff do not have titles like “Peer Mentor” or “Peer Specialist,” but they are open to sharing their lived experience with their clients.

Training. In the past two years, El Hogar managers brought in qualified trainers to develop staff skills in recovery and wellness. They continue to offer ongoing training to staff to create a learning environment and continually improve services. El Hogar has utilized an online training program and have trained staff in Dialectical Behavior Therapy (DBT).

Data. Figure 7 shows that El Hogar has a comprehensive array of services. Approximately 90% of the clients are receiving individual rehab/therapy, case management, and medication support. There were 911 clients in CY 2010 who received an average of 22.44 hours per year. Persons received an average of 10 hours per year of individual rehab/therapy. Staff also assist clients to utilize the Wellness and Recovery Centers.

Figure 7
Adult Outpatient Mental Health Services
El Hogar RST
CY 2010
(Data from AVATAR)



* Source: U.S. Census Bureau, 2009 Population Estimates. Adults include those 18 years of age and older.

Human Resources Consultants (HRC) RST

Human Resources Consultants (HRC) offers outpatient services through two programs:

- RST
- TCORE HRC (discussed later in this chapter)

Access/Intake. Staff at HRC review the authorization list from the Access Team daily and contact clients to schedule appointments. Staff are usually able to see clients within one week. Staff noted that this strategy has reduced their no show rate for new intakes; they estimated that approximately 20% of individuals do not show up for a scheduled intake appointment.

Service Delivery. Staff at HRC are organized into two treatment teams. Staff do not have individual caseloads, but rotate caseloads on a monthly basis. Some clients struggle with this model, and staff are open to making accommodations for individual clients.

Staff reported that "recovery-based services were here from the inception, but have gotten a little watered down over time." They encourage staff to work with clients on their goals, even if staff are not sure the client can achieve those goals. At one time, they had an employment team, but it was eliminated due to budget cuts. When clients indicate that they are interested in getting a job, staff will provide mentoring and identify opportunities to support clients to reach employment goals. Of the groups that they offer, they have found that clients are most interested in the DBT groups. Their Russian speaking support group is also popular. They have found that most clients prefer one-on-one contact. Although their services are primarily clinic-based, they do have a staff person out in the community on a daily basis.

Crisis Response/Coordination with Inpatient. In a crisis situation, staff support the individual and provide resources to potentially de-escalate the crisis before calling 9-1-1. They will also go out to the client's home during working hours to help resolve a crisis situation, which is very helpful for clients. They reported doing this two to three times per month. After hours, clients call 9-1-1 when they are in crisis. Inpatient staff will call when they want to schedule an appointment for clients being discharged. Staff from the program attend a monthly meeting with the private hospitals to discuss ongoing coordination issues.

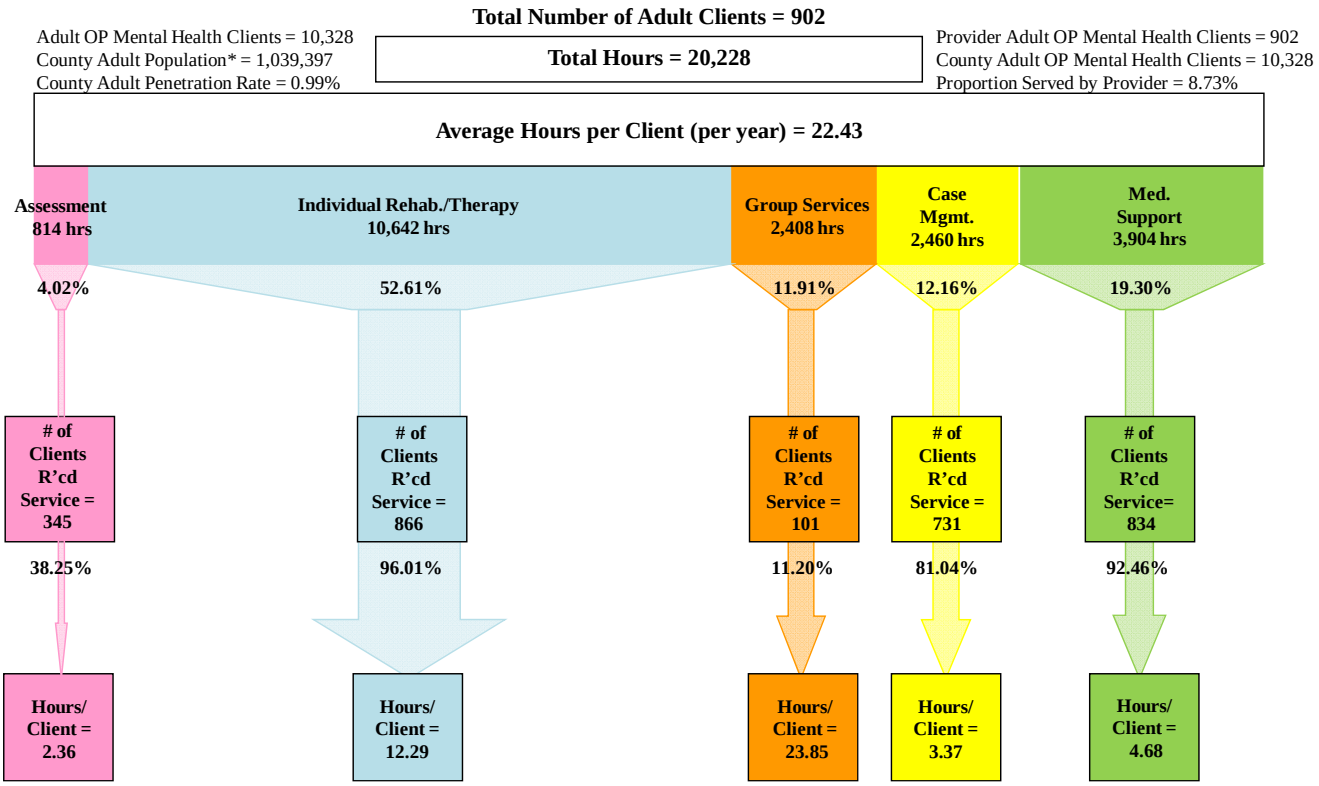
Culture/Language Issues. Staff reported serving a larger percentage of Russian clients and have hired bilingual and bicultural staff to respond to this need.

Staff with Lived Experience. HRC has a history of employing individuals with lived experience as part of their treatment team. While they do not have designated peer positions, they do encourage staff with lived experience to openly share their perspective with staff and clients.

Training. When new staff are hired, HRC provides a one month training program that includes county and agency-level training.

Data. Figure 8 shows that 902 clients received services at HRC RST in CY 2010, and the clients averaged 22.43 hours per year. Ninety-six percent (96%) of the clients received individual rehab/therapy, with an average of 12.29 hours per year for each client. These individual services represent nearly 53% of all service hours.

Figure 8
Adult Outpatient Mental Health Services
Human Resources Consultants (HRC) RST
CY 2010
(Data from AVATAR)



* Source: U.S. Census Bureau, 2009 Population Estimates. Adults include those 18 years of age and older.

Northgate Point RST

Turning Point has several outpatient programs, including:

- Northgate Point RST
- Pathways, an MHSA-funded FSP program to assist persons who are homeless in finding a place to live (discussed later in this chapter)
- Integrated Service Agency (ISA), an MHSA-funded intensive program for Level IV clients (discussed later in this chapter)

All Pathways and ISA clients are FSP. In addition, Turning Point has a Crisis Residential Program, which will be discussed later in this Report.

Access/Intake. Clients contact Northgate Point after their authorization. Staff reported that clients typically have their initial assessment within one week of making that call. They report that once a client has scheduled an appointment, 10% do not show for their initial appointment. The individual meets with their PSC who does the initial paperwork, provides them with an agency handbook, and explains the services offered.

Service Delivery. While staff are able to do some services in the field, the majority of services are clinic-based. They will assist clients with transportation to attend groups at the clinic. They offer a wide range of groups that are developed in response to client request and staff strengths. They indicated that they have gotten positive feedback from clients on SACPort Groups.

Crisis Response/Coordination with Inpatient. Staff respond to crisis situations during business hours, if contacted by the client. They will also go out in the community and facilitate a hospitalization, if needed. Staff indicated that they are sometimes contacted by the MHTC if one of their clients is hospitalized at that facility. They reported that they are not typically contacted by the private hospitals if a client is admitted in one of those facilities. After hours, clients call 9-1-1 when they are in crisis.

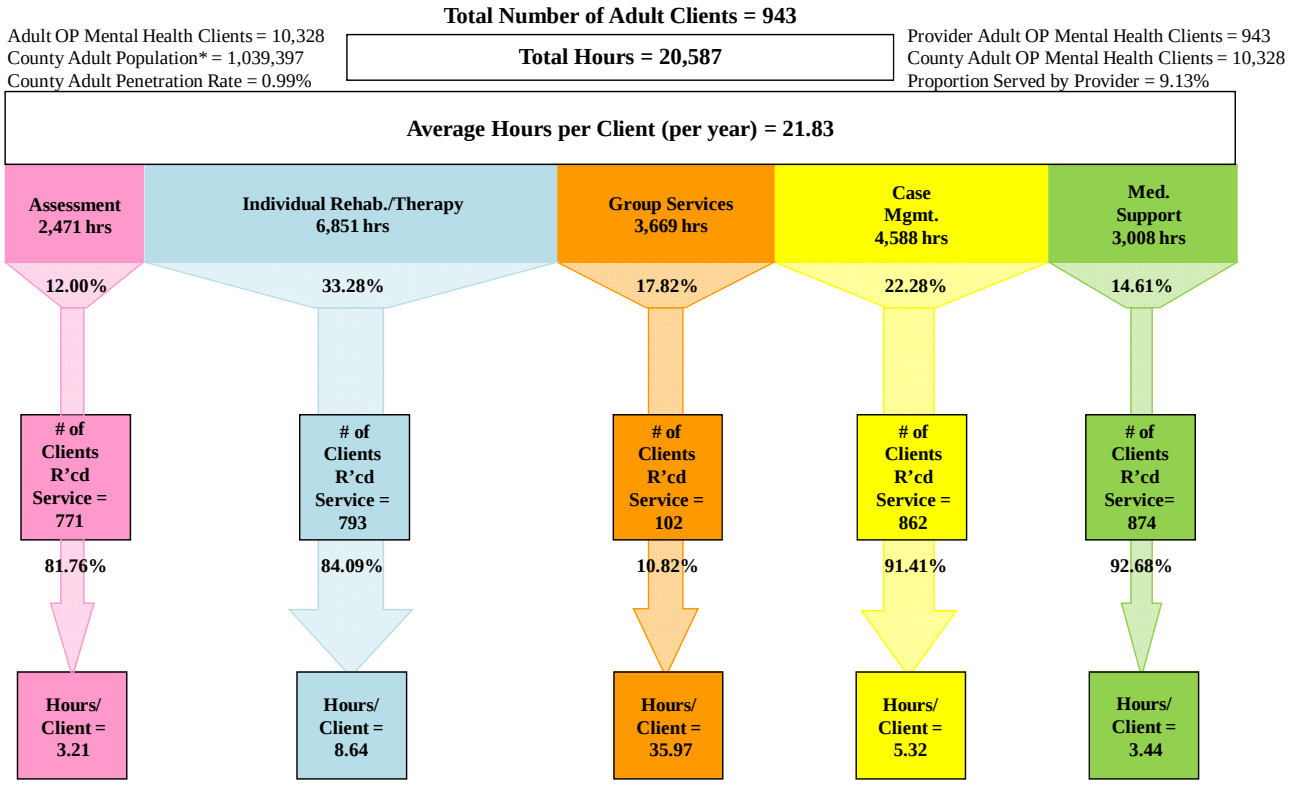
Cultural/Language Issues. Turning Point employs a number of staff who are bilingual/bicultural. They have staff who can speak Spanish, Russian, Ukrainian, Vietnamese, and other languages. When possible, they have staff from their other programs help with interpretation.

Staff with Lived Experience. Northgate Point has one Peer Partner on staff. This person primarily runs the SacPort groups and assists clients with transportation.

Training. Northgate Point has an orientation manual for new staff. They have new staff members shadow more experienced staff while on the job.

Data. Northgate Point RST served 943 adults in CY 2010 (see Figure 9). These clients averaged 21.83 hours of services per year. Over 90% of the clients received case management services (5.32 hours per year) and medication support (3.44 hours per year).

Figure 9
Adult Outpatient Mental Health Services
Northgate RST
CY 2010
(Data from AVATAR)



* Source: U.S. Census Bureau, 2009 Population Estimates. Adults include those 18 years of age and older.

Visions RST

Visions Unlimited, Inc., operates RST services for adults that are provided in two locations, south Sacramento and Galt.

Access/Intake. After contacting the county Access Team, assigned clients call Visions to schedule an intake appointment. Staff noted that if the client calls to schedule this initial intake, it indicates they are motivated to received services. They estimated 15-20% of the clients do not show up for their initial intake appointment. In addition to meeting with their PSC, clients are seen by a nurse who completes the county health questionnaire.

Service Delivery. The team delivers the highest number of services across all of the Level II providers. Staff work with clients to ensure that they are safe in their living arrangements.

In addition to psychiatrists, Visions also has a Nurse Practitioner on staff. This individual prescribes medication for clients, but also adopts a holistic approach, looking at nutrition, social, and family resources. The Nurse Practitioner goes out into the community to provide services at local Board and Care homes in the Galt area. This community-based approach is appreciated by the Board and Care operators and guarantees that the client is available for appointments. This arrangement works well and provides excellent support to clients. There are 105 clients being served at the Galt location; there is one mental health worker assigned to these clients, in addition to the Nurse Practitioner.

One of the groups that is offered at the clinic is a Job Support Groups. The staff person who runs this groups assists clients with referrals to the Department of Rehabilitation and to Crossroads (an employment program). Because Visions also operates a children's program, they have developed a transition process for young adults authorized to receive services from the RST.

Crisis Response/Coordination with Inpatient. Visions has a staff person who specializes in working with clients who are in crisis. This individual is certified to write 5150 evaluations and is able to go into the community to work with clients who are experiencing a crisis. This individual is also able to meet with clients while they are in the MHTC and will meet with them once they are discharged. Visions' goal is to meet with clients within 72 hours of discharge. A crisis management plan is developed with the client to help avoid future hospitalizations. After hours, clients call 9-1-1 when they are in crisis.

One of the Vision staff checks a daily census report to find out who is in jail or an inpatient setting. This information is given to the Primary Service Coordinator. The Nurse coordinates with staff at the MHTC about medication and treatment issues. The program works to ensure that clients are able to get a medication appointment shortly after being discharged from a locked setting.

Cultural/Language Issues. The Visions team is culturally-diverse and works collaboratively to meet the needs of their clients. The team does whatever it takes to help the client. The culturally diverse staff work well together to be part of the community and deliver culturally sensitive services. These staff have come to be known as trusted contact persons within their cultural

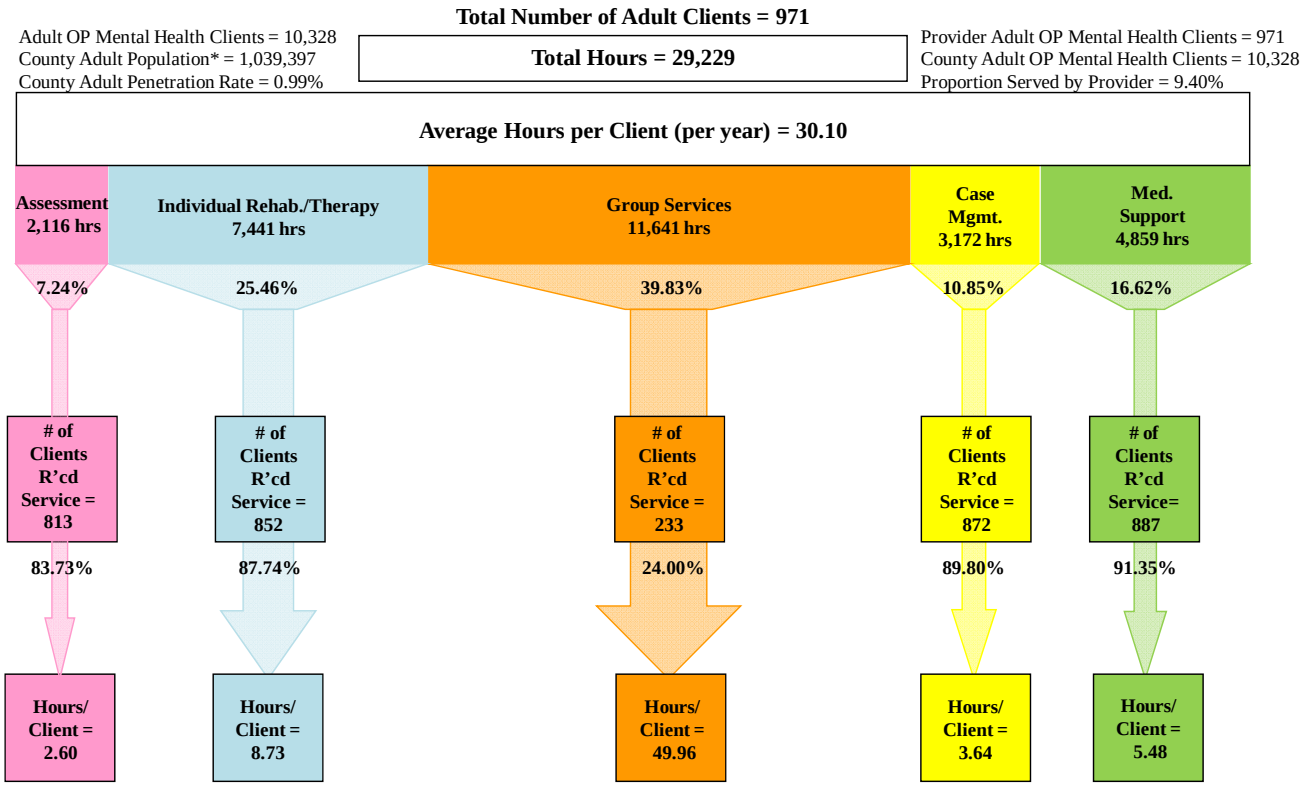
communities, which helps to encourage individuals to seek services who might not otherwise try to access mental health services. The Visions team has the capacity to speak several different languages, including Spanish, Mein, Vietnamese, Cambodian, and Hmong.

Persons with Lived Experience. Visions does not have designated peer positions. The RST is located near one of the Wellness Recovery Centers and refers clients to that program for peer support.

Training. New staff are oriented through supervision and attending county trainings. Visions staff specifically mentioned wanting training on dealing with co-occurring substance abuse issues.

Data. Figure 10 shows that Visions served 971 clients in CY 2010 and delivered 29,229 hours of service. This shows that each client received an average of 30.10 hours of service in the year. Twenty-four percent (24%) of the clients received group services, with an average of nearly 50 hours per year.

Figure 10
Adult Outpatient Mental Health Services
Visions RST
CY 2010
(Data from AVATAR)



* Source: U.S. Census Bureau, 2009 Population Estimates. Adults include those 18 years of age and older.

Aftercare Clinic (Level II)

Access/Intake. Clients call the Aftercare Clinic after being authorized by the county Access Team. The clinic reports a 40% no-show rate for clients who have been authorized for services. Given their close location to the MHTC (they are located on the same grounds as the Mental Health Treatment Center), staff from the Aftercare Clinic work closely with MHTC staff on referrals of indigent, unlinked clients. Aftercare Clinic staff are able to meet clients while they are still at the MHTC and get them an appointment for intake and psychiatric services. Clients are seen within 30 days of discharge from the MHTC.

Service Delivery. Staff are organized into two multidisciplinary treatment teams. While staff reported that some services are delivered in the field, the majority of services are clinic-based. Some alcohol and drug services are available at the clinic. There are two Alcohol and Drug counselors that work at the Aftercare Clinic and APSS. As described more fully later in this report, psychiatric services are contracted with the UC Davis Department of Psychiatry.

Crisis Response/Coordination with Inpatient. Aftercare Clinic clients who are experiencing a crisis during business hours may be seen by the Clinician of the Day, who will work to de-escalate the crisis. If this is not effective, staff will typically take the client to a nearby Emergency Department for an evaluation for meeting 5150 criteria. The MHTC will accept the individual if a bed is available and if the client can be safely transported. 9-1-1 is called in situations where the client is violent or dangerous.

Given their close proximity to the MHTC, some individuals who are in crisis, but are not assigned to a mental health provider, will sometimes show up at the Aftercare Clinic for services. In these cases, the individuals are directed to an Emergency Department. After hours, clients call 9-1-1 when they are in crisis.

Staff are able to meet with clients in the MHTC prior to discharge from that facility and schedule them follow-up appointments. For new, unlinked clients, they make contact at the MHTC once the Access Team has authorized them. When called by private hospital discharge planners, the Clinic provides follow-up appointment times. The county standard is for clients to be seen within 30 days of discharge.

Cultural/Language Issues. Aftercare has bilingual and bicultural staff who are fluent in three languages, including Spanish and Cantonese.

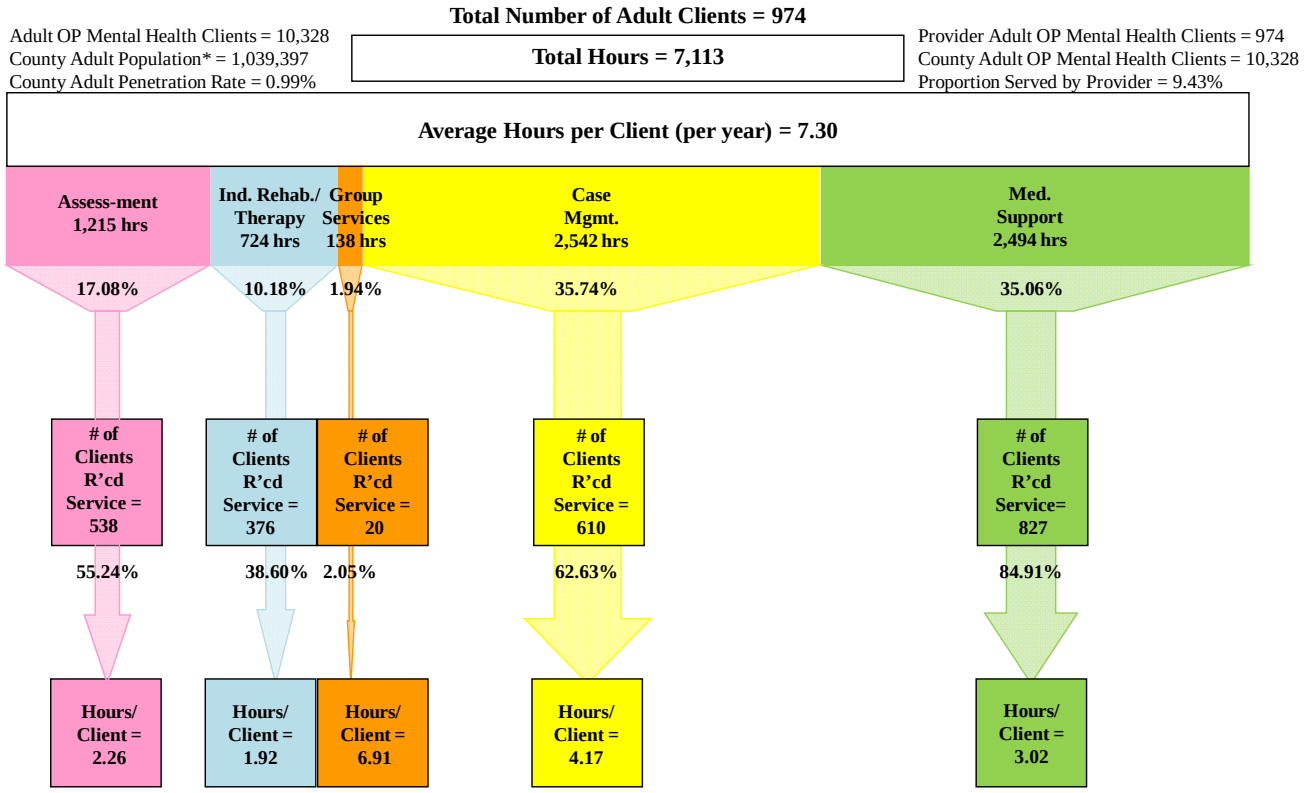
Staff with Lived Experience. The Aftercare Clinic has contracted with two agencies to place four (4) Peer Specialists \and their supervisor at the clinic. The Mental Health Association of Northern California provides supervision and two Peer Specialists; the Hmong Women's Heritage Association also provides two Peer Specialists. Peer Specialists from the Mental Health Association of Northern California are assigned to one of the teams; the Peer Specialists from the Hmong Women's Heritage Association are assigned to a second treatment team which specializes in serving the Hmong community.

Peer specialists assist clients in applying for benefits, finding housing, budgeting, and other services. They work in a modular building adjacent to the main clinic and, although they are assigned to the treatment teams, they are somewhat isolated from the other clinic staff. They have their own charts to record their work, but also have access to the Clinic's charts. Each Peer Specialist works with approximately 20 clients at a time.

Training. Staff have a formal case presentation monthly. They ask all new staff to attend various county trainings, including WRAP (Wellness and Recovery Action Planning Training).

Data. The Aftercare Clinic served 974 clients in CY 2010, and delivered 7,113 hours of service. This data shows that each client averaged 7.30 hours of service in the year. This is approximately one-third the hours of service received by clients at the RSTs. The array of services is also different. Figure 11 shows that 38.60% of the clients received individual rehab/therapy (1.92 hours per year), 62.63% received case management (4.17 hours per year), and 84.91% received medication support (3.02 hours per year). As noted earlier, the two county outpatient clinics experienced programmatic changes in CY 2010, which may have contributed to the lower number of services delivered.

Figure 11
Adult Outpatient Mental Health Services
County Aftercare Clinic
CY 2010
(Data from AVATAR)



* Source: U.S. Census Bureau, 2009 Population Estimates. Adults include those 18 years of age and older.

Adult Psychiatric Support Service (APSS) Clinic (Level II)

Access/Intake. After clients have been authorized through the county Access Team, they call the clinic and are scheduled for an intake appointment. Staff do not track the no-show rate for new intake appointments, but they did report a 50% no-show rate for initial appointments with a psychiatrist.

Service Delivery. The two county clinics operate on the same basic model and provide the same services. The APSS Clinic has recently hired two Peer Specialists. These positions have been filled through contracts with the Mental Health Association of Northern California and the Hmong Women's Heritage Center. As described later in this report, psychiatric services are contracted with UC Davis Medical Center.

The APSS Clinic reported that they operate from a recovery-based philosophy. They have provided some training for staff in this model. They generally do not refer clients to the nearby Wellness and Recovery Centers, as they provide groups within their clinic. Staff are able to provide services in the community with supervisor approval, but the majority of services are delivered in the clinic. Some alcohol and drug services are available at the clinic. There are two Alcohol and Drug (AOD) counselors at the APSS Clinic. These individuals also deliver services at the Aftercare Clinic.

Crisis Response/Coordination with Inpatient. Clients who are experiencing a crisis during business hours can usually be seen by a clinician or the Clinic Director, who will attempt to de-escalate the crisis. If this is not successful, 9-1-1 is typically called. Sometimes the police will not come to the clinic. In those situations, staff will either transport the client to an Emergency Department or make a plan with the client to go to an Emergency Department. The MHTC will accept the individual if a bed is available and if the client can be safely transported.

If the client is in their home, the staff will talk with the client over the phone. If this does not resolve the situation, they will call the police to do a health and safety check. After hours, clients call 9-1-1 when they are in crisis.

Cultural/Language Issues. A number of staff are bilingual and bicultural. Languages spoken include Farsi, Cantonese, Hmong, and Spanish. One of the psychiatrists participates in a Hmong support group. A number of clients mentioned how helpful this group was to them.

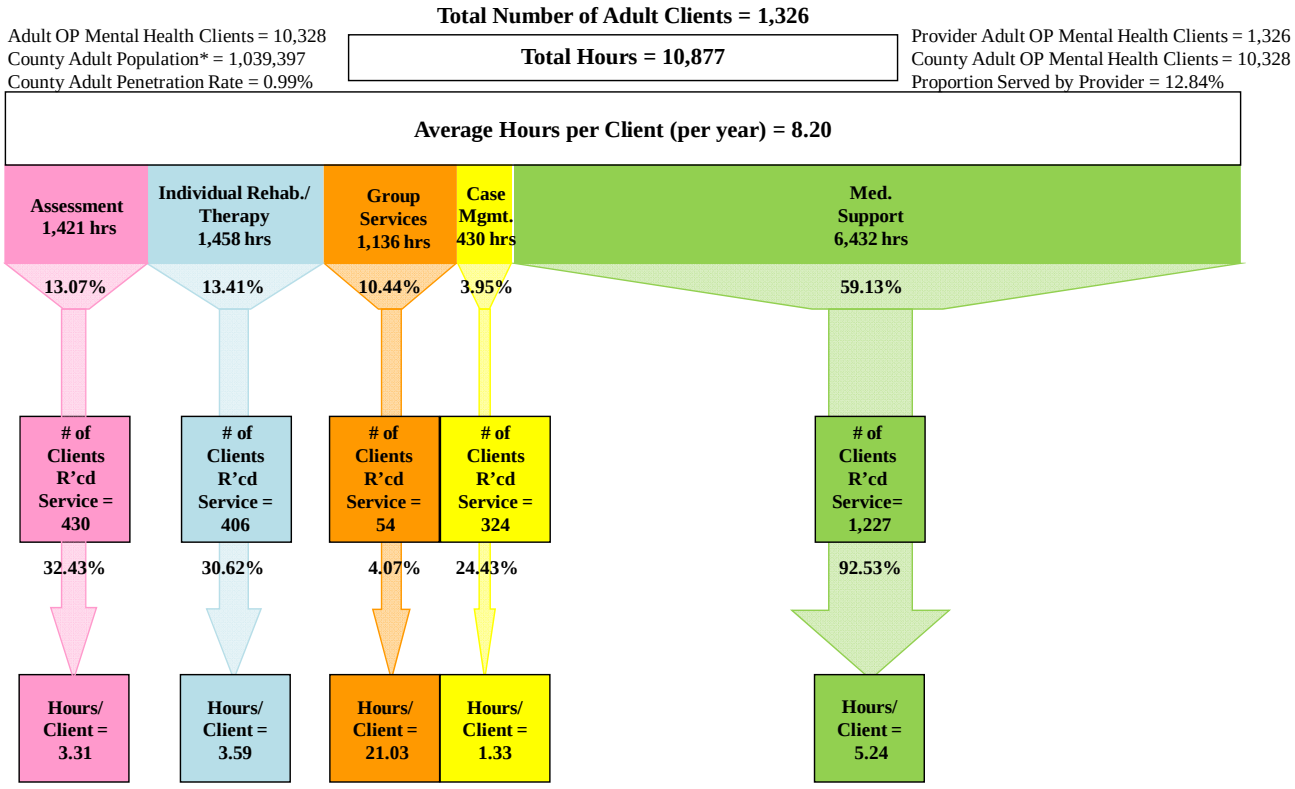
Staff with Lived Experience. As noted above, the program has recently hired two (2) Peer Specialists.

Training. Staff mentioned a strength-based intervention training that was particularly helpful. Staff were also encourage to attend a multi-day training on working with substance abuse issues.

Data. As shown in Figure 12, the county APSS Clinic served a larger number of clients (1,326) compared to the other RSTs and the county Aftercare Clinic. The total outpatient hours was 10,877. The average client received 8.20 hours per year. Nearly 60% of these service hours were medication support, with approximately 92% of all clients receiving medication support. A

small percent of clients received individual rehab/therapy, group services, or case management. Similar to the county Aftercare Clinic, APSS Clinic delivered one-third of the hours of services received by clients at the RSTs. The array of services is also different from the RSTs. In the APSS Clinic, nearly 60% of all service hours were medication support. In contrast, the data for the RSTs show that less than 20% of the service hours were medication support. The service hours in the RSTs offer individual rehab/therapy and case management.

Figure 12
Adult Outpatient Mental Health Services
County Adult Psychiatric Support Service (APSS) Clinic
CY 2010
(Data from AVATAR)



* Source: U.S. Census Bureau, 2009 Population Estimates. Adults include those 18 years of age and older.

Level III Services

Human Resources Consultants (HRC) TCORE

HRC TCORE is the only designated Level III program. Referrals to HRC TCORE come from the Access Team. Staff at the TCORE program are divided into four teams. Each team has a consumer/family advocate and a personal service coordinator staff member. The teams provide a range of services including individual rehab/therapy, case management, and group services. A number of their services are provided in the field. Due to their location, they also provide transportation to their facility for clients that need that level of assistance. The program has a half-time position dedicated to employment services; this person works with a small number of clients from all of the teams. They also coordinate with the Department of Rehabilitation to help clients navigate that system. The program trains all their staff in Motivational Interviewing and Motivational Engagement.

The program offers an after-hours "warm line" and crisis services through a contract with Crisis Support Services of Alameda County. This service is available from 8pm to 5am. Crisis Support Service Staff can provide phone interventions to callers. They can also contact the on-call staff person from TCORE to call individuals after-hours. They generally respond to the situation over the phone but are able to go out and respond in person, if necessary. TCORE reports receiving about 30 after-hours calls per month.

When clients are hospitalized at the MHTC, TCORE staff can be notified once the patient is accepted from an Emergency Department, at the time of admission, or the following business day. Staff are sent to check in with the client and coordinate with the Treatment Center staff. They are sometimes aware when a client has been hospitalized in a private hospital. When they are aware of this admission, they make contact with the hospital staff to coordinate discharge plans.

Each of their teams has a Consumer/Family Advocate position assigned to it. They work as Primary Service Coordinators and able to share their peer/family perspective with clients and staff.

TCORE implemented a different system for medication appointments after discovering that they had a 50% no-show rate for psychiatric appointments. The new system requires that the client calls the clinic on the morning that they want an appointment. Clients have been instructed to call prior to running out of medication, as they may not get an appointment the first time that they call. Clients start calling at 8:00 am and the appointment slots are usually filled by 8:15 am. A few medication appointment times are held open to accommodate emergency prescription refills and for clients coming out of hospitals. TCORE reports that their psychiatric no-show rate was reduced to 7% after implementing this system.

TCORE also has a sophisticated phone system which shows clients who repeatedly call and are unsuccessful at getting an appointment time. Personal Service Coordinators are available to assist clients if they are having difficulty making a medication appointment.

Level III Clients and Service Utilization

As shown in Figure 13, TCORE served 810 clients in CY 2010 and delivered 26,103 hours of service. On average, each client receive 32 hours of services each year.

Figure 13
Adult Outpatient Mental Health Services: Level III
Clients, Hours, and Hours per Client
CY 2010
(Data from AVATAR)

Level III			
	# of Clients	**# of Hours**	**Annual Hrs/Clt**
Human Resources Consultants TCORE	810	26,103.15	**32.23**

Proportion of Clients with Medi-Cal (Level III)

TCORE primarily serves Medi-Cal clients, with 89.14% of the clients eligible for Medi-Cal (Figure 14). This practice creates the opportunity for staff to maximize federal reimbursement to produce revenue to support the program.

Figure 14
Adult Outpatient Mental Health Services: Level III
Number and Percent of Clients by Funding Source
CY 2010
(Data from AVATAR)

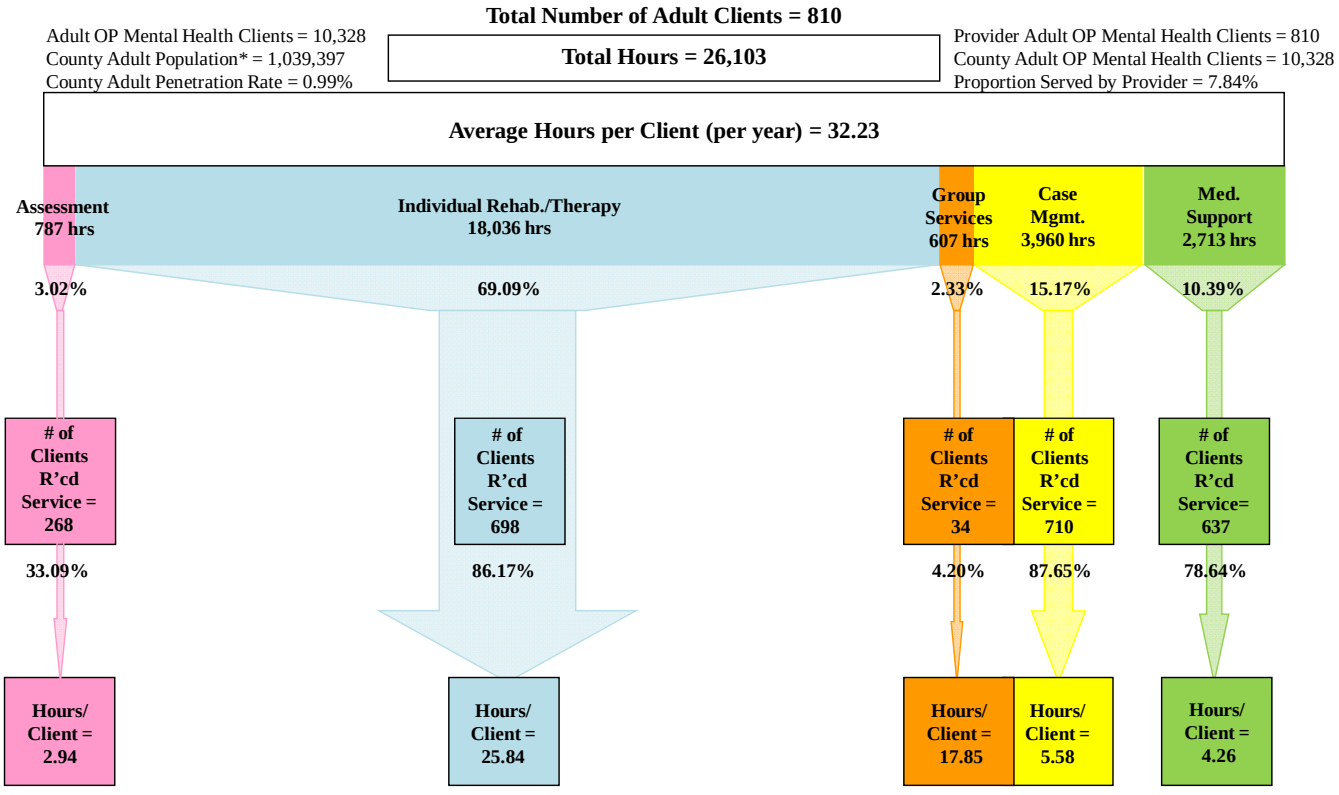
Level III					
	Medi-Cal		**Non Medi-Cal**		**Total**
	# of Clients	**% of Clients**	**# of Clients**	**% of Clients**	**# of Clients**
Human Resources Consultants TCORE	722	89.14%	88	10.86%	810

Array of Level III Services

The CY 2010 data shows that TCORE delivers a higher number of hours of service than the RSTs (see Figure 15). TCORE served 810 clients, and each client received an average of 32.23 hours of service per year. In examining the array of services, the biggest difference in services is that 69% of all services were individual rehab/therapy. Each client who received individual rehab/therapy services averaged 25.84 hours per year.

TCORE clients receive an average of 32 hours per year, which calculates into 10 hours of services per year more than Level II clients. The majority of these hours are individual rehab/therapy.

Figure 15
Adult Outpatient Mental Health Services
Human Resources Constants
TCORE Program
CY 2010
(Data from AVATAR)



* Source: U.S. Census Bureau, 2009 Population Estimates. Adults include those 18 years of age and older.

Mental Health Services Act (MHSA) and Level IV Services

A number of different programs were funded through the Mental Health Services Act (MHSA). These programs were developed to address and serve specific target populations in the county. The majority of these programs are considered Level IV programs and identify their clients as Full Service Partnership clients, which allows them to access flex funds for high-need and/or special need clients. These funds offer flexibility in helping an individual obtain housing, pay for first and last month's rent, pay for medications that are not covered by Medi-Cal, and/or purchase basic needs for setting up an apartment.

Level IV services are designed to provide the highest level of community-based services. Individuals needing Level IV services are at high risk of hospitalization and/or require intensive services to remain in the community when they are discharged.

Currently, the majority of clients in the MHSA-funded FSP programs meet this criteria. Other programs, designed to serve specific populations, such as the homeless or culturally diverse populations, have some individuals whose needs more accurately meet the criteria for ongoing Level II or III services. Level IV programs also have contract terms which outline the number of times per month a client receives services. Persons enrolled in these programs (excluding Guest House) typically receive weekly contacts, but may receive more services based on clinical need.

MHSA-Funded and Level IV Clients and Service Utilization
Figure 16 shows a summary of the FSP programs and designated area of specialization, showing the number of clients, hours, and hours per client for each program.

Guest House is designed as an entry point to the mental health system for persons who are homeless. In CY 2010, they served 834 clients. Each client averaged 9.42 hours of service in the year. TLCS New Direction and Turning Point Pathways help individuals who are homeless obtain housing. Staff also provide support to keep these individuals stable in their new living arrangement. In CY 2010, both programs served approximately the same number of people and delivered approximately the same number of hours.

The Asian Pacific Community Counseling (APCC) Transcultural Wellness Center and El Hogar's Sierra Elder Wellness program serve unique populations and offer different services to support these individuals. As a result, there is variability in the hours. The Transcultural Wellness Center served 200 clients, with each client averaging 86.89 hours of service in the year. Sierra Elder Wellness served 186 clients, with each client averaging 178.97 hours per client per year.

Turning Point's Integrated Service Agency (ISA) and Telecare SOAR served the highest-need persons in the system. Turning Point has been delivering services for many years, while Telecare SOAR started seeing clients and delivering services in February 2010. When Telecare SOAR opened, Turning Point was asked to refer clients to the SOAR program. While Telecare SOAR started in February 2010, they did not reach their full capacity of clients until October 2010.

Figure 16
Adult Outpatient Mental Health Services: Summary of MHSA-Funded Programs
Clients, Hours, and Hours per Client
CY 2010
(Data from AVATAR)

MHSA-Funded Programs				
	Population	**# of Clients**	**# of Hours**	**Annual Hrs/Clt**
Guest House	**Homeless**	834	7,859.14	**9.42**
TLCS New Direction	**Homeless and FSP**	341	19,759.14	**57.94**
Turning Point Pathways	**Homeless and FSP**	333	20,393.64	**61.24**
Transcultural Wellness Center	**Asian Pacific Populations and FSP**	200	17,378.87	**86.89**
Sierra Elder Wellness	**Older Adults and FSP**	186	33,288.97	**178.97**
Turning Point ISA	**High-need persons and FSP**	280	28,785.29	**102.80**
Telecare SOAR*	**High-need persons and FSP**	145	13,487.28	**93.02**
Total MHSA-Funded		2,141	140,952.33	**65.83**

*The data shows the actual service hours delivered by Telecare SOAR in CY 2010. This data shows that Telecare SOAR served 145 clients in the year and delivered 13,487 hours of service. The Review Team estimates that if Telecare SOAR had been at full capacity for the entire year, they would have delivered approximately 16,358 hours, with a per person average of 112.82 hours (based upon pro-rating data for October - December 2010).

Proportion of Clients with Medi-Cal (MHSA-Funded and Level IV)

Figure 17 shows a high percentage of clients with Medi-Cal, with the exception of Guest House. Guest House has a lower percentage of Medi-Cal reimbursement because their role in the system is to be a point of entry into outpatient services. Guest House also provides services to outreach, assess, and facilitate persons to obtain Medi-Cal benefits. Therefore, persons who are homeless do not typically have Medi-Cal benefits when they start receiving services from Guest House.

The other programs all have a relatively high percentage of clients with Medi-Cal. This data demonstrates that each of these other six providers have the opportunity to deliver a high proportion of services that are eligible for Medi-Cal reimbursement.

Figure 17
Adult Outpatient Mental Health Services: MHSA-Funded Programs
Number and Percent of Clients by Funding Source
CY 2010
(Data from AVATAR)

MHSA-Funded Programs					
	Medi-Cal		Non Medi-Cal		Total
	# of Clients	% of Clients	# of Clients	% of Clients	# of Clients
Guest House	358	42.93%	476	57.07%	834
TLCS New Directions FSP	277	81.23%	64	18.77%	341
Turning Point Pathways FSP	291	87.39%	42	12.61%	333
Transcultural Wellness Center FSP	168	84.00%	32	16.00%	200
Sierra Elder Wellness FSP	180	96.77%	6	3.23%	186
Turning Point ISA FSP	275	98.21%	5	1.79%	280
Telecare SOAR FSP	143	98.62%	2	1.38%	145

Array of MHSA and Level IV Services

Each of the MHSA-funded programs will be discussed individually, along with the data model that was used in the discussion of Level II and III services. Three of the programs serve the homeless, two programs target special populations (older adults and Asian cultures), and two programs serve the highest-need clients.

El Hogar – Guest House

El Hogar's Guest House is an MHSA-funded program that is designed as an entry point into the outpatient service delivery system for persons who are homeless and qualify for mental health services. Guest House is located in downtown Sacramento, which is a convenient location for the homeless population to access services. It is also located near other services that offer programs for the homeless.

Guest House's function is to engage persons who are homeless and seriously mentally ill. The program also helps these individuals get benefits and linkages to needed resources. Housing is one of the first services that is addressed for these individuals.

Guest House has designed a system that provides homeless individuals with access to mental health services. Guest House staff are very effective and skilled in working with the homeless, providing outreach in the shelters, homeless camps, along the river, and in other known places in the community. The bilingual, bicultural staff are skilled at engaging and offering services, and continue to visit individuals until they have built the trust and relationship to encourage the individual to access services at Guest House.

In order to access services from Guest House, individuals must come in person early in the morning. Clients often line up before 8 a.m. and wait for the clinic to open. The first five clients are screened to see if they meet criteria. Clients who meet the necessary criteria receive a clinical assessment and are opened to services that day. The other clients who stand in line but are not served must come back another day and line up again to see if they can receive services.

Most clients received individual rehab/therapy, case management, and medication support services. Guest House provides short-term assessment and treatment services, then refers the individual to other levels of care for ongoing services. Guest House staff also link the individual to housing programs (i.e., TLCS residential programs) and other supports to help end their cycle of homelessness.

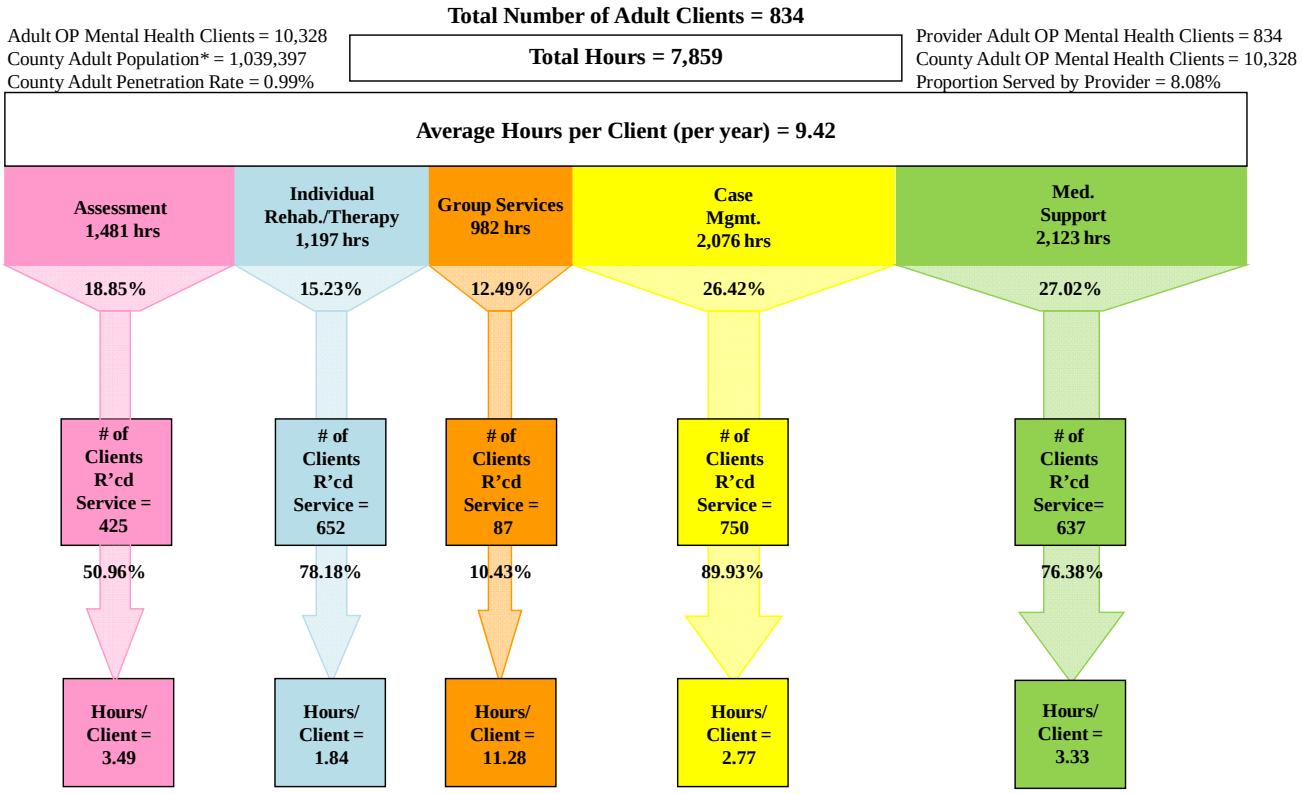
Guest House has developed an expedited benefits approval process to help an individual apply for benefits. This process utilizes a four-person team, which includes a physician and nurse, to conduct the required physical and complete the needed medical examination and paperwork to start the Medi-Cal application process. The team also includes a case manager to assist the individual in getting all official documents needed to complete the application (e.g., social security number, residence, proof of identity). There is also an eligibility worker on the team from the Department of Human Assistance. The eligibility worker assists the individual and team to complete the needed documents, helps complete the on-line application, and expedites the processing and approval of the application over the next week.

Guest House is not a Full Service Partnership program. If a client who they are currently working with is experiencing a mental health crisis, during business hours, Guest House staff will work with them to help avoid a hospitalization. After business hours, clients call 9-1-1.

Some of the staff who work at Guest House have been homeless themselves and know what it is like to be living on the streets. This "lived experience" seems particularly relevant to the clients that they serve.

Figure 18 shows that in CY 2010, Guest House served 834 clients. Each client averaged 9.42 hours of service in the year.

Figure 18
Adult Outpatient Mental Health Services
Guest House (El Hogar) Program
CY 2010
(Data from AVATAR)



* Source: U.S. Census Bureau, 2009 Population Estimates. Adults include those 18 years of age and older.

TLCS – New Direction

Transitional Living and Community Supports (TLCS) developed New Direction through MHSA funding. This is a creative "housing first" program which supports persons who are homeless, or at risk of homelessness, to find and keep a safe home. These dollars are also used to match HUD housing dollars to create low-cost housing options for persons who are homeless in Sacramento County.

TLCS has created an range of exemplary housing options in the county. These housing options create a number of different programs, which creatively use diverse funding sources to maximize the number of housing options available in the community. TLCS staff also provide the supports and services on-site to ensure that individuals can remain living in their home and thrive. Staff are organized into treatment teams based on HUD funding categories. Staff on each of the teams provide the full range of mental health services.

The TLCS team has worked effectively to create linkages and resources across the community, and build trusting relationships that support a network of services to meet the needs of the persons who they serve. There are bilingual, bicultural staff who are available to meet the needs of the homeless community.

The TLCS treatment team includes two dedicated nurses who work closely with staff and clients to achieve the most effective outcomes. The nurses use an interview checklist to obtain information from the client regarding what is needed and how their medications are working. This checklist is valuable to the psychiatrist in providing effective treatment for each individual.

New Direction staff are able to intervene with clients who are experiencing a crisis 24/7. During regular business hours, the Primary Service Coordinator or other available staff will work with the client to help avoid a hospitalization. After hours, clients can call the after-hours line, which is answered by one of the New Direction staff. A supervisor is also on call to assist staff in responding to the crisis situation. Staff at TLCS have developed good working relationships with the police, who work with homeless clients in the downtown area. When the program was located next to Guest House, police would sometimes drop off clients who were experiencing a crisis, rather than taking them to the Emergency Department. In addition to the regular 24/7 line, one of the housing programs, Bell Street Co-op, has developed a "Hope Line" operated by residents. This line is available between 5 p.m. and 8 a.m. and on weekends.

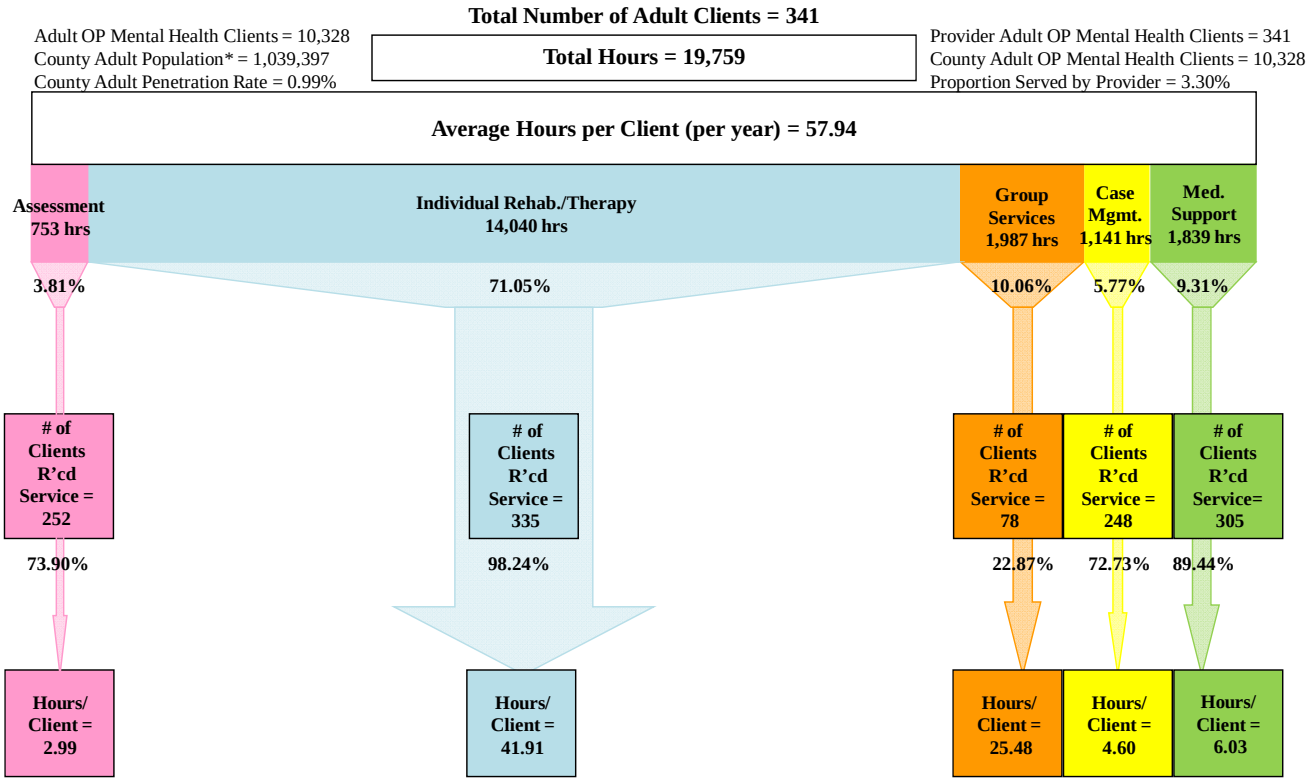
Staff from New Direction are often aware when one of their clients has been hospitalized at a private hospital or the MHTC. They will contact the inpatient facility to help coordinate the discharge, which at times includes picking the client up when they are discharged.

New Direction employs persons with lived experience, but they do not have designated peer positions.

The staff have been trained in Motivational Interviewing. During the site review, it was evident that the EBP was being used across the organization. Staff reported that these skills help them to be more effective in engaging clients in services and achieving their goals.

Figure 19 shows the array of mental health services offered at New Direction. The program served 341 clients in CY 2010 and delivered 19,759 hours of services. Each client received an average of 58 hours per year, with the majority of those services (71%) being individual rehab/ therapy. Nearly all clients (98%) received individual rehab/ therapy services and medication support services (90%).

Figure 19
Adult Outpatient Mental Health Services
TLCS New Direction FSP Program
CY 2010
(Data from AVATAR)



* Source: U.S. Census Bureau, 2009 Population Estimates. Adults include those 18 years of age and older.

Turning Point – Pathways

Pathways to Success After Homelessness is managed by Turning Point and offers mental health services and housing for individuals who are homeless, or at risk for homelessness.

This MHSA-funded program serves all ages, including:

- children and their families (N=45),
- transition age youth: ages 18 – 25 (N=45),
- adults: ages 26 – 59 (N=250), and
- older adults: ages 60 and older (N=5).

The majority of persons served by Pathways have been screened and referred by Guest House. Guest House screens and assesses each person and determines the level of care needed. Guest House staff then call the Access Team and obtain authorization for services. The Access Team authorizes the individual for one year of services. Guest House then refers the individual to Pathways.

Pathways staff also have an MOU with TLCS for two beds at Carol's Place, an emergency shelter, where individuals or families can stay and maintain their homeless status while finding permanent and/or transitional housing. Section 8 HUD Housing and Shelter Plus Care are other (limited) options available for individuals receiving services from Pathways. This FSP program has flex funding that can be used for housing subsidies, with a requirement to renew every six months.

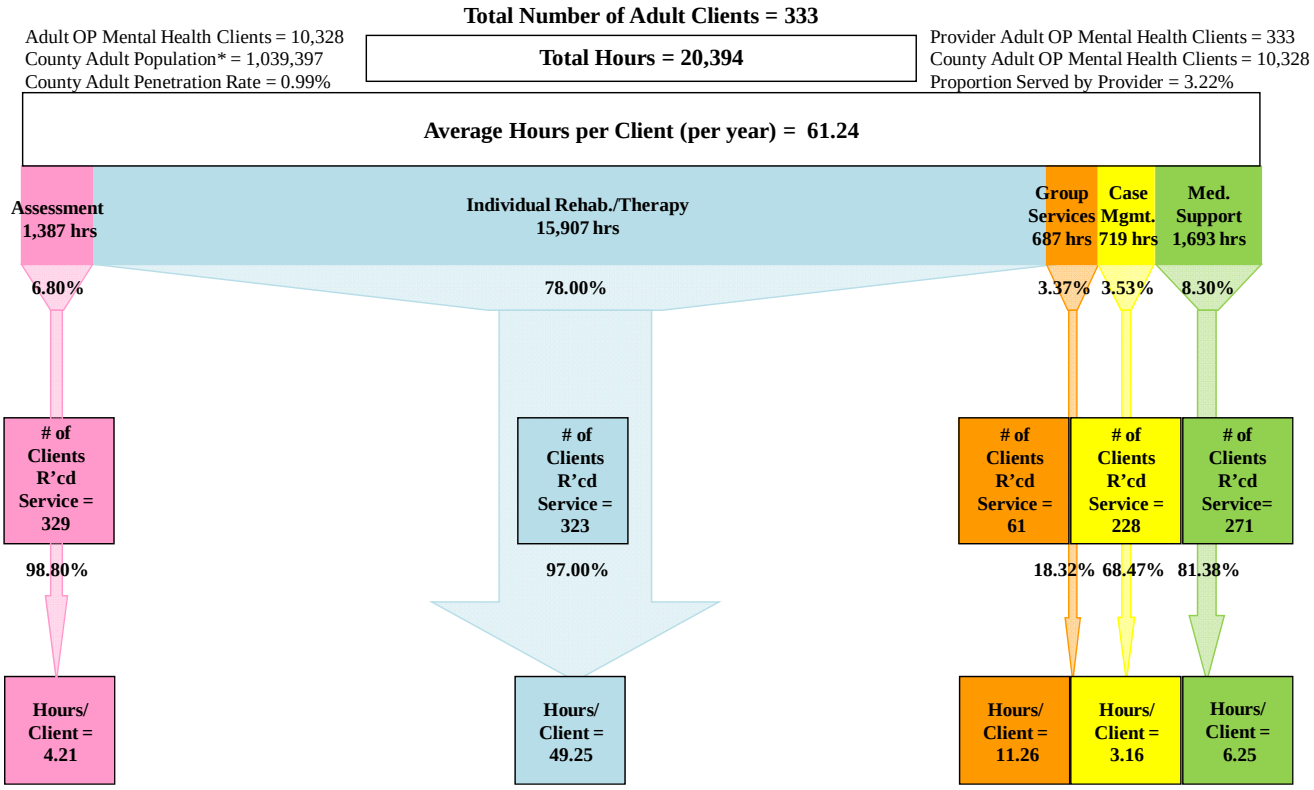
As an FSP program, staff offer the full range of services. They have staff located on-site at transitional apartments to help provide support for clients placed there. Staff assist clients in accessing needed services, Wellness Center activities, and social services. Pathways has a 24/7 on-call line to respond to calls for their FSP clients. Staff are able to respond to clients in crisis to help them avoid hospitalization.

Pathways also helps link individuals to the Department of Rehabilitation. In the past, Pathways had an Employment Specialist position but that position was cut. Staff will refer clients to the Department of Rehabilitation when they are ready for employment. Per contract requirements, Pathways' focus shifted from developing employment skills to assisting clients in getting benefits. Staff help clients get SSI benefits by helping them gather medical records, complete forms, and submit the paperwork to the Department of Human Assistance. The goal is to have their paperwork processed within 90 days. Staff help clients link to community colleges when the individual specifies education as a goal.

Pathways does not have any designated Peer Support positions, but they do have staff who identify as consumers and family members of persons with a mental illness. They currently do not have any staff with a history of homelessness.

In CY 2010 (see Figure 20), Pathways served 333 clients. The average client at Pathways received 61.24 hours of services per year. The majority (78%) of all services delivered at the agency were individual rehab/therapy. Ninety-seven percent (97%) of the clients received individual rehab/therapy services, with the average client receiving 49.25 hours per year. Eighty-one percent (81%) of the clients received medication support services.

Figure 20
Adult Outpatient Mental Health Services
Turning Point Pathways FSP Program
CY 2010
(Data from AVATAR)



* Source: U.S. Census Bureau, 2009 Population Estimates. Adults include those 18 years of age and older.

APCC – Transcultural Wellness Center

The Asian Pacific Community Counseling Transcultural Wellness Center received MHSA funds to expand culturally sensitive services to the diverse population of Asian cultures in Sacramento County. The Transcultural Wellness Center staff offers services in over nine Asian languages to support persons with who qualify for mental health services. In addition, the team offers supportive services to families, and other individuals in their community, to provide culturally sensitive service within the individual's culture. The staff coordinate services with traditional healers and are sensitive to the individual's cultural beliefs. The center also offers a drop-in center for Transition Age Youth. This is a popular program for youth who are enrolled in services.

> *"**If the person uses traditional healing methods and does not believe in our services, the treatment goals go nowhere. We let the client teach us what works best for them."***
> - Transcultural Wellness Center Staff

Referrals to the Transcultural Wellness Center come from the Access Team. The staff offer services that focus on recovery and wellness, and integrate families into all aspects of treatment. "Services are client-centered, and strength-based, with a consideration of the person's culture. Clients determine their goals and how they will achieve their goals." Staff noted that sometimes they need to re-conceptualize concepts of recovery for their clients within the parameters of a person's culture. For example, for many individuals, "independence" is not a value that they would relate to; instead, they would be striving for "interdependence."

The weekly team meeting, which includes the psychiatrist, discusses high-risk clients, and considers the person's culture, family, and community supports in designing the appropriate intervention. The team discusses the client's symptoms and ideas on how to best support the family through the crisis.

Nine of the staff rotate weekly for on-call 24/7 responsibility. The clients and family know to call the center in times of crisis. Each client has a Safety Plan and calls staff when in crisis. Transcultural Wellness Center staff accompany a client to an Emergency Department, or call 9-1-1, only as a last resort to resolve a crisis. Also, when there are signs of an escalating crisis, staff have the client come into the clinic more frequently (3-4 times a week) to help resolve the issue. As needed, the staff also go to the person's home to support the family. "We help them feel comfortable, so we can help de-escalate the crisis." Staff use the Safety Plan, and other safety protocols, as well as staff and family meetings to address the needs of the client and family. If the individual needs to be hospitalized, the staff work closely with the hospital on discharge planning, and provide a bridge between the hospital and the family. The psychiatrist works with the hospital's physicians to determine what is needed for discharge.

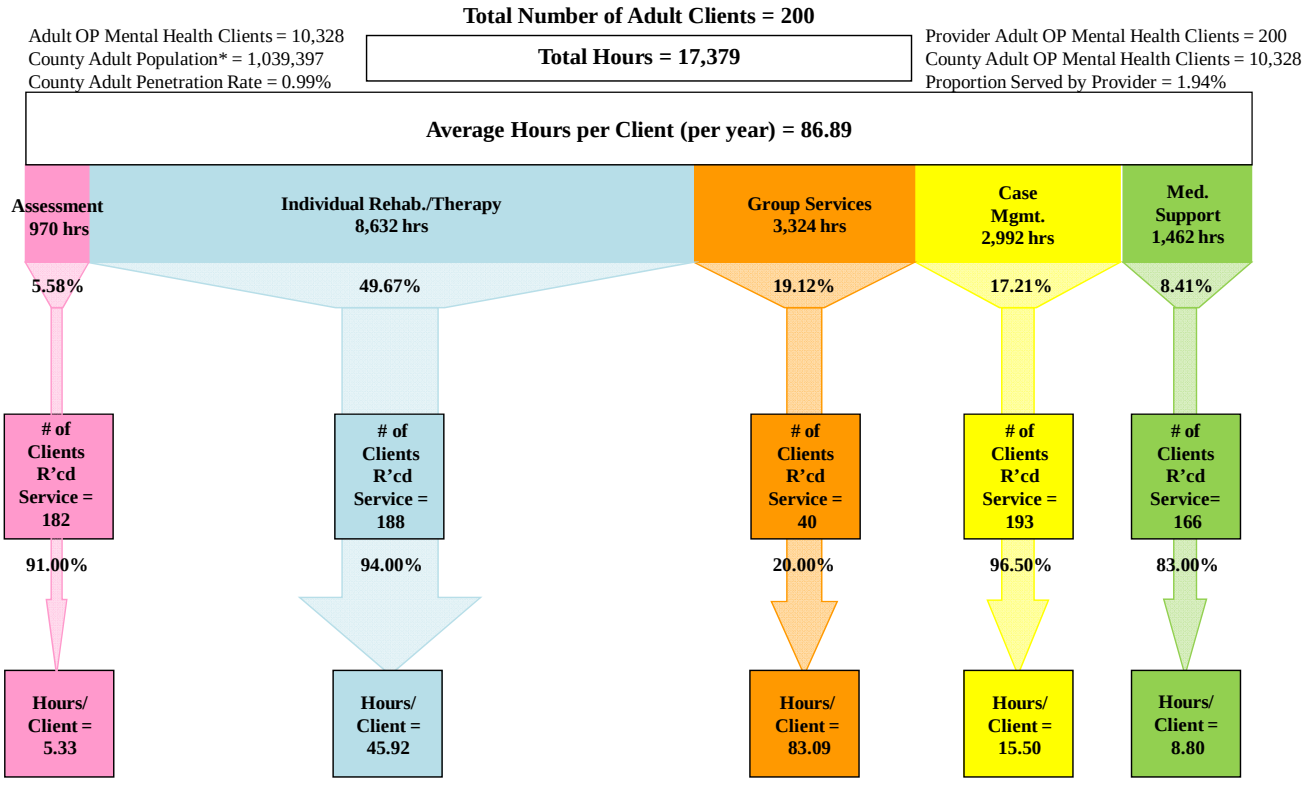
The Transcultural Wellness Center also has a "warm line" for persons with different Asian Pacific primary languages. This service is important to those individuals who need information and/or a supportive person to contact.

While the program does not have designated Peer Specialist positions, they do have staff from a diversity of cultures and, as noted above, work with the whole family system.

"We try to make services human. We walk beside them and with them, until they can walk alone." - Transcultural Wellness Center Staff

In CY 2010 (Figure 21), the Transcultural Wellness Center served 200 clients. The average client at the Transcultural Wellness Center received 86.89 hours of service per year. Half of the services (49.67%) were individual rehab/therapy, with 94% of the clients received these individualized services. The Transcultural Wellness Center also delivered more case management services, relative to the other providers, with 96.5% of the clients receiving this supportive services, averaging 15.5 hours per client. This reflects the needs of this community, having staff assist clients to access other services, provide interpreter services, and help individuals improve their health and wellness. Eighty-three percent (83%) of the clients received medication support services.

Figure 21
Adult Outpatient Mental Health Services
APCC Transcultural Wellness Center FSP Program
CY 2010
(Data from AVATAR)



* Source: U.S. Census Bureau, 2009 Population Estimates. Adults include those 18 years of age and older.

El Hogar – Sierra Elder Wellness

The Sierra Elder Wellness program is funded by MHSA and run by El Hogar. The program provides supportive services to individuals ages 55 years and older, who have a mental illness and are at risk of higher levels of placement to skilled nursing facilities and/or inpatient hospitals. The program has a capacity of 160, with 186 unduplicated clients served during CY 2010. The Sierra Elder Wellness program delivers mental health services and provides transportation Monday – Friday to help individuals get to services and appointments. The Sierra Elder Wellness program primarily offers group services, with two groups offered each day, Monday through Friday. These groups include SacPort, Cognitive Behavioral Therapy, and the 12-Step Program.

"Seniors fall through the cracks. We show them there is still life." - Sierra Elder Wellness Staff

Referrals to Sierra Elder Wellness come from the Access Team. Services at Sierra Elder Wellness have a recovery focus and are offered in the community. The program has bilingual, bicultural staff (e.g., Spanish, Hmong), and offer culturally sensitive services in the home. Some of the Service Coordinators are persons with lived experience, and these individuals provide an excellent model of wellness and recovery. The Service Coordinators help link clients to health care, senior centers, and other community programs. The Service Coordinator will accompany an individual to see a health care provider, and help them to communicate with their physician. The Service Coordinator then provides linkage and information back to the other staff at Sierra Elder Wellness. These services help promote wellness and recovery.

"I advocate as the consumer, not for the consumer." - Sierra Elder Wellness Peer Support Specialist

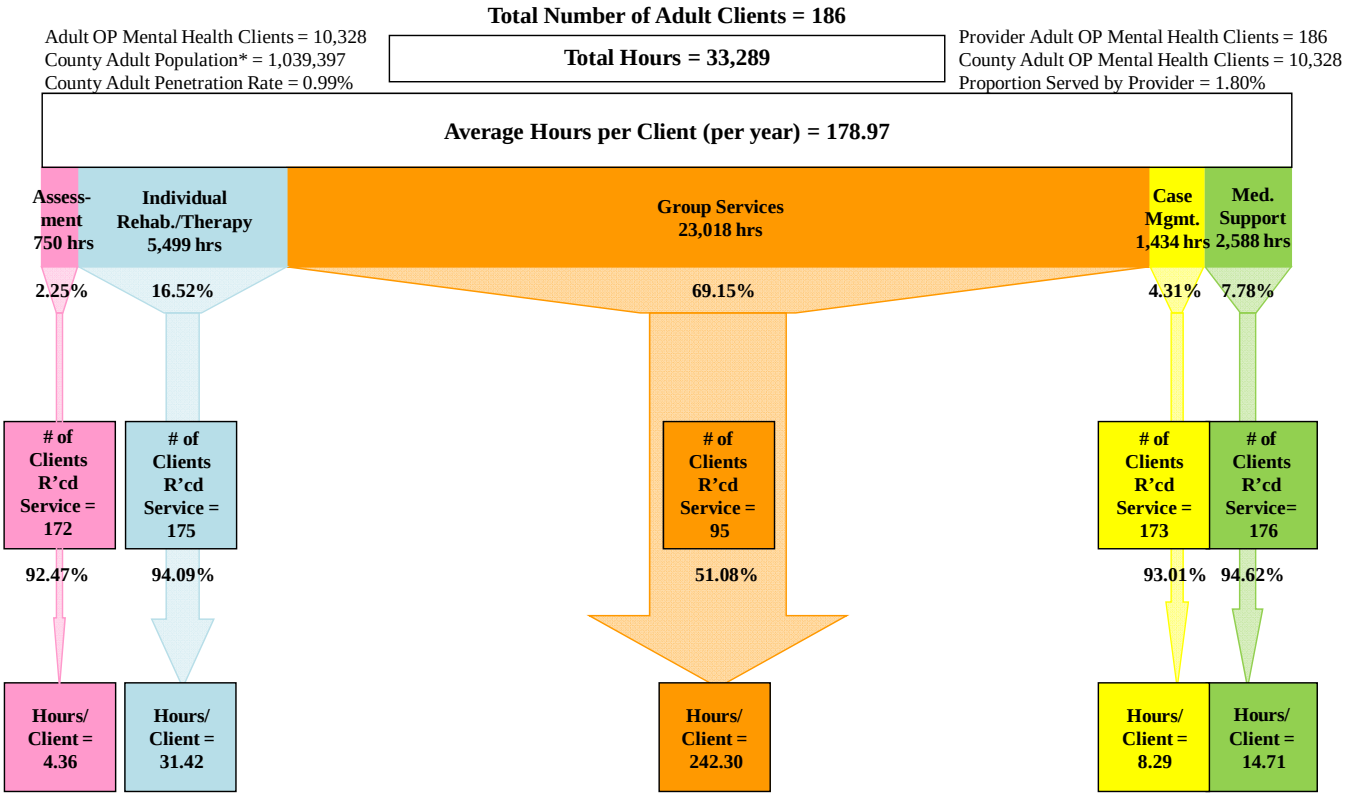
As an FSP program, Sierra Elder Wellness provides a 24/7 crisis response line. Staff will work with clients to help them avoid a hospitalization. Staff will also coordinate with the hospital staff on discharge. Due to the population served, their clients are sometimes hospitalized for medical reasons.

All of the individuals at Sierra Elder Wellness are eligible to receive FSP flex funds. These are used for housing subsidies, dental work, assisted living devices, and personal supplies (e.g., shoes, incontinence supplies).

Many of the individuals remain in this program for several years, with little turnover in the client population. This situation decreases the availability of the program to other older adults in the community who may also need a higher level of care. For example, in CY 2010, a total of 186 individuals were served, with a capacity of 160. This data shows that there were 26 new clients in the year. These figures highlight a need for the system to review ways to expand services to meet the needs of older adults at all service levels. This approach may include developing specialized case loads and training for staff in working with older adults.

In CY 2010 (Figure 22), the average client at Sierra Elder Wellness received nearly 179 hours of services. Nearly 70% of all services delivered at the agency were group services. Group services were delivered to 51% of the clients. Medication support services were delivered to 95% of the clients.

Figure 22
Adult Outpatient Mental Health Services
Sierra Elder Wellness (El Hogar) FSP Program
CY 2010
(Data from AVATAR)



* Source: U.S. Census Bureau, 2009 Population Estimates. Adults include those 18 years of age and older.

Turning Point – Integrated Service Agency

Turning Point manages the Integrated Service Agency (ISA), which was funded by MHSA in late 2009, along with Telecare SOAR. Prior to this funding, Turning Point served high-need clients through a pre-existing intensive service program. Both Turning Point and Telecare were awarded a contract to deliver intensive services in the county. As a result of two programs being funded to serve high-need clients, Turning Point was asked to refer some of their clients to Telecare's SOAR program. Between February and September 2010, Turning Point referred clients to SOAR. The number of clients reflected in the Turning Point ISA program (280) includes some of the clients who were eventually referred to the SOAR program. ISA and Telecare serve the highest need clients in the system.

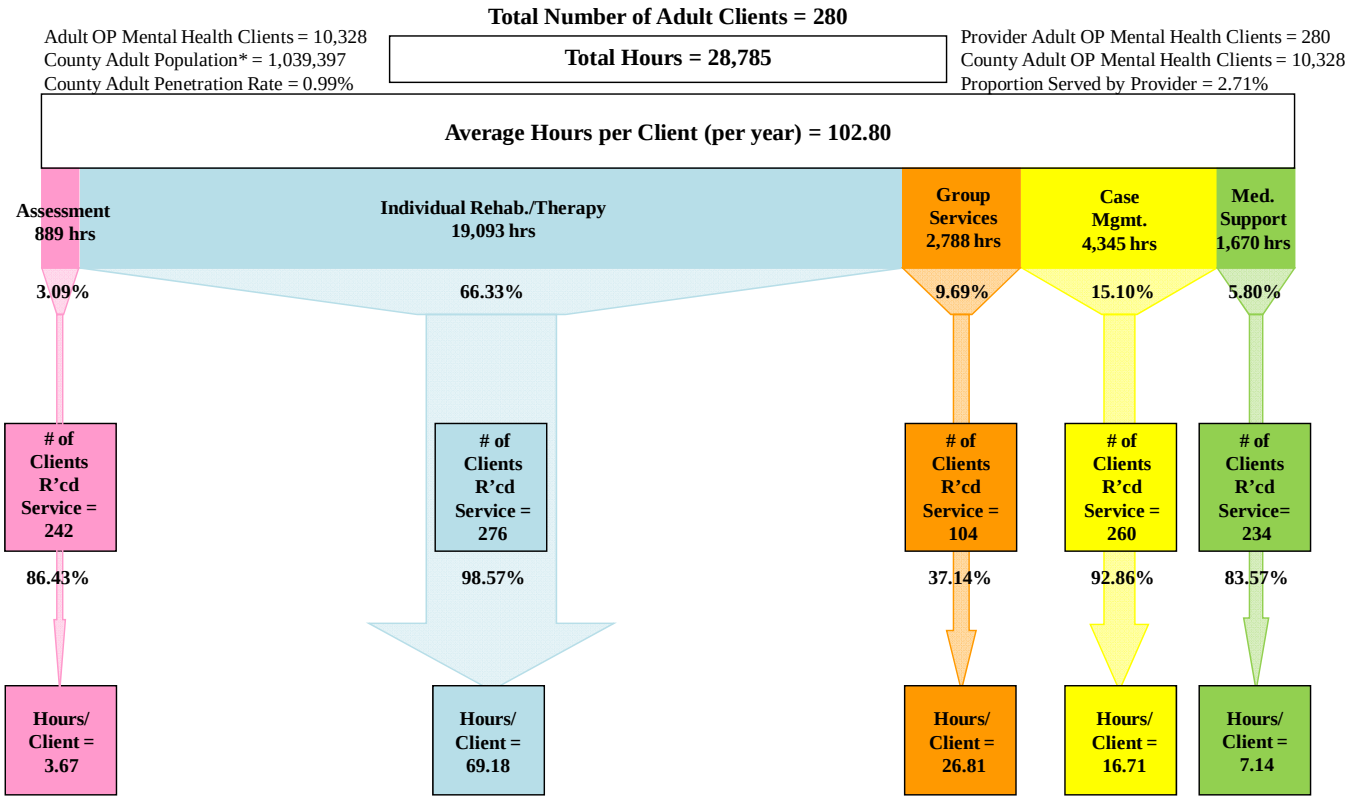
The Adult Services' Intensive Placement Team (IPT) authorizes placement into ISA. All clients in the ISA are FSP clients and receive a full range of services. The ISA programs has a strong emphasis on developing Wellness and Recovery Action Plans (WRAP) with their clients. ISA staff work closely with the clients, and at times, with the families. They also have a staff person who is very knowledgeable of the housing resources in the community. This helps people find a place to live and remain stable in their home. At one time, they had an employment program, but they had to eliminate this program due to cuts. They refer clients to the Department of Rehabilitation and Crossroads for employment opportunities.

ISA staff work closely with Board and Care operators and landlords in the Room and Board facilities where clients are living. This communication helps to resolve problems and helps keep people stable in their living environment. Their regular program hours include Saturdays. When clients are experiencing a crisis after hours, they have access to an on-call staff person. There is also another clinical staff, or supervisor, on call to assist staff in responding to crisis situations. Staff who answer the on-call line indicated that sometimes they instruct clients to call 9-1-1 if it seems they need hospitalization. They noted that they are usually contacted when one of their clients is in one of the private psychiatric hospitals or the MHTC. They have a designated hospital liaison staff person to work with the inpatient facilities to help facilitate a timely discharge.

ISA has hired Peer Support Specialists and staff reported that these individuals work in the program. The activities they perform include working at the front desk and cleaning services. In some cases these individuals are also clients of the program.

In CY 2010 (Figure 23), Turning Point ISA served 280 clients. The average client received 102.8 hours of service per year. Of the 28,785 hours of service, 66% were individual rehab/therapy hours.

Figure 23
Adult Outpatient Mental Health Services
Turning Point ISA FSP Program
CY 2010
(Data from AVATAR)



* Source: U.S. Census Bureau, 2009 Population Estimates. Adults include those 18 years of age and older.

Telecare – SOAR

The Sacramento Outreach Adult Recovery (SOAR) program is funded by MHSA, managed by Telecare, and serves Level IV/Full Service Partnership clients. SOAR is the newest FSP program and opened its doors in February 2010.

Telecare hired staff in January 2010 and utilized the first month to provide extensive training to all staff in different evidence-based practices (e.g., Motivational Interviewing, Dialectical Behavior Therapy (DBT), Cognitive Behavior Therapy (CBT), Trauma-informed Therapy, and wellness and recovery principles). Clients were initially referred to SOAR from Turning Point's ISA program, and other programs, beginning in February 2010. Close examination of the data showed that the SOAR program was close to full capacity in October 2010. Staff reported that they are pleased that they are finally getting the referrals needed to reach full capacity. The Adult Services' Intensive Placement Team (IPT) authorizes placement into SOAR.

Telecare SOAR is currently implementing a web-based program called CommonGround, developed by Pat Deegan, Ph.D. This program is a comprehensive model that supports individuals in communicating with their psychiatrist. The program was developed by persons with lived experience. The program supports an individual in expressing themselves with their psychiatrist regarding their symptoms, side effects, and goals for treatment, which makes the face-to-face time more productive and effective. Computers are available to clients in the waiting room and the web-based program. The system has a touch screen and can be set to auditory or visual modes. A Peer Support Specialist is available to help anyone who needs assistance. The program offers a comprehensive training program, using a Train-the-Trainer model. An ongoing support team provides frequent technical assistance and linkage to an extensive library of materials and worksheets.

The Review Team saw the extensive training of SOAR staff reflected in the services, staff's strength-based discussion of the individuals served, and their strength-based goals. The first service plan had a goal on symptom management and also included a strength-based goal to guide services and outcomes.

"It is amazing to see the change in clients after we implemented the recovery model. Clients now take ownership and control of their lives.
Before: 'Hi! My name is John, and I am bipolar.'
After: 'Hi! My name is John, and I can achieve my dreams.'" - FSP Supervisor

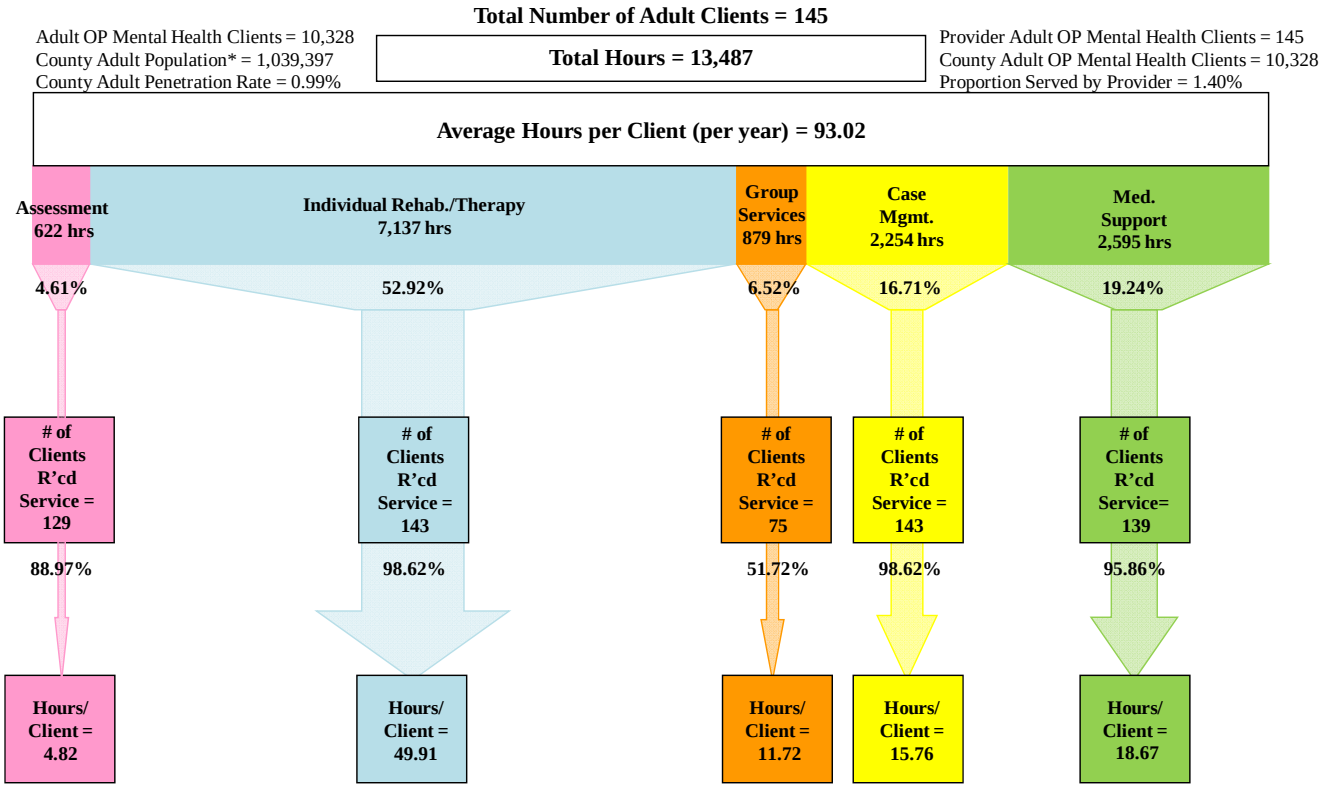
Telecare SOAR utilizes two teams to support individuals. These teams meet daily to collectively review, plan, and implement activities to support their members. This team approach assures that all staff integrate a strength-based recovery approach for each client and assures continuity across the staff. This model also allows the team flexibility in utilizing the best staff person, for any particular task, to meet the needs of each individual.

In addition to a 24/7 crisis phone capacity, this program is also proactive in working with clients to de-escalate a situation, stabilize the crisis, and avoid unnecessary hospitalization, whenever possible. Staff have also provided support to members overnight until they could be seen at the

office the next day. While this is an intensive model, this provides an overall savings to the system and to the individual, by preventing a hospitalization.

In CY 2010 (Figure 24), SOAR served 145 clients, with a capacity of 150. The average client received 93.02 hours of service per year. Of the 13,487 hours of service, 53% were individual rehab/therapy. Nearly 20% of the hours were medication support.

Figure 24
Adult Outpatient Mental Health Services
Telecare SOAR FSP Program
CY 2010
(Data from AVATAR)



* Source: U.S. Census Bureau, 2009 Population Estimates. Adults include those 18 years of age and older.

Wellness and Recovery Centers

There are two Wellness and Recovery Centers (the North site at Marconi and the South site at Franklin). These centers are multi-service community programs that promote wellness and recovery through the delivery of meaningful activities and community involvement. These centers are directed and operated by consumers.

The Wellness and Recovery Centers offer a welcoming environment for persons seeking support and services. The Marconi site is extremely welcoming and offers a comfortable, peaceful place to visit. Visitors are greeted as they walk in the door and asked what they need. The visitor is told, "We are glad you are here!"

"Here, I breathe differently than I do elsewhere…seriously—I can breathe here." – Mental Health Client discussing a Wellness and Recovery Center

This program serves as a resource center and is perceived as a safe place to get support, learn, and develop skills. There are a number of different groups available to people; many of the groups are open to participants and welcome new members at any time. These groups include self-esteem, Cognitive Behavior Therapy, dual diagnosis, managing bi-polar symptoms, Dialectical Behavior Therapy, and developing wellness plans. There are also groups available to develop skills in employment, and other vocational activities. There are eight to ten computers available for anyone who would like to access mental health resources online. There are also social activities, art projects, and other classes taught by members.

If an individual starts to show signs of a crisis, they know they can come to either of the Centers and stay all day. There is a "breathing room" where one can relax, and there is always someone on-site to help de-escalate a crisis. Clients reported that these centers provide a safe place where people don't feel judged. The clients who were welcomed into the Centers, and who immediately received services, reported to the Review Team that they felt immediately at ease and their fears of receiving mental health services were reduced.

In 2009/10, the county asked the Wellness and Recovery Center director to begin delivering Medi-Cal reimbursable services, including medication support. The director was concerned about offering medication services at the centers because medication services are not considered a part of the wellness and recovery model. However, the county was firm and the Wellness and Recovery Centers began delivering Medi-Cal services. In addition to medication support, case management and individual rehabilitation Medi-Cal services are also offered.

While it is estimated that each center sees over 1,000 clients in a year, only those receiving Medi-Cal services are reported to AVATAR. As a result, the Medi-Cal data for the Wellness and Recovery Centers is not comparable to the other Level II providers. The centers offer a variety of supportive recovery services and classes that are not reported to AVATAR and are not billed to Medi-Cal.

Figure 25 shows the clients, hours, and hours per client for those clients receiving Medi-Cal services at the two Wellness and Recovery Centers. The Franklin site served 338 Medi-Cal clients and the Marconi site served 495 Medi-Cal clients. The annual hours of Medi-Cal services per client was 13.78 for the Franklin site and 9.76 for the Marconi site. Again, this data represents only a small portion of all of the clients and services offered at these two centers.

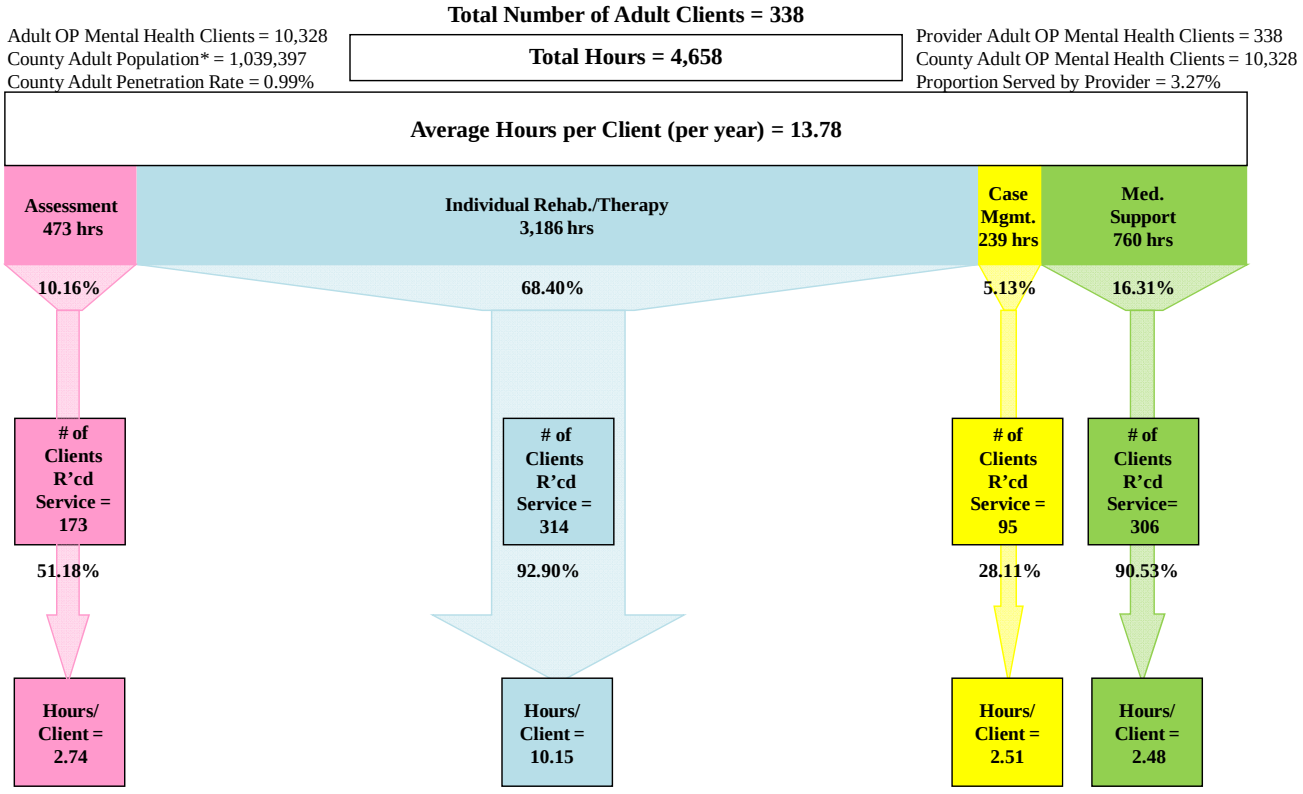
Figure 25
Adult Outpatient Mental Health Services: Wellness and Recovery
Clients, Hours, and Hours per Client
CY 2010
Medi-Cal Clients Only
(Data from AVATAR)

Wellness and Recovery Centers			
	# of Clients	**# of Hours**	**Annual Hrs/Clt**
Wellness and Recovery Center Franklin	338	4,658.39	**13.78**
Wellness and Recovery Center Marconi	495	4,831.04	**9.76**

Array of Wellness and Recovery Services

The data for the Franklin Center (Figure 26) shows that of the 338 individuals receiving Medi-Cal services, the majority (92.90%) received individual rehab/therapy, with an average of 10.15 hours per year. Ninety percent (90.53%) of the 338 individuals received medication support services, with an average of 2.48 hours per person per year.

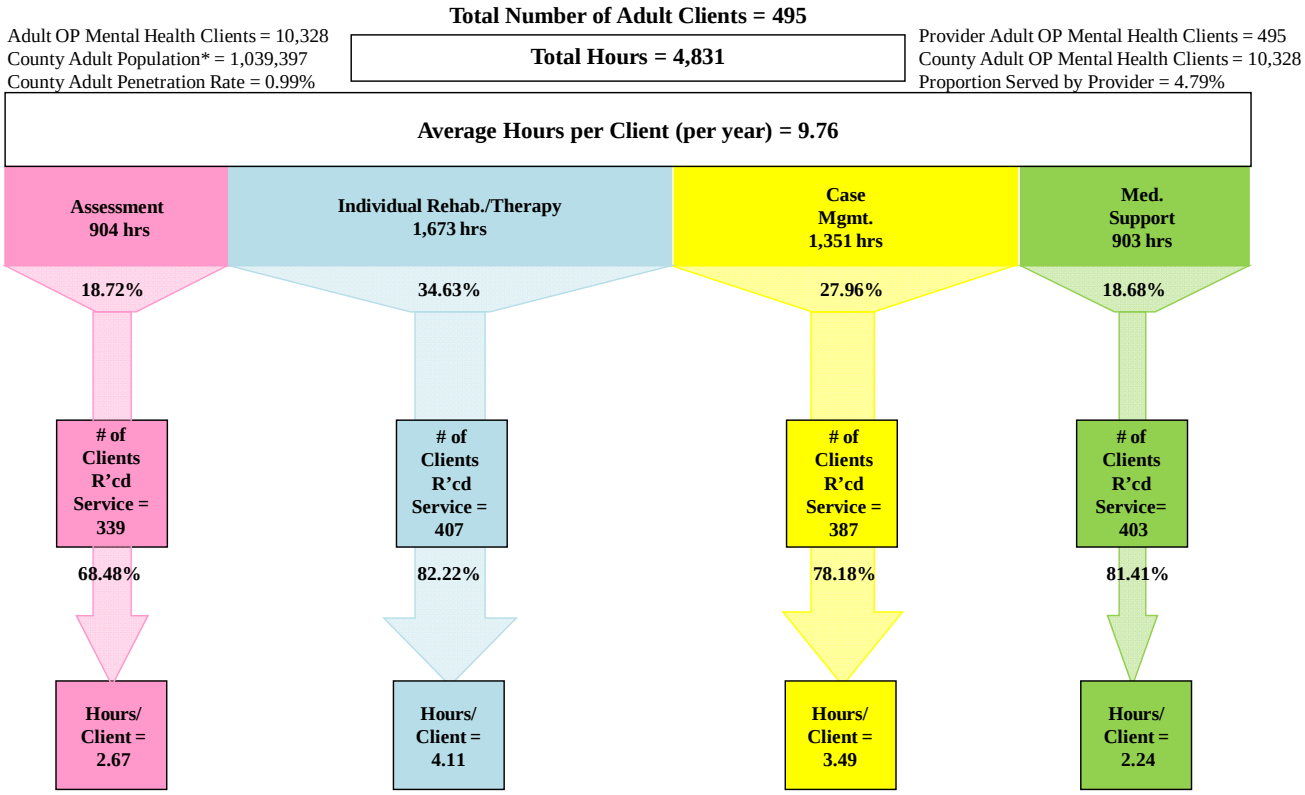
Figure 26
Adult Outpatient Mental Health Services
Wellness and Recovery Center – Franklin Center
Medi-Cal Clients Only
CY 2010
(Data from AVATAR)



* Source: U.S. Census Bureau, 2009 Population Estimates. Adults include those 18 years of age and older.

The data for the Marconi Center (Figure 27) shows that 495 individuals received Medi-Cal services that were reported to AVATAR. These 495 individuals averaged 9.76 hours per year of Medi-Cal services reported to AVATAR. The majority of these 495 individuals received individual rehab/therapy (82.22%) and case management (78.18%). Eighty-one percent (81.41%) of the 495 individuals received medication support services, with an average of 2.24 hours per person per year.

Figure 27
Adult Outpatient Mental Health Services
Wellness and Recovery Center – Marconi Center
Medi-Cal Clients Only
CY 2010
(Data from AVATAR)



* Source: U.S. Census Bureau, 2009 Population Estimates. Adults include those 18 years of age and older.

These centers provide an exemplary model of person-centered, recovery-focused services. They are demonstrating that by creating a welcoming environment, with a safe and trusting program, people needing mental health services can thrive. The Wellness and Recovery Centers offer a model for achieving positive outcomes by focusing on a person's strengths and listening to their voice.

University of California, Davis – Psychiatry Services

Sacramento County and the University of California, Davis, Department of Psychiatry have a long history of working together to provide quality medication management services to persons with a mental illness. The current annual contract with UC Davis is nearly $2,000,000 for outpatient services. This funding pays for UC Davis Residents and staff from the Department of Psychiatry to deliver services in the outpatient clinics. In addition, UC Davis also receives additional contract funding to deliver services at the Mental Health Treatment Center (MHTC).

All psychiatrists working in the county-operated mental health programs are employees of UC Davis. The Medical Director, who is also the Chief Psychiatrist at the Mental Health Treatment Center (MHTC), is also an employee of the UC Davis Department of Psychiatry.

This contractual arrangement benefits the Department of Psychiatry by providing a training ground for UC Davis Residents in Year II and Year IV of their four-year residency. The contract benefits the county by having access to an ongoing group of Residents to provide medication management services to clients.

UC Davis Residents rotate through different placements each year. In Year II, Residents work at the MHTC inpatient facility, the two county-operated outpatient clinics, the Transcultural Wellness Center, and at Crestwood Behavioral Health. In the fourth year of their residency, Residents return to the MHTC. The Residents also have the option of choosing other sites during their final year; some of these may include county-operated programs.

The UC Davis Resident's rotation through the clinics creates a continually changing medical treatment team for the clients assigned to Residents. Research has consistently demonstrated that clients need a trusting relationship with their practitioner in order to achieve positive outcomes. Typically, a Resident will work with a client for a short period of time, then move to another placement. This rotation creates the need for clients to "tell their story" to a new Resident every few months. Some clients reported that they choose to receive services from a Physician's Assistant or Nurse Practitioner, who are permanent staff at the clinic, rather than keep changing Residents. Other clients were not aware that there are other options for medication services.

Mental health programs in many counties have a difficult time hiring psychiatrists. The ability to have access to a pool of psychiatrists to work with clients is an important resource for Sacramento County. In addition, many psychiatrists who were trained at UC Davis are now employed by mental health outpatient and inpatient providers in Sacramento County.

The UC Davis Residents are well trained in medication management services. The data shows that there is an emphasis on the use of medications throughout the county. In Sacramento County, 83% of all adult outpatient clients receive medication management services. At the county outpatient clinics (where UC Davis provides the psychiatric services), 89% of the clients receive medication management services. These percentages show that a high proportion of clients are prescribed medications in Sacramento County.

Crisis Response and Crisis Intervention Services

Crisis response and crisis intervention services are an important component of the array of services available in a mental health system. A crisis is an unplanned event or situation that results in a person's need for an immediate mental health intervention, and which may include a variety of interventions and services that prevent a dramatic deterioration of functioning**.** The situation may be urgent or emergent (see definitions below). Crisis services in Sacramento County may be delivered in a clinic, in the field, in the community, or in an Emergency Department. The services must be delivered by a mental health staff or individuals with training and skills to perform such interventions and services.

Definition of Urgent Condition: A situation experienced by an individual that, without timely intervention, is certain to result in an immediate emergency psychiatric condition.

Definition of Emergency Condition: As a result of a mental disorder, the individual is a danger to self or others, or gravely disabled.

The outpatient providers can respond to a crisis event during regular business hours, or after business hours, by providing intervention and supportive services to de-escalate the crisis. Only Full Service Partnerships (FSPs) are required to have the capability to have a 24/7 after-hours capability to respond to their own enrolled FSP clients. Other outpatient providers do not have this requirement and may rely on the MHTC's 24/7 response system. This 24/7 toll-free after-hours line that responds to any caller, assesses the call, and provides crisis or other supportive information. In addition, the 24/7 Intake and Referral Team responds to calls from Emergency Department staff. The Intake and Referral Team provides necessary treatment information, consultation, and other essential information regarding clients who present at the hospitals or Emergency Departments. The Intake and Referral Team also provides consultation to law enforcement when they call for information.

During the site visits with the providers and county staff, many reported that they call 9-1-1 when they need assistance with a crisis situation. When staff were asked what they do when an individual is in crisis, in most instances, staff responded that they call 9-1-1. While some providers spoke about working with the individual to de-escalate the crisis, many providers simply stated that they call 9-1-1.

The crisis response capacity for FSP programs is different. Each FSP program has the requirement to offer a 24/7 on-call response line for their FSP clients. This 24/7 on-call capacity is available to provide support services and crisis response and intervention, as needed. This on-call capacity is available during the day, at night, and on the weekends. The FSP client may call when they are having a crisis. If at any time the outpatient provider feels unable to meet the needs of a person in crisis, they will call 9-1-1 and have the police respond to the situation.

At a system level, the MHTC has a 24/7 phone line that responds to crisis calls. In addition, the MHTC recently expanded their staffing for this 24/7 line to provide additional information to the hospital Emergency Department staff who call. This coordination helps hospitals know if the person is currently receiving mental health services in the county. The MHTC Intake and

Referral Team also assists with placing clients who need a hospital stay, either at the MHTC or at the Crestwood PHF. In addition, it is the policy for the MHTC staff call the providers to notify them when their clients are in the hospital. The MHTC is working to meet this policy for all persons admitted to the hospital, including those placed in the private psychiatric hospitals.

Despite the capacity of the mental health system to respond to a crisis situation, in Sacramento County, when a person calls 9-1-1 regarding a mental health crisis, the 9-1-1 dispatch operator calls law enforcement to respond to the mental health related crisis situation. The 9-1-1 dispatch operator (typically with the local police or Sheriff's department) triages the call and determines that the situation involves a mental health crisis. At this point, the 9-1-1 dispatch operator will transfer the call to the local law enforcement. There are many different law enforcement agencies in Sacramento County.

Once law enforcement responds, the officer makes a determination if the person is a danger to self, danger to others, or is gravely disabled. If so, the officer places a 5150 involuntary hold on the individual. Once law enforcement has placed a 5150 hold, the individual is transported to an Emergency Department for medical clearance. Mental health providers are typically not called in by law enforcement to be involved in this process.

By California law, counties have the authority to designate one or more mental health professionals to conduct and complete 5150 applications. Sacramento County has designated a number of different entities with the authority to conduct evaluations for meeting 5150 criteria. This policy may impact the number of persons detained under 5150.

Prior to October 2009, when law enforcement placed a person on a 5150 involuntary hold, the police could bring the individual to the Crisis Stabilization Unit (CSU). The CSU was co-located at the Mental Health Treatment Center. The police could drop the individual off at the CSU, which was an efficient process for the police. The officer could then leave the CSU and be available for the next emergency. This process worked efficiently for law enforcement. However, some of the individuals who were dropped off at the CSU had other unmet needs, such as detoxification and/or medical needs. The individual was evaluated by CSU staff and then transported to the appropriate service provider.

Now that the CSU is closed, law enforcement has to transport the individual to an Emergency Department. This may require the officer to wait with the individual in the hospital waiting room until Emergency Department staff are available. This may take several hours.

In an effort to avoid having to wait at an Emergency Department for long periods of time, law enforcement may ask the person if they are willing to go to the hospital voluntarily. If the person agrees to go as a voluntary admission, the police do not complete the 5150 evaluation and therefore are not required to stay with them in the Emergency Department until staff are available. In these situations, the officer has a "warm handoff" with hospital staff and the officer can leave the Emergency Department and return to his/her patrol. This has reduced the number of 5150 evaluations in the past few months.

However, when the person is "voluntary" and gets tired of waiting in the Emergency Department of the hospital, persons interviewed noted that the individual may choose to leave the Emergency Department before being evaluated for a 5150 and possibly admitted for treatment.

Neither law enforcement, nor the Emergency Department staff routinely call the MHTC to try to coordinate this crisis response with mental health service providers. The providers are not routinely notified of the person's crisis or hospitalization. As a result, they are unable to assist with the crisis situation, provide crisis intervention services, and/or help support the individual during the hospitalization and plan for discharge. Since April 2011, the MHTC has expanded staff to address this issue, by expanding the 24 hour Intake and Referral Team to respond to calls from the Emergency Department. This linkage helps to identify individuals who are current clients and notify providers of hospitalizations. This will greatly improve coordination of services across the system and help improve outcomes.

The limited amount of crisis intervention services delivered by the outpatient mental health system is also shown in the data. In reviewing Level II crisis intervention data from AVATAR, there are very few crisis intervention services delivered to clients. Figure 28 shows a small number of clients and a small number of hours of crisis intervention services for each of the Level II providers. This data illustrates the unduplicated count of clients served, the number of clients receiving crisis intervention services, the percent of clients receiving crisis intervention services, the total hours of crisis intervention services, and an annual calculation of average hours per client. Many of the providers reported that they call 9-1-1 if a client is in a crisis. This data is consistent with that practice.

Figure 28
Adult Outpatient Mental Health Services: Level II
Crisis Intervention Services
Clients, Hours, and Hours per Client
CY 2010
(Data from AVATAR)

Level II				
	Crisis Intervention Clients	% of Total Clients	Crisis Intervention Hours	Crisis Intervention Annual Hrs/Clt
El Hogar RST (N=911)	67	7.4%	129.24	1.93
Human Resources Cosultants RST (n=902)	33	3.7%	58.25	1.77
Northgate RST (n=943)	2	0.2%	3.01	1.51
Visions RST (n=971)	37	3.8%	63.54	1.72
County Aftercare Clinic (n=974)	28	2.9%	36.79	1.31
County APSS Clinic (n=1326)	13	1.0%	21.66	1.67
Total Level II (n=5644)	179	3.2%	312.49	1.75

Level IV FSP providers are required to offer a 24/7 after-hours capability to respond to enrolled clients. This 24/7 response offers a "friendly support person" answering the call, and allows the individual to talk with someone he/she knows. Often, just having someone to talk to helps to resolve the situation and de-escalate the crisis situation or intervene in pre-crisis phases to a

variety of after-hours issues that come up. This availability may, in some instances, prevent higher level services, including potential inpatient hospitalization.

The Review Team noted that Telecare SOAR and the Transcultural Wellness Center have comprehensive and responsive teams which respond to crises in a timely and effective manner. These two programs have a comprehensive system that responds to each mental health crisis situation. Some of the FSP programs reported that they use extensive efforts to resolve crises, and only call in 9-1-1 as a last resort. Others reported that they call 9-1-1 when a crisis situation arose.

However, the data for the MHSA Level IV and FSP programs (Figure 29) is similar to the Level II data. Across these MHSA programs, there were only 146 individuals who received crisis intervention services during CY 2010 (out of 2,141 MHSA clients). This data shows that 6.8% of clients received crisis intervention services. This may reflect the outcome of having a more intensive services for FSP clients, so potential crisis situations are resolved before they exacerbate to the level of a crisis.

Figure 29
Adult Outpatient Mental Health Services: Level IV
Crisis Intervention Services
Clients, Hours, and Hours per Client
CY 2010
(Data from AVATAR)

MHSA-Funded Programs				
	Crisis Intervention Clients	% of Total Clients	Crisis Intervention Hours	Crisis Intervention Annual Hrs/Clt
Guest House (n=834)	23	2.8%	25.37	1.10
TLCS New Directions FSP (n=341)	14	4.1%	15.43	1.10
Turning Point Pathways FSP (n=333)	10	3.0%	8.42	0.84
Transcultural Wellness Center FSP (n=200)	15	7.5%	47.15	3.14
Sierra Wellness FSP (n=186)	24	12.9%	78.90	3.29
Turning Point ISA FSP (n=280)	36	12.9%	85.42	2.37
Telecare SOAR FSP (n=145)	29	20.0%	112.94	3.89
Total MHSA-Funded (n=2141)	146	6.8%	373.63	2.56

It is unknown at what frequency providers truly deliver crisis intervention services as the data shows to very low numbers. Providers who deliver crisis intervention services may not be reporting the service as a crisis intervention. Since crisis intervention services are reimbursed at a higher Medi-Cal rate (compared to individual rehab/therapy), there may be opportunities to more accurately document crisis intervention services and receive additional reimbursement for crisis intervention services.

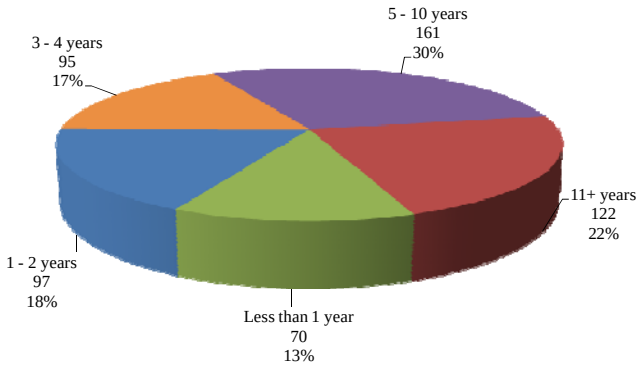
Adult Consumer Survey Results – Sacramento County

As part of the Independent Expert Review, an adult consumer survey instrument was developed by the Review Team. The survey instrument was translated into the county's five threshold languages (Chinese, Hmong, Russian, Spanish, and Vietnamese). A total of 577 surveys were completed.

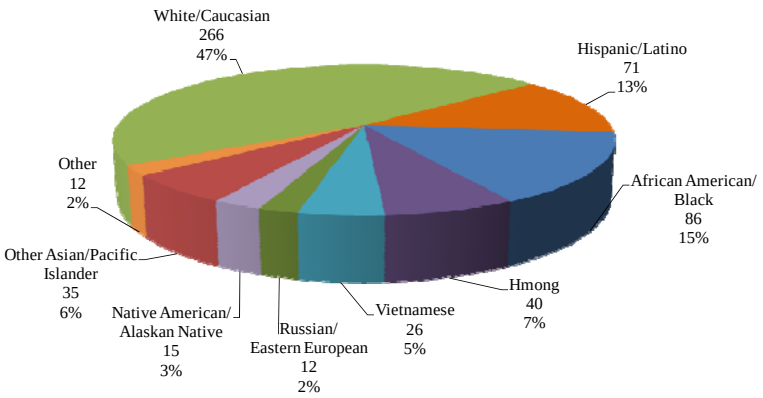
For each graph below, the number of responses for each question is shown in parentheses. Not all questions were answered on every survey, resulting in a different total number of responses for each question (the "N" of each graph). Additional survey results are supplied in Appendix D. Survey results for each program are available upon request.

Figure 30
Adult Consumer Survey Results
(N=577)
March 2011

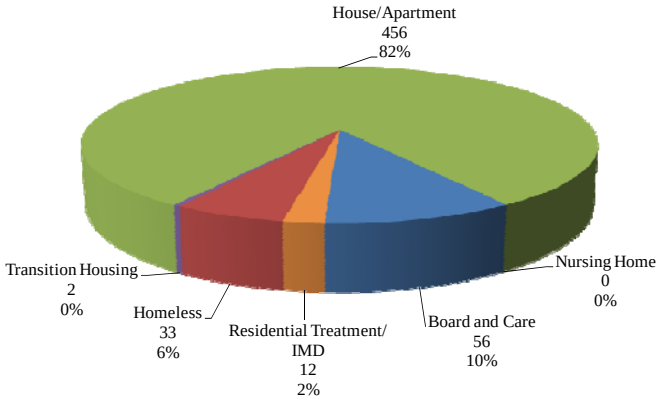
How long have you received mental health services in this county?
(N=545)

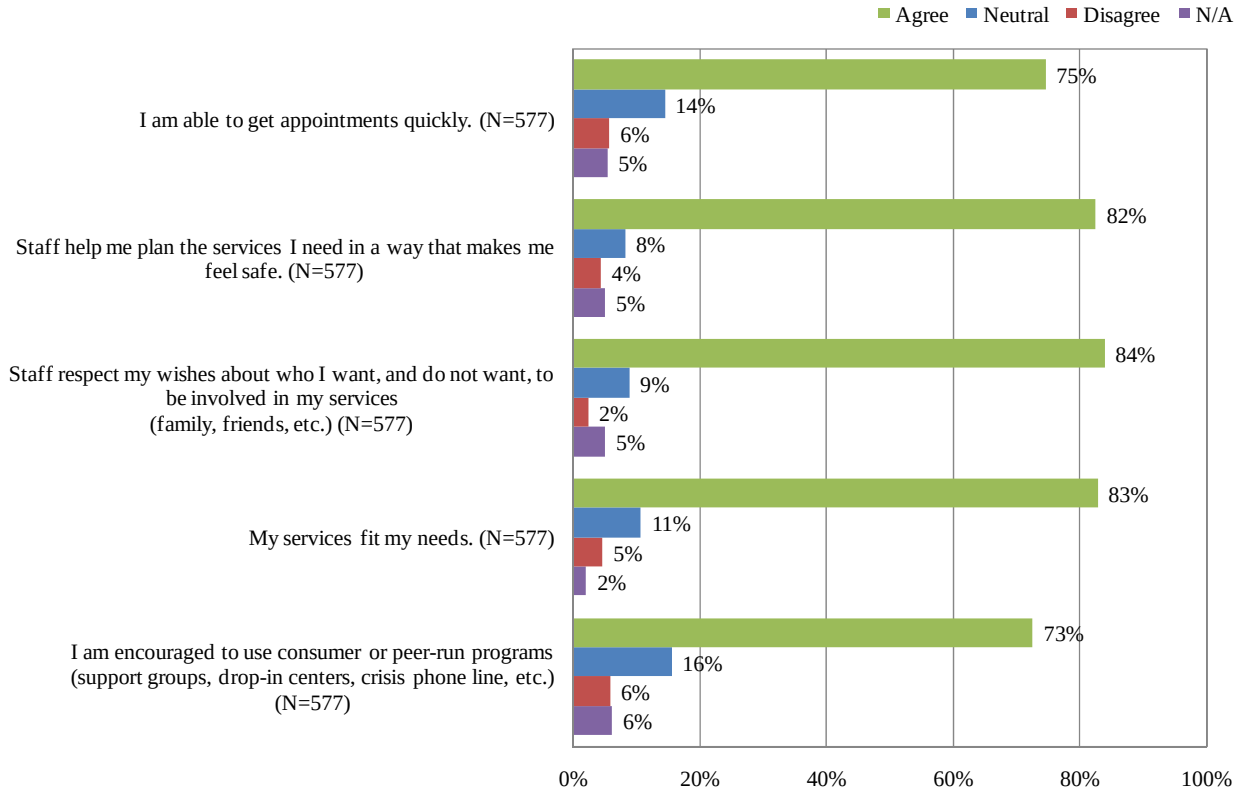


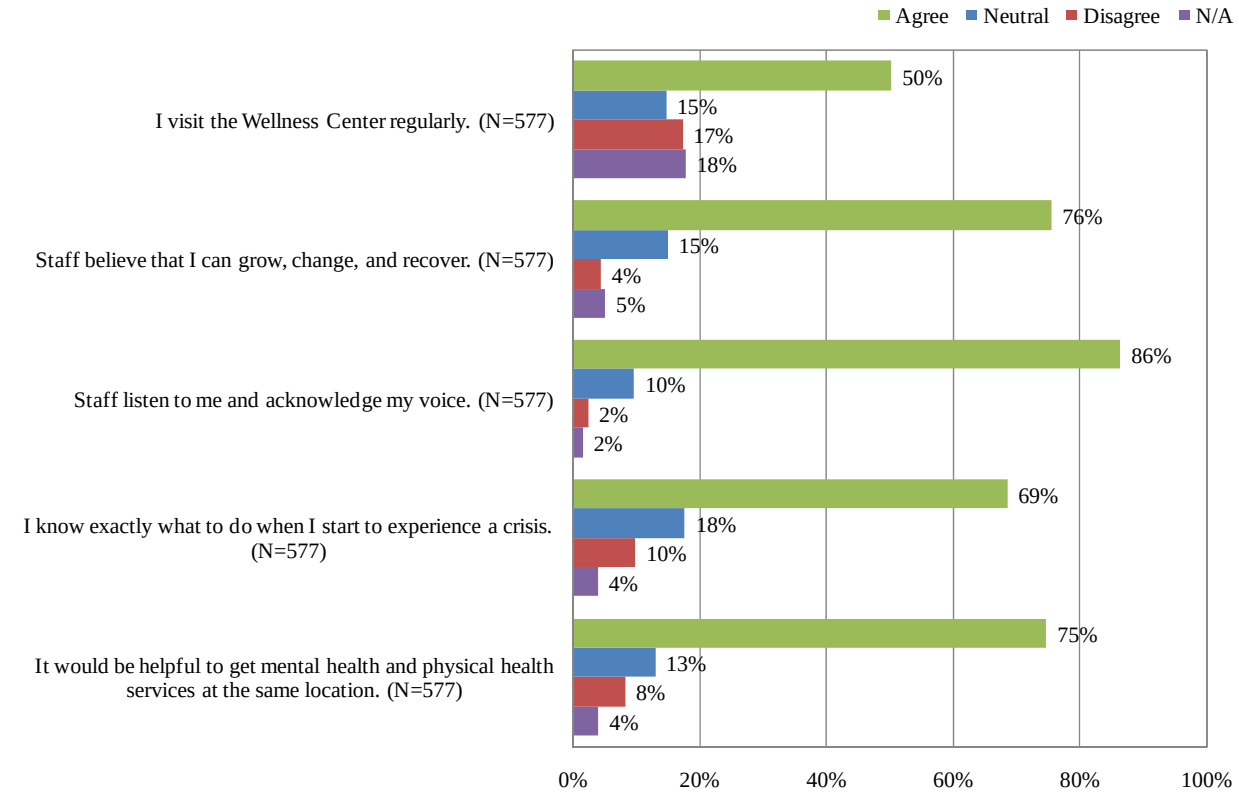
What is your race/ethnicity?
(N=563)

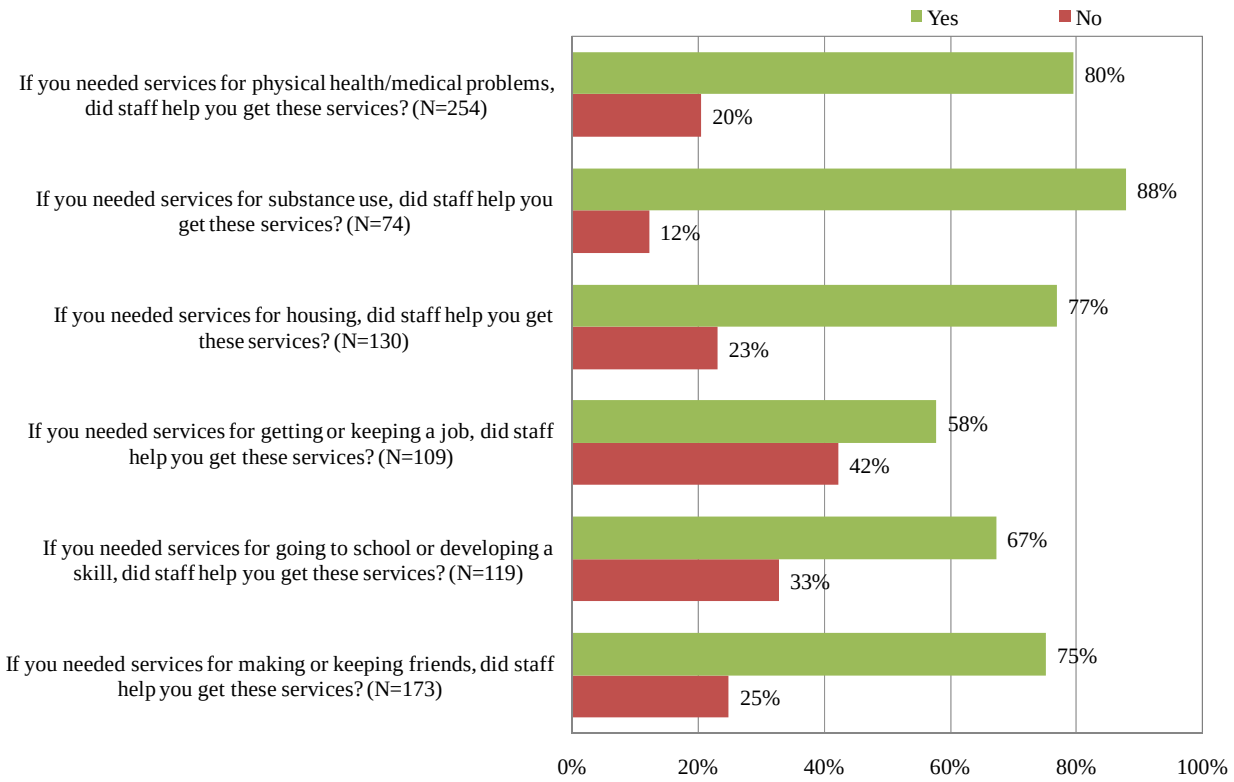


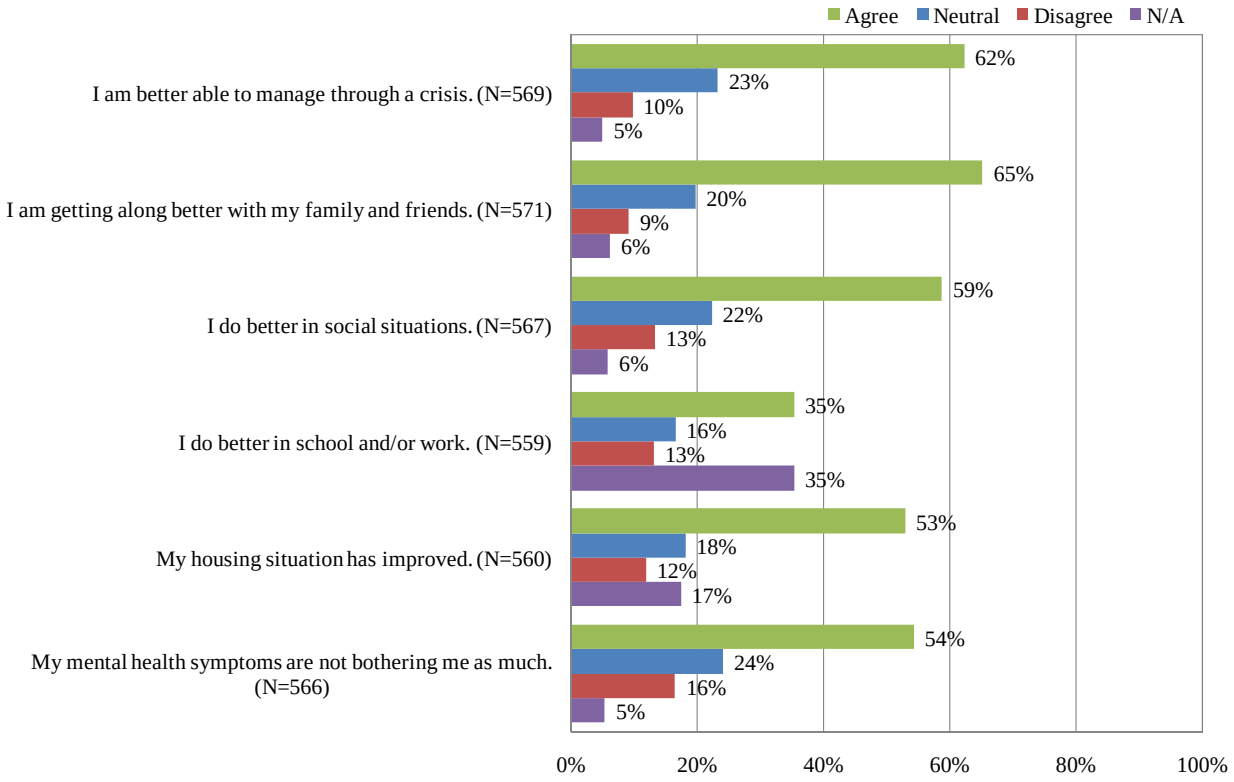
What is your current living situation?
(N=559)




Agree
Neutral
Disagree
N/A
I am able to get appointments quickly. (N=577)
75%
14%
6%
5%
Staff help me plan the services I need in a way that makes me feel safe. (N=577)
82%
8%
4%
5%
Staff respect my wishes about who I want, and do not want, to be involved in my services (family, friends, etc.) (N=577)
84%
9%
2%
5%
My services fit my needs. (N=577)
83%
11%
5%
2%
I am encouraged to use consumer or peer-run programs (support groups, drop-in centers, crisis phone line, etc.) (N=577)
73%
16%
6%
6%
0%
20%
40%
60%
80%
100%


Agree
Neutral
Disagree
N/A
I visit the Wellness Center regularly. (N=577)
50%
15%
17%
18%
Staff believe that I can grow, change, and recover. (N=577)
76%
15%
4%
5%
Staff listen to me and acknowledge my voice. (N=577)
86%
10%
2%
2%
I know exactly what to do when I start to experience a crisis. (N=577)
69%
18%
10%
4%
It would be helpful to get mental health and physical health services at the same location. (N=577)
75%
13%
8%
4%
0%
20%
40%
60%
80%
100%


Yes
No
If you needed services for physical health/medical problems, did staff help you get these services? (N=254)
80%
20%
If you needed services for substance use, did staff help you get these services? (N=74)
88%
12%
If you needed services for housing, did staff help you get these services? (N=130)
77%
23%
If you needed services for getting or keeping a job, did staff help you get these services? (N=109)
58%
42%
If you needed services for going to school or developing a skill, did staff help you get these services? (N=119)
67%
33%
If you needed services for making or keeping friends, did staff help you get these services? (N=173)
75%
25%
0%
20%
40%
60%
80%
100%


Agree
Neutral
Disagree
N/A
I am better able to manage through a crisis. (N=569)
62%
23%
10%
5%
I am getting along better with my family and friends. (N=571)
65%
20%
9%
6%
I do better in social situations. (N=567)
59%
22%
13%
6%
I do better in school and/or work. (N=559)
35%
16%
13%
35%
My housing situation has improved. (N=560)
53%
18%
12%
17%
My mental health symptoms are not bothering me as much. (N=566)
54%
24%
16%
5%
0%
20%
40%
60%
80%
100%

CHAPTER 1.2: ADULT OUTPATIENT SYSTEM TRANSFORMATION RECOMMENDATIONS

Transformation Vision

To create a single, integrated, continuum of recovery-based services to provide comprehensive, community-based mental health services and supports for all adults and older adults who qualify for mental health services. Services will promote wellness and recovery and are individualized based upon the needs and goals of the individual.

A wellness and recovery-based service delivery system is:

- Driven by the needs of the individual;
- Infused with resiliency, wellness, and recovery principles;
- Delivered by culturally diverse and sensitive providers;
- Supported by persons with lived experience working and delivering services at all levels of the system to help clients thrive; and
- Inclusive of all persons in the system committed to work together to meet the needs of individuals.

To successfully transform the adult and older adult mental health system, every director and manager must work together with a clear vision and plan. Leaders from both the county and the providers are encouraged to utilize this Report as a foundation for changing the system to "create positive individual and system level outcomes." Together, all components of the system can transform into a wellness and recovery-oriented service delivery system that empowers people by listening to their voice and giving them power and control to achieve their goals.

Core Components of a Recovery-Based Outpatient System

There are many opportunities to strengthen the adult outpatient mental health system. Each of the following components will be discussed to guide the transformation of outpatient services:

1. Easy and Timely Access to Services, including Mental Health Crisis Response
2. A Continuum of Services at Each Provider
3. Wellness and Recovery at every Provider: Peer Support Specialists and a Welcoming Environment
4. Evidence-Based and Promising Practices across the System
5. Medication Services delivered in Partnership with the Client's Voice
6. Increase Medi-Cal Billing

1. Easy and Timely Access to Services, including Mental Health Crisis Response

Vision. Persons who need mental health services have one well-advertised phone number to call to receive mental health services. The phone is answered by a live person who welcomes the individual and offers immediate assistance. Individuals can also access services by walking into or calling any mental health provider in the system and requesting services. This approach creates a "no wrong door" policy that quickly links individuals into the service delivery system, regardless of the method of entry. Individuals can call their provider or the county to obtain help to de-escalate a crisis 24/7.

Easy access to services is the core foundation of a person-centered mental health system. When a client finally builds up the courage to ask for mental health services, they are welcomed into the system with an offer of immediate assistance. Unfortunately, the current clinical and administrative process for assessing and authorizing new requests for services is not working for clients or the mental health system.

Discussion: Current access system. The existing Access Team in Sacramento County is comprised of clinicians who answer the Access Line between 8 a.m. and 5 p.m., Monday – Friday. Clinical staff member at the MHTC are responsible for answering the Access Line during after-hours. The county's policies and procedures require an individual to call and request services for him/herself. When all Access Team members are busy, the person calling the Access Line is asked to leave their name and phone number. The Access Team may call the individual back the same day, or days later. At times, the client may not have a phone, so the Access Team cannot reach the person. In these instances, the client then has to call the Access Team again and make another request for services. Some clients reported going to an Emergency Department to get services because they could not get assistance through the existing process.

Barriers to Accessing Services:

a) The client needs to have access to a phone to make the call, and be near a phone when the Access Team returns the call. It has been reported, from county staff, that 30 - 50% of the people calling the Access Team do not receive a call back. Access Team policies require that the client has to be the one to make the call; the Access Team will not accept a call from a provider on the client's behalf. Similarly, if the person finds a provider in the community and walks in to get help, the provider cannot make the call for the client. The client must call the Access Team.
b) Once the client is assessed on the phone and the Access Team gives them the name and phone number of the appropriate provider, the client has to make a second call to make an appointment with the provider, or their provider may attempt to reach them directly after noting the Access referral sent to them via Avatar. It may take up to a day or more for the client's information and the Access Team's authorization for services to be entered into the computer system. In some situations, the Access Team may call providers with the referral; the provider then calls the client for an appointment. Some providers (especially FSP providers) are proactive and look at their referral list from the Access Team each day and call the client to set up an appointment, instead of waiting for

the client to call. Other providers wait for the client to contact them for an appointment. If the client does not connect with the provider, then the client does not receive services.

It is evident that there are numerous dedicated, hard-working, and caring individuals working within this system. However, the current access system is neither, from a client's perspective, easily accessible nor, with a few notable exceptions, welcoming.

Recommendation: Develop a Response Team to strengthen the access system. It is recommended that the county develop a 24/7 Response Team to ensure that individuals have easy and timely access to services. The Response Team utilizes a well-known, centralized phone number that the community can call when requesting mental health services and/or experiencing a mental health crisis. The Response Team provides a skilled telephone response to all callers, supplying information and linking them to the appropriate service in the community. The Response Team provides several services, including:

- Performing the functions of the existing "Access Team," by screening requests for mental health services and linking callers to services;
- Responding to calls from persons experiencing a mental health crisis and working with them to resolve the crisis;
- Conducting evaluations for meeting 5150 criteria at local Emergency Departments;
- Performing the functions of the current Intensive Placement Team to authorize sub-acute residential placement, as well as helping to discharge individuals from these higher levels of care; and
- Conducting Utilization Reviews for all services, authorizing and reauthorizing services.

The Response Team creates a welcoming, fluid, and flexible system that provides information and links people to services. Persons needing outpatient mental health services may also access services at the individual provider level.

Recommendation: Providers conduct intake assessments for easy access to services. To ensure easy access to mental health services, individuals seeking mental health services can call or walk into any mental health provider. (The client is no longer required to make a phone call to the Access Team for an initial authorization.) Mental health providers are required to maintain an Access Log that tracks all requests for services and the outcomes of those requests; the providers are required to submit the Access Log to the Response Team on a monthly basis. The provider welcomes the person, and completes a brief screening and a clinical assessment. If the provider determines that the person does not qualify for specialty mental health services, they provide referrals to community-based services, including FQHC providers, substance abuse providers, and the Wellness and Recovery Centers (for non-Medi-cal billed services). If the provider determines that the person qualifies for mental health services, they send a copy of the assessment and treatment authorization request to the county Utilization Review for authorization. If the assessment indicates the need for Level IV services, the provider also completes the LOCUS and submits it with the initial paperwork to county Utilization Review.

Discussion: Crisis Response and Crisis Intervention Services. Currently, it is very difficult for clients to know who to call if they are in crisis. Most people call 9-1-1. The Review Team asked providers across the county what they did when a client's behavior escalated and/or the client called and said they were in crisis. Many providers said, "We call 9-1-1." When clients were asked what they do when they are in crisis, most responded that they call 9-1-1. When family members were asked what they do when a loved one was in crisis, they responded, "Call 9-1-1." During the focus groups, no one mentioned calling a mental health crisis line to receive help. Many focus group clients also stated that they would have gladly called a number to talk with someone at an outpatient mental health program during a crisis, if they had known who to call.

In California, all county mental health programs respond to mental health-related 9-1-1 crisis calls. Each county has a mental health professional available on-call, 24/7, and clients are given the 24/7 county mental health number to call when they are in crisis. In addition, in some counties, acute hospitals provide direct psychiatric emergency access. There are different agreements at the local level to manage the 24/7 access for mental health crises. This is done differently from county to county depending on its local resources and geography.

In many counties, if a person calls 9-1-1, the dispatch will assess the call and transfer the call to the mental health 24/7 line, if it is not a safety issue. The on-call mental health professional immediately responds to the call, talks with the caller, and assists the individual in crisis to resolve the issue and maintain functioning in the community, whenever possible. The types of crisis response services include a phone and/or in-person triage evaluation by mental health professionals to determine the level of urgency/crisis and the appropriate course of intervention. The on-call professional assesses the individual's ability to maintain community functioning in the least-restrictive environment and determines the most appropriate level of care for that person at that time. In many situations, the crisis can be averted and the individual can be seen in the clinic the same day, or the next morning, depending upon the time of the crisis call. If the person needs to be evaluated, the mental health professional may arrange to meet with the individual at a nearby Emergency Department. Transportation to an Emergency Department is arranged, if needed.

Recommendation: Redesign Crisis Response and Crisis Intervention Services at the county and provider level.

County Responsibility: The 9-1-1 dispatch forwards all mental health-related calls to the Response Team, except 9-1-1 calls involving safety issues. These safety issues are immediately linked to the police/sheriff. The Response Team handles all Sacramento County calls from the 9-1-1 dispatch related to crisis situations. In addition, Sacramento County Mental Health has one (1) county mental health phone number, well publicized, to provide a first response to all mental health crisis calls. The Response Team goes to the Emergency Department and conducts 5150 evaluations.

Provider Responsibilities: Each provider has an individual assigned to respond to crisis situations during business hours. This "responder of the day" talks with individuals on the phone, is available to see them, and coordinates services with the county Response Team. The

providers also develop the capacity to respond to crisis situations by phone 24/7, provide information on current clients, and assist the Response Team in de-escalating crisis situations. If a client needs a 5150 evaluation, on-call staff notifies the county Response Team and arranges for clients to be transported to an Emergency Department.

Recommendation: Develop a Welcoming Line to offer consumer support 24/7. To provide a supportive phone service to individuals who need someone to talk to, it is recommended that a Welcoming Line (also called a Warm Line) be developed. The Welcoming Line is staffed by persons with lived experience and trained in this specific task. It is also recommended that the Welcoming Line be co-located at the Wellness and Recovery Centers, so that individuals answering the phone can have support from other mental health staff. The Universal Language Line is used to interpret, as needed. If the person calling is Asian/Pacific Islander, he/she is referred to the Transcultural 24/7 Response Line.

2. A Continuum of Services at Each Provider

Vision. A continuum of recovery-based services are available at each outpatient provider. The intensity of services can change, depending on the immediate needs of the individual. Services reflect wellness and recovery principles, are delivered in a culturally sensitive manner, and integrate persons with lived experience.

Discussion: Current outpatient system does not quickly respond to a client's change in service intensity needs. The current county contract for outpatient providers creates artificial service requirements, which do not promote individualized services. Programs have been developed to primarily serve clients in one of three primary service levels (Levels II-IV). Contracts with agency providers specify service expectations on the minimum number of services to be delivered monthly to each individual.

The RST contracts and county operated clinics are designated to serve clients with Level II service needs. The Level II provider contract terms specify that each client receives a minimum of one service contact per month. While this amount does not appear to be "too much" for some clients, it is more than is needed to remain stable and living independently. For others, one service contact a month is not sufficient to help the individual address key stressors in their life and provide the support needed to prevent a crisis and/or hospitalization. With a case load of 80 - 100 clients, the Level II staff spend the majority of their time simply meeting the contract terms each month. This contract language does not allow for extra time to spend with higher-need clients.

For MHSA-funded Level IV FSP providers, the contract requires a minimum of four contacts per month. Again, while many of the clients receiving Level IV FSP services need four or more contacts per month, some may not need this intensity of services.

While the contracts allow the providers to increase or decrease the number of contacts based on clinical need for a period of time, for a prolonged change in service need (e.g., a person at level II needs ongoing level IV services), there is less flexibility for the provider. If a Level II program determines that a client needs more services for a prolonged period of time, they will need to transfer the client to another program and provider. Similarly, if a client in a Level IV program is improving and not in need of intensive services, they will have to be transferred to another program and provider. This policy creates a lack of continuity for the clients and a lack of flexibility for providers, making it difficult for clients to receive the "right service" at the "right time."

If providers were able to serve clients at all service levels and design their programs accordingly, the result would be a better "fit," with better outcomes for the client, at a lower cost. The client can remain at the same provider and receive the appropriate services, as the client's needs change over time.

Being able to provide a continuum of services at each provider may also allow programs to increase their ability to serve older adults. Staff are able to share expertise in this area and develop new skills through training and supervision.

Recommendation: Redesign the regional outpatient system to offer a continuum of services at each provider. Each regional outpatient provider develops a continuum of recovery-focused services, with the flexibility to serve clients with all outpatient levels of need (Levels II - IV). Providers that offer different levels of services combine services, and staff, to develop a continuum of services (i.e., Turning Point Northgate and Pathways). MHSA FSP services continue to be offered and are available across all providers.

Each provider has the capacity to designate a level of service for a client that is based on need, not based on the specific provider delivering the services. The Response Team will authorize Level II and III services, with reauthorization required every two years. For persons identified as Level IV, the provider documents the need for Level IV services and submits a request to Utilization Review. The Response Team Utilization Reviewer reviews the request for Level IV services (FSP), and authorizes up to one year of service. Each provider has access to MHSA flex funds, as needed, to support the goals of persons designated as FSP. All providers also have expectations for maximizing Medi-Cal revenue, whenever possible.

Contracts are modified to remove the specific expectations of one visit per month for Level II services and four visits per month for Level IV FSP services. Contracts have service standards for the total number of hours per year, rather than a specific number of contacts per person per year. Key outcome measures are also used to measure performance.

"We had a client who had received services off and on for over nine years, with a long history of no-shows and inpatient services. One of our clinicians hopped into a van and drove out to the client's house, picked her up, and brought her into the clinic. We were amazed! It really worked!! She is now stable on her medications and has NOT been admitted to inpatient services for the past year!" - Level II Clinic Supervisor

Discussion: Collaboration between inpatient and outpatient service providers. At the present time, communication between the Emergency Departments, the MHTC, and the outpatient providers is not optimal. At the time of the site reviews, there were no consistent standards of practice, in which the Emergency Departments called the county to determine if the person in crisis is receiving mental health services through the county mental health system. Recently, the MHTC has expanded the capacity to respond to calls and provide this level of information to the EDs on a 24/7 basis. Similarly, during interviews with providers, staff noted that the MHTC does not routinely call the provider during the crisis to notify them of the admission; the MHTC is more likely to call the outpatient provider during the hospital admission. While these organizations are working to improve communication, collaboration is not standard procedure and does not occur with every hospitalization.

Hospital staff may call the county, or outpatient provider, to notify them of a discharge from an inpatient facility. In some instances, when the outpatient provider is aware of the inpatient or MHTC admission, the provider visits the hospital to plan the discharge. However, it is not a

routine practice to involve the outpatient provider in the crisis, the inpatient admission, or the inpatient discharge.

Following discharge from an inpatient facility, it is the county's expectation that the discharged individual is seen by a provider within thirty (30) days of discharge. Other counties that have developed effective programs to engage individuals in the community to prevent a re-hospitalization have developed programs that link the individual with supportive services at the time of discharge, or within a few days. If the client does not adequately manage their medications, or if they are isolated and not able to perform daily activities, the individual is at risk for another hospitalization. Immediate linkage to the outpatient provider during the hospitalization and, ideally, on the day of discharge quickly engages the person back into the community and greatly improves outcomes. An intensive outpatient program is also effective at helping clients who are discharged from sub-acute residential programs to successfully integrate back into the community.

Recommendation: Improve notification of inpatient and MHTC admissions and coordinate discharge planning. The Response Team is aware of all inpatient admissions and will notify the outpatient providers when the provider has a client who is admitted to an inpatient hospital or the MHTC. This process informs providers of admissions so that they can coordinate services and support a timely discharge from the hospital or MHTC. Response Team staff also tracks the admissions to ensure that provider staff have made contact with the hospitals. For clients who are not linked, the Response Team is responsible for coordinating discharges and making outpatient referrals to the appropriate provider.

Recommendation: Develop Intensive Outpatient Services (IOS) program(s) to help persons discharged from sub-acute residential placements successfully return to the community. The county utilizes existing providers to develop intensive outpatient program(s) targeted to serve persons discharged from higher levels of care, including Mental Health Rehabilitation Centers and the State Hospital. Each IOS serves at least 12 people coming out of higher levels of care and will offer daily programs and deliver supportive services. The IOS offers weekend services, as needed (e.g., medication support services in the person's home). The provider works closely with the person's identified support persons to problem solve issues in a timely manner. The county closely monitors the planning and implementation of the IOS to provide technical assistance and to ensure that the provider successfully helps the individual live in the community.

Discussion: County outpatient clinics. The initial vision for the county outpatient clinics was to serve persons who are indigent. The data discussed earlier in this Report shows that the county outpatient clinics do not offer clients the range, or intensity, of services that are delivered by the outpatient contract providers. In addition, the expectation that the county would primarily serve persons who are indigent did not occur. The majority of persons served in the two county outpatient clinics receive Medi-Cal benefits. As shown in the data, Aftercare Clinic's population is 87% Medi-Cal. Similarly, the APSS Clinic served 84% Medi-Cal clients. While these percentages are lower than the outpatient contract providers, it does not reflect the initial plan to primarily serve only indigent.

The array of services at the county clinics is also different from the contract providers. While most clients (90%) receive medication support services, only a small proportion of clients receive individual rehab/therapy, group, or case management services. Each client receives an average of 7.3 hours per year at Aftercare and 8.2 hours per year at APSS. In contrast, clients at the RSTs received an average of over 20 hours per year. The limited array of services at the county clinics does not promote positive outcomes of wellness and recovery.

Recommendation: Consolidate the two county outpatient clinics and plan how the remaining staff can best support the system transformation. It is recommended that the county combine the two county outpatient clinics and review staffing and function requirements to achieve positive outcomes in the system. These staff may offer additional support to the Response Team. For example, for persons who are indigent, these staff could conduct face-to-face assessments for persons who are new to the system; meet with individuals at the Emergency Department and/or private inpatient setting to link them to a provider; provide urgent outpatient care; and coordinate with the psychiatrist.

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3. Wellness and Recovery at every Provider: Peer Support Specialists and a Welcoming Environment

Vision. All aspects of the Mental Health System incorporate a Wellness and Recovery Orientation. Individuals with lived experience help guide the system and services.

It is recommended that the county develops a wellness and recovery-oriented system. This system will include a continuum of accessible services that are responsive to the needs of individuals and utilizes persons with lived experience to guide and strengthen outcomes.

Developing recovery-oriented services requires a transformation of the entire service delivery system. SAMHSA has developed a Policy Paper on The Role of Recovery Support Services in Recovery-Oriented Systems of Care (2008). This Policy Paper provides the framework for programs to become more responsive to meet the needs of individuals and families seeking services. Effective, recovery-oriented systems must infuse the language, culture, and spirit of recovery throughout their system of care. Programs have to develop values and principles that are shaped by individuals and families in recovery. The elements of a recovery-oriented system of care include:

- Incorporates the individual's voice, culture and personal belief systems;
- Incorporates a belief that the individual will learn, grow and improve;
- Person-centered services that involve family and other support systems;
- Individualized and comprehensive continuum of services with links to collaborating partners;
- Continuity of care with integrated health and mental health services;
- Incorporates peer supports and the voices of persons with lived experiences
- Supports a learning environment of education, training, and coaching for staff and individuals receiving services;
- Uses data on client and system outcomes to improve the quality of services;
- Services that focus more on collaboration and less on hierarchy;
- Strength-based (emphasis on individual strengths, assets, and resilience);
- Responsive to personal belief systems; and
- Commitment to peer recovery support services.

An important component of recovery-oriented services is the integration of peer recovery support services, that are delivered by persons with lived experience. Peer recovery support services provide social support to individuals at all stages of the continuum of change toward recovery. These services can help strengthen an individual's motivation for change, accompany an individual to treatment, support relapse prevention, and/or be delivered apart from the service delivery system when a person cannot, or chooses not, to enter the formal treatment system.

Discussion: Current medical model of outpatient services. Outpatient mental health services (Level II) are primarily clinic-based services, with a heavy emphasis on medications, with minimal staff training to develop wellness and recovery-oriented services utilizing evidence-based practices and person-centered services. While the county outpatient system has two excellent examples of Wellness and Recovery Centers, few providers have embraced and learned from the model by creating a welcoming environment for their services.

Both contract and county outpatient providers reported having services that promote wellness and recovery. Through conversations with staff, case presentations, chart reviews, and talking with clients, the Review Team found that some providers integrate wellness and recovery principles throughout their service delivery system. Other providers are moving toward wellness and recovery, and the remaining providers show little evidence of delivering recovery-oriented services.

While staff from the providers reported that they focus on wellness and recovery, there was little evidence that they used language to discuss their expectations regarding the client's ability to thrive. Some of the staff exhibited stigma about mental health (i.e., "we have staff with lived experience, but they would never share that with the clients"). Others didn't expect much from the client ("I try to help her, not thrive, but function"). Many of the service plans did not reflect goals of recovery. Many clients only had one goal on their service plan, and that goal was "symptom management." Clients will not recover and thrive if they are only focused on managing symptoms, especially when the symptom is not identified as a measurable, observable behavior.

"The client's goal is to get work. I talked with him so he is aware of his disability and limitations." - (Provider staff member)
Follow-up Note: The next week, the client found a job on his own.

Recommendation: Create wellness and recovery-focused services in a welcoming environment at each provider. All providers are encouraged to visit the Wellness and Recovery Centers, especially the Marconi site, to experience a welcoming environment that promotes a recovery-oriented, person-centered program. The Marconi Center creates an environment that helps people realize that they can achieve their goals and feel empowered to make them a reality. Each provider is encouraged to visit the Center and use it to stimulate ideas for modifying their own facility to make it more inviting, friendly, and wellness and recovery-focused (for example, home-like décor, plants, comfortable seating, etc). All providers are encouraged to warmly greet individuals as soon as they walk in the door, as this helps individuals to feel comfortable and welcomed. It is also recommended that staff receive trainings on nonverbal communication and the way it can influence whether a person feels welcomed when he/she walks in the door.

Promising Practice: Wellness and Recovery Centers. The Review Team found the Wellness and Recovery Centers to be extremely welcoming and inviting. The centers were busy with individuals participating in different groups, and using the computer lab. Individuals were also receiving individual rehab/therapy and medication services. There

was also an employment group and a WRAP group, with 10 - 20 members involved in each group.

Discussion: Peer Support Specialists. The use of Peer Support Specialists can expedite the transition from a cold, unfriendly environment to a welcoming clinic. For example, Peer Support Specialists can offer groups and activities, organize walking groups, teach cooking classes, support clients to learn to ride the bus, shop at the grocery store, and/or budget their finances. The majority of services delivered by Peer Support Specialists are eligible for Medi-Cal reimbursement. It is a matter of philosophy whether the centers choose to increase Medi-Cal reimbursement from the services delivered.

Recommendation: Hire Peer Support Specialists for volunteer and paid service delivery positions. It is recommended that the county fund positions for Peer Support Specialists, to deliver services within each provider's service delivery system. Providers work closely with the Wellness and Recovery Centers to develop job descriptions and skills, train new hires, and provide ongoing support to Peer Support Specialists. Providers also utilize training from Wellness and Recovery staff to help them promote wellness and recovery principles throughout their system and understand how to integrate Peer Support Specialists throughout the service delivery system.

Recommendation: Provide Wellness and Recovery Training. It is recommended that the county develop a contract with an organization to deliver training to Peer Support Specialists. This training provides a Wellness and Recovery certification for working within the mental health system, as well as developing core skills for supporting clients. This organization also provides a training for provider and county staff to learn wellness and recovery principles and how to integrate Peer Support Specialists into the service delivery team.

In addition, it is recommended that the county contract with a local organization to provide ongoing monthly mentoring/training groups to support and monitor all Peer Support Specialists hired across the county. This training is offered periodically throughout the year.

4. Evidence-Based and Promising Practices across the System

Vision. The service delivery system utilizes evidence-based and promising practices to provide quality services and promote wellness and recovery. Services for persons with co-occurring disorders, mental health and substance abuse, will be available at all providers.

Discussion: Current required training program. Sacramento Psychosocial Options for Rehabilitation Training (SacPort) training program designed to improve community functioning of clients with a persistent mental illness. However, SacPort is not listed on any of the federal lists for evidence-based practices. Providers are required to teach two different modules each month, with at least two groups for each module. There are typically 3 - 12 participants in each group. The modules include:

1. Basic Conversation Skills;
2. Community Re-Entry Program;
3. Friendship and Intimacy;
4. Medication Management;
5. Recreation for Leisure;
6. Substance Abuse Management;
7. Symptom Management;
8. Workplace Fundamentals;
9. Involving Families in Mental Health.

Many of the providers continue to offer the groups because it is a component of their contract. However, clients have varying opinions of the program. The Review Team observed a module on symptom management and found that the program was not recovery-oriented. The program was initially developed for persons in residential facilities, so there is limited relevance for the majority of outpatient clients.

Recommendation: Identify innovative evidence-based practices and provide training, supervision, and ongoing feedback to integrate these new skills throughout services. Providers have the flexibility to use a range of practices to improve the quality of services. Service delivery staff are trained and supervised to provide evidence-based and promising practices, which focus on improving quality of care and core client outcomes, including: stability in housing, employment, education, and developing positive social supports. Suggestions for training include: Motivational Interviewing, Supported Employment, Cognitive Behavioral Therapy, Trauma Informed CBT, and/or Dialectical Behavioral Therapy. Training could be funded with MHSA funds, and delivered to all county and provider staff. There are also effective web-based training sites that offer courses on a wide range of topics and allow clinical staff to earn continuing education units (CEUs), as well as information for clients and family members. In addition to providing training on evidence-based and promising practices, it is important that the training is practiced and integrated into services; supervisors mentor staff to effectively implement the new skills as they deliver services.

It is also recommended that the county host a monthly meeting to allow providers to share and discuss their experiences with implementing evidence-based and promising practice models

through a case presentation format. This strategy helps showcase services and allows providers to share experiences about what they have found to be most effective in helping clients achieve measurable outcomes.

Promising Practice: Telecare SOAR. Telecare SOAR has utilized a comprehensive, integrated approach to assure staff has the necessary knowledge and skills to provide strength-based and recovery-oriented care. Telecare SOAR has developed a Recovery-Centered Clinical System (RCCS), which is an informative and useful guide to strengthening staff and individual skills to promote hope, choice, identity, and recovery. Staff is also trained in evidence-based practices relevant to their specific work. These skills are brought together and applied through ongoing case planning that focuses on the quality of care and meeting the individual's needs as they change over time. These materials are available for download on the Telecare website (http://www.telecarecorp.com/page3-60/RCCSMaterials).

Recommendation: Implement a training program that facilitates communication between consumers and psychiatrists. The county is encouraged to identify, contract, and implement an innovative training program to promote and facilitate communication between consumers and psychiatrists. This program helps clients prepare for their appointment with the psychiatrist and make decisions for their treatment and recovery. Train-the-trainer models have been found to be cost-effective and efficient ways to develop skills across all staff in the system.

Promising Practice: Promoting communication between the individual and the psychiatrist throughout the system. Telecare SOAR is currently implementing a web-based program called CommonGround, developed by Pat Deegan, Ph.D. This program is a comprehensive model that supports individuals in communicating with their psychiatrist. The program was developed by persons with lived experience. The program supports an individual in expressing themselves with their psychiatrist regarding their symptoms, side effects, and goals for services, which makes the face-to-face time more productive and effective. Computers are available to clients in the waiting room, where they can access a web-based program using a touch screen. The software has auditory and visual modes. A Peer Support Specialist is available to help anyone who needs assistance. The program offers a comprehensive training program, using a train-the-trainer model. An ongoing support team provides frequent technical assistance and linkage to an extensive library of materials and worksheets. This web-based program gives the individual an opportunity to communicate with the psychiatrist and highlight key concerns prior to the medication appointment, which facilitates a conversation and makes the face-to-face time more productive and effective.

Discussion: Treatment for co-occurring disorders. During the review process, the Review Team noted that many of the providers have limited services to treat persons with co-occurring disorders (persons with both mental health and substance abuse diagnoses). Some programs offer relapse prevention groups, and the county APSS Clinic and Aftercare Clinic have Alcohol and Other Drug (AOD) counselors assigned to provide services.

Staff in TCORE and Crisis Residential programs discussed the impact of co-occurring disorders on the clients that they serve.

Staff also identified the need for more training in this area. Staff collect information on substance abuse on their intake assessment and are required to complete another specific tool, the CODA (Co-Occurring Disorders Assessment), if substance abuse issues are present. Staff reported that they generally will refer clients to AOD services if they want help in this area, but that these services are often difficult to access. The need for social detoxification services was also noted by some providers.

Recommendation: Identify evidence-based practices and provide training for staff on the treatment of co-occurring disorders. Training on the treatment of individuals with co-occurring disorders would improve outcomes for clients with co-occurring diagnoses. Motivational Interviewing has proven to be effective in working with individuals who have co-occurring disorders. The county is also encouraged to offer training in other evidence-based practices that have been found to be effective for persons with co-occurring disorders.

5. Medication Services delivered in Partnership with the Client's Voice

Vision. Medications are <u>one</u> treatment option. A full array of services provided to assist individuals to improve functioning in the community and attaining wellness and recovery.

Discussion: UC Davis Psychiatric Residents and client communication. The UC Davis Department of Psychiatry is an exemplary training and educational program. However, there is a heavy emphasis on prescribing medications. In reviewing charts and talking with clients, there was little evidence of psychiatrists promoting the use of behavioral techniques to manage symptoms. There was also little evidence of the Residents promoting client voice and choice in services. This was demonstrated by the limited array of services at the county outpatient clinics. Fifty percent of services are medication support services.

"There are many ways to heal. Medications are only one of them." - Transcultural Wellness Center Staff

Clients also reported concern about the communication style of some of the Residents. In a focus group of clients at a county clinic, the clients expressed concern that they have to "tell their story" to a different Resident every three (3) months. This causes the individual to continually re-live their history. Others felt that the Residents do not listen to what the client says and do not have the time to develop an ongoing therapeutic relationship.

"I want the psychiatrist to listen to me, learn about my symptoms, and understand how the medications affect me and my life. I know my symptoms better than anyone else." - Outpatient client

As a result of the frequent rotation of the Residents, the client does not have an opportunity to develop a trusting relationship with the psychiatrist. It was reported that the Residents are not focused on recovery and do not ask about other factors in the individual's life that may contribute to their current symptoms or compliance with medications. In addition, Residents are less likely to know about other resources in the county, so they are less likely to link or refer clients to other community resources (e.g., Wellness and Recovery Centers, employment).

Family members and other support persons are also an important component of treatment. Residents are less likely to talk with other persons in the individual's life to train and involve them in the service delivery process. However, when the individual is discharged from the facility, it is the family/support persons who help them manage their medications and contribute to their success in remaining stable in the community.

While the MHTC staff and Residents work in a complex setting, there are opportunities to hire persons with lived experience to help advocate for clients and help ensure quality care in a cost-effective manner. This would help provide support to the individual receiving service, outreach to family, and optimally, reduce the length of the inpatient stay.

The county clinics and MHTC are good training and educational sites. However, there is a need for county oversight to ensure that an individual's wellness and recovery are the highest priority. This is a perfect opportunity to train Residents to listen to an individual's voice, hear what the person is saying, and use them as an integral part of the team to plan and implement the best possible care.

Recommendation: Develop a training program to train UC Davis Residents to integrate clients' voice in treatment. It is recommended that UC Davis Residents receive training from persons with lived experience to learn about integrating client voice and choice to empower clients and support wellness and recovery. Prior to starting a rotation at the outpatient clinic or MHTC, the Residents receive training from persons with lived experience. This training provides a consumer's perspective to the Resident about listening and valuing the individual's voice, and the importance of supporting wellness and recovery. At the MHTC, persons with lived experience share the impact of a hospitalization on an individual's recovery, the importance of involving family in the treatment and discharge planning, and the value of treating a client with respect and dignity to promote recovery. NOTE: The MHTC has recently received funding to develop a training program for residents. They plan to have two psychiatrists run the training. Consumers and family members will participate on panel discussions as part of this training program.

Recommendation: Integrate persons with lived experience as part of the MHTC service delivery team to ensure communication. It is recommended that persons with lived experience are active members of the MHTC Treatment Team. These individuals provide support and information to the individual hospitalized, as well as offering support services to the client's family during the hospitalization. As employees of the MHTC, they are active partners in service delivery and part of the Discharge Planning Committee to promote recovery, wellness, and linkage to outside resources that would facilitate a timely and successful discharge.

Promising Practice: Culturally Sensitive Psychiatric Services. The Review Team interviewed a psychiatrist who was trained at UC Davis and is now employed in the outpatient system at the APCC Transcultural Wellness Center. The psychiatrist provides an exemplary model for psychiatrists in how to listen to clients and respecting them as people. The psychiatrist talked about how important it is to listen to the client and hear their voice. The psychiatrist gave one example of a client had not taken her medications for several months. The woman finally told the case manager that she had not told anyone because she was afraid that she might have disappointed the doctor. The case manager talked with the psychiatrist and the psychiatrist asked the case manager to bring the client in. When she arrived, the psychiatrist thanked her for being brave and trusting their relationship. The psychiatrist then asked "How can I make you more comfortable in talking with me?"

6. Increase Medi-Cal Billing

Vision. Opportunities for maximizing Medi-Cal reimbursement are identified and implemented at all providers to support, fund, and expand community-based services.

Discussions: Maximizing Medi-Cal billing. There are two basic ways to increase Medi-Cal billing. 1) ensure that every client who would qualify for SSI and Medi-Cal applies for benefits; and 2) ensure that staff are billing for as many Medi-Cal reimbursable services as possible.

The most significant way to increase Medi-Cal billing for the adult mental health system is to look at ways that inpatient care can be provided in facilities that are eligible for Medi-Cal reimbursement. This recommendation regarding inpatient services will be discussed in another section of the Report.

Recommendation: Develop an expedited process for helping individuals qualify for Medi-Cal benefits. The mental health program is encouraged to use the Guest House model of expedited access to services and benefits as an example for developing similar programs at the outpatient clinics. Each person who is in crisis, and/or hospitalized, costs the county several thousand dollars in services. If clients were quickly enrolled in the Medi-Cal program, the expedited team would pay for the cost of staff by saving county dollars in reduced inpatient and service costs. This expedited benefits process enhances the county's ability to obtain federal matching dollars for mental health services.

For many people, Medi-Cal billing is seen as a "medical model" that does not promote wellness and recovery. The State has recently adopted a new State Plan Amendment which expanded the definition of many of the Medi-Cal reimbursable services to include wellness and recovery services. This development enhanced staff's ability to bill for services to support a person's functioning and recovery; it also helps programs obtain federal reimbursement and sustain these important outpatient programs.

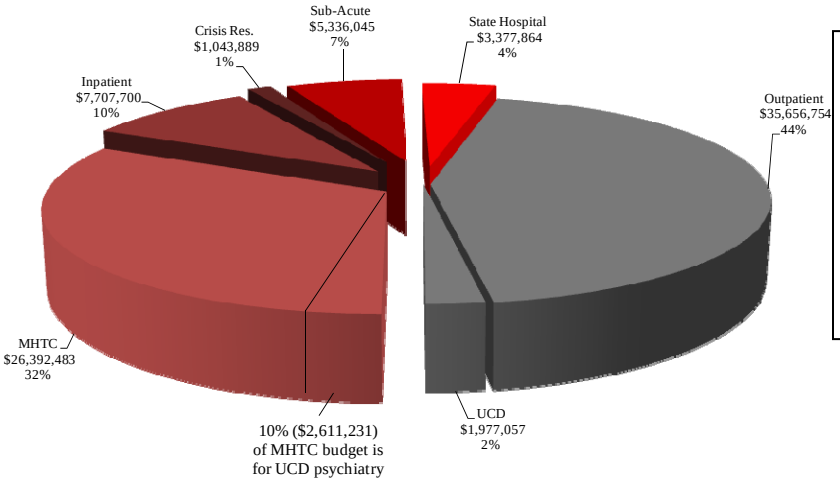
Promising Practice: El Hogar – Guest House. Guest House has developed an expedited benefits approval process to help an individual apply for benefits. This process utilizes a four-person team, which includes a physician and nurse, to conduct the required physical and complete the needed medical examination and paperwork to start the Medi-Cal application process. The team also includes a case manager to assist the individual in getting all official documents needed to complete the application (e.g., social security number, residence, proof of identity). Often, persons who are homeless do not have these personal identification documents and the case manager has to help locate these official documents.

There is also an eligibility worker on the team from the Department of Human Assistance. The eligibility worker assists the individual and team to complete the needed documents, helps complete the online application, and expedites the processing and approval of the application over the next week. The Guest House team takes pride in this expedited process, which typically

takes 10- 30 days, rather than the traditional 3-6 months, or longer. This expedited process is an exemplary program which would be useful across the county. There is a high need for similar programs.

Recommendation: Maximize billing for services that are eligible for Medi-Cal reimbursement. Program and county quality management staff begin or continue to monitor the percent of Medi-Cal services billed on a monthly basis. In addition to tracking staff productivity (the amount of time staff spend delivering Medi-Cal eligible services), programs also track the percent of services provided that are eligible for Medi-Cal reimbursement. Staff billing practices need to be reviewed during supervision to make sure that they understand the types of services that can be billed to Medi-Cal. County Utilization Review staff continue to provide training to programs on ways to document services that are wellness-focused and eligible for Medi-Cal reimbursement.

CHAPTER 2.1: ADULT CRISIS RESIDENTIAL, INPATIENT, & SUB-ACUTE RESIDENTIAL SERVICES



Crisis Residential, Inpatient, and Sub-acute Component

CY 2010 Budget: $43,857,981 (54%)

Overview of Higher Levels of Care

In addition to outpatient services, the adult mental health system in Sacramento County also has an array of services for higher levels of care. The county has a 12-bed Medi-Cal crisis residential program that is an alternative to hospitalization and operated by Turning Point; a Medi-Cal psychiatric health facility (PHF) operated by Crestwood (12 beds); three private hospitals (Heritage Oaks, Sierra Vista, and the Sutter Center for Psychiatry) that offer psychiatric inpatient services; and the Sacramento County Mental Health Treatment Center (50 beds).

There are also a number of sub-acute residential treatment settings, including transitional residential, neurobehavioral, skilled nursing facilities (SNFs), mental health rehabilitation centers (MHRCs), and the State Hospital. Each of these higher levels of care will be described along with their role in the delivery of services for persons with a serious mental illness.

Crisis Residential Services

The Turning Point Crisis Residential program provides a valuable service within the full array of mental health services. Crisis residential services provide an alternative to outpatient services and potentially address and treat crises to prevent inpatient care. These services are used as a "step down" from an inpatient facility, when an individual needs supportive services to continue to improve their level of functioning. Crisis residential services are eligible for Medi-Cal reimbursement, which makes this program very cost-effective.

Referrals come to the Turning Point Crisis Residential program from other programs, including private hospitals, Crestwood PHF, and the MHTC. Turning Point Crisis Residential determines who will be admitted into their program. They accept both Medi-Cal and indigent clients. There are some exclusionary factors, such as convictions for drug trafficking, sexual offenses, or arson.

Residents also need to be able to manage their own health conditions. The average length of stay at Turning Point is about three weeks.

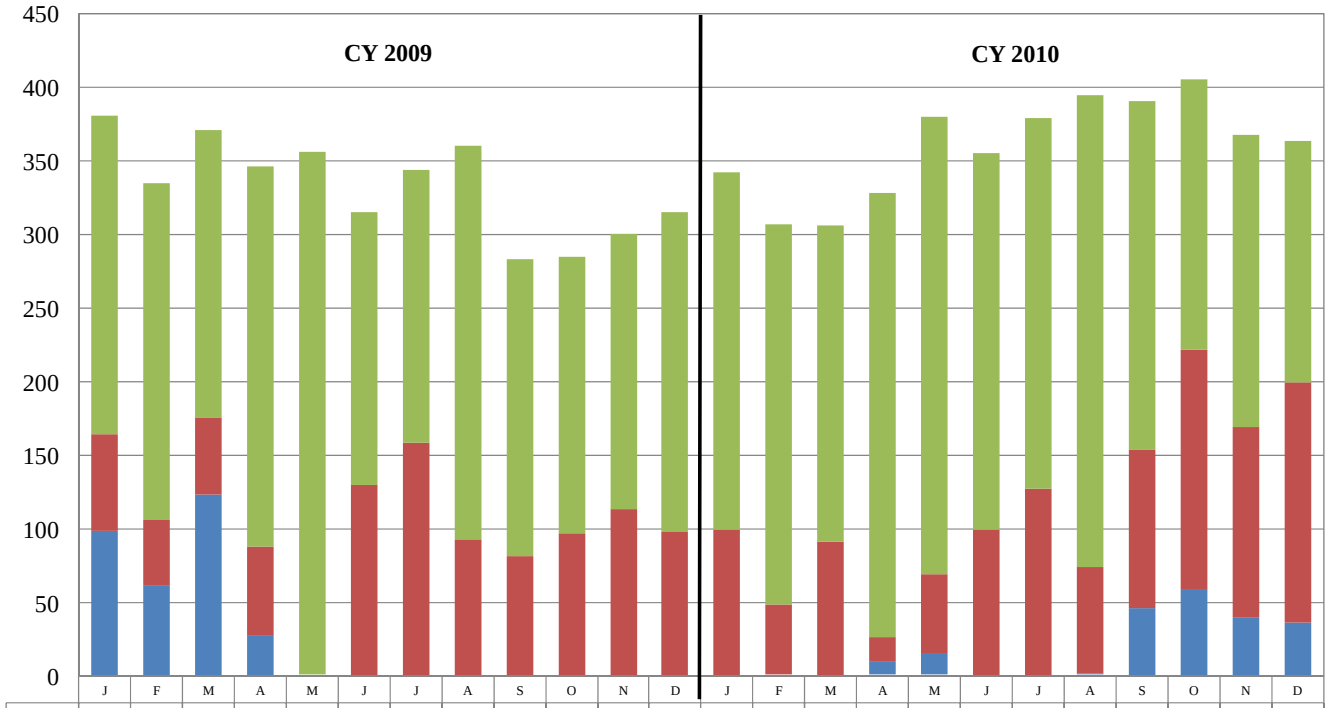
The Turning Point Crisis Residential program is located in a house in Sacramento. This means that residents live in a home-like environment and are responsible for chores as well as meal preparation. The focus of services is to help people gain more stability in their lives. Staff assist clients with signing up for benefits and accessing other community services. If clients are homeless, Guest House can assist them in finding housing.

The service delivery process begins with an in-depth clinical assessment and development of a specific service plan. Because the services are time-limited, staff work with clients on developing very specific and achievable goals. They also focus on developing specific crisis plans and run Wellness Recovery Action Plan (WRAP) groups. In the service planning process, there is a strong emphasis on what the client wants. The result is client-driven plans, with goals and steps that are relevant to what the client wants to achieve in their lives. Individuals are able to develop the skills and strategies to resolve crisis situations as quickly as possible. This service planning process could serve as a model for the rest of the adult mental health system.

Staff at Turning Point Crisis Residential are very warm and welcoming and provide supportive quality services to this high-need population. The Review Team was very impressed with the quality of the crisis residential services that have a wellness and recovery focus. Persons with lived experience work effectively at the crisis residential program. In addition, clients who have graduated from the program are welcome to come back and participate in groups and activities, serving as models of success for those in the programs. This strategy helps clients develop skills that they can use when they are discharged into the community.

Figure 31 shows data for the Turning Point Crisis Residential program for two calendar years (CY 2009 and CY 2010). As noted above, this program is eligible for Medi-Cal reimbursement. The county primarily refers clients with Medi-Cal to the facility in order to maximize the federal reimbursement.

Figure 31
Adult Crisis Residential Services
Total Days of Crisis Residential Services by Month and Funding Source
CY 2009 and CY 2010
Turning Point Crisis Residential



	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D
Total	380	334	370	345	355	314	343	359	282	284	300	314	341	306	305	327	379	354	378	394	390	405	367	363
MC	216	229	195	258	355	185	185	267	201	188	187	217	242	258	214	301	311	255	251	321	237	184	198	164
Non-MC	66	44	52	60	-	129	158	92	81	96	113	97	99	48	91	17	54	99	127	72	107	163	130	163
Unk	98	61	123	27	-	-	-	-	-	-	-	-	-	-	-	9	14	-	-	1	46	58	39	36
%MC	56.8%	68.6%	52.7%	74.8%	100.0%	58.9%	53.9%	74.4%	71.3%	66.2%	62.3%	69.1%	71.0%	84.3%	70.2%	92.0%	82.1%	72.0%	66.4%	81.5%	60.8%	45.4%	54.0%	45.2%

Inpatient Services

Historical Overview

Psychiatric inpatient services have had a significant impact on the Sacramento County mental health system for over 20 years. During most of this time, the county MHTC has been the primary provider for all county clients who need psychiatric inpatient services. The MHTC has always had an important role as the primary inpatient resource in the county. While the MHTC qualifies as a psychiatric health facilities (PHF), it is not eligible for Medi-Cal reimbursement because it has a capacity of 50 beds. Medi-Cal requires that stand-alone PHFs must be 16 beds or fewer.

The three local hospitals that contract with the county to provide psychiatric inpatient services are also not eligible for Medi-Cal reimbursement, except for children/youth under the age of 21 and persons age 65 and older.

In addition to the MHTC, the county also ran a Crisis Stabilization Unit (CSU), at the same location, until 2009. The CSU played an important role in the continuum of mental health services in Sacramento County. It provided a safe, expert setting for law enforcement to bring people in crisis in for an evaluation and linkage to the appropriate level of service. The CSU was licensed as a 23-hour service designed to de-escalate people in crisis and provide a few hours to evaluate the need for ongoing psychiatric inpatient services. The CSU was eligible to receive Medi-Cal reimbursement and delivered over 9,000 crisis stabilization services per year.

In 2009, as a result of budget cuts, the county closed the CSU and reduced the number of beds at the MHTC from 100 to 50. The county initiated discussions with the private hospitals about the feasibility of the private hospitals paying for some of the costs of the crisis stabilization services or developing alternative inpatient services.

During this time, State Senator Darrell Steinberg's office was contacted by community advocates. His office set up meetings with county providers, advocates, and the hospitals, leading to the development of a process coordinated by the local Hospital Council. Three workgroups were developed to review the crisis response system and the continuum of care. These groups developed a series of recommendations in July 2010.

The county also began negotiations with Heritage Oaks and Sierra Vista regarding payment for services for Medi-Cal clients. As a result of these negotiations, the county agreed to pay the providers, including the Sutter Center for Psychiatry, $950 per day for inpatient services delivered to Medi-Cal clients. The hospitals agreed to serve persons who were indigent and needed psychiatric hospitalization, at no charge. The three hospital contracts were implemented in August 2010.

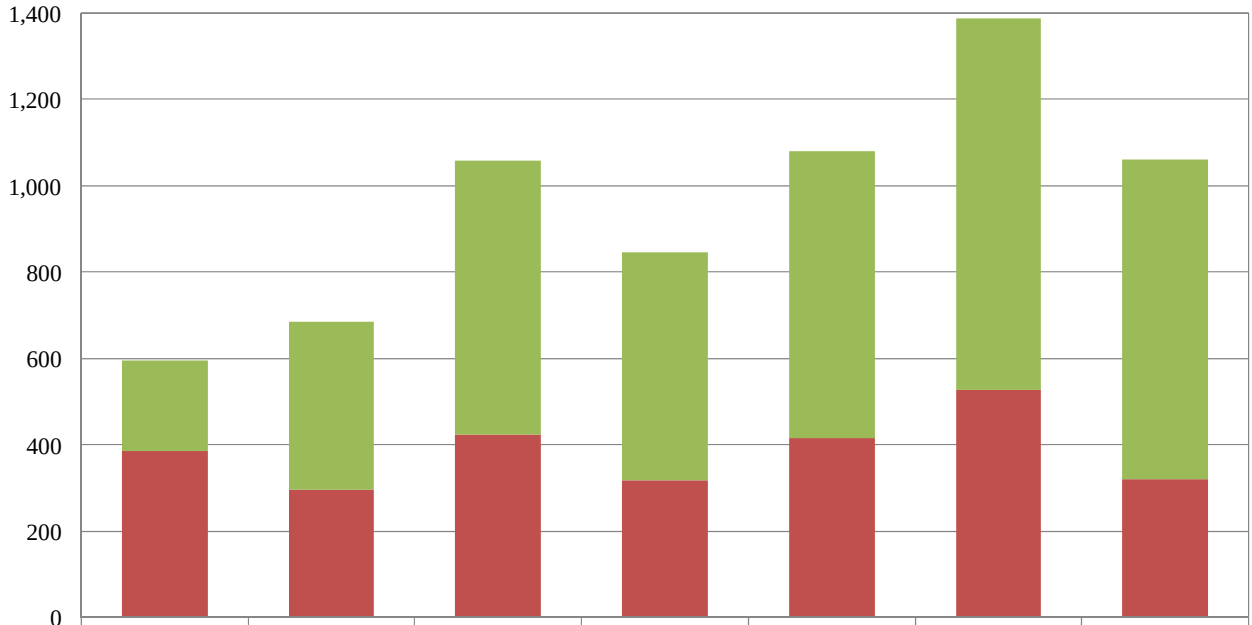
The contracts with the private hospitals created additional inpatient resources in the county. However, none of the three hospitals meet the requirements to be eligible for Medi-Cal reimbursement. As a result, the county pays all costs associated with these Medi-Cal bed days, except for adults in Medi-Cal who are 18-21 years of age, or 65 and older.

Hospital Inpatient Providers

Data for the three psychiatric inpatient facilities will be discussed, followed by a discussion of the MHTC service utilization patterns.

Figure 32 shows the total days of inpatient services combined across the three private hospitals between August 2010 and February 2011. Please note that August 2010 is not a full month of data, since the contract started mid-month. Across the three hospitals, the total days of inpatient services increased from 595 days in August 2010 to a high of 1,386 in January 2011. The proportion of days used by Medi-Cal clients also increased. The proportion of Medi-Cal days was 35.5% in August 2010 and increased to 69.8% in February 2011. The hospitals are only paid for bed days used by Medi-Cal clients.

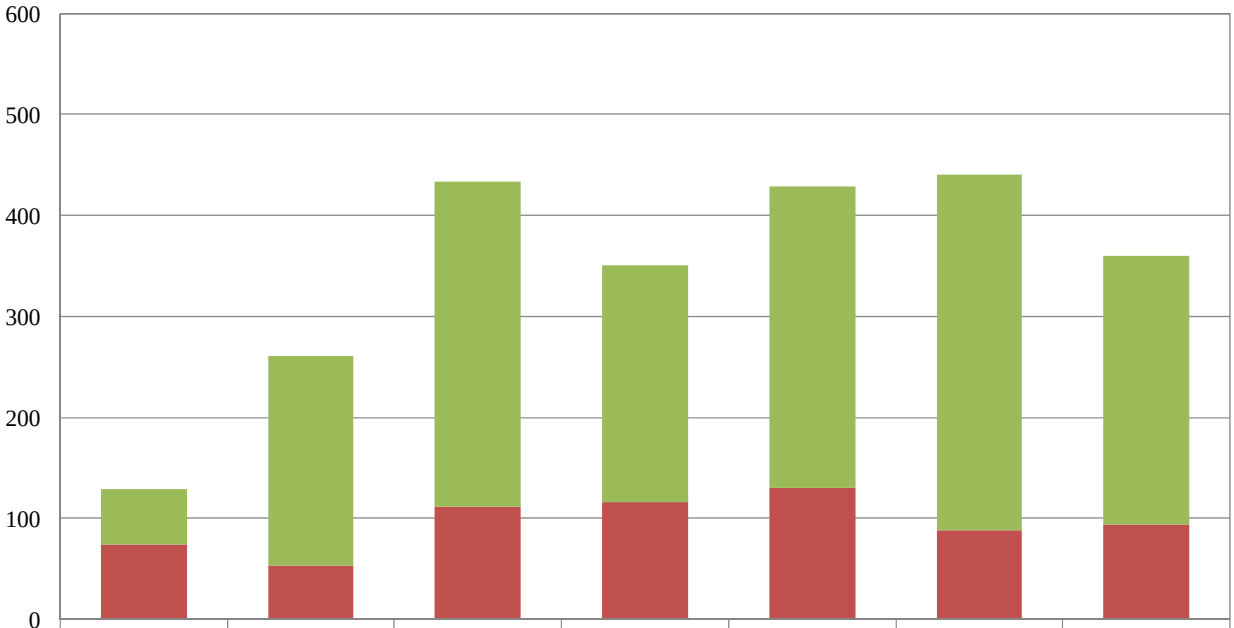
Figure 32
Adult Inpatient Services
Total Days of Inpatient Services by Month and Funding Source
August 2010 through February 2011
Heritage Oaks, Sierra Vista, and Sutter Combined
(Medi-Cal Data from AVATAR, Non Medi-Cal Data from County Private Hospital Files)



	Aug. 10	Sep. 10	Oct. 10	Nov. 10	Dec. 10	Jan. 11	Feb. 11
Total	595	684	1,057	844	1,078	1,386	1,060
MC	211	390	635	528	664	860	740
Non-MC	384	294	422	316	414	526	320
% MC	35.5%	57.0%	60.1%	62.6%	61.6%	62.0%	69.8%

The same data is shown for each of the three private hospitals individually. Figure 33 shows the data for Heritage Oaks. Beginning in September 2010, Heritage Oaks primarily served clients with Medi-Cal, with 67% – 80% of the bed days utilized by clients with Medi-Cal.

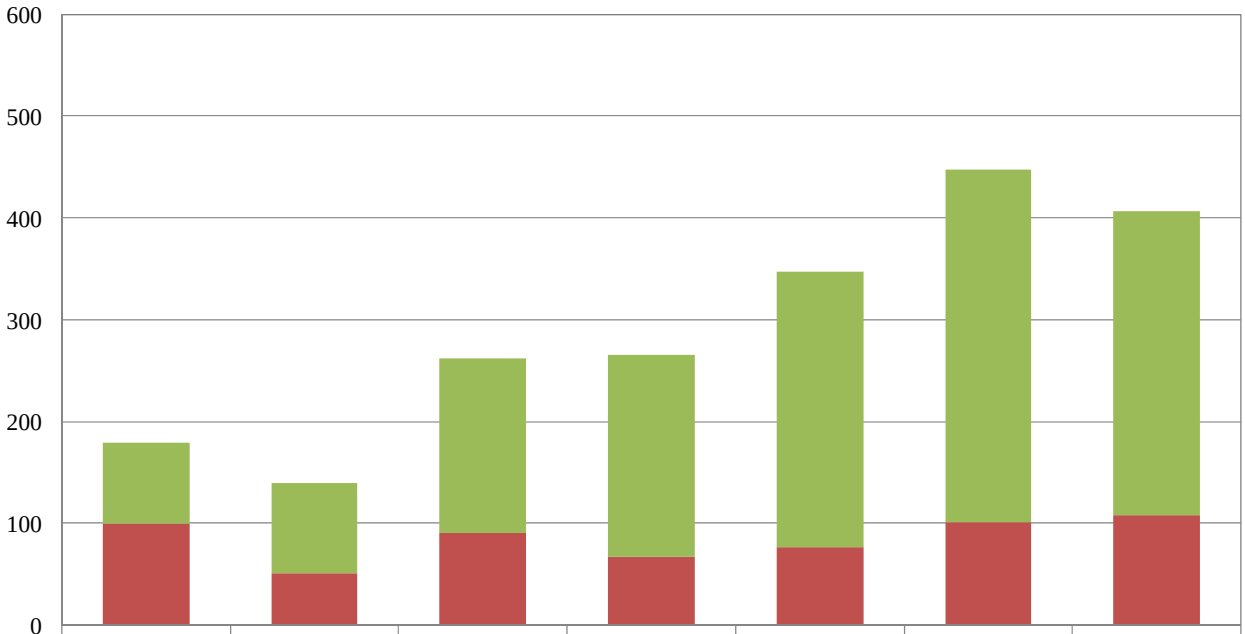
Figure 33
Adult Inpatient Services
Total Days of Inpatient Services by Month and Funding Source
August 2010 through February 2011
Heritage Oaks
(Medi-Cal Data from AVATAR, Non Medi-Cal Data from County Private Hospital Files)



	Aug. 10	Sep. 10	Oct. 10	Nov. 10	Dec. 10	Jan. 11	Feb. 11
Total	129	260	433	350	428	440	359
MC	55	208	322	235	298	352	266
Non-MC	74	52	111	115	130	88	93
% MC	42.6%	80.0%	74.4%	67.1%	69.6%	80.0%	74.1%

Figure 34 shows similar data for Sierra Vista. For September 2010 through February 2011, the percentage of the bed days utilized by clients with Medi-Cal ranged between 64% and 78%.

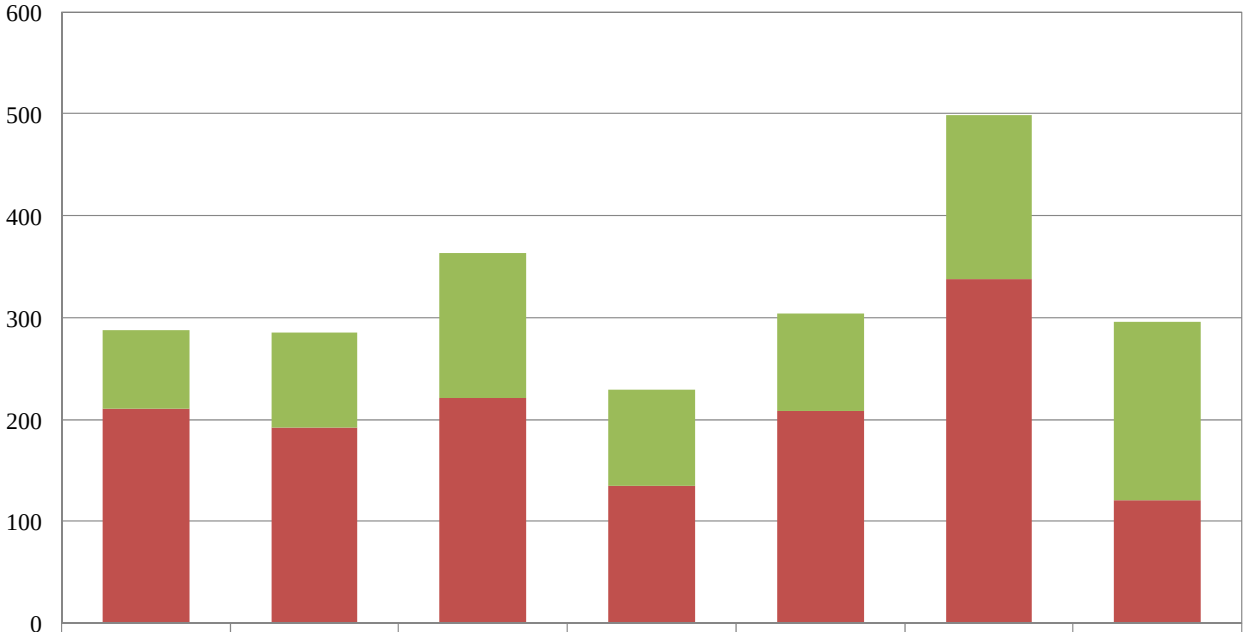
Figure 34
Adult Inpatient Services
Total Days of Inpatient Services by Month and Funding Source
August 2010 through February 2011
Sierra Vista
(Medi-Cal Data from AVATAR, Non Medi-Cal Data from County Private Hospital Files)



	Aug. 10	Sep. 10	Oct. 10	Nov. 10	Dec. 10	Jan. 11	Feb. 11
Total	179	139	261	265	346	447	406
MC	79	89	171	198	270	347	299
Non-MC	100	50	90	67	76	100	107
% MC	44.1%	64.0%	65.5%	74.7%	78.0%	77.6%	73.6%

The Sutter Center for Psychiatry served a much higher percentage of indigent clients during this seven-month time period (see Figure 35). Between September 2010 and February 2011, the proportion of bed days utilized by clients with Medi-Cal ranged from 31.6% to 59.3%.

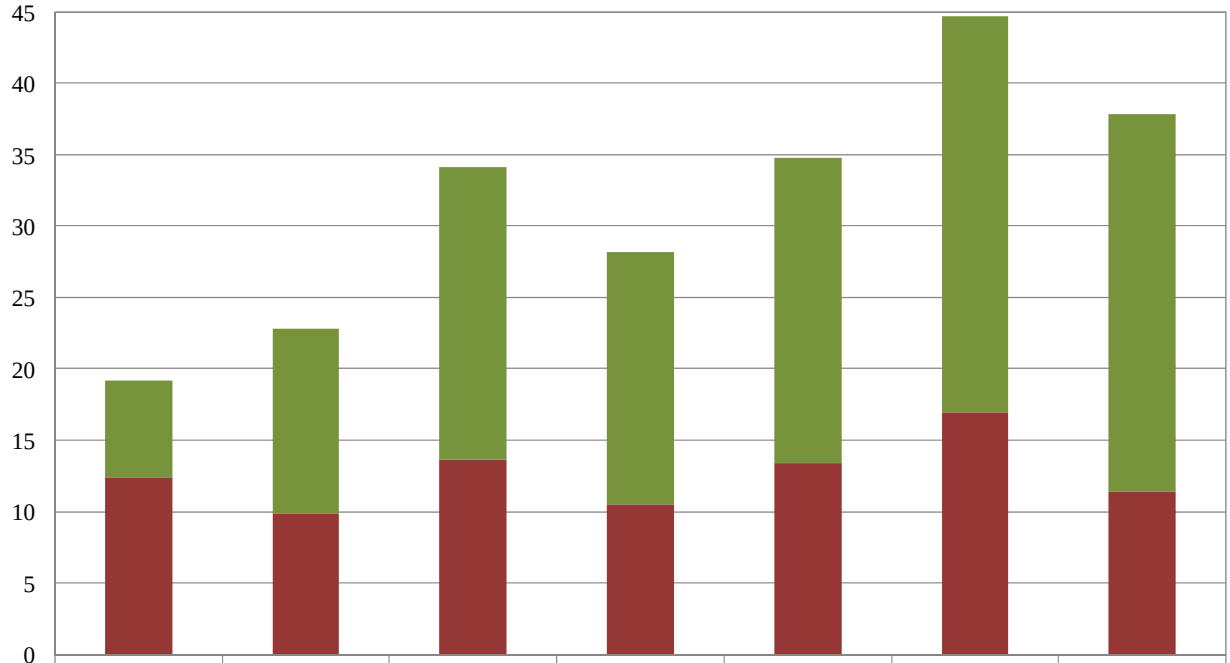
Figure 35
Adult Inpatient Services
Total Days of Inpatient Services by Month and Funding Source
August 2010 through February 2011
Sutter
(Medi-Cal Data from AVATAR, Non Medi-Cal Data from County Private Hospital Files)



	Aug. 10	Sep. 10	Oct. 10	Nov. 10	Dec. 10	Jan. 11	Feb. 11
Total	287	285	363	229	304	499	295
MC	77	93	142	95	96	161	175
Non-MC	210	192	221	134	208	338	120
% MC	26.8%	32.6%	39.1%	41.5%	31.6%	32.3%	59.3%

In addition to the total number of bed days utilized for inpatient services, the estimated number of inpatient beds used was calculated for this seven-month period, using the current utilization of services. Figure 36 shows a calculation of the total number of beds used each month, for the three psychiatric hospitals combined. This data shows that a total of 45 beds were used in January 2011, with 28 filled by clients with Medi-Cal and 17 filled by clients who were indigent. This number is calculated by dividing the total number of bed days by the number of days in each month. This information is useful for planning purposes, and shows the number of psychiatric inpatient beds needed in the community by funding source.

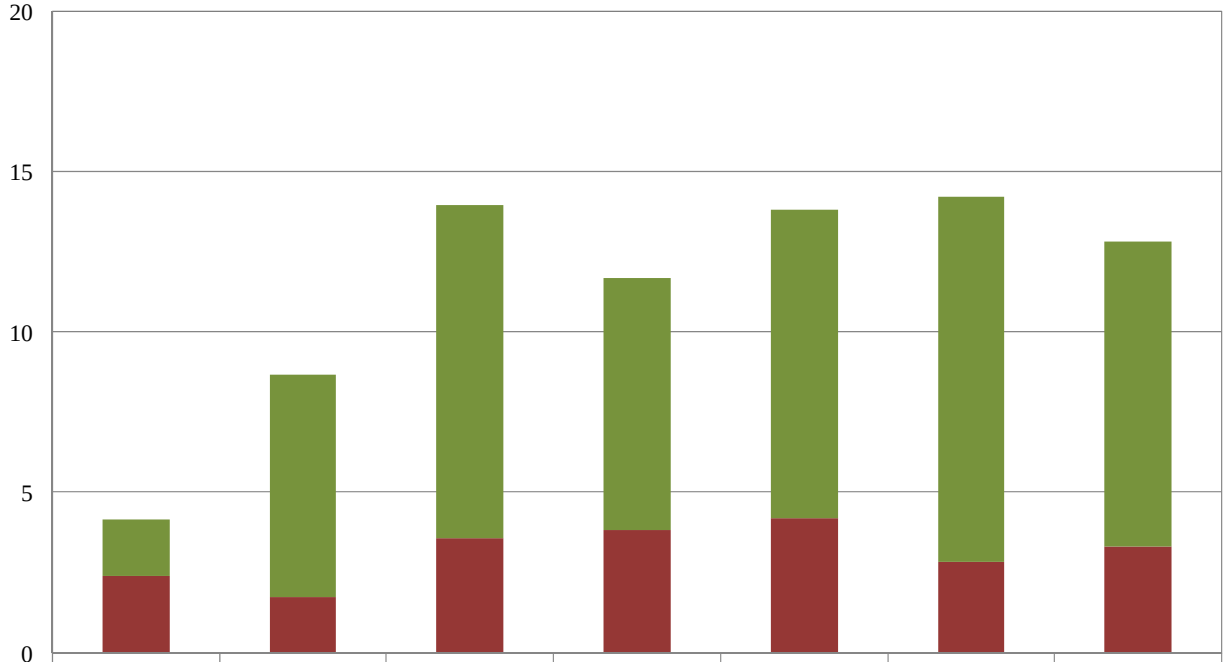
Figure 36
Adult Inpatient Services
Number of Beds Utilized for Inpatient Services by Month and Funding Source
August 2010 through February 2011
Heritage Oaks, Sierra Vista, and Sutter Combined
(Medi-Cal Data from AVATAR, Non Medi-Cal Data from County Private Hospital Files)



	Aug. 10	Sep. 10	Oct. 10	Nov. 10	Dec. 10	Jan. 11	Feb. 11
Total	19	23	34	28	35	45	38
MC	7	13	20	18	21	28	26
Non-MC	12	10	14	11	13	17	11

Figure 37 shows the same data for Heritage Oaks. Heritage Oaks filled about 14 beds each month. Ten of these beds were typically filled by clients with Medi-Cal.

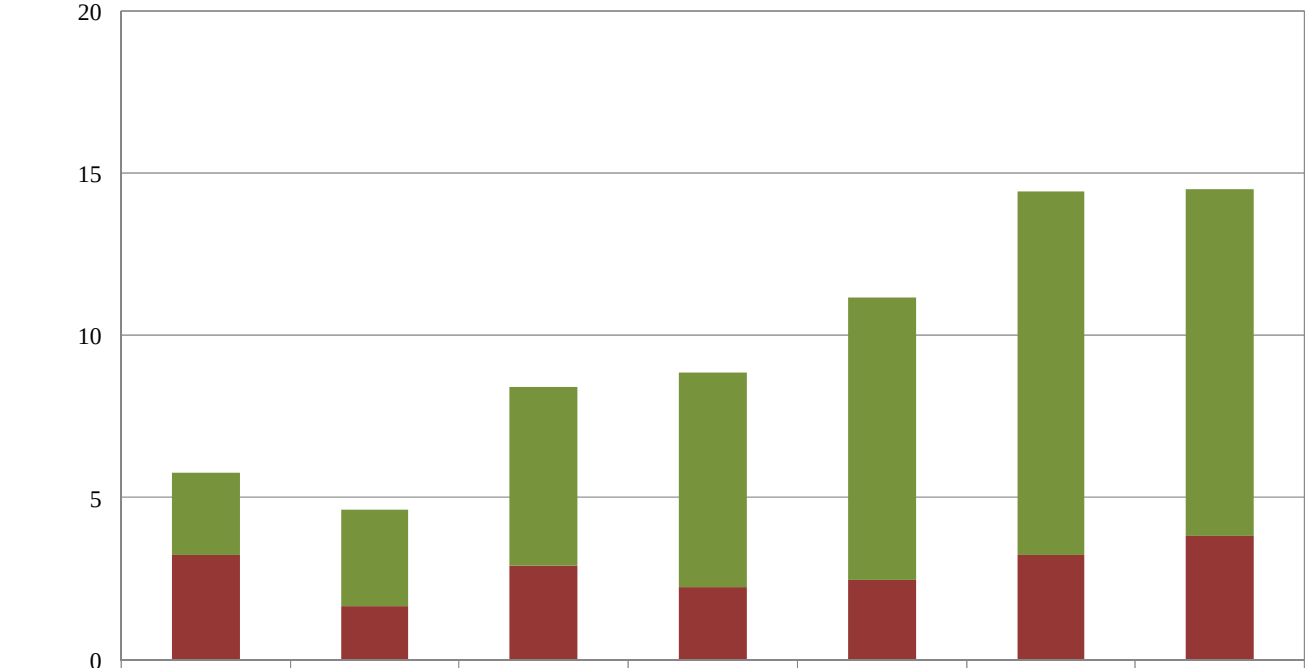
Figure 37
Adult Inpatient Services
Number of Beds Utilized for Inpatient Services by Month and Funding Source
August 2010 through February 2011
Heritage Oaks
(Medi-Cal Data from AVATAR, Non Medi-Cal Data from County Private Hospital Files)



	Aug. 10	Sep. 10	Oct. 10	Nov. 10	Dec. 10	Jan. 11	Feb. 11
Total	4	9	14	12	14	14	13
MC	2	7	10	8	10	11	10
Non-MC	2	2	4	4	4	3	3

Figure 38 shows data for Sierra Vista, which is similar to Heritage Oaks. In February 2011, Sierra Vista filled 15 beds, with 11 beds used by clients with Medi-Cal.

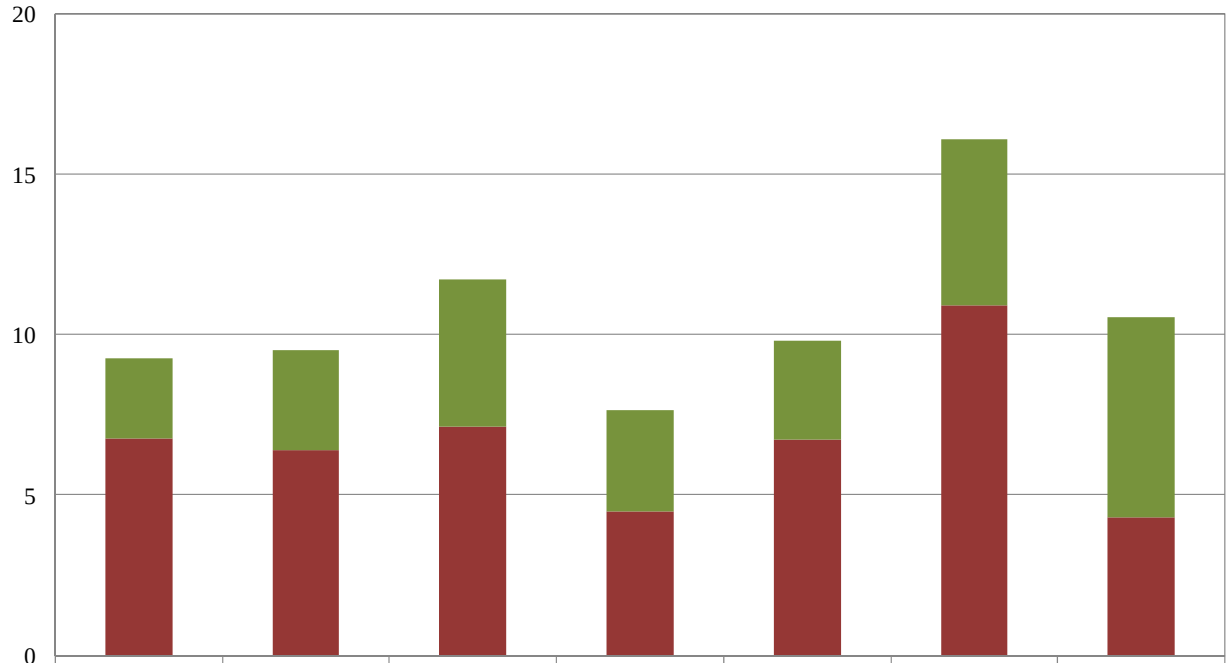
Figure 38
Adult Inpatient Services
Number of Beds Utilized for Inpatient Services by Month and Funding Source
August 2010 through February 2011
Sierra Vista
(Medi-Cal Data from AVATAR, Non Medi-Cal Data from County Private Hospital Files)



	Aug. 10	Sep. 10	Oct. 10	Nov. 10	Dec. 10	Jan. 11	Feb. 11
Total	6	5	8	9	11	14	15
MC	3	3	6	7	9	11	11
Non-MC	3	2	3	2	2	3	4

The data for Sutter Center for Psychiatry in Figure 39 shows a slightly lower number of beds used (about 10 to 12) except in January, when 16 beds were filled. For most months, 3 to 6 beds were filled by clients with Medi-Cal; the remainder was filled by persons who are indigent.

Figure 39
Adult Inpatient Services
Number of Beds Utilized for Inpatient Services by Month and Funding Source
August 2010 through February 2011
Sutter
(Medi-Cal Data from AVATAR, Non Medi-Cal Data from County Private Hospital Files)

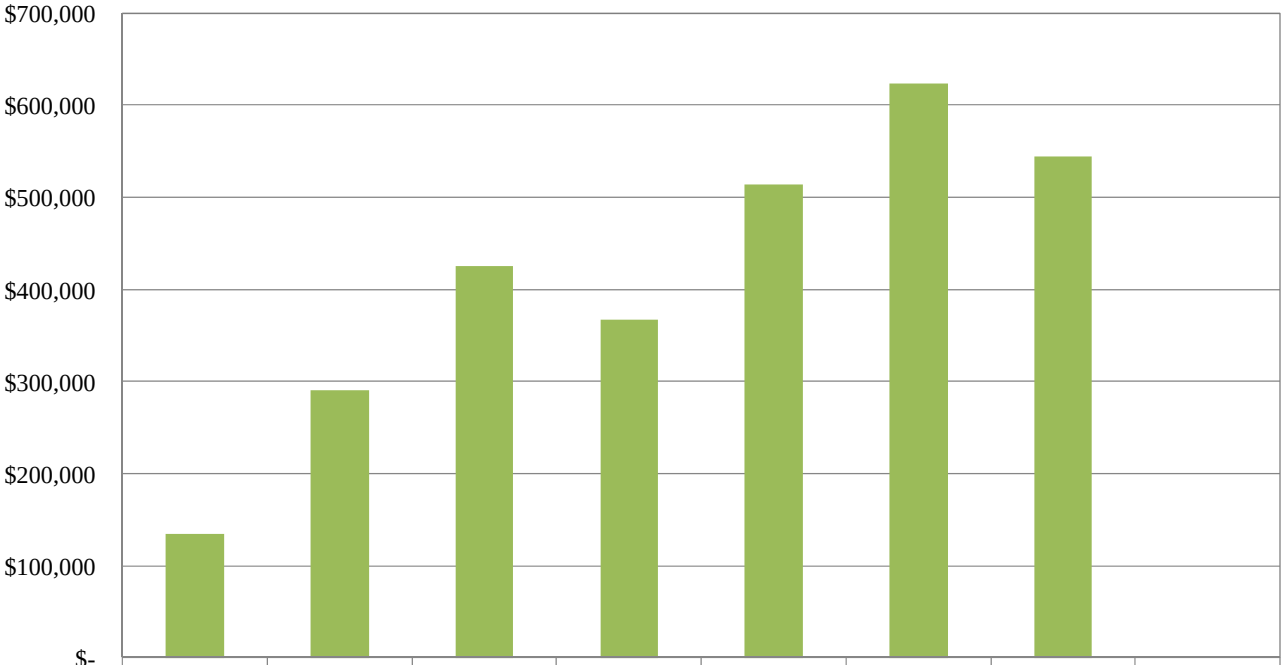


	Aug. 10	Sep. 10	Oct. 10	Nov. 10	Dec. 10	Jan. 11	Feb. 11
Total	9	10	12	8	10	16	11
MC	2	3	5	3	3	5	6
Non-MC	7	6	7	4	7	11	4

The cost of the Medi-Cal bed days across the three hospitals is shown in Figure 40. Of the 4,028 bed days utilized by Medi-Cal clients, the county paid a total of $2,899,400. Note: This data shows actual paid costs. Some of the days were not paid at the full $950 rate because they were considered "administrative days," which means that the individual was no longer acute, but was waiting for placement in the community. These three hospitals are not eligible for Medi-Cal reimbursement, except for adults, ages 18-21, and 65 and older. The county paid all of these costs. If these Medi-Cal bed days met medical necessity and were reimbursed by Medi-Cal, these costs would be reduced.

Based on current State Maximum Allowance rates, the county is reimbursed $298.94 for each Medi-Cal eligible acute psychiatric bed day provided in a Medi-Cal eligible psychiatric health facility. Changes in the reimbursement structure are pending per the State Plan Amendment fiscal provisions.

Figure 40
Adult Inpatient Services
Costs Paid for Inpatient Services by Month
August 2010 through February 2011
Heritage Oaks, Sierra Vista, and Sutter
(Data from Hospital Invoices)



	Aug. 10	Sep. 10	Oct. 10	Nov. 10	Dec. 10	Jan. 11	Feb. 11	Total Aug. 10 - Feb. 11
MC Bed Days	211	390	635	528	664	860	740	4,028
$ Costs	$134,900	$290,700	$424,650	$366,700	$513,950	$624,150	$544,350	$2,899,400

Mental Health Treatment Center

In addition to the three private psychiatric hospitals, the MHTC also provides psychiatric inpatient services. While the MHTC is classified as a PHF, it is unable to receive Medi-Cal reimbursement because it has more than 16 beds. Figure 41 shows the total days of inpatient services by month and funding source, between January 2009 and December 2010. The MHTC closed 50 of the 100 beds in October 2009. This data also shows the proportion of bed days with Medi-Cal clients ranged from 72% to 94.4%.

Figure 41
Adult Inpatient Services
Total Days of Inpatient Services by Month and Funding Source
CY 2009 and CY 2010
Mental Health Treatment Center (Total CY 2010 Budget = $26,392,483)
(Data from AVATAR)

	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D
Total	3,000	2,697	3,065	3,046	2,981	2,570	2,689	2,534	1,902	1,494	1,488	1,543	1,542	1,386	1,522	1,414	1,516	1,474	1,504	1,516	1,423	1,499	1,449	1,499
MC	2,352	2,118	2,326	2,547	2,452	2,145	2,159	2,117	1,695	1,288	1,293	1,409	1,368	1,308	1,334	1,234	1,273	1,239	1,127	1,275	1,136	1,110	1,044	1,079
Non-MC	192	192	300	283	486	425	530	417	207	206	195	134	174	78	188	180	243	235	377	241	287	389	405	420
Unk	456	387	439	216	43	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
%MC	78.4%	78.5%	75.9%	83.6%	82.3%	83.5%	80.3%	83.5%	89.1%	86.2%	86.9%	91.3%	88.7%	94.4%	87.6%	87.3%	84.0%	84.1%	74.9%	84.1%	79.8%	74.0%	72.0%	72.0%

This data also shows that the MHTC is at capacity each month. The Intake Team at the MHTC utilizes clinical staff to review all referrals from the Emergency Departments, sub-acute providers, County Jail, County Conservator Office, and private hospitals. As soon as a bed is available at the MHTC, first priority is given to conservatees, sub-acute care providers, and the County Jail. These referrals are relatively small in comparison to the majority of admissions to the MHTC, which come from the Emergency Departments. When a bed is available at the MHTC and no referrals are being made from the above sources, the MHTC consults with the

private hospitals and accepts transfers from those facilities. This strategy helps reduce the cost of the private psychiatric hospitals.

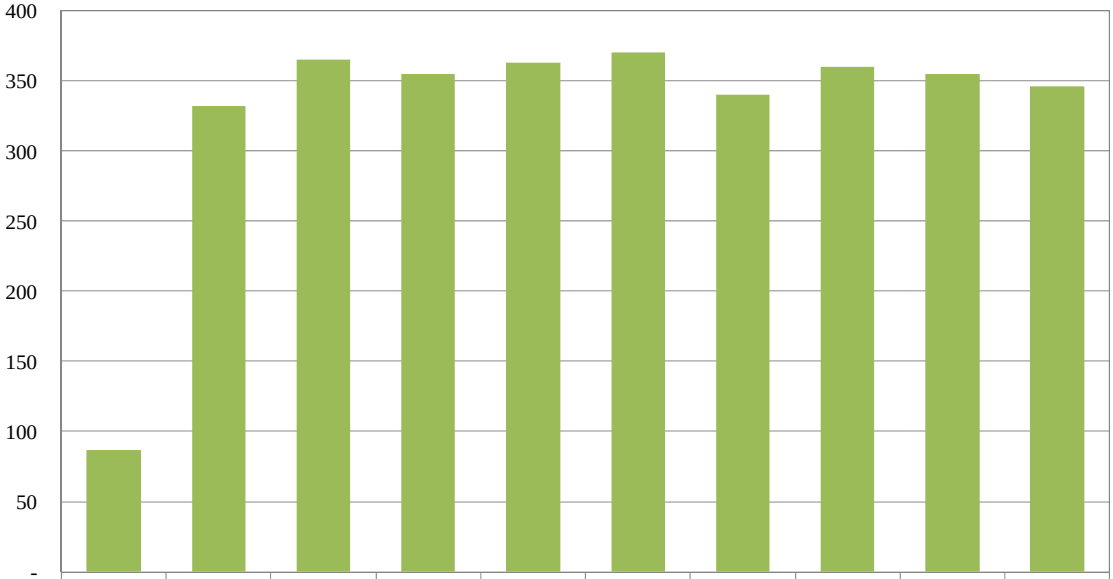
As an estimate, the CY 2010 budget for the MHTC was $26,392,483. It is important to note that this budget amount also includes costs for additional services offered by the MHTC staff. These services include the Child Crisis Unit, the Intake Support Unit, physical plant, and after-hours response services. The MHTC budget also includes costs to pay for any out-of-county hospitalizations for persons who are Sacramento County residents but are hospitalized when they are traveling outside of the county (e.g., when visiting a friend in LA County). In addition, approximately 10% of the MHTC budget is allocated to UC Davis to pay for psychiatry services ($2,611,231).

Psychiatric Health Facilities (PHF)

Psychiatric Health Facilities (PHF) are the one type of acute psychiatric inpatient services that can be certified by Medi-Cal and can receive federal reimbursement. There are several PHFs in the county, including the MHTC. At the present time, there is only one PHF in Sacramento County that is eligible for Medi-Cal reimbursement; this facility is operated by Crestwood and has 12 beds. This PHF is certified by Medi-Cal, so the county primarily utilizes this facility for persons who are Medi-Cal eligible. This strategy helps to maximize federal revenue. The Crestwood PHF is an important component of the continuum of inpatient services because it is a very cost-effective program. The day rate is lower for this facility; the ability to draw down Medi-Cal reimbursement makes it a cost-effective option.

Figure 42 shows the total days of inpatient services for the Crestwood PHF. The program is always at full capacity and only clients with Medi-Cal are referred to the program. The MHTC staff help facilitate this program to ensure that it is used to its full capacity.

Figure 42
Adult Inpatient Services
Total Days of Inpatient Services by Month and Funding Source
March 2010 through December 2010
Crestwood PHF



	Mar. 10	Apr. 10	May 10	Jun. 10	Jul. 10	Aug. 10	Sept. 10	Oct. 10	Nov. 10	Dec. 10
Total	87	332	365	355	363	370	340	360	355	346
MC	87	332	365	355	363	370	340	360	355	346
Non-MC	-	-	-	-	-	-	-	-	-	-

Sub-Acute Residential Services

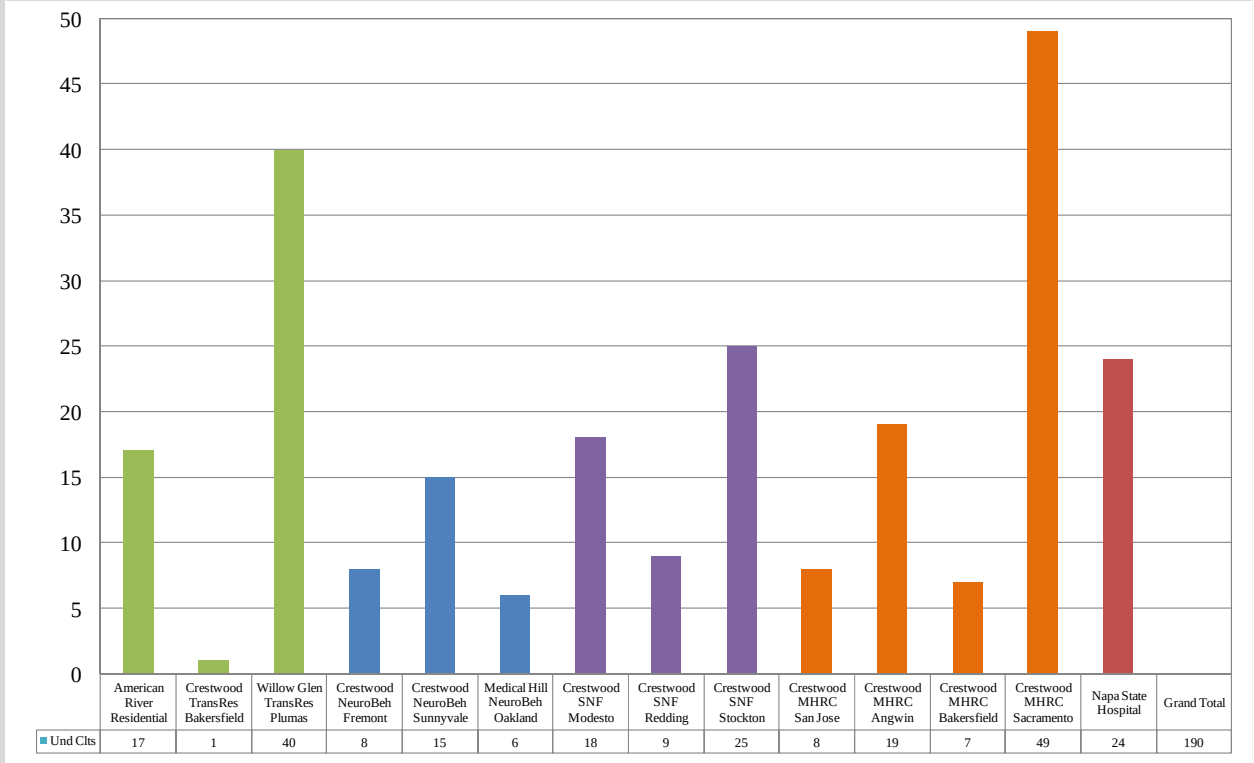
In addition to psychiatric inpatient services, there are other sub-acute residential services for persons who are seriously mentally ill. These sub-acute residential services includes a number of different service settings, including transitional residential, neurobehavioral, skilled nursing facilities, mental health rehabilitation centers (MHRC), and the State Hospital. The majority of these facilities are only allowed to bill Medi-Cal for individuals under the age of 21 and 65 and older. All of these facilities offer a WRAP program.

Figure 43 (next page) shows the unduplicated number of clients (N=190) in different residential settings in CY 2010. The residential programs on the left (green) show the community-based adult transitional residential programs that provide a supported living setting for persons who need ongoing daily supportive services. The three neurobehavioral programs (blue) provide long-term care to individuals diagnosed with an organic brain disease, including dementia. They also provide specialized neurobehavioral programs for persons with severe neurological problems, including Huntington's Chorea, traumatic brain injury, etc.

The Skilled Nursing Facilities (SNF) (purple) provide behavioral interventions in a secure residential setting. Services include behavior modification, skilling nursing, prevocational and life skills training, and rehabilitation. The Mental Health Rehabilitation Centers (MHRC) (orange) provide psychosocial rehabilitation programs in secure residential settings. Services include behavioral interventions, vocational training, self-advocacy, peer counseling, and case management.

The State Hospital on the right (red) provides intensive, 24-hour support in a locked setting (Crestwood MHRC and Napa State Hospital).

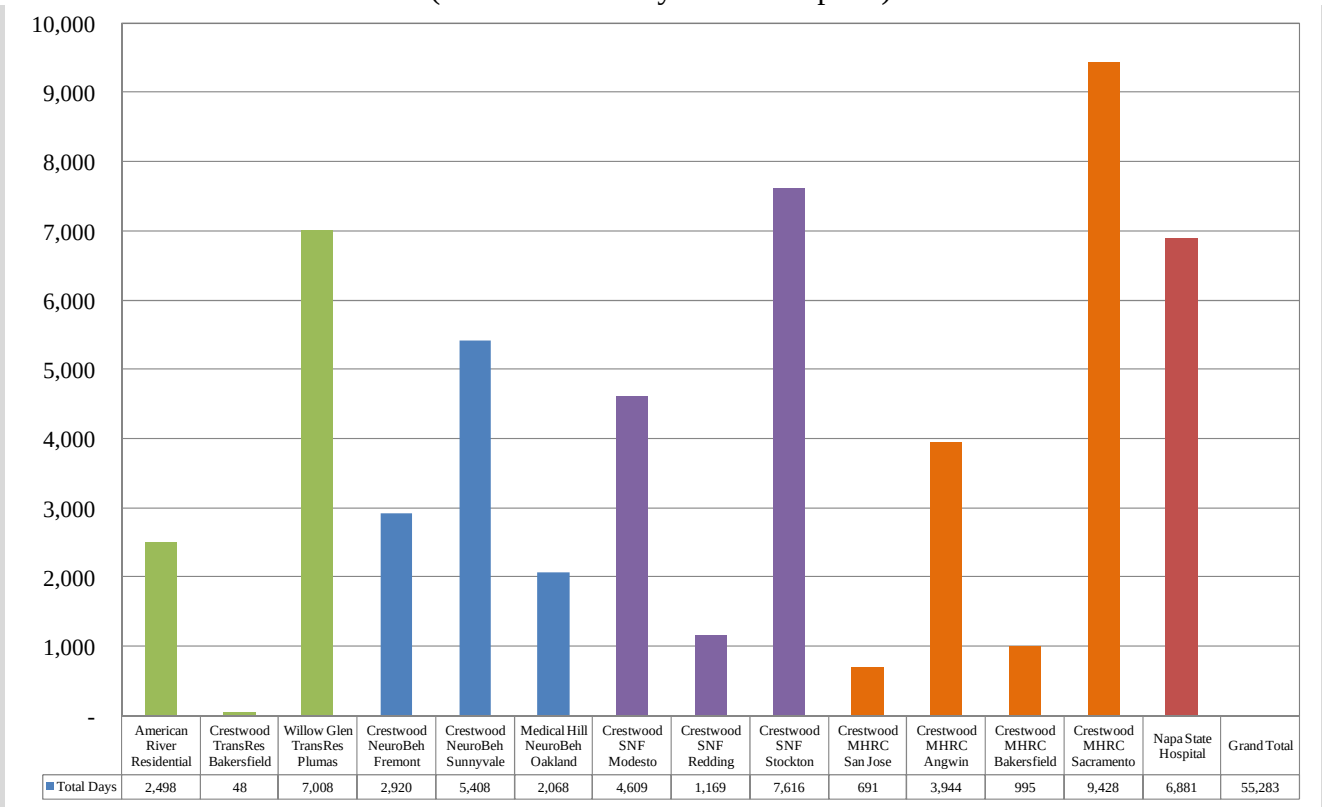
Figure 43
Residential and Locked Psychiatric Facilities
Unduplicated Sacramento County Clients by Facility
CY 2010
(Data from County Census Reports)



	American River Residential	Crestwood TransRes Bakersfield	Willow Glen TransRes Plumas	Crestwood NeuroBeh Fremont	Crestwood NeuroBeh Sunnyvale	Medical Hill NeuroBeh Oakland	Crestwood SNF Modesto	Crestwood SNF Redding	Crestwood SNF Stockton	Crestwood MHRC San Jose	Crestwood MHRC Angwin	Crestwood MHRC Bakersfield	Crestwood MHRC Sacramento	Napa State Hospital	Grand Total
Und Clts	17	1	40	8	15	6	18	9	25	8	19	7	49	24	190

Figure 44 shows the total days in residential settings, by facility in CY 2010. Across all facilities, there were 55,283 bed days. The mental health rehabilitation centers (MHRC) and the state hospital delivered a total of 21,939 bed days. Nearly half of the bed days are for this level of care. While the county has actively worked to discharge clients from these higher levels of care and a number of people have been discharged from these facilities, this data shows there are more opportunities to develop more community-based services that will meet the needs of these high-need individuals. As recommended in Chapter 1, the development of Intensive Outpatient programs to support persons moving back to the community will be effective at reducing the costs associated with these sub-acute services.

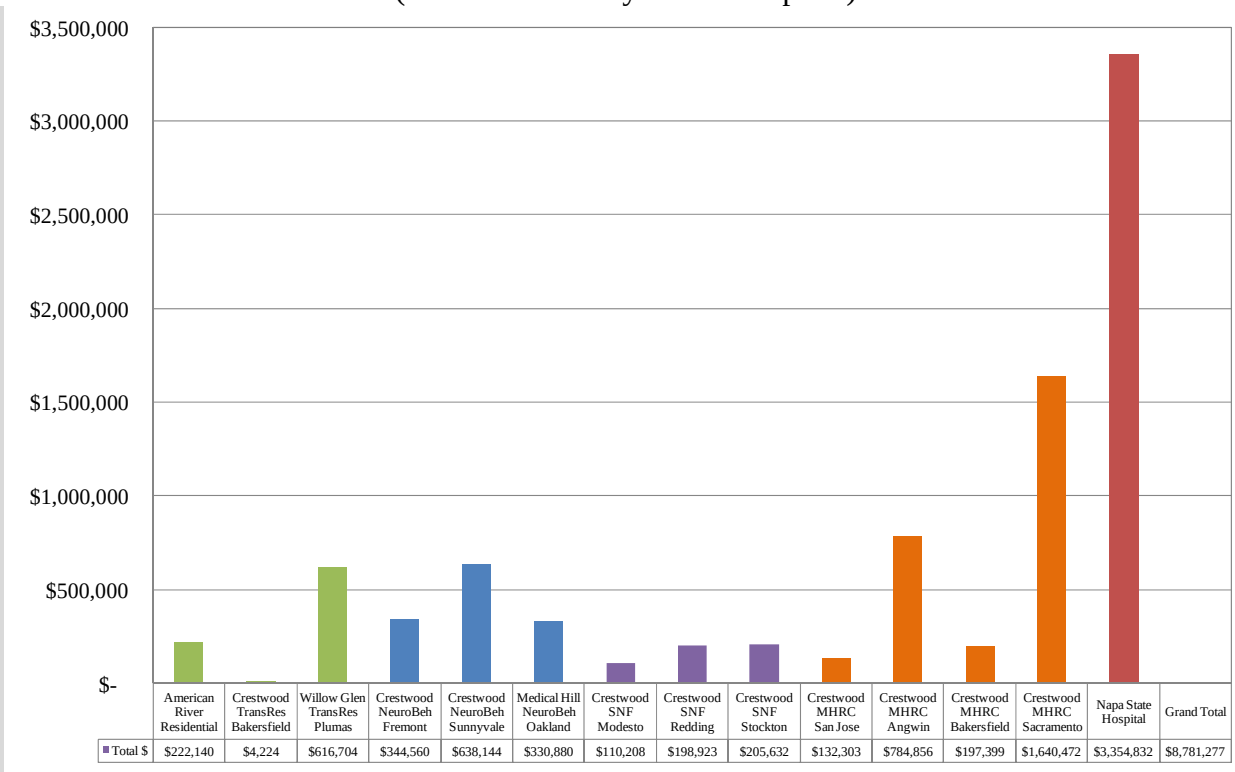
Figure 44
Residential and Locked Psychiatric Facilities
Total Days by Facility
CY 2010
(Data from County Census Reports)



	American River Residential	Crestwood TransRes Bakersfield	Willow Glen TransRes Plumas	Crestwood NeuroBeh Fremont	Crestwood NeuroBeh Sunnyvale	Medical Hill NeuroBeh Oakland	Crestwood SNF Modesto	Crestwood SNF Redding	Crestwood SNF Stockton	Crestwood MHRC San Jose	Crestwood MHRC Angwin	Crestwood MHRC Bakersfield	Crestwood MHRC Sacramento	Napa State Hospital	Grand Total
Total Days	2,498	48	7,008	2,920	5,408	2,068	4,609	1,169	7,616	691	3,944	995	9,428	6,881	55,283

The total cost to Sacramento County for these residential or locked psychiatric facilities was $8,781,277 in CY 2010 (see figure 45). Napa State Hospital was the highest cost to the county, at $3,354,832. The combined cost of the four Crestwood MHRCs was $2,755,030. Any reduction in these costs can be used to develop more effective intensive outpatient services, as described in Chapter 1 of this Report. These intensive outpatient services will help keep the funds in the county, to support community-based services.

Figure 45
Residential and Locked Psychiatric Facilities
Total Costs by Facility (only county share)
CY 2010
(Data from County Census Reports)

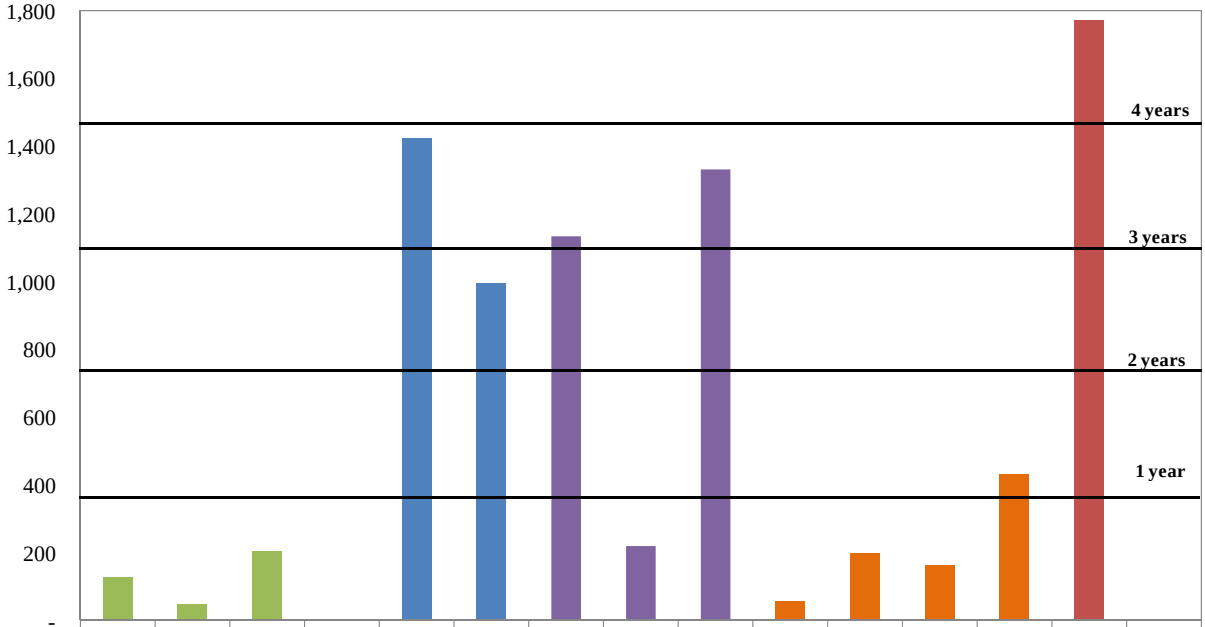


	American River Residential	Crestwood TransRes Bakersfield	Willow Glen TransRes Plumas	Crestwood NeuroBeh Fremont	Crestwood NeuroBeh Sunnyvale	Medical Hill NeuroBeh Oakland	Crestwood SNF Modesto	Crestwood SNF Redding	Crestwood SNF Stockton	Crestwood MHRC San Jose	Crestwood MHRC Angwin	Crestwood MHRC Bakersfield	Crestwood MHRC Sacramento	Napa State Hospital	Grand Total
Total $	$222,140	$4,224	$616,704	$344,560	$638,144	$330,880	$110,208	$198,923	$205,632	$132,303	$784,856	$197,399	$1,640,472	$3,354,832	$8,781,277

Figure 46 shows the average length of stay (LOS) by facility, for clients who were discharged in CY 2010. There were 111 individuals discharged from these facilities in CY 2010. The state hospital had the longest LOS. There were five people discharged from the state hospital, with an average LOS of 1,771 days, or nearly 5 years.

The Crestwood MHRCs vary by the number of persons discharged and their average LOS. For the San Jose MHRC, there were 5 people discharged, with an average LOS of 57 days. For the Sacramento MHRC, there were 18 people discharged in CY 2010. The average LOS was 430 days, or slightly over 1 year.

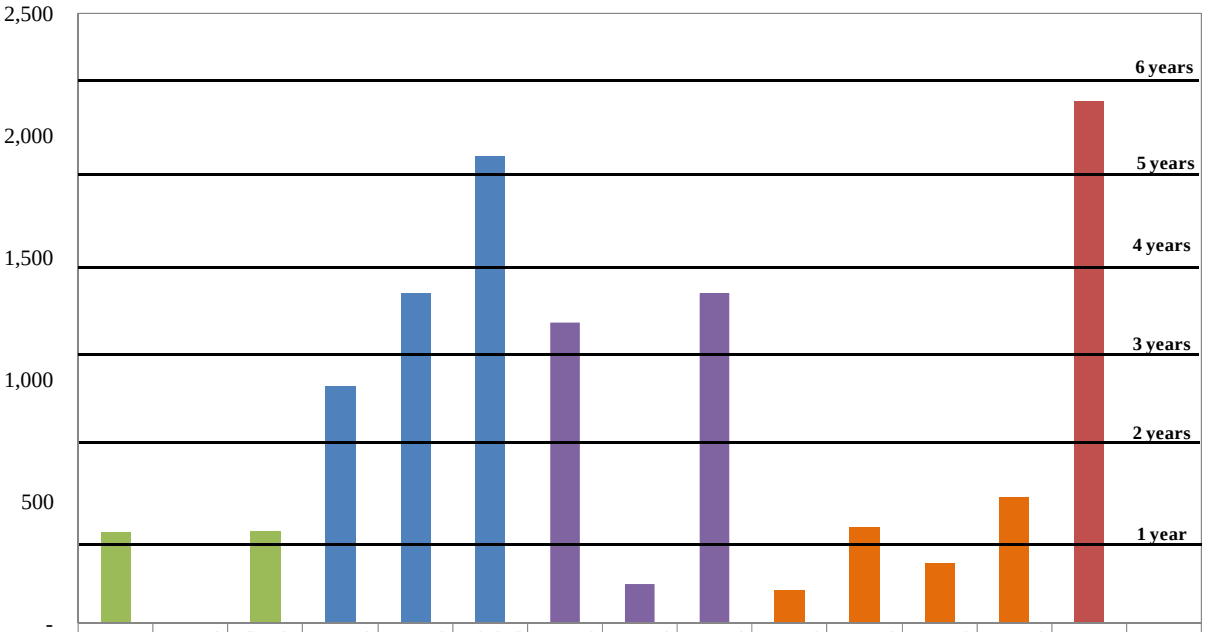
Figure 46
Residential and Locked Psychiatric Facilities
Average Length of Stay (LOS) by Facility
Only Clients Discharged in CY 2010
(Data from County Census Reports)



	American River Residential	Crestwood TransRes Bakersfield	Willow Glen TransRes Plumas	Crestwood NeuroBeh Fremont	Crestwood NeuroBeh Sunnyvale	Medical Hill NeuroBeh Oakland	Crestwood SNF Modesto	Crestwood SNF Redding	Crestwood SNF Stockton	Crestwood MHRC San Jose	Crestwood MHRC Angwin	Crestwood MHRC Bakersfield	Crestwood MHRC Sacramento	Napa State Hospital	Grand Total
Total Days	1,678	48	5,300	-	5,686	1,988	10,206	655	13,301	284	1,595	1,145	7,734	8,853	58,473
Und Clts	13	1	26	-	4	2	9	3	10	5	8	7	18	5	111
Avg. LOS	129	48	204	-	1,422	994	1,134	218	1,330	57	199	164	430	1,771	527

Figure 47 shows the average LOS for individuals still residing in the facilities on December 31, 2010. The LOS was calculated by subtracting the date of admission from December 31, 2010. All of these clients were still in the facility as of December 31, 2010, so their LOS will increase over time. There were 147 clients in these facilities as of December 31, 2010, with a total LOS of 142,126 days. This data gives an average LOS of 967 days, or 2.65 years per person. The 19 clients still in the state hospital have an average LOS of nearly five years.

Figure 47
Residential and Locked Psychiatric Facilities
Average Length of Stay (LOS) by Facility
Only Clients Still Residing at the Facility as of December 31, 2010
(Data from County Census Reports)



	American River Residential	Crestwood TransRes Bakersfield	Willow Glen TransRes Plumas	Crestwood NeuroBeh Fremont	Crestwood NeuroBeh Sunnyvale	Medical Hill NeuroBeh Oakland	Crestwood SNF Modesto	Crestwood SNF Redding	Crestwood SNF Stockton	Crestwood MHRC San Jose	Crestwood MHRC Angwin	Crestwood MHRC Bakersfield	Crestwood MHRC Sacramento	Napa State Hospital	Grand Total
Total LOS	1,486	-	5,660	7,753	18,931	7,661	12,331	959	24,329	407	5,121	246	16,529	40,713	142,126
Und Clts	4	-	15	8	14	4	10	6	18	3	13	1	32	19	147
Avg. LOS	372	-	377	969	1,352	1,915	1,233	160	1,352	136	394	246	517	2,143	967

CHAPTER 2.2: ADULT CRISIS RESIDENTIAL, INPATIENT, & SUB-ACUTE RESIDENTIAL TRANSFORMATION RECOMMENDATIONS

Transformation Vision

Persons who need acute and sub-acute services will receive services in the most appropriate and community-based level of care possible. Inpatient services will be utilized when all other community-based services have been exhausted. Individuals in crisis will be supported and treated by programs that focus on wellness and recovery and utilize significant support persons to prevent inpatient and institutional care. The system will utilize a range of options, including crisis stabilization, crisis residential, psychiatric health facilities, and sub-acute services. The system will be more cost-effective by utilizing inpatient service facilities that can capture federal Medi-Cal revenue, whenever possible.

As this higher intensity of care is revised and enhanced, it is important to integrate the elements of a recovery-oriented system in all services, creating a system that is:

- Driven by the needs of the individual;
- Infused with resiliency, wellness, and recovery principles;
- Delivered by culturally diverse and sensitive providers; and
- Supported by persons with lived experience working and delivering services at all levels of the system to help clients thrive.

Discussion: Utilization of higher levels of care with limited Medi-Cal reimbursement opportunities. Higher levels of care, including crisis residential, inpatient services, sub-acute, and the state hospital account for $43,857,981. This figure represents 54% of the adult mental health system dollars. The majority of these dollars are not producing Medi-Cal revenue and are diverting potentially dollars from outpatient services. For example, if a portion of the $26 million dollars spent on the MHTC were used for outpatient services, and inpatient services were reimbursed through Medi-Cal funding, the system would have additional funds to expand outpatient services in Sacramento County. These funds would create and expand community-based services that support wellness and recovery. Similarly, if the same number of services were delivered in a PHF that is eligible for Medi-Cal reimbursement, there would be lower costs, resulting in savings which could be used to create additional community-based services.

The first step in the shift from inpatient to outpatient services is to closely manage all inpatient services. This shift includes having the County Response Team, and county providers, offer crisis response in the community and de-escalate all crises as early as possible (as discussed in Chapter 1).

Second, the county will be responsible for managing all 5150 evaluations. The Response Team will conduct and/or manage all 5150 evaluations and link the individual to the most appropriate inpatient hospital, or other facility. By having the Response Team manage the 5150s, the county

keeps the authority and oversight of this expensive service and becomes knowledgeable of alternative resources.

The role of the Response Team is not to restrict access to inpatient services, but to assure that individuals in higher levels of care are receiving the most appropriate level of care, are quickly stabilized, and are returned to their support system and community as quickly as possible. The involvement of the Response Team in all 5150s also guarantees communication between the hospital Emergency Department staff, the outpatient providers, and the MHTC staff.

There a number of recommendations to address this complex system that provides higher levels of care.

Recommendation: Expand Crisis Residential programs. It is recommended that Sacramento County develop additional crisis residential programs in other parts of the county. Crisis residential programs are effective at de-escalating a crisis situation and helping clients return to the community within thirty (30) days. The crisis residential programs are eligible for Medi-Cal reimbursement and produce federal revenue to support the cost of the program.

Promising Practice: Turning Point Crisis Residential Program. Turning Point Crisis Residential program provides an excellent example of community-based services, with a wellness and recovery focus. The program provides a warm, welcoming environment for persons who are at risk of being hospitalized by helping these persons restore and improve their level of functioning. The program also serves as a "step-down" program when an individual is discharged from an inpatient facility and needs additional support and stabilization before being discharged back into the community. This program is cost-effective through Medi-Cal reimbursement.

Recommendation: Expand PHF Services. It is recommended that Sacramento County expand the number of available inpatient beds by contracting with other local organizations that have a 16-bed PHF, when available. PHFs with 16 beds are eligible for Medi-Cal reimbursement and are an important resource for people who need inpatient services in Sacramento County. The county is encouraged to develop additional 16-bed PHFs in the county to help reduce the cost of inpatient services.

Recommendation: Develop a county Crisis Stabilization Unit. It is recommended that the county develop a 23-hour Crisis Stabilization Unit (CSU), that is eligible for Medi-Cal reimbursement, and has strict admission criteria. For example, individuals would only be admitted if they have been medically cleared by a hospital Emergency Department. The CSU provides support to the Response Team to help de-escalate clients and prevent hospitalizations. Close collaboration with other providers is needed to ensure that there is the capacity in the community to admit individuals to inpatient facilities within the 23-hour requirement.

Recommendation: Develop Crisis Respite Services. Crisis Respite services are non-medical alternative programs that offer a non-judgmental environment for persons who are experiencing a mental health crisis. These programs are often run by persons with lived experience. Crisis Respite services are similar to crisis stabilization programs and are often located in a home-like environment. The county is currently discussing the development of crisis respite programs with the MHSA Oversight Committee.

Recommendation: Reduce the number of MHTC beds. The MHTC provides an important function in the county and serves difficult-to-place clients. However, the MHTC is an expensive resource. The county is encouraged to identify other options for this facility and to develop opportunities to redirect funds to maximize Medi-Cal reimbursement. Whenever possible, any savings would be used to expand the outpatient service delivery system to enhance wellness and recovery.

Recommendation: Reduce the use of private Psychiatric Hospitals. It is recommended that the county reduce utilization of private psychiatric hospitals, whenever possible. The county works with the outpatient provider network to de-escalate persons in crisis, and potentially avoid hospitalizations by providing community support to help clients remain in the community. If a hospitalization is unavoidable, the hospital staff communicate with the outpatient providers to share clinical information during the hospital stay and facilitate a timely planned discharge back to the community. County management reviews data on all inpatient admissions, by hospital and providers, to identify gaps and opportunities to improve the service delivery system. Individual providers review all clients who were hospitalized from their teams to discuss possible improvements in crisis response and ongoing services.

Recommendation: Reduce the use of Mental Health Rehabilitation Centers and State Hospital. It is recommended that the county reduce utilization of the Mental Health Rehabilitation Centers and the State Hospital, whenever possible. The Intensive Placement Team staff, who are recommended to be part of the Response Team, actively works with all sub-acute residential facilities to identify clients who are able to move back to the community. These clients are discharged to the Intensive Outpatient Services Programs, and receive support services to ensure a successful transition back to the community.

CHAPTER 3: FISCAL ANALYSIS

Summary

Mike Geiss, Fiscal Consultant, provided an estimate of the fiscal impact of the proposed recommendations. All amounts shown in this section are in thousands (000's) of dollars.

The proposed recommendations, based on the assumptions below, result in the estimated impact shown in Table 1, below. The estimated total cost represents the net increase in costs as a result of the proposed recommendations. Estimated total cost is shown by the recommendations to the outpatient system transformation and the crisis residential, inpatient, and sub-acute residential system transformation. The three primary funding sources are Medi-Cal Federal Financial Participation (FFP), County funding (sales tax and vehicle license fees referred to as realignment), and Mental Health Services Act (MHSA) funds.

Table 1
Estimated Fiscal Impact of Proposed Recommendations
(Dollars in Thousands)

	Year 1	Year 2	On-Going
Estimated Total Cost			
Outpatient	$2,650	$5,200	$5,000
Crisis Res., Inpatient and Sub-Acute	$1,840	$6,750	$5,700
Total	$4,490	$11,950	$10,700
Estimated Funding			
Medi-Cal FFP	$2,980	$7,730	$8,510
County*	$450	$2,475	$605
MHSA	$1,060	$1,745	$1,585
Total	$4,490	$11,950	$10,700

* County includes realignment and other county discretionary funding.

As shown by Table 1, the estimated total on-going costs of the recommendations are $10.7 million. These additional costs are estimated to be funded primarily with Medi-Cal FFP and little cost to the county. Medi-Cal is a reimbursement program whereby the Federal Government reimburses the county (through the State) a percentage of the county's actual costs. In California, the percentage reimbursement has typically been 50 percent and that is what is assumed for this fiscal analysis. Thus, the county must incur the full expenditure in order to receive the 50 percent reimbursement. This may cause cash flow issues in years in which the State budget is late or when claims processing system changes result in delayed Medi-Cal FFP payments to the county.

Table 1 also shows that to truly transform the system requires an up-front investment by the county with realignment revenues in the first two years. After that initial investment, the on-going unreimbursed costs to the county are approximately $2.2 million, which could be funded primarily with MHSA resources. The county has a prudent reserve of approximately $14 million in MHSA funds, as well as additional unspent MHSA funds which could be used to fund the initial costs and on-going costs. It is recommended that future increases in MHSA funding be directed towards the system transformation.

One of the primary reasons for the net savings in county costs has to do with the redirection of existing resources from non-reimbursed inpatient services to more intensive Medi-Cal reimbursable outpatient services and Medi-Cal reimbursable inpatient services. Table 2 shows the composition of the estimated total costs in terms of cost increases and cost savings.

Table 2
Estimated Cost Increases and Cost Savings
(Dollars in Thousands)

	Year 1	Year 2	On-Going
Outpatient			
Cost Increases	$3,650	$7,000	$7,000
Cost Savings	($1,000)	($1,800)	($2,000)
Estimated Total Cost	$2,650	$5,200	$5,000
Crisis Res., I/P and Sub-Acute			
Cost Increases	$5,150	$17,750	$19,800
Cost Savings	($3,310)	($11,000)	($14,100)
Estimated Total Cost	$1,840	$6,750	$5,700
Estimated Total Cost			
Cost Increases	$8,800	$24,750	$26,800
Cost Savings	($4,310)	($12,800)	($16,100)
Estimated Total Cost	$4,490	$11,950	$10,700

Table 2 shows that the proposed recommendations should result in significant cost savings as the system is transformed. Much of the cost savings is derived from reducing the number of inpatient beds and the Mental Health Treatment Center that is currently ineligible for Medi-Cal FFP and using the savings to develop alternative inpatient settings that are eligible for Medi-Cal FFP, as well as expanding the availability of intensive outpatient services that also are eligible for Medi-Cal FFP.

This fiscal viability of this system transformation relies significantly on reducing various high cost services that are not eligible for Medi-Cal reimbursement. The inherent risk associated with

this type of system transformation is that these savings are not realized. Table 2 can be used to quantify this risk in that the transformed system is projected to result in almost $27 million in cost increases for new services once fully implemented. This would represent the maximum exposure to the County of these proposed recommendations. Subtracting the estimated Medi-Cal FFP shown in Table 1 provides a more realistic estimate of $18 million as the potential risk of implementing these recommendations without subsequent cost reductions.

Further, it is generally assumed that most of the transformed programs will serve approximately 80 percent Medi-Cal clients and 20 percent non-Medi-Cal clients based on current data that shows that approximately 88 percent of the outpatient clients across Level II, III, IV and Wellness and Recovery being eligible for Medi-Cal. The actual percentage of Medi-Cal will vary, depending on numerous factors, including implementation of the recent California Section 1115 Federal Demonstration Waiver Low Income Health Program (California's Bridge to Reform) in 2011 and the Federal Affordable Care Act in 2014. Both of these initiatives should increase the percentage of Medi-Cal clients and increase overall Medi-Cal FFP, especially for services (based on client eligibility) that will be reimbursed at 100 percent Medi-Cal FFP (rather than the normal 50 percent) under the Affordable Care Act. However, these initiatives might result in new clients to the Medi-Cal specialty mental health system, thereby increasing the required County share for those Medi-Cal services reimbursed at 50 percent Medi-Cal FFP.

There also have been vague proposals at the federal level that would modify the Federal Medicaid program (called Medi-Cal in California) from a fee-for-service reimbursement system to a block grant program. This could have a significant impact on Medi-Cal FFP and provides an incentive to maximize Medi-Cal FFP under the current fee-for-service system as soon as possible prior to Medi-Cal FFP ever becoming a fixed block grant. Given the uncertainties associated with these various proposals, no adjustments were made to the fiscal analysis.

Finally, this fiscal analysis assumes a phased implementation of the recommendations with specific timing for each recommendation. More than likely, the actual implementation schedule will vary from the assumed schedule, and, as a result, the associated fiscal impacts also will vary.

Table 3 shows the estimated fiscal impact of each of the individual recommendations. Table 3 only includes recommendations that had a measureable fiscal impact. Some recommendations, such as increase the use of data decision support tools and maximize Medi-Cal billable services, will most likely either result in decreased costs or increased revenues but were not quantifiable as part of this analysis.

Table 3
Independent Expert Review Report
Sacramento County Adult Mental Health Service Delivery System
Estimated Fiscal Impact of Recommendations
(Dollars in Thousands)

Recommendations	Year 1				Year 2				On-Going			
	Estimated Total Cost	Funding			Estimated Total Cost	Funding			Estimated Total Cost	Funding		
		FFP	County*	MHSA		FFP	County*	MHSA		FFP	County*	MHSA
Outpatient System Transformation												
Develop Response Team/UR Activities	$1,000	$400	$600		$2,000	$800	$1,200		$2,000	$800	$1,200	
Provider Intake and Assessment	$300	$120	$180		$600	$240	$360		$600	$240	$360	
Develop Welcoming Line					$400			$400	$400			$400
Redesign Regional Outpatient System	$650	$260		$390	$1,300	$520		$780	$1,300	$520		$780
Develop Intensive Outpatient Services Program	$600	$240		$360	$1,200	$480		$720	$1,200	$480		$720
Consolidate County Clinics	($1,000)	($200)	($250)	($550)	($1,800)	($360)	($250)	($1,190)	($2,000)	($400)	($250)	($1,350)
Increased Peer Support	$400	$100		$300	$900	$225		$675	$900	$225		$675
Provide Training on Wellness and Recovery	$200			$200	$150			$150	$150			$150
Provide Training on Evidence Based Practices	$300			$300	$150			$150	$150			$150
Peer Support Specialists and MHTC	$100		$100		$200		$200		$200		$200	
Medi-Cal Benefits Acquisition	$100		$100		$100		$100		$100		$100	
Total Outpatient System Transformation	$2,650	$920	$730	$1,000	$5,200	$1,905	$1,610	$1,685	$5,000	$1,865	$1,610	$1,525
Crisis Residential, Inpatient, and Sub-Acute Transformation												
Expand Crisis Residential	$3,000	$1,200	$1,800		$3,000	$1,200	$1,800		$3,000	$1,200	$1,800	
Expand PHF Services	$2,050	$820	$1,230		$6,150	$2,460	$3,690		$8,200	$3,280	$4,920	
Reopen Crisis Stabilization Unit					$8,500	$2,125	$6,375		$8,500	$2,125	$6,375	
Reduce MHTC Beds	($2,060)		($2,060)		($8,500)		($8,500)		($11,000)		($11,000)	
Reduce Use of Psych Hospitals	($450)		($450)		($900)		($900)		($1,100)		($1,100)	
Reduce MHRC and State Hospital Services	($800)		($800)		($1,600)		($1,600)		($2,000)		($2,000)	
Decision Support Tools	$100	$40		$60	$100	$40		$60	$100	$40		$60
Total Crisis Res., Inpatient, and Sub-Acute Transformation	$1,840	$2,060	($280)	$60	$6,750	$5,825	$865	$60	$5,700	$6,645	($1,005)	$60
Total System Transformation	$4,490	$2,980	$450	$1,060	$11,950	$7,730	$2,475	$1,745	$10,700	$8,510	$605	$1,585

* County includes realignment and other county discretionary funding.

Assumptions

Develop Response Team. The new Response Team is assumed to be staffed with approximately 17 Full Time Equivalent (FTE) positions once fully implemented in order to provide 24 hour coverage 7 days a week. These staff will be housed at existing facilities so the non-personnel costs should be fairly minimal. It is assumed that the Response Team will only be staffed half of Year 1 and so only half of the costs will be incurred in Year 1 with the team fully operational in Year 2. It is assumed that most of the clients (80 percent) would be Medi-Cal and so 80 percent of the costs of the Response Team would be eligible for Medi-Cal reimbursement at the 50 percent reimbursement rate. It is also assumed that the majority of the staff for the Response Team would ultimately come from consolidating the two county clinics and reducing the number of beds and the MHTC. Most of the funding is assumed to be from County realignment funds but this program could be structured such that MHSA Community Services and Supports (CSS) funding could also be used since it is a new service that the County has not previously provided.

Utilization Review Activities. The Response Team members will also conduct Utilization Review activities when not taking calls and/or delivering crisis intervention services. It is assumed that most of the clients (80 percent) would be Medi-Cal and so 80 percent of the costs of the Utilization Review activities would be eligible for Medi-Cal reimbursement at the 50 percent reimbursement rate.

Provider Intake and Assessment. It is assumed that five additional clinicians would be required to implement a provider intake and assessment process. These clinicians would be housed at existing provider sites so non-personnel costs would be minimal. It is assumed that this process will not be implemented until the last six months of Year 1, so only half the costs will be incurred in Year 1 with the process fully implemented by Year 2. It is assumed that most of the clients (80 percent) would be Medi-Cal and so 80 percent of the costs of this program would be eligible for Medi-Cal reimbursement at the 50 percent reimbursement rate. The balance is assumed to be funded with County realignment funds but the program could be structured such that MHSA CSS funding could also be used.

Develop Welcoming Line. The Welcoming Line is assumed to be staffed with five peer support FTEs once fully implemented in Year 2. Again, these staff will be housed at existing facilities so the non-personnel costs should be fairly minimal. It is also assumed that the funding would be from MHSA.

Redesign Regional Outpatient System. It is assumed that six additional clinicians would be required to redesign the regional outpatient system. Additionally, some of the MHSA CSS Full Service Partnership (FSP) client flexible funds would also be needed. Finally, additional funds will be needed to fund overtime costs for outpatient staff to respond to crisis calls 24 hours a day, 7 days per week. It is assumed that the redesign will not be implemented until the last six months of Year 1, so only half the costs will be incurred in Year 1 with the system redesign fully implemented by Year 2. It is assumed that most of the clients (80 percent) would be Medi-Cal

and so 80 percent of the costs of this program would be eligible for Medi-Cal reimbursement at the 50 percent reimbursement rate.

Develop Intensive Outpatient Services Program(s). It is assumed that there ultimately will be three pilot programs of 12-15 clients throughout the County for a total of 36-45 clients. Each pilot program is assumed to cost approximately $400,000. It is assumed that the pilots will not begin until the last six months of Year 1, and so only half the costs are estimated for Year 1 with the full costs estimated in Year 2. It is assumed that most of the clients (80 percent) would be Medi-Cal and so 80 percent of the costs of these pilots would be eligible for Medi-Cal reimbursement at the 50 percent reimbursement rate. The balance is assumed to be funded with MHSA CSS funding.

Consolidate County Clinics. It is assumed that the process to consolidate county clinics will begin in Year 1, but will not be fully realized until Year 2. Some of the staff are assumed to be transferred to the Response Team. The cost savings are assumed to be primarily MHSA funds since they are the majority of funding for the current county clinics.

Increased Peer Support. It is assumed that an additional 12 Peer Support Specialist positions will be hired to support this recommendation. Approximately half of the positions would be hired in Year 1 and the remaining positions filled in Year 2. The total costs also include on-going training and monitoring costs. It is also assumed that only 50 percent of the costs of these staff would be eligible for Medi-Cal reimbursement at the 50 percent reimbursement rate because some activities may be non-allowable, so the majority of funding would be from MHSA.

Provide Training on Wellness and Recovery. It is assumed that the County will be able to procure system wide training on Wellness and Recovery services, including developing an ongoing mentoring program for Peer Support Specialists who are hired at each of the provider sites in order to support the outpatient transformation. It is assumed an initial cost of $200,000 in Year 1 with on-going training and monitoring of $150,000 per year. This training and monitoring would be funded through one of the MHSA components.

Provide Training on Evidence Based Practices (EBPs). It is assumed that the County will be able to procure system wide training on EBP in order to support the outpatient transformation. It is assumed an initial cost of $300,000 in Year 1 with on-going training and monitoring of $150,000 per year. This training and monitoring would be funded through one of the MHSA components.

Peer Support Specialists at MHTC. It is assumed that three additional peer support FTEs would be hired to assist at the MHTC. These positions will be filled by persons with lived experience by the second half of Year 1 so Year 1 represents 50 percent of the costs with the positions fully hired in Year 2. Since the MHTC is not eligible for Medi-Cal reimbursement, it is assumed that the cost of these positions is entirely funded with County realignment funds.

Medi-Cal Benefits Acquisition. It is assumed that additional County funding would be required to help fund Department of Human Services co-located staff at the various outpatient clinics during the week to expedite clients getting enrolled in the Medi-Cal system.

Expand Crisis Residential. It is assumed that the County will be able to expand crisis residential fairly quickly and be fully implemented in Year 1. The costs for this program are assumed to be $3 million per year based on the approximate cost of the existing crisis residential program in the County. It is assumed that most of the clients (80 percent) would be Medi-Cal and so 80 percent of the costs of the crisis residential program would be eligible for Medi-Cal reimbursement at the 50 percent reimbursement rate. It is assumed that the balance of funding would come from County realignment funds but the program could be structured to use MHSA funds.

Expand Psychiatric Health Facility (PHF) Services. It is assumed that the County will be able to implement a new 16 bed PHF by the second half of Year 1. It is also assumed that the County will be able to implement a second 16 bed PHF by the second half of Year 2. The estimated costs of each PHF are based on the current PHF costs. It is assumed that the majority of clients (80 percent) would be Medi-Cal and so 80 percent of the costs of the PHFs would be eligible for Medi-Cal reimbursement at the 50 percent reimbursement rate. The balance of the funding is assumed to come from County realignment funds.

Reopen Crisis Stabilization Unit. It is assumed that the cost of reopening the Crisis Stabilization Unit is approximately $8.5 million based on estimates provided by the County. It is assumed the unit will be open and fully operational by Year 2. It is also assumed that approximately half of the clients would be Medi-Cal and so 50 percent of the costs of the unit would be eligible for Medi-Cal reimbursement at the 50 percent reimbursement rate. The balance of the funding is assumed to come from County realignment funds.

Develop Crisis Respite Services. The County is considering, with the MHSA Oversight Committee, the use of MHSA Innovation funding for the program. This program has already been included in the County's budget and this recommendation will not result in any additional costs.

Reduce Mental Health Treatment Center (MHTC) Beds. It is assumed that the County will begin to reduce the number of MHTC beds from 50 to 25 beginning in the last six months of Year 1 and fully completed by the end of Year 2. It is assumed that the savings in Year 1 would be solely based on reducing and redirecting staff for half of the year. It is assumed that the savings in Year 2 would basically equate to the reopening of the Crisis Stabilization Unit as staff and costs are moved from the MHTC to the Crisis Stabilization Unit. Finally, it is assumed that the on-going savings represent full implementation of the other system transformation recommendations so that only 25 beds are required at the MHTC. Since the MHTC is generally not eligible for Medi-Cal reimbursement, all the savings come from County realignment funding.

Reduce the Use of Psychiatric Hospitals. It is assumed with the transformation of the outpatient system that ultimately 25 percent of the costs of these psychiatric inpatient hospitals can be reduced. However, this level of savings will take time so it is assumed that these costs will be reduced by 10 percent in Year 1, 20 percent in Year 2, and 25 percent on-going. The entire savings is current County realignment funding.

Reduce Mental Health Rehabilitative Center and State Hospital Services. It is assumed with the transformation of the outpatient system that ultimately 25 percent of the costs of these non-Medi-Cal reimbursable services can be reduced. However, this level of savings will take time so it is assumed that these costs will be reduced by 10 percent in Year 1, 20 percent in Year 2, and 25 percent on-going. The entire savings is current County realignment funding.

Decision Support Tools. It is assumed that the County will use up to $100,000 per year to obtain and develop additional tools and training to help managed adult mental health services in the County. It is also assumed that 80 percent of the costs of such tools will be eligible for Medi-Cal reimbursement with the balance funded through MHSA.

CHAPTER 4: LEADERSHIP AND DECISION SUPPORT

Transformation Vision

Leaders from both the county and the providers collaborate to create a person-centered, recovery-oriented, evidence-based, quality-driven continuum of services to help individuals to achieve healthy outcomes.

Discussion: Current use of data. Sacramento County has recently changed to a new Management Information System, AVATAR, to collect and produce data for billing, administration, and contract compliance. This system will be an effective tool for providing fiscal, performance, and outcome data across the continuum of services. Currently, managers are using data to direct scarce resources; for example, the MHTC director and staff track MHTC inpatient admissions and discharges on a daily basis to manage utilization at all inpatient facilities. Data for the inpatient psychiatric hospitals is also collected, but the data is not reviewed as frequently. Similarly, the Intensive Placement Team closely monitors the list of persons in sub-acute residential placements and uses this information to develop discharge strategies. The Budget Officer of the Division of Behavioral Health Services collects data on costs, expenses, and revenue across the system. The Research, Evaluation, and Performance Outcomes (REPO) staff produce data on a broad range of topics to meet various reporting requirements and special requests.

These various activities illustrate that staff and managers are using their data, which provides a good foundation for expanding this practice and developing systematic data reports to inform managers of key outcomes and performance measures on a routine basis.

Recommendation: County leadership adopts a continuous quality improvement process to use data to inform system-level decisions. It is key to the system transformation to develop a continuous quality improvement process to use data to guide the implementation of system reform and ongoing management of the continuum of services. This quality improvement process creates a feedback loop to systematically track and manage the key outcomes for the system. A continuous feedback loop is used to:

- Set goals for improving client outcomes and system performance
- Collect and produce client outcome and system performance data to measure progress in meeting the identified goals
- Review and discuss data at monthly managers meeting on the identified goals and potential barriers to achieving those goals
- Identify and discuss changes to the system to potentially improve client outcomes
- Produce and share data reports to measure changes to outcomes over time

Recommendation: Develop the capacity to systematically produce accurate data reports. It is crucial to develop the capacity to produce accurate and timely data reports, and create decision-support tools to measure client outcomes and system performance. This Independent Expert Review Report provides a good foundation of baseline data for managers to use to identify priority outcomes and set goals for system improvement. Decision-support tools can be developed to track the priority outcomes over time (monthly).

Once the decision-support model is developed, staff can be trained to produce consistent, quality data reports each month for management review.

Recommendation: Promote communication and collaboration between the county and the providers. Both the county and the providers have indicated that they would like to work together to build a strong service delivery system. The development of a clear, common vision and identified outcome and performance measures will enhance communication and collaboration. By having a clear vision and shared goals, leaders from the county and the providers can work together to develop strategies and services to meet these identified goals. It is also imperative to include clients in these discussions to ensure that these individuals have ongoing input in improving services.

Recommendation: Develop an Outcomes Leadership Group comprised of managers from the county and providers, as well as clients, to work together to use data to measure client and performance outcomes, identify gaps, and develop strategies to improve outcomes. Key managers and clients are selected to form an Outcomes Leadership Group. This group meets monthly to review outpatient and higher level of care data, using the decision-support tools developed. Following a review of the data, the group identifies areas of success, areas for improvement, and discusses strategies to modify the system to improve outcomes. This approach promotes a supportive learning environment which can use data to:

- Celebrate successes,
- Identify training and technical assistance needs to improve outcomes, and
- Examine policies and practices to ensure the system can accomplish the identified performance goals and outcomes.

Reducing inpatient utilization is recommended as one of the first outcomes to measure. Examples of the data produced for the Outcomes Leadership Group may include:

- Number of inpatient admissions
- Number of inpatient bed days, by hospital; MHTC
- Number of inpatient admissions that had an outpatient service within 24 hours before the admission
- Number of inpatient admissions that had an outpatient service within 24 hours after discharge
- Number of clients with two inpatient admissions within six months; one year
- Number of clients with three of more inpatient admissions within six months; one year
- Number of clients with two or more inpatient admissions without an outpatient service between inpatient admissions

Transformation Summary

There are many opportunities to strengthen and transform the adult mental health service delivery system in Sacramento County. County managers, provider staff, and clients must collaborate together to successfully transform the system. As the phases of the transformation are implemented, client and system-level outcomes will be accomplished, including the delivery of person-centered services, with a focus on wellness and recovery. Providers will have the flexibility to individualize services to meet a client's needs. The integration of Peer Support Specialists in the service delivery teams will help promote healthy outcomes. Leaders, service delivery staff, and individuals receiving services are all ready to work together to create a coordinated, recovery-oriented, quality-driven mental health system.

One of the responsibilities of the county leadership is to provide oversight and management of the outpatient mental health programs. As the system implements these recommendations, the county is encouraged to evaluate each provider and county program to ensure that services are delivered in a manner that reflects the goals of the system transformation and meets the needs of clients. As the transformation is implemented, the county may consider using a competitive selection process to fund some of these services, to help ensure that clients receive the highest quality services.

As this transformation begins to be implemented, the system must be flexible in how services are funded. For example, if the mental health programs are effective at reducing crises and inpatient services, and discharging people from higher levels of sub-acute residential care, the savings in dollars can be used to support the intensive outpatient services in the community, as well as other innovative, person-centered, recovery-oriented services to support healthy outcomes. The fiscal analysis supports the recommendations and transformation of the system. As shown, it is more cost-effective to deliver services in the community, whenever feasible.

The mental health system will also need to begin planning for and expanding services to prepare for health care system reform. One of the first steps will be to assist clients to identify a person-centered health care home. This strategy helps the individual to establish an ongoing relationship with a health provider to ensure that primary and preventative health services are coordinated. Mental health providers can help individuals utilize local Federally Qualified Health Centers (e.g., primary care, the Effort) to help coordinate services and support the individual to improve physical health outcomes. This coordination with primary care also helps mental health providers to support healthy behaviors and develop activities that promote positive routines (e.g., exercise, smoking cessation, nutrition).

With leadership, a clear vision, and close collaboration with all persons involved in the mental health system, Sacramento County can successfully create an exemplary person-centered, recovery-oriented, quality-driven adult mental health system. This system transformation will also positively impact other community partners, including law enforcement, jails, and hospitals. Collaboration and coordination will be key factors to the success of the system transformation.

APPENDIX A: DEFINITIONS – ACRONYMS AND TERMS USED IN THIS REPORT

Assessment – The California Department of Mental Health states that an assessment is a service activity designed to evaluate the current status of a beneficiary's mental, emotional, or behavioral health. Assessment includes one or more of the following: mental status determination; analysis of the beneficiary's clinical history; analysis of relevant biopsychosocial and cultural issues and history; diagnosis; and the use of testing procedures. *(CA State Plan Amendment: Medi-Cal Regulations, Effective 10/1/2010)*

AVATAR – A management information system comprised of several modules that perform different functions. The Practice Management Module performs a fiscal and billing function and is the source of the data in this Report. The Division of Behavioral Health Services is also beginning to implement the Clinician's Workstation, which will be the foundation of an Electronic Health Record.

Calendar Year (CY) – Calendar Year refers to a time frame measured from January 1 through December 31 of the same year. In this Report, Calendar Year refers to the CY 2010, from January 1, 2010 through December 31, 2010.

Client Plan – The California Department of Mental Health states that a Client Plan is a documented plan for the provision of services to a beneficiary who meets medical necessity criteria; it contains specific observable and/or quantifiable goals and service objectives, proposed type(s) of intervention, and the proposed duration of the intervention(s). A Client Plan is consistent with the beneficiary's diagnosis or diagnoses. A client plan is signed by the person providing the service(s), or a person representing a team or program providing services, and must include documentation of the beneficiary's participation in, and agreement with, the client plan. *(CA State Plan Amendment: Medi-Cal Regulations, Effective 10/1/2010)*

Collateral – The California Department of Mental Health states that collateral is a service activity to a significant support person or persons in a beneficiary's life for the purpose of providing support to the beneficiary in achieving client plan goals. Collateral includes one or more of the following: consultation and/or training of the significant support person(s) that would assist the beneficiary in increasing resiliency, recovery, or improving utilization of services; consultation and training of the significant support person(s) to assist in better understanding of mental illness and its impact on the beneficiary; and family counseling with the significant support person(s) to improve the functioning of the beneficiary. *(CA State Plan Amendment: Medi-Cal Regulations, Effective 10/1/2010)*

Crisis Intervention – Crisis Intervention is an unplanned, expedited service, to or on behalf of a beneficiary to address a condition that requires more timely response than a regularly scheduled visit. Crisis intervention is an emergency response service enabling a beneficiary to cope with a crisis, while assisting the beneficiary in regaining their status as a functioning community member. The goal of crisis intervention is to stabilize an immediate crisis within a community or clinical setting. Crisis intervention may be provided face-to-face, by telephone or by telemedicine with the beneficiary and/or significant support persons and may be provided in a

clinic setting or anywhere in the community. *(CA State Plan Amendment: Medi-Cal Regulations, Effective 10/1/2010)*

Crisis Residential Treatment – The California Department of Mental Health states that treatment services are therapeutic or rehabilitative services provided in a non-institutional residential setting which provides a structured program (short term – 3 months or less) as an alternative to hospitalization for beneficiaries experiencing an acute psychiatric episode or crisis who do not have medical complications requiring nursing care. The services include a range of activities and services that support beneficiaries in their efforts to restore, improve and/or preserve interpersonal and independent living skills, and to access community support systems. The service is available 24 hours a day, seven days a week and structured day and evening services are available all seven days. *(CA State Plan Amendment: Medi-Cal Regulations, Effective 10/1/2010)*

Crisis Response – A generic term referring to law enforcement, staff or other individuals who reach out to, or intervene with, an individual who is experiencing a mental health crisis.

Crisis Stabilization – The California Department of Mental Health states that Crisis Stabilization is an unplanned, expedited service lasting less than 24 hours, to or on behalf of a beneficiary to address an urgent condition requiring immediate attention that cannot be adequately or safely addressed in a community setting. The goal of crisis stabilization is to avoid the need for inpatient services. *(CA State Plan Amendment: Medi-Cal Regulations, Effective 10/1/2010)*

Crossroads – Crossroads is a 501(c)(3) nonprofit public benefit corporation that has served the Sacramento region since 1978 with specialized employment and placement services. Clients may access these services through the Department of Rehabilitation (DOR).

Department of Rehabilitation (DOR) – A state agency that provides employment services. They work in partnership with consumers and other stakeholders to provide services and advocacy resulting in employment, independent living, and equality for individuals with disabilities.

DOR—See **Department of Rehabilitation**.

Emergency Department (ED) – Hospital emergency rooms that respond to persons experiencing an acute medical distress. In Sacramento County, they also respond to persons experiencing a mental health crisis.

Evidence-Based Practice (EBP) – Evidence-based practices are approaches to prevention or treatment services that are validated by some form of documented scientific evidence. Evidence-based practice stands in contrast to approaches that are based on tradition, convention, belief, or anecdotal evidence. EBPs effectively integrate the best research evidence with clinical expertise, cultural competence, the values of the person receiving the service, and consistent scientific evidence showing improved outcomes for clients.

Federally Qualified Health Center (FQHC) – A community-based health organization that provides comprehensive primary health, dental, mental health, and substance abuse treatment services to persons of all ages.

Fiscal Year (FY) – Fiscal Year refers to a time frame utilized for accounting purposes. For California counties, including Sacramento, the Fiscal Year runs from July 1 of one year through June 30 of the next year. In this Report, Fiscal Year typically refers to FY 2009/10, which runs from July 1, 2009 through June 30, 2010.

FQHC – see **Federally Qualified Health Center**.

FSP – see **Full Service Partnership**.

Full Service Partnership (FSP) – An enrollee-based level of care provisioned by the California Mental Health Services Act that targets the highest-need mental health clients. Services funded by the FSP program include a 24/7 support system, intensive mental health and substance abuse services, linkages to ancillary services, and flexible funding to provide "whatever it takes" to promote positive outcomes for the client and his/her family, as appropriate. The program is designed to help clients in the short-term, disenrolling them to a lower level of care, when this high level of support is no longer required.

HUD – U.S. Department of Housing and Urban Development. This Department provides funding for housing purchases and develops low-cost housing options.

IMD – see **Institution for Mental Disease**.

Inpatient Services – Inpatient mental health services are 24-hour settings that provide services to individuals with acute psychiatric conditions, who require hospitalization on a voluntary or involuntary basis for maximum benefit, and who may be a danger to self, others, or gravely disabled. The goals of acute inpatient services are to provide clinical assessment, stabilize acute symptoms, stabilize the acute symptoms, while addressing a person's health and safety needs, and return the individual to the community, as appropriate, through comprehensive discharge plan.

Institution for Mental Disease (IMD) – A hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services. Services to persons under 21 years and 65 and older are eligible for Medi-Cal reimbursement.

Intensive Outpatient Services (IOS) – A generic term used in the Report to indicate a program that provides 24/7 services to a small number of clients. They are designed to help people successfully live in the community who have previously been living in sub-acute residential facilities.

LOCUS (**Level of Care Utilization System**) – LOCUS is a widely-used instrument for determining the appropriate level of service intensity for persons with mental illness.

Sacramento County uses the Adult Version, developed by the American Association of Community Psychiatrists. This tool provides a standardized assessment approach in determining level of care and service needs. The LOCUS contains specific evaluation dimensions and defines levels of care in the service continuum.

Mental Health Rehabilitation Center (MHRC) – A hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services.

Mental Health Services Act (MHSA) – A California Act passed in 2005 that imposes a 1% income tax on personal income in excess of $1 million. Funds are used to support county mental health programs and monitor progress toward statewide goals for children, transition age youth, adults, older adults, and families. The MHSA Act addresses a broad continuum of prevention, early intervention and service needs, and the necessary infrastructure, technology, and training elements that effectively support this system. The MHSA Act requires specific types and levels of funding to ensure quality care for underserved and unserved persons in California communities.

Mental Health Treatment Center (MHTC) – A mental health facility operated by the Sacramento County Mental Health Division that serves persons who need acute psychiatric services and/or are awaiting placement in other facilities.

MHRC – see **Mental Health Rehabilitation Center**.

MHSA – see **Mental Health Services Act**.

MHTC – see **Mental Health Treatment Center**.

Outpatient Mental Health Services – The California Department of Mental Health states that these services are individual, group or family-based interventions that are designed to provide reduction of the beneficiary's mental or emotional disability, restoration, improvement and/or preservation of individual and community functioning, and continued ability to remain in the community consistent with the goals of recovery, resiliency, learning, development, independent living, and enhanced self-sufficiency. Mental health services may be provided face-to-face, by telephone or by telemedicine with the beneficiary or significant support person(s) and may be provided anywhere in the community. *(CA State Plan Amendment: Medi-Cal Regulations, Effective 10/1/2010)*

Peer Support Specialist – An individual who has lived experience as a mental health client, or as a family member of a client, who works with consumers, welcoming them to the mental health system, providing supportive services, and promoting positive outcomes for clients.

Person-Centered Health Care Home – A health care delivery model in which an individual establishes an ongoing relationship with a physician, or other licensed health care provider, to

deliver comprehensive, accessible, and continuous evidence-based primary and preventative health care. This model helps to coordinate services to improve health outcomes for clients.

PHF – see **Psychiatric Health Facility**.

Promising Practice – This term refers to innovations in clinical or administrative practice that responds to the critical needs of a particular program, population, or system, and which provide good outcomes, but do not have enough research or replication to support generalized outcomes. In this Report, the term is also used to highlight programs that may serve as service models to the mental health system in Sacramento County.

Psychiatric Health Facility (PHF) – The California Department of Mental Health states that services are therapeutic and/or rehabilitative services including one or more of the following: psychiatric, psychosocial, and counseling services, psychiatric nursing services, social services, and rehabilitation services provided in a psychiatric health facility licensed by the Department of Mental Health. Psychiatric health facilities are licensed to provide acute inpatient psychiatric treatment to individuals with major mental disorders. *(CA State Plan Amendment: Medi-Cal Regulations, Effective 10/1/2010)*

Recovery – A process of healing and transformation that enables a person with a mental health problem to live a meaningful life in a community of his or her choice, while striving to achieve his or her full potential. Recovery means that having a mental illness does not prevent clients from living a full and meaningful life. "Recovery is a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by illness" (*Bill Anthony, 1994).* An important component of achieving recovery goals is having hope. Clients need to have hope for themselves. Clients also need to have people in their lives that are supportive. For clients, hope means believing that they can feel better, recognizing the ups and downs of the recovery process, and realizing that recovery takes time.

Regional Support Team (RST) – Mental health programs that provide mental health services and support for adults residing in Sacramento County. Individuals must meet Sacramento County Mental Health Plan (MHP) target population criteria for a persistent mental health disorder and/or co-occurring substance use disorder. Currently, all four RST programs are operated by community based agencies that have contracts with the county. They provide medication support, individual and groups services, and case management. These programs serve individuals who have been found to need Level II services. They are located in key geographical areas (regions) throughout Sacramento County.

Rehabilitation – The California Department of Mental Health states that rehabilitation is a recovery or resiliency-focused service activity identified to address a mental health need in the Client Plan. This service activity provides assistance in restoring, improving, and/or preserving a beneficiary's functional, social, communication, or daily living skills to enhance self-sufficiency or self-regulation in multiple life domains relevant to the needs of the beneficiary. Rehabilitative services allow beneficiaries to sustain their current level of functioning, remain in the community, prevent deterioration in an important area of life functioning, and prevent the need

for institutionalization or a high-level of medical care intervention. *(CA State Plan Amendment: Medi-Cal Regulations, Effective 10/1/2010)*

Residential Treatment Services – The California Department of Mental Health states that adult residential treatment services are recovery-focused rehabilitative services, provided in a non-institutional, residential setting, for beneficiaries who would be at risk of hospitalization or other institutional placement if they were not in the residential treatment program. The service includes a range of activities and services that support beneficiaries in their efforts to restore, improve, and/or preserve interpersonal and independent living skills, and to access community support systems that support recovery and enhance resiliency. The service is available 24 hours a day, seven days a week; and structured day and evening services are available all seven days. *(CA State Plan Amendment: Medi-Cal Regulations, Effective 10/1/2010)*

RST – see **Regional Support Team**.

State Hospital – The California Department of Mental Health operates five state hospitals throughout California including: Atascadero State Hospital (San Luis Obispo County), Coalinga State Hospital (Fresno County), Metropolitan State Hospital (Los Angeles County), Napa State Hospital (Napa County), and Patton State Hospital (San Bernardino County). Each State Hospital provides inpatient treatment services for Californians with serious mental illnesses. In this Report, "State Hospital" typically refers to Napa State Hospital, which is the State Hospital utilized by Sacramento County.

Telemedicine – The California Department of Mental Health states that telemedicine provides a service via the use of information exchanged from one site to another via electronic communications to improve a beneficiary's mental health condition. Electronic communication means the use of interactive telecommunications equipment that includes, at a minimum, audio and video equipment permitting two-way, real time interactive communication between the beneficiary, and the service provider at the distant site. *(CA State Plan Amendment: Medi-Cal Regulations, Effective 10/1/2010)*

Therapy – The California Department of Mental Health states that therapy is a therapeutic intervention that focuses primarily on symptom reduction and restoration of functioning as a means to improve coping and adaptation and reduce functional impairments. Therapeutic intervention includes the application of cognitive, affective, verbal or nonverbal, strategies based on the principles of development, wellness, adjustment to impairment, recovery, and resiliency to assist a beneficiary in acquiring greater personal, interpersonal and community functioning or to modify feelings, thought processes, conditions, attitudes or behaviors which are emotionally, intellectually, or socially ineffective. *(CA State Plan Amendment: Medi-Cal Regulations, Effective 10/1/2010)*

Transition Age Youth (TAY) – TAY refers to youth who are ages 16-25 and who are transitioning out of the children's mental health system into the adult mental health system. For many young adults, this transition is difficult as they often have received a high level of support from foster care homes, residential treatment programs, and mental health service programs designed to provide brief 24/7 in-home support. As youth transition into adulthood, they may

"fall through the cracks" and have an increased risk for homelessness and substance abuse problems.

University of California, Davis (UC Davis) – This term is used in the Report to refer to the UC Davis Medical Center or the UC Davis Department of Psychiatry.

Wellness – Mental health wellness is the way that individuals think, act, and cope with life and the stressors and challenges that are part of the human experience. The state of one's mental health can influence the ways in which they look at themselves, their life and others around them. It also strongly influences an individual's potential for achieving their goals and is an important tool in obtaining and maintaining a feeling of well being. Individuals with mental health wellness are better able to function during stressful situations. Mental health wellness is reflected in the ability to bounce back from adversity, communicate one's feelings, form healthy interpersonal relationships, set and achieve realistic goals, seek help in difficult times, enjoy life to the fullest, and appreciate oneself.

Wellness and Recovery Model – A process through which a mental health consumer achieves independence, self-esteem, and a meaningful life in the community through supportive services by mental health professionals and peer support. Recovery can be facilitated by particular features of care and the care system which are referred to as recovery-oriented planning and recovery-oriented services. These principles have widespread support including, for example, the *President's Commission on Mental Health, 2003* and Substance abuse and Mental Health Services Administration (SAMHSA) (www.samsha.gov).

"Whatever it takes" – An MHSA philosophy of providing "whatever it takes" – in terms of quantity, level, and type of services and supports – to help a client achieve positive outcomes. All Level IV providers receive MHSA flexible funds for "whatever it takes." These funds offer flexibility in helping a Full Service Partnership individual obtain housing, pay for first and last month's rent, pay for medications that are not covered by Medi-Cal, and/or purchase basic needs for setting up an apartment.

WRAP® – Wellness and Recovery Action Plan. A plan written by a mental health consumer to help identify what makes them well and then use their own wellness tools to relieve difficult feelings and maintain wellness, resulting in recovery and long-term stability (http://www.mentalhealthrecovery.com/aboutwrap.php).

APPENDIX B: INDEPENDENT EXPERT REVIEW METHODS & MATERIALS

Interviews

In January 2011, IDEA Consulting contacted key informants from allied agencies to set up face-to-face interviews. These face-to-face interviews took place from January through March 2011. The Review Team conducted thirty (30) interviews with leaders and representatives from various county, city, stakeholder, and provider agencies.

- Provider and stakeholder organizations interviewed:
  - American Medical Response
  - The Effort
  - Homeless Coalition/Steps Forward
  - Hospital Council
  - Mental Health Contractor's Association: President
  - National Alliance on Mental Illness (NAMI)
  - Northern California Health Care Systems
  - Sacramento City Police
  - Sacramento County Sheriff
  - Sacramento Metro Fire Department
  - University of California, Davis, Department of Psychiatry
  - University of California, Davis, Department of Psychiatry – Jail Services
  - University of California, Davis, Medical Center Emergency Department
  - Mental Health Board:
    - Current Chair: Terence Imai
    - Past Chair: Chad Thompson
    - Board Members: Langley Kreuze, Frank Topping, Michael Hansen, Jane Fowler, Susan McCrea, Lois Cunningham

- Sacramento County Department of Health and Human Services staff interviewed:
  - Ann Edwards, MFT, Director
  - Tracy Herbert, Ph.D., Deputy Director, Financial and Administrative Services
  - Mary Ann Bennett, Mental Health Director
  - Dorian Kittrell, MFT, Executive Director, Mental Health Treatment Center; Interim Chief, Adult Services
  - Jeff King, Sr. Administrative Analyst, Behavioral Health Services
  - Uma Zykofsky, LCSW, Program Manager, Quality Management, Behavioral Health Services
  - Rod Kennedy, MFT, Program Manager, Adult Mental Health Services, Contracted Services
  - JoAnn Johnson, Program Manager, Cultural Competence and Ethnic Services
  - Kelli Weaver, MSW, Acting Program Manager, Adult Mental Health Services, County-Operated Programs
  - Stacy Starr, LCSW, Program Coordinator
  - Cosette Telesford, LCSW, Program Coordinator, Access Team
  - Jody Hoyt-Dunning, MFT, Senior Mental Health Counselor

- Angela Zolow, MFT, Senior Mental Health Counselor
- Takeshi Abe, MFT, Senior Mental Health Counselor
- Mike Waldron, Administrative Services Officer II, Adult Mental Health Services
- Evan Miller, Mental Health Counselor, Sacramento County Mental Health Treatment Center
- Sandy Damiano, Ph.D., Deputy Director, Primary Health Services Division
- Maria Morfin, Division Manager, Alcohol and Drug Services Program
- Marguerite Story-Baker, Program Manager, Alcohol and Drug Services Program

These interviews were a critical component of the report, as each informant provided detailed information, valuable input, and important perspectives.

Site Visits

In January and February 2011, the Expert Review Team conducted one-to-two day on-site reviews at each of the adult mental health provider agencies. The site reviews provided an opportunity for the review team to obtain an in-depth understanding of the adult mental health system in Sacramento County. A total of 157 county and provider staff participated in interviews during the on-site reviews. Clinical care was reviewed through 104 chart reviews and 50 case presentations using a performance-based review process.

All site visits included an Administrative Overview session and a Program Review session. The Administrative Overview session included a review of programs, system linkages, fiscal process, and productivity. This session also included a review of the array of services, quality management, performance measures, and recovery-focused services. The Program Review session included case presentations, chart reviews, and face-to-face discussions with consumer staff.

Agency	Number of Staff Involved in Site Visit	Number of Case Presentations	Number of Chart Reviews
El Hogar Admin	8	-	-
El Hogar RST	5	3	7
Human Resources Consultants RST	9	3	7
Turning Point Admin	13	-	-
Northgate RST	9	3	7
Visions RST	14	3	8
County Aftercare Clinic	8	4	8
County APSS Clinic	7	3	7
HRC TCORE	7	3	6
Guest House	3	2	6
TLCS New Direction FSP	15	3	-
Turning Point Pathways FSP	7	3	6
Transcultural Wellness Center FSP	10	3	6
Sierra Elder Wellness	7	3	6
Turning Point ISA FSP	8	3	7
Telecare SOAR FSP	9	3	6
Wellness and Recovery Center Franklin	5	2	5
Wellness and Recovery Center Marconi	6	3	6
Turning Point Crisis Residential	7	3	6
Total	**157**	**50**	**104**

Adult program managers, clinical staff, quality management staff, case managers, and Peer Support Specialists were involved in the site visits. Each program director received a review packet prior to the scheduled site visit. The review packet included a list of materials needed from providers, an agenda of the site review, the case presentation protocol, a list of administrative key discussion points, a list of client ID numbers for chart reviews, and bio-sketches of the Review Team. A sample of this review packet begins on the next page.

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LIST OF REQUESTED MATERIALS FROM PROVIDERS

Note: Please submit existing documentation that provides information related to the following list. Any documentation that you can provide will be appreciated. If you have already submitted specific items on this list, there is no need to submit the document again.

1. Organization Chart

2. Staffing patterns with FTE and title/license by program

3. Description of programs and services, including brochures, if available

4. Data on the number of clients served, by program
   Include information on client demographics by program, if available: age, race/ethnicity, diagnosis. Examples of written Strategic Reports and/or Annual Reports

5. Written Reports to Stakeholders showing performance and client outcomes

6. Fiscal and budget information by program (funding resources, budgets by program)

7. Management Reports showing performance and client outcomes, client utilization of services, and system performance (client outcomes, staff productivity)

8. Any reports that you send to the county as part of their contract monitoring process

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Materials may be sent to I.D.E.A. Consulting by any of the following methods:

Email: ncallahan.idea@gmail.com
Fax: 530-231-5663
Postal:
2108 Alameda Avenue
Davis, CA 95616

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MATERIALS SENT TO PROVIDER BY I.D.E.A. CONSULTING

1. Independent Review Agenda (included below)

2. Key Discussion Points to be covered during interviews (included below)

3. Case Presentation Protocol (3 cases to be presented) (included below)
   Provider will select three cases to present to the Team. Two (2) cases will be selected to demonstrate the work and linkages the programs provide to clients to achieve positive client outcomes. One (1) case selected will show system challenges and how they were addressed and resolved by the provider.

4. Chart Review Protocol and selected chart IDs (included below)
   (16 charts have been selected using key criteria and random selection). A total of 10-12 charts will be reviewed, with a focus on understanding the services provided by the program, linkages to other services, and client outcomes. Additional charts have been identified in case some of the clients have been discharged from services.

5. Bio-sketches of Review Team Members (included below)

Independent Review Team – IDEA Consulting Site Review

HUMAN RESOURCES CONSULTANTS (HRC)

January 31, 2011

Administrative Overview – Monday, January 31, 2011 Time: 8:30 am – 1:30 pm

8:30 am – 10:00 am	**Agency Overview** Review of programs and system linkages; review fiscal process and productivity	*Director* *Other staff as needed*
10:00 am – 10:10 am	*Break*	
10:10 am – 10:50 am	**Array of Services; Quality Management; Performance Measures**	*Clinical Manager* *QM Coordinator* *Other staff as needed*
10:50 am – 11:00 am	*Break*	
11:00 am – 12:00 pm	**Recovery-Focused Services**	*Consumer staff* *Coaches* *Other staff as needed*
12:00 pm – 1:30 pm	*Lunch*	

◆

Program Review – Monday, January 31, 2011 Time: 1:30 pm – 5:00 pm

1:30 pm – 3:50 pm	**Case Presentations** (N=3)	*Direct Service staff*
3:50 pm – 4:00 pm	*Break*	
4:00 pm – 4:30 pm	**Chart Review** (N=16)	*IDEA Consulting*
4:30 pm – 4:45 pm	**Face-to-Face Discussion with Consumer Staff**	*IDEA Consumer Team Member*
	Independent Review Team Discussion	*IDEA Consulting*
4:45 pm – 5:00 pm	**Summary Discussion**	*Program Director* *Other staff as needed*

Note: Agenda may need to be revised based on any driving time

Performance Based Review Case Presentation Methodology

What is the Case Presentation Review? The case presentation review is an onsite method of assessing care that uses a "case presentation" approach rather than a traditional record review. It is an in depth clinical discussion about a consumer looking across a number of dimensions. The consumer's needs are assessed along with what services are being coordinated/provided and the "fit" between the two. The methodology is used to understand how care is being conceptualized and implemented and the organizational issues related to care.

What is being assessed? While individual consumers are reviewed, the intended focus is **NOT** on the clinical work of specific staff. Rather, the intent is to look behind the actual work to understand the program, organizational, and system issues related to care. The presentation provides a window to observe the structure and support being provided by the provider agency, as well as by the County.

Process: There will be two to four clinician/reviewers on-site at the agency who will listen to the presentation and ask questions for clarification and exploration of salient issues. This is an interactive process among the review team and the presenters. The format and sequence will follow the Case Presentation Structure (see attached). The presenter(s) should be prepared to talk about the consumer's needs and capacities, how they are being supported and who (both formal and informal) is involved in the consumer's life and services.

Who should be involved? Those who best know and work with the consumer should make the presentation. This usually includes, at a minimum, the case manager or therapist and a supervisor and/or agency administrator. This is part of an independent review and not a case consultation or clinical team planning meeting. While the review incorporates various aspects of consumer/support input into the review process, it is inappropriate for the consumer and/or family members to be present during this review.

Preparation Attached is a copy of the Case Presentation Structure. Presenters should be familiar with this document and be prepared to discuss each content area. Utilizing this particular framework for discussion facilitates the process and assures the clinical team's ability to capture the necessary information. The formal presentation should be kept to under one hour.

What should be brought to the review: The clinical record will be reviewed during the case presentation. This is done to assess congruence or fit between the content of the presentation and the documentation. No additional written documentation needs to be prepared for this review.

Performance-Based Review
Case Presentation Overview

What is the Performance-Based Review?

The Performance-Based Review is a case presentation methodology that uses individual clinical cases to better understand program, agency and system strengths and barriers. This methodology is utilized in the context of a broader comprehensive review process.

What is being assessed?

While individual consumers are reviewed, the intended focus is **NOT** on the clinical work of specific providers/staff. Rather, the intent is to look behind the actual work to understand the program, organizational, and system issues related to care. The presentation provides a window to observe the structure, coordination, support, and improvements within the system and its relation to actual service delivery. Specifically, the team is using the cases to evaluate the capacity to manage resources and deliver services of the appropriate quality and intensity and the interplay within the community. The presentations should address the following:

- *The clinical appropriateness or fit between what is needed and what is received*
- *The degree to which services provided are driven by recipient needs*
- *The degree to which services and planning incorporate the service recipient's voice*
- *The degree to which services and planning are age, culturally, and linguistically competent*
- *The degree to which services are provided in the least restrictive environment*
- *The degree to which needs for housing, employment, and education options are assessed and support and services are provided*
- *The degree to which there is inclusion, recruitment, and use of natural supports and other community resources*
- *The degree to which there are appropriate linkages and integration with other systems and settings*
- *The degree to which there is congruency between the chart including assessment, treatment plan, and progress notes and the actual supports and services provided*

Case Selection

The case selection criterion focuses on the provider's capacity to assess, plan and implement care to consumers in community settings. A total of three cases will be selected. Of these cases, one shall be a person who belongs to one of the threshold language cultural groups and one shall have experienced a psychiatric crisis.

Two (2) cases demonstrating agency capacity

These case presentations should reflect how the provider's planning/collaboration/involvement contributes to community reintegration, rehabilitation, and/or recovery for the consumer and should include larger service/system improvements.

One (1) case that identifies service/system issues

This case presentation should reflect how system/service issues were elevated and how they have been resolved or how they are currently being addressed.

Process

There will be two or more clinician/reviewers on-site that will listen to the presentations and ask questions for clarification and exploration of relevant issues. This is an interactive process among the review team and the presenters. The presenter(s) should be prepared to talk about how the consumers' needs and capacities are being addressed and who (both formal and informal) is involved in the consumer's life and services, with the focus on larger system issues.

Who should be involved?

The key to the Performance-Based Review is for the provider to take the lead with a team presenting how clinical service/system gaps, barriers, strengths are elevated through the provider network and how efforts are coordinated to expand or improve care. Cases should be selected that exemplify this process. It is most helpful to include those people who have critical information that augments a comprehensive presentation. This usually includes those who best know and work with the consumer and those most intimately involved/aware of relevant system issues. This would likely include the case manager/therapist. The supervisor and/or agency administrator, and allied system personnel involved in providing resource and supporting the consumer and/or system may have important information.

What should be brought to the review?

The clinical record will be reviewed during the case presentation. This is done to assess congruence between the content of the presentation and the documentation. No additional written documentation is required for this review.

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KEY DISCUSSION POINTS

Agency Site Review: Administrative Discussion Content Areas

During the Site Review, Review Team members will have discussion with administrative and clinical staff on a range of topics. Specific questions will evolve during the interactive discussions about the agency, its interface with other organizations and the broader community.

The following content areas will form the basis for the discussions:

1. Agency organization, structure and operations
2. How Consumers enter the agency
3. How the agency and larger community respond to consumers in crisis
4. How the agency determines the needs of the consumer and the support they receive
5. How the consumer has a voice in their care
6. How the agency incorporates a focus on recovery into their activities

Sacramento Independent Review
I.D.E.A. Consulting
REVIEW TEAM BIO-SKETCHES

Nancy M. Callahan, Ph.D., is the President of I.D.E.A. Consulting and has provided consultation services to public health, mental health, drug and alcohol, and human service agencies for over 20 years. She was the evaluator for the Substance Abuse and Mental Health Services Administration (SAMHSA) Children's System of Care Cooperative Agreement with Glenn County, California, 2003-2009. In addition, she and her company provide consultation with county mental health managed care plans, State Departments of Mental Health and Drug and Alcohol, and other behavioral health organizations. Consultation services include designing comprehensive systems of care; developing outcome measures, performance indicators, and evidence-based practices for improving service delivery; evaluating System of Care programs for both California State- and SAMHSA-funded grants; performing CMS Independent Assessments of Access, Quality, and Cost-effectiveness; and developed comprehensive system-wide recommendations for system improvements. Dr. Callahan has written a number of different publications and statewide reports on the evaluation of mental health and substance abuse services.

Kathy Cramer, L.C.S.W., has a breadth of experience working in the mental health field. Before becoming the Director of Mental Health for Solano County, she administered the County's adult system of care. While managing one of their adult outpatient clinics, she worked on a number of projects to improve service delivery and was a Quality Improvement trainer. After leaving Solano County, Ms. Cramer worked for the City of Berkeley where she coordinated their Mental Health Service Act planning processes and Quality Improvement programs. She recently worked with the Alameda County Vocational Program on improving their intake processes. Ms. Cramer is retired and living in Napa County.

Michele D. Curran received a Bachelors of Science degree from CSU, Sacramento, majoring in Public Administration and Economics. She also earned an AA and an AS from the Contra Costa Community College District. Michele first noticed the psychiatric distress that made her feel isolated from surrounding classmates when she entered Jr. High and realized that it increased in intensity throughout High School and her first attempt at college. She began receiving treatment in the early 1960s, but not much was known about the despair that she experienced. Michele has been challenged by her disability for over 55 years, and, in spite of the setbacks and years of darkness, she has managed to raise two wonderful daughters, to find rewarding adventures in several high profile careers, and to discover the joy of wellness. Michele now spends her senior years working for the voice of mental health consumers where invited, and participating on several policy/planning committees on the National, the State, and local levels.

Vijay Ganju, Ph.D., is the Secretary General and Chief Executive Officer of the World Federation for Mental Health. He also works as a consultant with national, state, and local public and private agencies. He has worked in various positions at the state, national, and international levels in the areas of mental health transformation and systems change, mental health financing, quality improvement, implementation of evidence-based practices, and mental health performance measurement and outcomes. Dr. Ganju was the project director for a statewide mental health transformation initiative in Texas. Prior to this position, he was the Director of the federally-funded Center on Mental Health Quality and Accountability at the NASMHPD Research Institute. At the state level, he was the director responsible for mental health planning, research and evaluation. He has led several national initiatives related to mental health planning, performance and outcomes measures, data standards and evidence-based practices. He developed the module on mental health financing and co-authored the module on

mental health quality management for the World Health Organization. Recently, Dr. Ganju has been working on a best practices project for indigenous populations in the Pacific region.

Casey Jackson, L.I.C.S.W., has worked in the social service field for over 23 years. He was a case manager/therapist in child welfare/treatment foster care and in a sexually aggressive youth program; an outpatient therapist with drug abusing adolescents and their families; and a treatment provider for adult inmates in both state & federal prisons. Mr. Jackson currently works for the Washington Institute for Mental Health Research & Training/Washington State University as the Director of Training and Technical Assistance. In conjunction with WIMHRT, he was a clinical consultant to the Washington State Division of Mental Health headquarters since 1997 where he was the Clinical Lead for the annual Integrated Review of the public mental health system. Mr. Jackson provides tailored trainings on a variety of topics including Motivational Interviewing, chemical abuse and addiction, and mental health issues. He is skilled in system and organizational assessments, quality management, and has performed fidelity reviews of evidence-based practice programs (i.e. PACT, IDDT, MI). He also maintains a private practice and contracts with Spokane Juvenile Court to provide counseling to youth (and their families) on probation and in drug court.

Dennis Olson, M.S.W., has spent over 20 years developing, managing, and evaluating mental health programs at the Washington State Mental Health System. He developed a Performance Based Review for assessing the quality of care being provided to diverse populations. He also developed and implemented a consolidated review process that integrated regulatory, contract, fiscal, program, and performance-based elements into a single, integrated process utilized to assess and improve Washington State's public mental health system. Mr. Olson has also conducted a range of university-based evaluations involving regional and community mental health systems.

Focus Groups

In February 2011, the Expert Review Team conducted focus groups at four (4) provider agencies. These focus groups provided an opportunity for Sacramento County clients and family members to share their experience and have their voices heard.

Focus Group Location	Number of Attendees
Northgate RST	16
County APSS Clinic	11
Wellness and Recovery Center Marconi	8
TLCS New Direction FSP	10
Total	**45**

Each focus group began with a discussion on access to services. Clients were able to share their experiences on getting into mental health services in Sacramento County. Individuals then described their experience in receiving mental health services, including whether they get the help they need, how they are involved in planning their services, whether family or friends are included in their services, and whether service providers are responsive to their cultural needs. Clients also described the role of individuals with lived experience within the programs and whether there are opportunities for consumer employment in their program.

An outline of the questions discussed during the focus groups begins on the next page.

Sacramento County Adult Mental Health Services
Focus Group Prompt Questions – I.D.E.A. Consulting
Page 1 of 2

Access:

1. The current system requires that an individual who needs mental health services call the Access Team for referral to a mental health program.

    - Tell us about your experience getting into mental health services.
    - How did you find out about Access?
    - Did the process help or hinder your getting into services?

Ongoing Services:

1. Did you get the help you needed, when you needed it?
2. How were you involved in planning your services?
3. Did you have a voice in planning and designing your treatment?
4. If you wanted family or friends included in your services, would they be welcomed?
5. Were you encouraged to include your family, or friends, in your treatment?
6. Given where you want to go with your life, are the services helping you get there?
7. Were your service providers responsive to your cultural needs?

Persons with Life Experience:

1. What role do individuals with life experience have within this program? How does that help you in your recovery?
2. Are there opportunities for employment with your program?

Wellness Centers:

1. Have you ever been to the Wellness Center (Marconi or Franklin)?
2. What was your experience?
3. How did you find out about it?
4. How can Wellness Center services help clients to recover?
5. Based on your experience, if the county were to develop more wellness centers across the county, what are the most important components to include?

Crisis/ Inpatient Services:

1. Have you used Crisis Services within the last two years?
2. What would have helped you to resolve the crisis early and not go to the hospital?

Sacramento County Adult Mental Health Services
Focus Group Prompt Questions – I.D.E.A. Consulting
Page 2 of 2

System Wide Changes:

1. What changes have happened within the mental health system in the last two years? How have these changes affected you and the services you receive?
2. If you had a magic wand, what is needed in the mental health system to improve services for clients?

Additional Questions – Homeless Population

1. At what point did you decide to seek help from mental health? Why then? What prompted you to seek mental health services?
2. What was it about the program/provider that helped to engage you in services?
3. What were your biggest needs? How easy or hard was it to get help meeting those needs?
4. Did a provider help you get benefits/money/food, etc.? How long did that take? What would have made the process easier?

Additional Questions – Wellness and Recovery Center Members

1. How did you first hear about the Wellness Center?
2. What helped you decide to go to the Wellness Center?
3. What was your impression when you first came to the Wellness Center? Did you feel welcomed?
4. How often do you go to the Wellness Center? What do you do there?
5. Do you also see the psychiatrist when you are there? Would you prefer to receive all of your services at the Wellness Center, or would you rather receive your medications at another provider?
6. What role do individuals with life experience have at the Wellness Center? How does that help you in your recovery?
7. What is the most helpful thing about the Wellness Center? Is there anything that could strengthen the program?
8. Based on your experience, if the county were to develop three or four wellness centers across the county, what are the most important components to include?
9. Have your cultural and language needs been met by this provider?
10. Have you used Crisis Services within the last two years? What was effective? What would have helped you to resolve the crisis and stay in the community?
11. What changes have happened within the mental health system in the last two years? How have these changes affected you and the services you receive?
12. If you had a magic wand, what else is needed in the mental health system to improve services for clients?

Consumer Surveys

As part of the Independent Expert Review, an adult consumer survey instrument was developed by the Review Team. The instrument surveyed individuals' perception of access and quality of services. The survey instrument was adapted from the California Department of Mental Health adult survey. Survey respondents answered questions about their length of services in mental health, race/ethnicity, and current living situation. They were also asked a number of questions regarding access to services, quality, and outcomes. In addition, they were asked if they needed additional types of services (e.g., physical health care, substance abuse treatment, housing); if they indicated that they needed an additional service, they were asked if staff helped them get the service that they needed.

The survey instrument was translated into the county's five threshold languages (Chinese, Hmong, Russian, Spanish, and Vietnamese). The surveys were copied in all languages and delivered to each of the county clinics and outpatient providers who participated in this review. The providers distributed the surveys for one week, March 14 -18, 2011. Turning Point Crisis Residential program also participated in the survey process.

A total of 577 surveys were completed. I.D.E.A. Consulting analyzed the survey results. Individual provider survey results are available upon request.

APPENDIX C: LEVELS OF CARE – ADULT OUTPATIENT SYSTEM

LEVEL I			**Care Coordination Ratio – 1:200**		
Authorization: *Completed as a step-down from Level II or III services only based on policy guidelines.*					
Service Indication	**Housing, Employment, Education**	**Medication & Health Services**	**Therapeutic Services**	**Peer/Family Support**	**Indicators for Success**
Consumers who have achieved a level of independence from the county treatment system, but continue to require minimal mental health services such as medication and peer support activities.	Has stable housing. Encouraged to participate in vocational or educational programs.	Psychiatrist appointment every 3-4 months. Medication Groups. If available, transition to Primary Care Provider or Wellness Center.	Primary service modality is group service, when desired. These may include psycho-educational, skill building, or therapy groups. Use of individual therapy is limited for psychosocial crisis which is time-limited and focused. Co-occurring services.	Engaged in community programs such as the Wellness and Recovery Center, Consumer Self-Help, NAMI, and Consumer Networks. Has a strong community support system.	The consumer has strong life goals, consistent illness management skills, carries a recovery orientation, and is engaged in recovery activities. Engaged in meaningful activities (e.g., work, education, volunteer) as defined by the consumer.

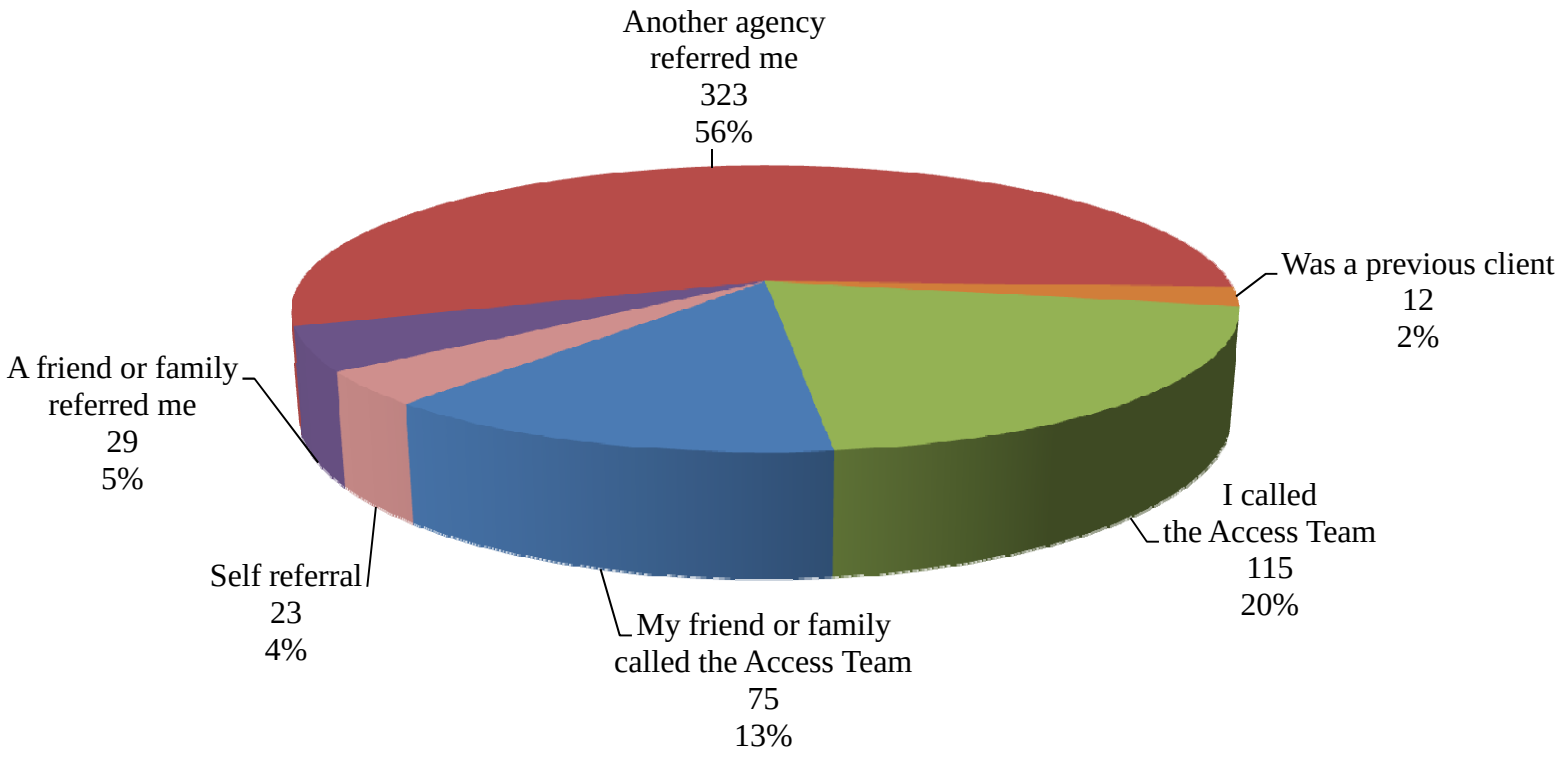
LEVEL II			**Care Coordination Ratio – 1:80 [estimated]; target 1:50**		
Authorization: *This is the primary service authorization by Adult Access for service entry.*					
Service Indication	**Housing, Employment, Education**	**Medication & Health Services**	**Therapeutic Services**	**Peer/Family Support**	**Indicators for Success**
Community support services for consumers and the main point of entry into the RSTs. Required mental health services. Develops and/or maintains a wellness plan. Needs a strong connection to treatment and support. Continues to work on relationships and responsibilities.	Assistance in accessing or maintaining community resources for housing, education, and employment. Varies from needing assistance to maintaining stable living environment. Supported employment, competitive work environment, and volunteer as desired.	Medication groups. Seen by Psychiatrist every 3 months, standby available. Developing a transfer plan to Primary Care Physician.	Primary service modality is group, psycho-educational, skill building, or therapy. Individual therapy is short-term, focused and time-limited based on identified issues. When authorized, utilizes evidence based practices. Co-occurring services.	Education and peer support in individual and group settings. Establishing and maintaining a Wellness Recovery Action Plans (WRAP) is highly encouraged. Encourage participation at the Wellness and Recovery Center, Consumer Self-Help, NAMI, and Consumer Networks. Makes use of individualized community supports.	Consumer shows very little impairment, engaged in community and peer activities. Has a plan for managing stress related to daily living including an emergency plan. Stable, supportive housing. May be involved in peer leadership activities.

LEVEL III			**Care Coordination Ratio – 1:20 – 1:25**		
Authorization: *LOCUS completion; authorization through Adult Access.*					
Service Indication	**Housing, Employment, Education**	**Medication & Health Services**	**Therapeutic Services**	**Peer/Family Support**	**Indicators for Success**
Community treatment for consumers who may be at risk and are in the pre-contemplation or contemplation stage of recovery. They may have started to engage in their treatment, but continue to demonstrate poor coping skills. This group is distinguished from a higher level by significantly reduced need for 24 hour support systems and a lower degree of impairment. Need for these services may be brief or need to be sustained for over a year. The focus of service is to firmly engage the consumer in treatment and motivate towards consumer-directed recovery.	Assistance locating housing or connecting with community resources. No housing subsidies. Can match Shelter+ Care. Vocational and educational opportunities are explored.	Seen by Psychiatrist monthly. Begin coordination with Primary Care Physician. Use of medication education, management, and health groups.	Groups available – psycho-educational, skill building, and therapy. Individual therapy is short-term, focused and time-limited based on identified issues. When authorized, utilizes evidence based practices. Co-occurring services.	Education and peer support in individual and group settings. Wellness Recovery Action Plans (WRAP) is highly encouraged. Encourage participation at the Wellness and Recovery Center, Consumer Self-Help, NAMI, Consumer Networks.	Responsive to services, some experience living independently, developing illness management skills, and developing peer and community support. Achieving some personal goals. Preparing or engaged in meaningful activity such as education, training, volunteer, or paid work.

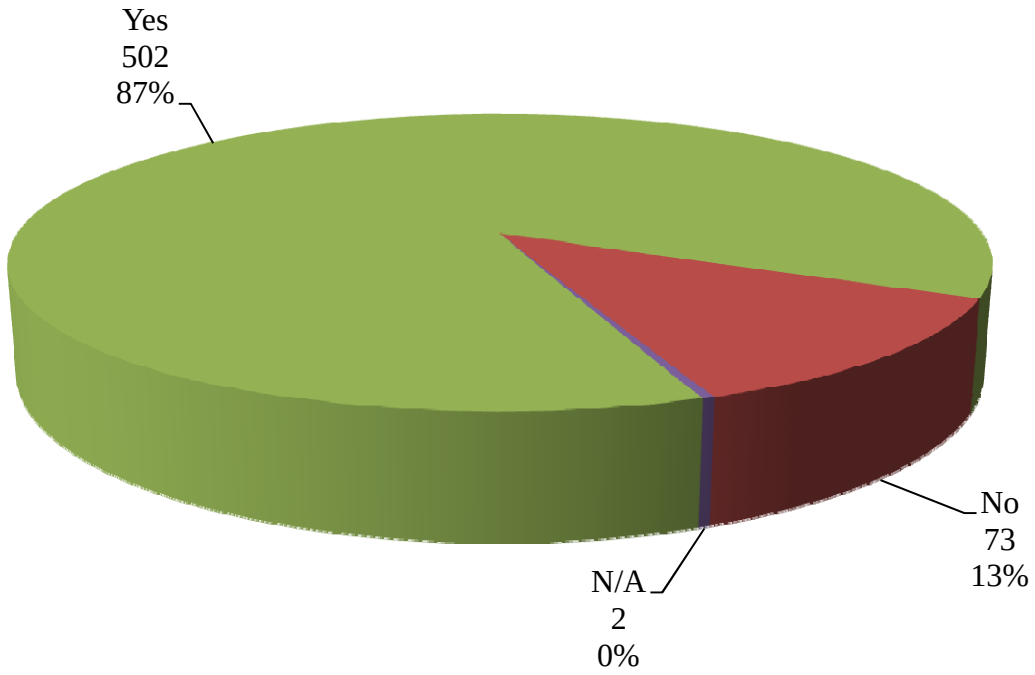
LEVEL IV			**Care Coordination Ratio – 1:10 – 1:15 per contract**		
Authorization: *LOCUS completion; authorization through Adult Access.*					
Service Indication	**Housing, Employment, Education**	**Medication & Health Services**	**Therapeutic Services**	**Peer/Family Support**	**Indicators for Success**
Highest level of community-based outpatient intensive services. These services are best for consumers who are at imminent risk of involuntary treatment, or would not be discharged without the availability of intensive community support. Team offers daily medication support, 24/7 response, integrated co-occurring disorders treatment, intensive rehabilitation and case management, and linking to benefits. Supported housing is available, and the focus of the treatment is to engage the consumer in services that will help them stabilize in a community setting.	Supported housing, subsidies when needed, services match Shelter+ Care. Supports vocational/ educational efforts.	Seen by Psychiatrist as needed. Begin coordination with Primary Care Physician. Use of medication education, management, and health groups.	Groups available – psycho-educational, skill building, and therapy. Individual therapy is short-term, focused and time-limited based on identified issues. When authorized, utilizes evidence based practices. Co-occurring services.	Education and peer support in individual and group settings. Wellness Recovery Action Plans (WRAP) is highly encouraged. Encourage participation at the Wellness and Recovery Center, Consumer Self-Help, NAMI, Consumer Networks.	Improved levels of functioning, increased interest in services, less need for 24/7 response. Linked to personal support and benefits. Stable housing. More hopeful outlook. Beginning to place value on work and community activities.

APPENDIX D: ADULT CONSUMER SURVEY RESULTS SACRAMENTO COUNTY MENTAL HEALTH SERVICES

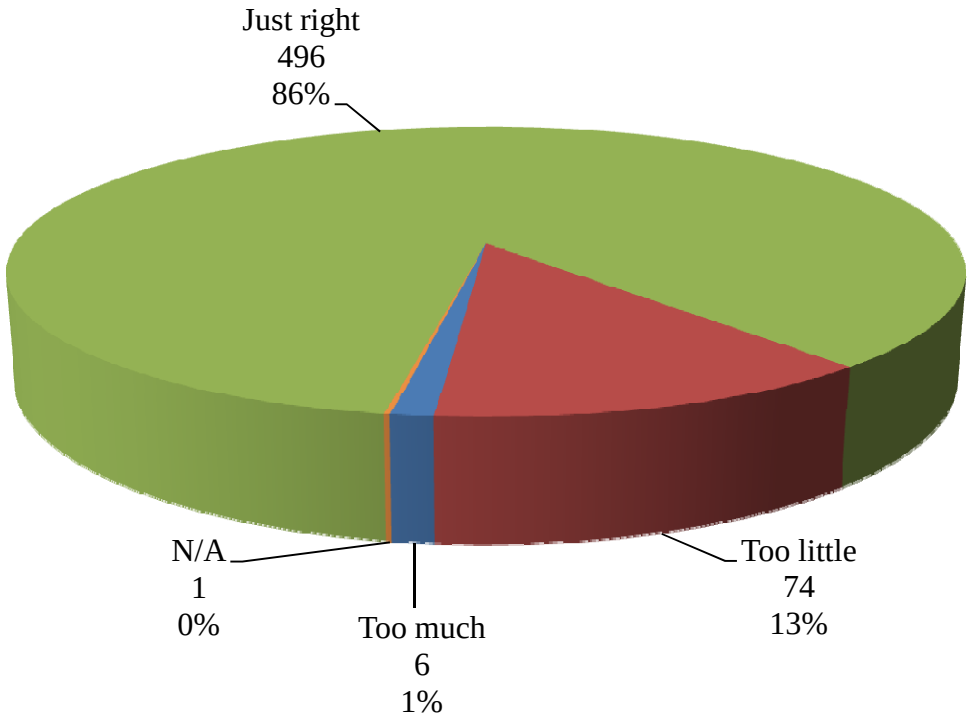
Adult Outpatient Mental Health Services
Adult Survey Results 2011
How did you get referred to this program?
(N=577)



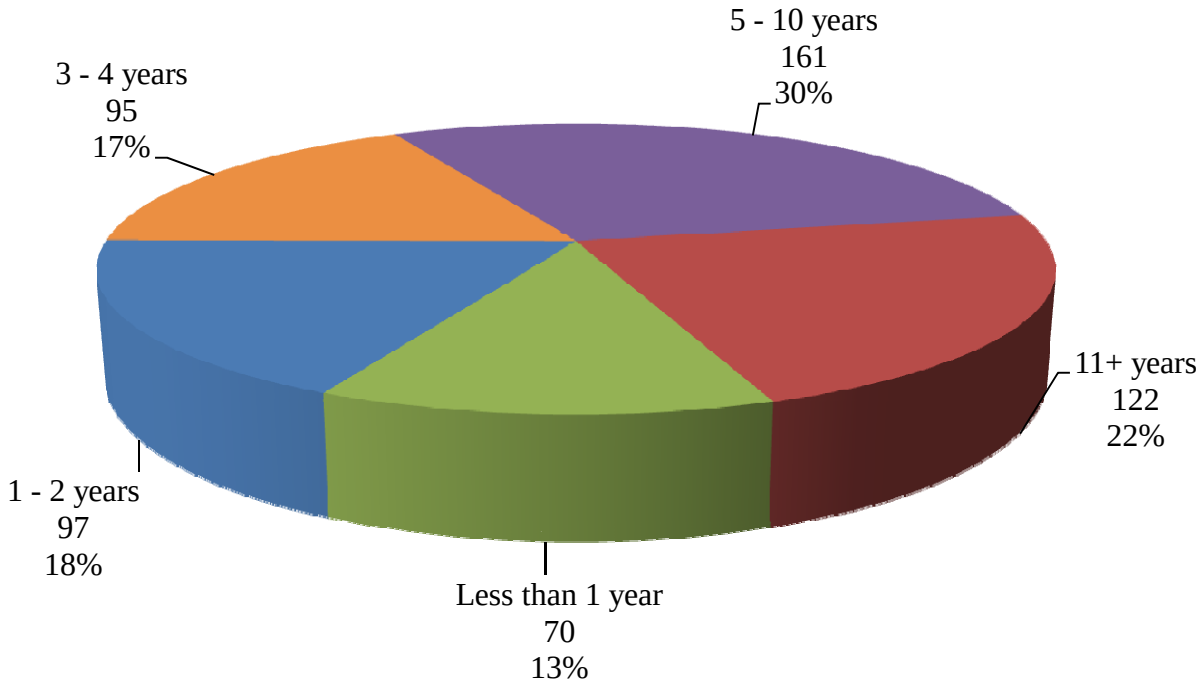
Adult Outpatient Mental Health Services
Adult Survey Results 2011
Was it easy for you to get your first appointment?
(N=577)



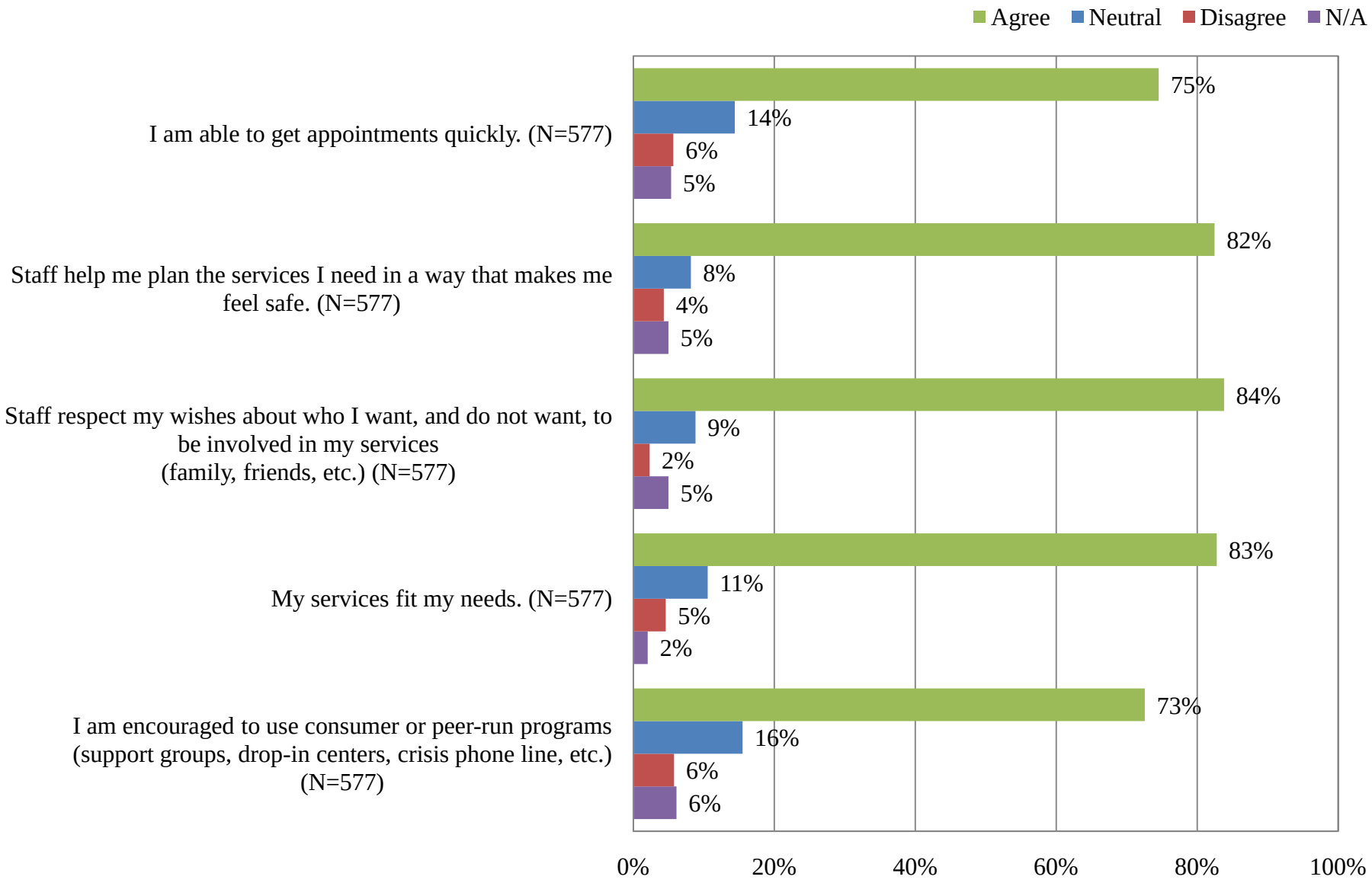
Adult Outpatient Mental Health Services
Adult Survey Results 2011
The amount of services I receive is:
(N=577)



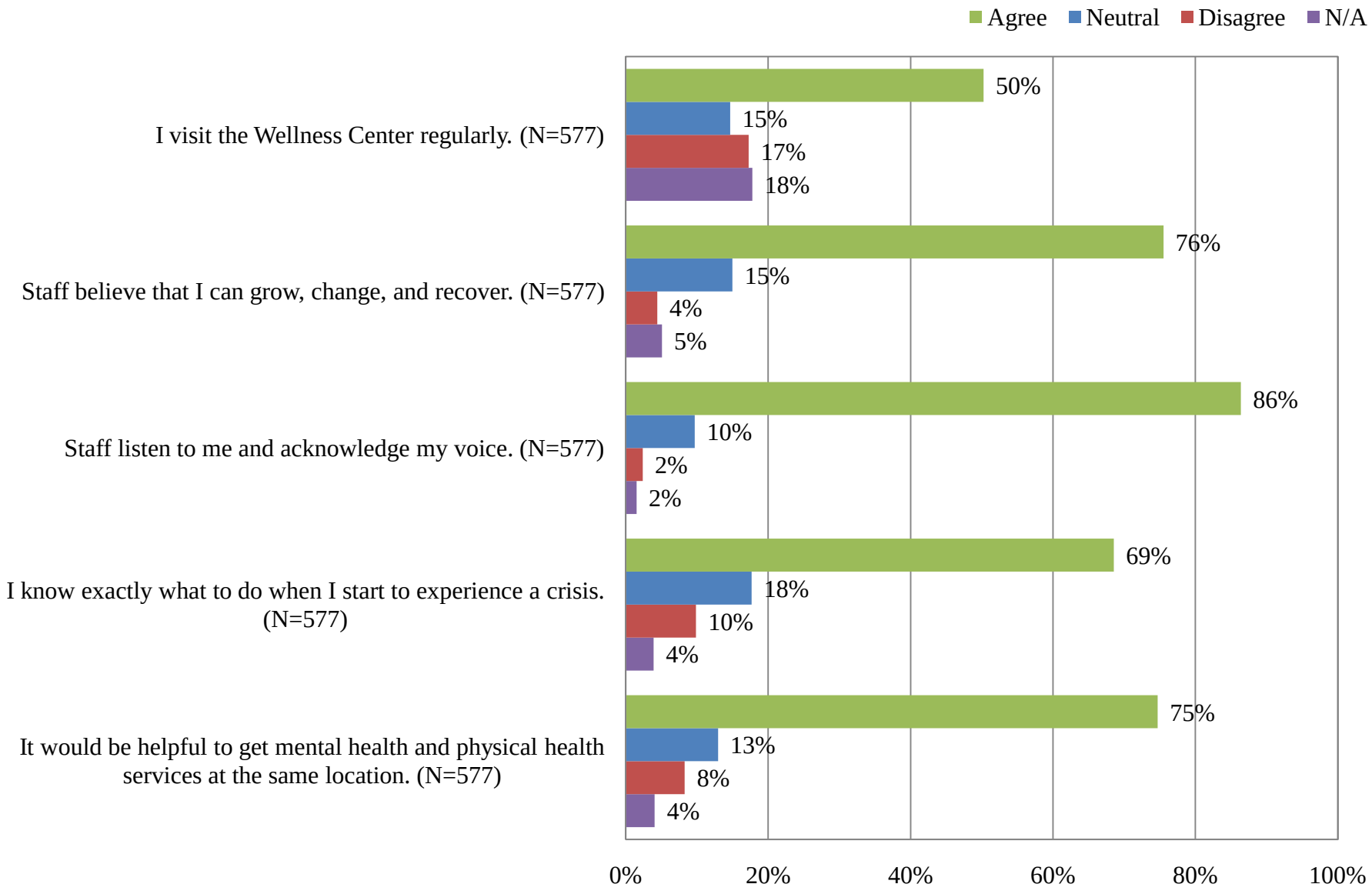
Adult Outpatient Mental Health Services
Adult Survey Results 2011
How long have you received mental health services in this county?
(N=545)



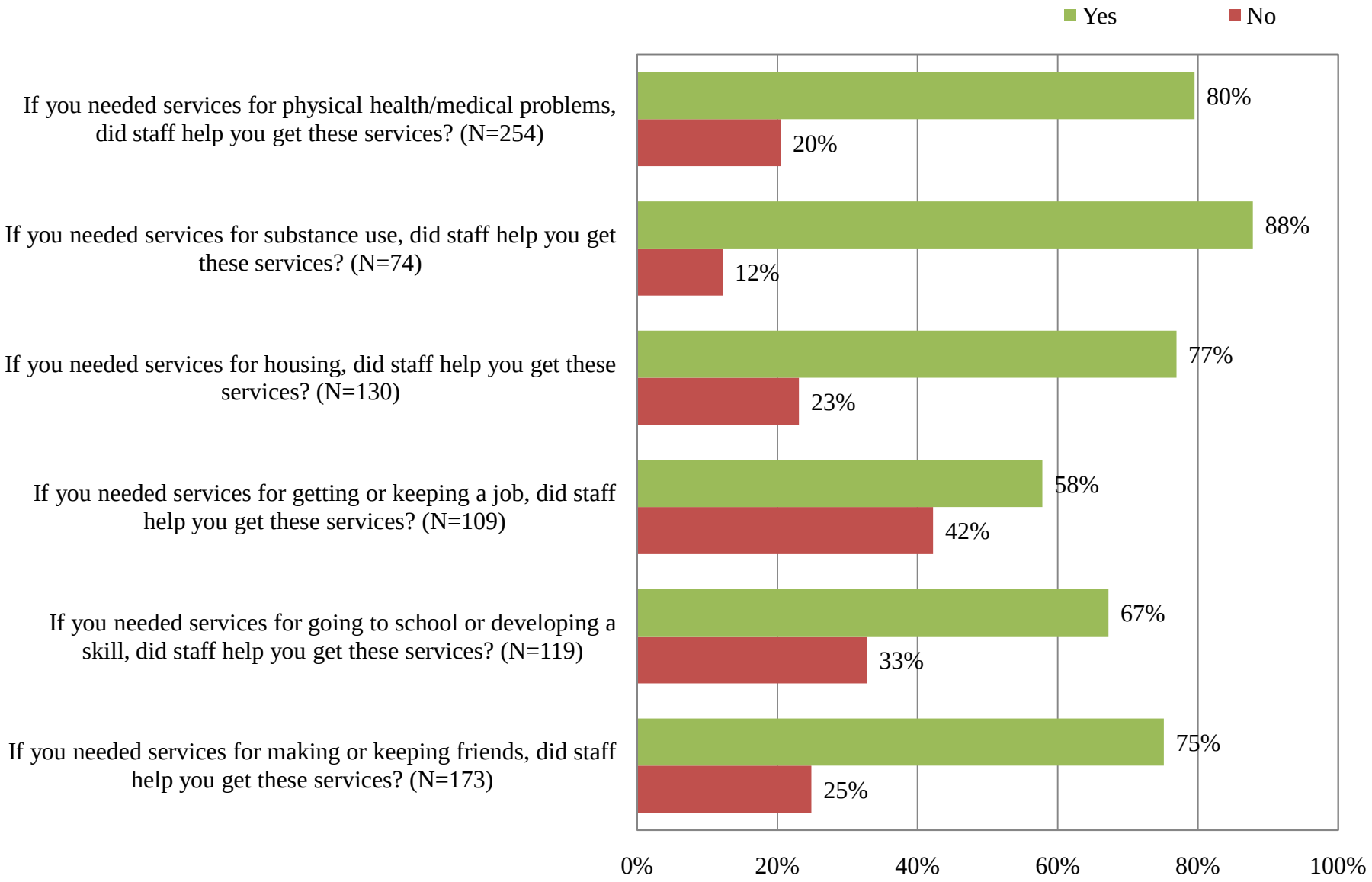
Adult Outpatient Mental Health Services
Adult Survey Results 2011



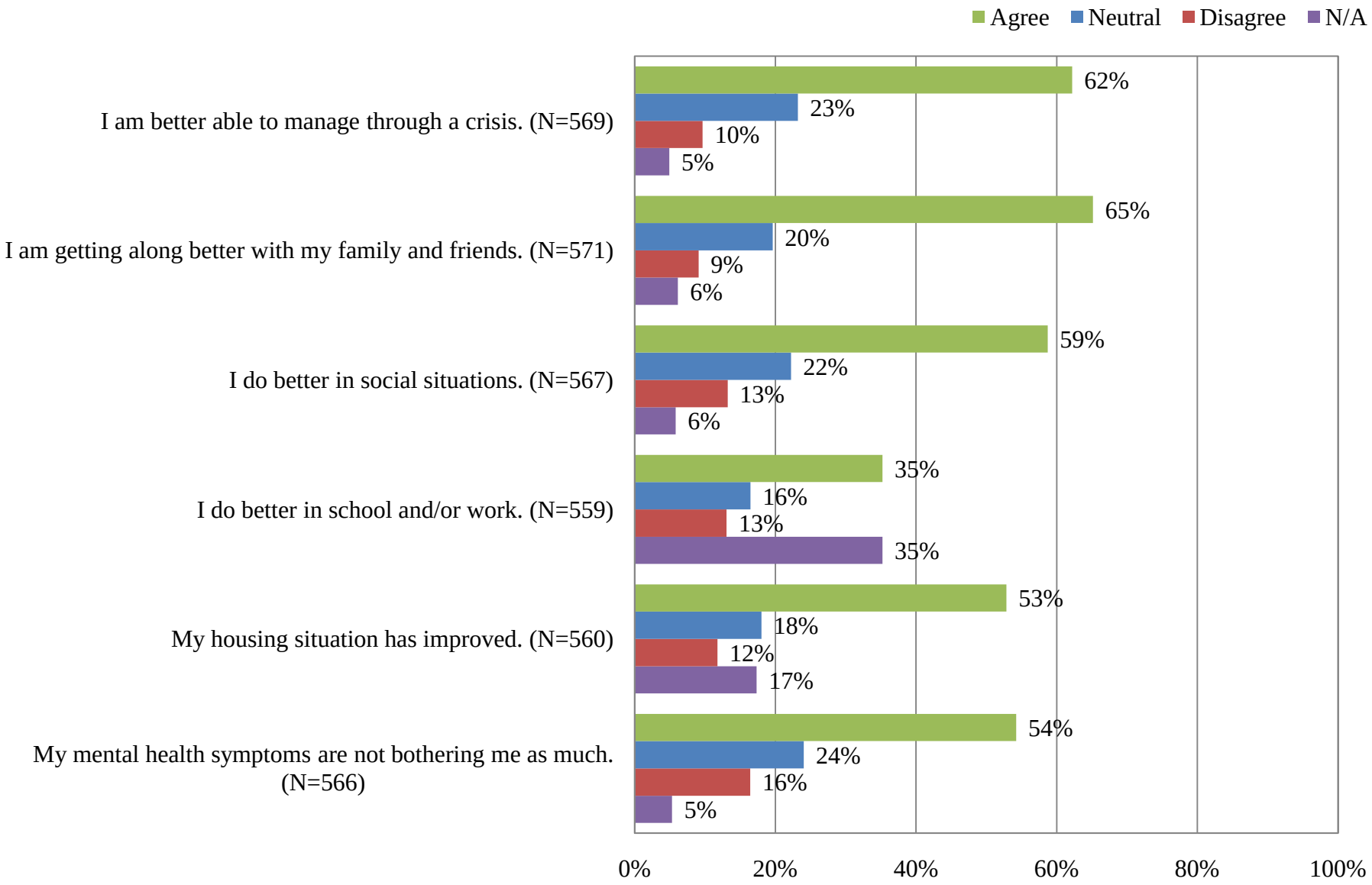
Adult Outpatient Mental Health Services
Adult Survey Results 2011



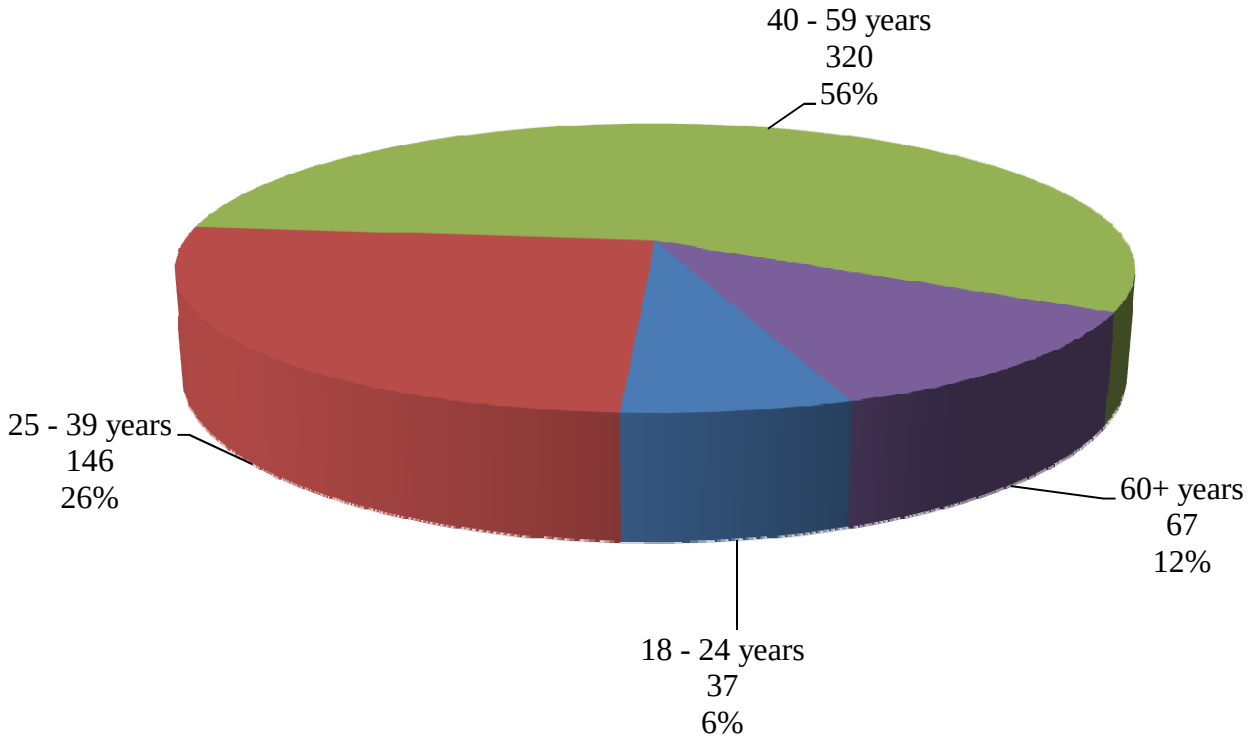
Adult Outpatient Mental Health Services
Adult Survey Results 2011



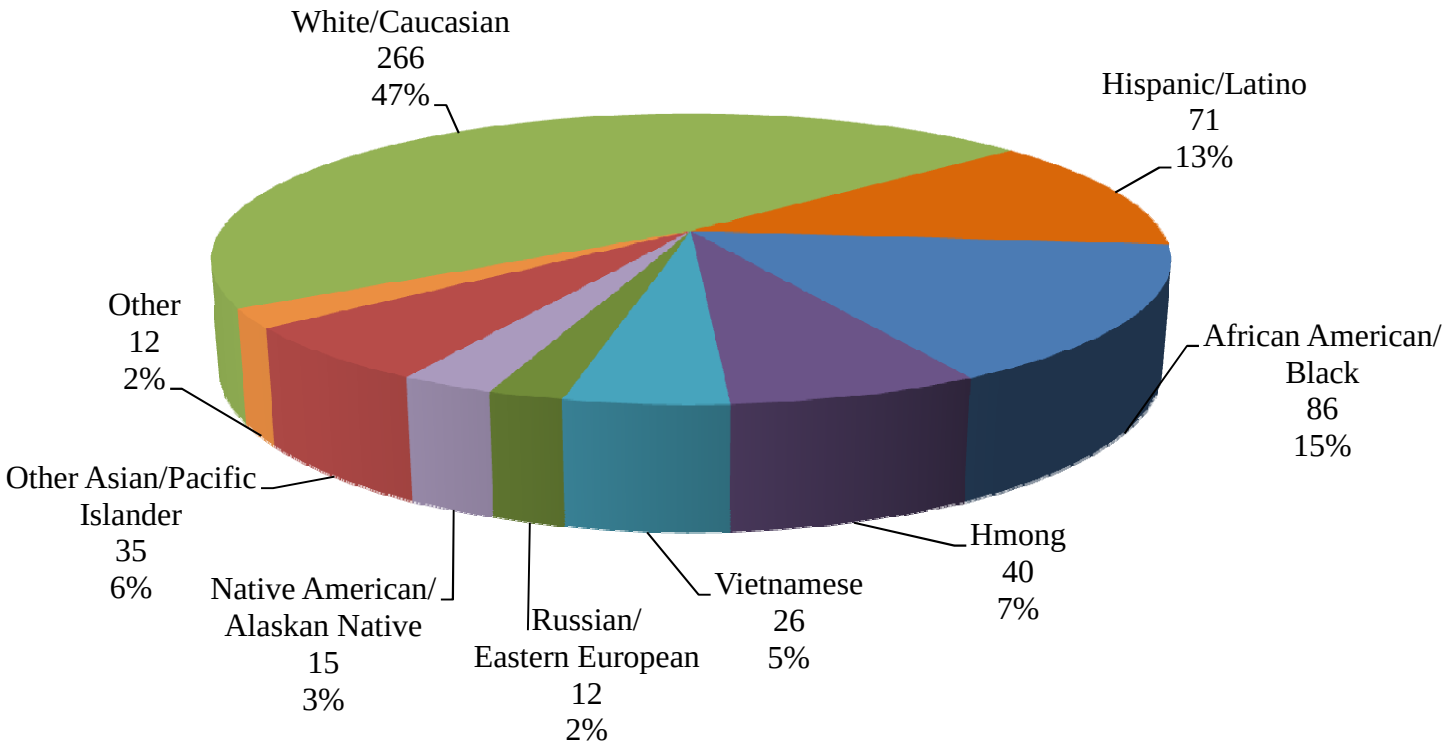
Adult Outpatient Mental Health Services
Adult Survey Results 2011



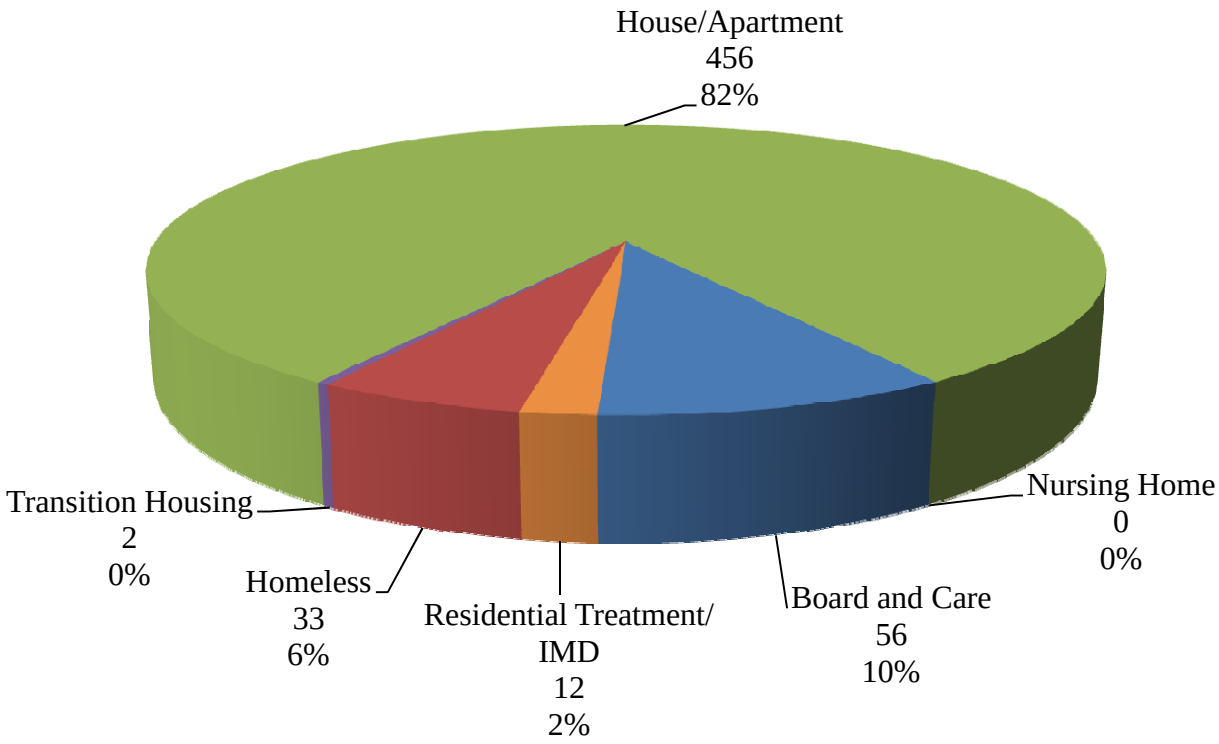
Adult Outpatient Mental Health Services
Adult Survey Results 2011
What is your age?
(N=507)



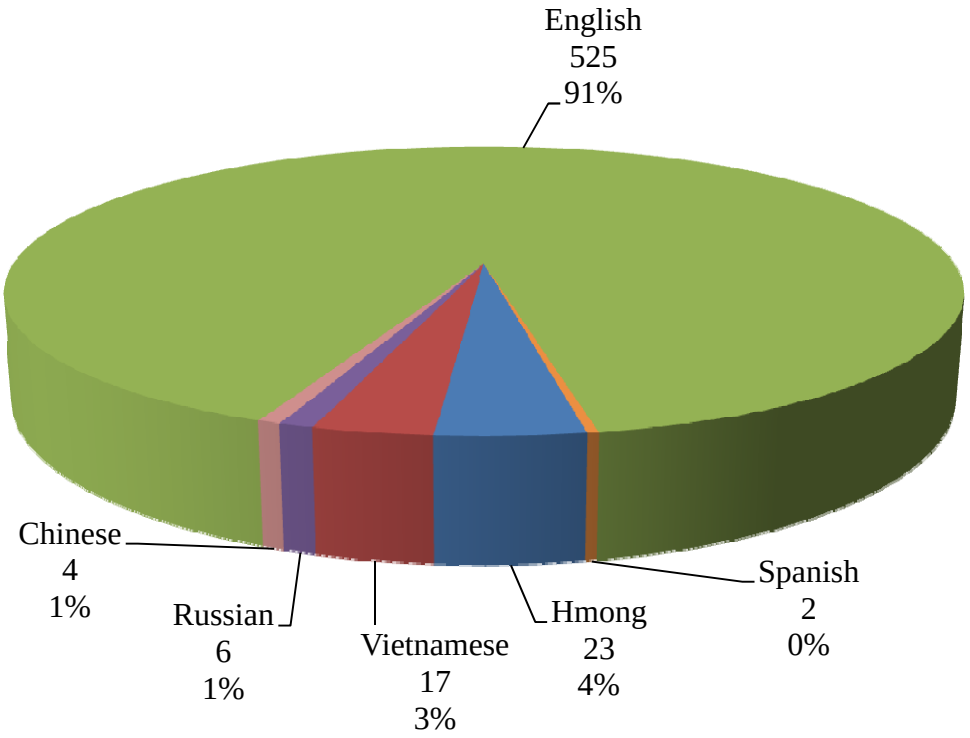
Adult Outpatient Mental Health Services
Adult Survey Results 2011
What is your race/ethnicity?
(N=563)



Adult Outpatient Mental Health Services
Adult Survey Results 2011
What is your current living situation?
(N=559)



Adult Outpatient Mental Health Services
Adult Survey Results 2011
Survey Language
(N=577)



APPENDIX E: REFERENCE MATERIALS

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