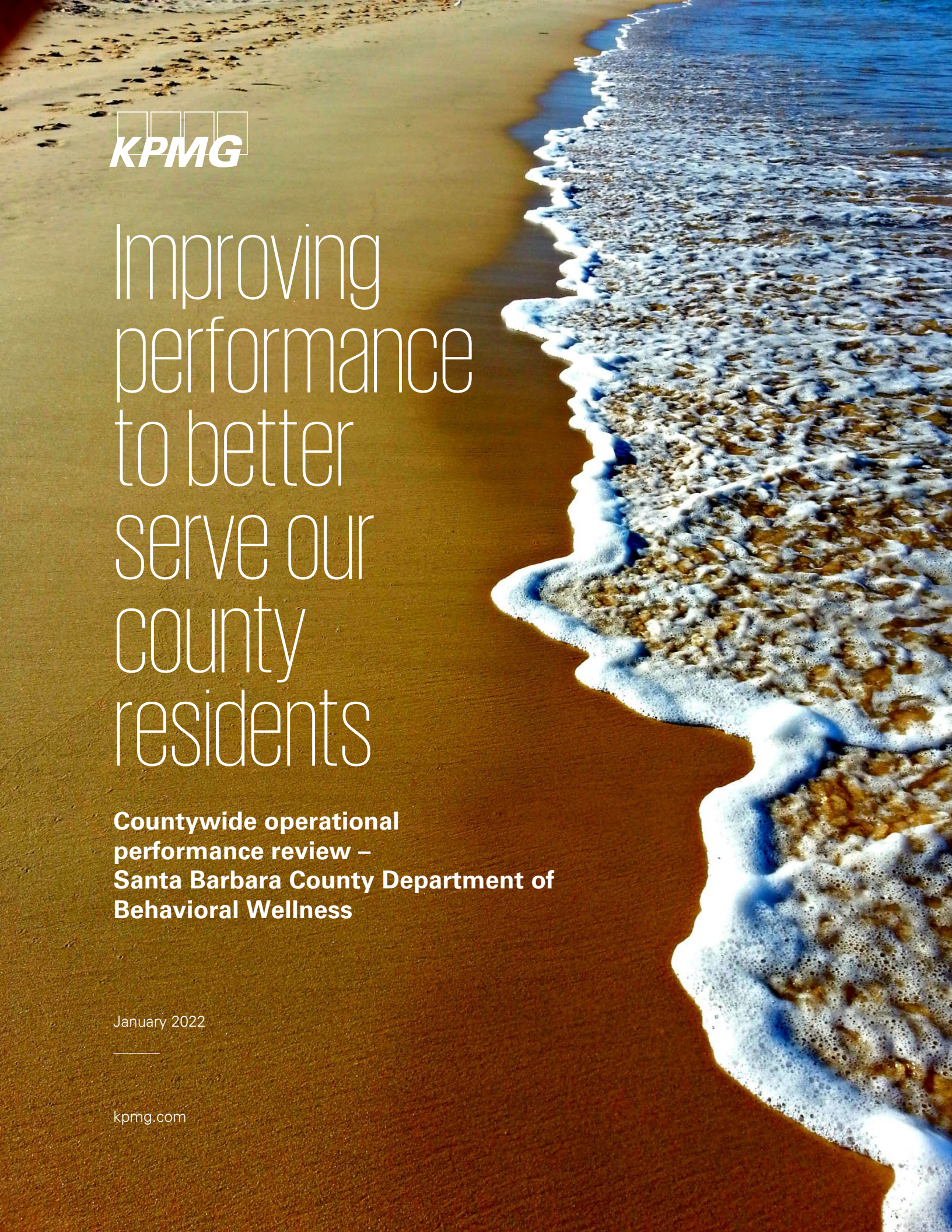


Improving performance to better serve our county residents

Countywide operational performance review – Santa Barbara County Department of Behavioral Wellness

January 2022

kpmg.com

Contents

Executive summary

Scope and methodology

The County of Santa Barbara (the County) contracted with KPMG in May 2019 to conduct an operational and performance review of all County Departments. The Behavioral Wellness Department (Behavioral Wellness or Department) review commenced in April 2021. The purpose of this review is to provide a high-level assessment of the Department to identify strengths and opportunities, and to benchmark financial and operational areas with similar jurisdictions with the focus on improving the overall operational efficiency, effectiveness, and service delivery provided by the Department.

Over a 12-week period, the KPMG team conducted the following activities:

Figure 1: Source: KPMG

- **More than 50 interviews** with Behavioral Wellness leadership and staff as well as a number of providers to understand the organizational structure, roles and responsibilities, operations, and processes of the Department
- **Analysis of available data, reports, and policy documents** to understand the demands upon and the operations of the programs and services offered by the Department
- **A benchmarking and leading practice review** was conducted of the recommended eight comparison counties: Monterey, Solano, Sonoma, Tulare, Placer, San Luis Obispo, Marin, and Santa Cruz. A number of these counties have combined Behavioral Health and Public Health Departments, and thus data specific to Behavioral Health was not publicly available. As such, the benchmarking detailed in this report focuses on Monterey, Solano and San Luis Obispo Counties from the recommended comparison counties as well as Lake County and San Bernardino County, which share a similar structure for delivering Behavioral Health services to Santa Barbara.

This report outlines recommendations to identify efficiencies and enhance service delivery across seven areas:

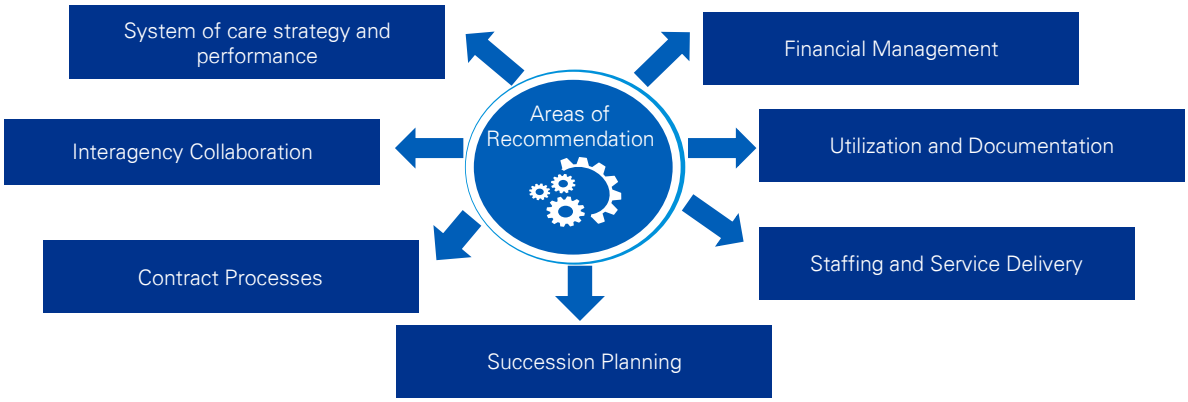


Figure 2: Source: KPMG

Department orientation

Mission statement: The mission of the Department of Behavioral Wellness is to promote the prevention of and recovery from addiction and mental illness among individuals, families, and communities, by providing effective leadership and delivering state-of-the-art, culturally competent services.

Focus areas within the scope of this review:

1. **Mental Health Outpatient & Community & Psychiatric Health Facility (PHF):** Clinic service, revenue and productivity models
2. **Program review:** Contract outcomes, fund utilization, and contract/service provider management
3. **Homeless Service Delivery & Systems Integration:** Integration of service delivery between Behavioral Health, Public Health, and criminal justice
4. **Contracting processes**: Review of internal processes for contracting to identify opportunities for efficiency and enhance collaboration with County Counsel
5. **Recruiting and retention:** Process review to include review of technology/automation use

Adopted budget (2020/21)[1]:

$134.5M	$0.2M	404
Operating expenses	Capital expenses	Full-time equivalents (FTE)

Figure 3: Source: County Budget

County benchmarks: The benchmarks utilized to develop the average FTEs and budget below relate only to those benchmark counties of Monterey, Solano and San Luis Obispo Counties, which share a similar structure for delivering Behavioral Health services to Santa Barbara.

	Santa Barbara	Average
2020 Behavioral Health Dept FTE	404	462
Percent of enterprise (FTEs)	9%	8%
2020 Behavioral Wellness Dept budget	$146.4M	$190.2M
Percent of enterprise (budget)	12%	12%

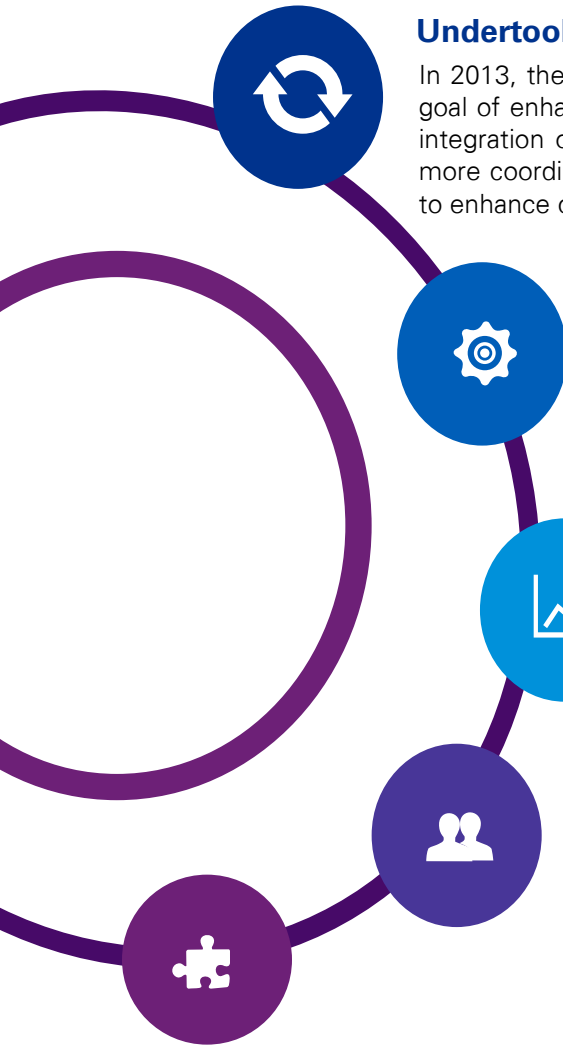
Figure 4 Source: KPMG

Organizational structure

Figure 5: Source: KPMG

[1] FY 2020-21 COSB Rec FINAL DRAFT w Bookmarks.pdf (countyofsb.org)

Commendations



Undertook a department-wide systems change initiative

In 2013, the Department began a multi-year systems change initiative with the overall goal of enhancing client access to care. Key outcomes from this initiative included the integration of Mental Health and Alcohol and Drug services to streamline and deliver more coordinated care to clients as well as the reforming of documentation processes to enhance compliance.

Championed investment in technology enablement

In recent years, the Department has made significant investments in technology enablement with the introduction of Tableau, ServiceNow, and Smartsheet. These systems enhance the efficiency of the day-to-day operations of the Department and evidence a clear commitment by Leadership to deploying technology to enhance efficiency and effectiveness.

Developed processes to track staff utilization

To maximize service delivery to County residents, the Department has implemented processes for tracking staff utilization, including a Tableau dashboard. This includes the formation of a utilization committee, which serves as a collaborative problem-solving forum with the aim of increasing Department-wide utilization, thereby working to increase the number of County residents with access to behavioral healthcare.

Deep and demonstrated commitment to serving high-need clients

At all levels of the Department there was demonstrated commitment to serving high-needs clients who often belong to vulnerable or marginalized populations. The Department has had to maintain operations during unprecedented circumstances within the last year due to the COVID-19 pandemic. During this time, staff remain deeply committed, passionate, and dedicated to serving the Department's high-needs clients and demonstrate a high degree of resiliency.

Expanded use of telemedicine

During the COVID-19 pandemic, the Department worked to safely maintain client service delivery by expanding telemedicine capabilities. Interviewees consistently reported satisfaction with this model of service delivery, noting that it enabled increased staff utilization and allowed partial mitigation of challenges related to chronic vacancies by allowing the Department to deploy staff from outside the County. While telehealth may not be appropriate for every patient, the Department should be commended for its efforts to deploy this model where appropriate to maximize efficiency.

Renew ’22 Mapping

The recommendations made within the operational and performance review have been aligned to the Renew ’22 Transformation Behaviors to help ensure that the recommendations are driving toward the Renew ’22 strategic vision, as seen in Figure 6 below. The colored tiles identify the Renew ’22 Transformation Behaviors that align to each recommendation.

			Transformation Behaviors				
			Alignment with vision	Data-driven decision-making	Strategic thinking	Risk taking	Collaborative problem-solving
Department recommendations	1.1	Conduct a comprehensive needs assessment and system of care performance assessment of target population to align service delivery to community needs					
	1.2	Conduct an analysis of high utilizers of County behavioral health services to identify highest-needs population and address gaps in existing services					
	2.1	Develop a utilization plan for existing grants and a prioritization and utilization plan for grant pursuits to align the pursuit and utilization of funding to the Department’s strategy to meet the needs of its target population					
	2.2	Develop a grant performance dashboard to track the performance and usage of grant funding on a regular basis					
	2.3	Commence departmental CalAIM readiness assessment to help ensure operational and fiscal alignment in conjunction with countywide efforts to prepare for this transition					
	3.1	Develop role-specific utilization targets and implement leading practices to enhance staff utilization across positions					
	3.2	Update data systems to enhance the reporting accuracy and data quality related to utilization tracking and unaccounted time					
	3.3	Develop a strategy and timeline related to EHR tools to address legacy systems and increase functionality					
	4.1	Review client acuity across ACT programs to assess viability of combining ACT Teams and transition to a Flexible Assertive Community Treatment (FACT) Model to better tailor service delivery to the needs of the target population					

			Transformation Behaviors				
			Alignment with vision	Data-driven decision-making	Strategic thinking	Risk taking	Collaborative problem-solving
Department recommendations	4.2	Implement demand-driven staffing and develop program-specific performance measures for Forensic Services programs to enable effective service delivery, measure program outcomes and cost benefit					
	4.3	Collaborate with County HR to review pay differentials for PHF nursing staff and adopt a team-based model of care to reduce recruitment and retention challenges					
	4.4	Collaboratively engage with Department HR to establish a policy for the managing sick leave and implement methods to reduce instances of sick leave					
	5.1	Collaborate with County Human Resources (County HR) to review human resource processes to speed recruitment timelines and develop recruiting pipelines					
	5.2	Develop a proactive strategy to enhance succession planning and department resiliency					
	6.1	Engage with County Counsel to increase specificity of expectation around turnaround times and scope of review to increase efficiency					
	6.2	Implement an electronic contract management system to better coordinate workflows and streamline the contract review and approval process					
	7.1	Enhance collaboration between homeless outreach efforts within Behavioral Wellness (homeless outreach team and clinic staffing) and between Behavioral Wellness and Community Service Department (CSD) to streamline and enhance service offerings					
	7.2	Strengthen and expand partnerships with criminal justice agencies to connect eligible justice-involved residents to behavioral health services					
	7.3	Conduct CalAIM reform planning to increase integration between Regional Health Authority and complementary County Departments including Public Health					

Figure 6: Source: KPMG

Prioritized timeline

The following report consists of 19 recommendations in seven focus areas. Recommended timing and prioritization for each recommendation is depicted below.

High-level timeline													
	Recommendations		Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12
System of care strategy and	1.1	Conduct a comprehensive needs assessment and system of care performance assessment of target population to align service delivery to community needs												
	1.2	Conduct an analysis of high utilizers of County Behavioral Health												
Financial management	2.1	Develop a prioritization and utilization plan for grant pursuits												
	2.2	Develop a grant performance dashboard												
	2.3	Commence departmental CalAIM readiness assessment												
Utilization management	3.1	Develop role-specific utilization targets, and implement leading practice to enhance utilization												
	3.2	Update data systems to enhance reporting accuracy and data quality related to utilization and unaccounted time												
	3.3	Develop a strategy and timeline related to EHR tools to address legacy systems and increase functionality												

	Recommendations		Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12
Staffing and service delivery	4.1	Review client acuity across ACT programs and transition to a FACT model												
	4.2	Implement demand-driven staffing and develop specific performance measures for the Forensic Services programs												
	4.3	Collaborate with County HR to review pay differentials for PHF nursing staff and adopt a team-based model of care												
	4.4	Collaboratively engage with Department HR to establish a policy for the managing sick leave												
Succession planning	5.1	Collaborate with County HR to review human resource processes												
	5.2	Develop a proactive strategy to enhance succession planning and Department resiliency												
Contracts processes	6.1	Engage with County Counsel to increase specificity of expectation around contract turnaround times and scope of review												
	6.2	Implement an electronic contract management system												
Interagency collaboration	7.1	Enhance collaboration between homeless outreach efforts												
	7.2	Strengthen and expand partnerships with criminal justice agencies												
	7.3	Conduct CalAIM reform planning												

Figure 7: Source: KPMG

Department recommendations

Department recommendations relate to the systems and processes needed for the Department to more efficiently manage its operations in delivering behavioral healthcare to County residents.

#	Department recommendations
System of care strategy and performance	
1.1	Conduct a comprehensive needs assessment and system of care performance assessment of target population to align service delivery to community needs
1.2	Conduct an analysis of high utilizers of County behavioral health services to identify highest-needs population and address gaps in existing services
Financial management	
2.1	Develop a utilization plan for existing grants and a prioritization and utilization plan for grant pursuits to align the pursuit and utilization of funding to the Department's strategy to meet the needs of its target population
2.2	Develop a grant performance dashboard to track the performance and usage of grant funding on a regular basis
2.3	Commence departmental CalAIM readiness assessment to help ensure operational and fiscal alignment in conjunction with countywide efforts to prepare for this transition
Utilization management	
3.1	Develop role-specific utilization targets and implement leading practices to enhance staff utilization across positions
3.2	Update data systems to enhance the reporting accuracy and data quality related to utilization tracking and unaccounted time
3.3	Develop a strategy and timeline related to EHR tools to address legacy systems and increase functionality
Staffing and service delivery	
4.1	Review client acuity across ACT programs to assess viability of combining ACT Teams and transition to a FACT Model to better tailor service delivery to the needs of the target population
4.2	Implement demand-driven staffing and develop program-specific performance measures for Forensic Services programs to enable effective service delivery, measure program outcomes and cost benefit
4.3	Collaborate with County HR to review pay differentials for PHF nursing staff and adopt a team-based model of care to reduce recruitment and retention challenges
4.4	Collaboratively engage with Department HR to establish a policy for the managing sick leave and implement methods to reduce instances of sick leave

Succession planning	
5.1	Collaborate with County HR to review human resource processes to speed recruitment timelines and develop recruiting pipelines
5.2	Develop a proactive strategy to enhance succession planning and department resiliency
Contracts processes	
6.1	Engage with County Counsel to increase specificity of expectation around turnaround times and scope of review to increase efficiency
6.2	Implement an electronic contract management system to better coordinate workflows and streamline the contract review and approval process
Interagency collaboration	
7.1	Enhance collaboration between homeless outreach efforts within Behavioral Wellness (homeless outreach team and clinic staffing) and between Behavioral Wellness and CSD to streamline and enhance service offerings
7.2	Strengthen and expand partnerships with criminal justice agencies to connect eligible justice-involved residents to behavioral health services
7.3	Conduct CalAIM reform planning to increase integration between Regional Health Authority and complementary County Departments including Public Health

Operating model maturity scale

Figure 8 below summarizes the Department of Behavioral Wellness current-state operating model across six areas of analysis, as well as the target state that can be achieved by implementing the recommendations in the following sections. The purple boxes indicate the Department's capabilities at the time of the review, and the gold boxes illustrate the level of maturity that KPMG believe is attainable through the recommendations in this report. Each operating model layer describes a continuum of maturity related to optimal service delivery. While the highest priority opportunity areas are detailed in call-out boxes in the diagram below, full descriptions of the six design layers can be found in Appendix D and Appendix E.

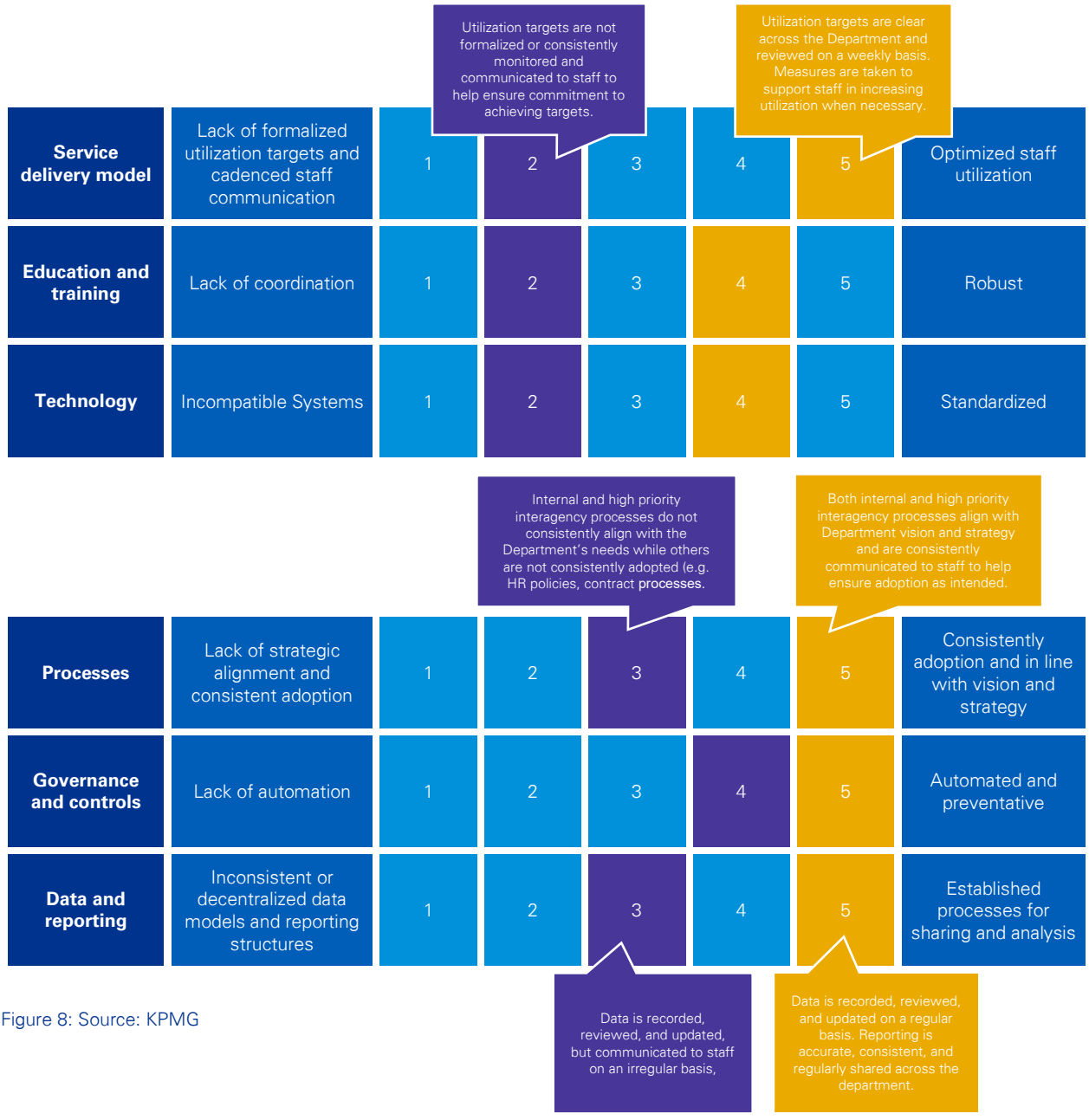


Figure 8: Source: KPMG

System of care strategy and performance

1.1 Conduct a comprehensive needs assessment and system of care performance assessment of target population to align service delivery to community needs

Healthcare and social service organizations within Santa Barbara County have conducted a number of community needs assessments in recent years, including the following:

- The Department of Public Health and providers such as Cottage Health published community needs assessments in 2016 and 2019 respectively, focusing on the public health needs of the distinct clients of these respective agencies.
- Cencal, the County's Managed Healthcare Plan, conducts an annual population needs assessment, which examines the health status of plan members.
- The Housing and Community Development Division (HCD) of CSD, acts as the lead agency for the Continuum of Care (CoC) and is mandated by the Department of Housing and Urban Development (HUD) to conduct an annual point-in-time count (PIT) of the number of persons experiencing homelessness in Santa Barbara County.
- The Department is evaluated annual External Quality Review Organization (EQRO) Audits to assess how DMC-ODS and Mental Health plans are functioning in terms of quality, timeliness and access
- The Department conducted a Community Wide Survey for COVID Recovery to assess the community's mental health symptoms, as well as assistance and recovery feedback
- In addition to the reviews identified above, Behavioral Wellness undertakes a community program planning process as part of its 3-Year MHSA Plan. This process involves soliciting feedback from stakeholders throughout the County of Santa Barbara on what to include in the initial plan draft. Feedback is collected via Department Action Team meetings on specific programs and /or needs at regional community stakeholder forums. Forum attendees include local community organizations with an awareness of mental health needs.

While the above reviews provide valuable insights to service providers within Santa Barbara County, even when taken together, they do not provide comprehensive insight into the needs of Behavioral Wellness' target population, particularly persons with behavioral health needs within the community who are not currently served by the Department. Additionally, the above studies are siloed— focused on particular subpopulations (e.g., Cencal members or homeless individuals) or conducted for a specific purpose (e.g., to inform the 3-Year MHSA Plan) and do not comprehensively identify the met and unmet needs of the full target population across the range of services offered by Behavioral Wellness including outpatient clinical services, inpatient care, crisis services, and forensic services.

In addition to the assessments operating in silos, these assessments do not include a community evaluation process. These assessments focus either on the operational aspect of accessing care rather than identifying what the needs of the community are in terms of programming and service, or on meetings with service providers at large forum meetings, rather than connecting with community at large. While the forums are open to the public, persons experiencing homelessness for example, or individuals in the County Jail who may have distinct and differentiated needs may not be engaged in these forums.

The Department would benefit from a comprehensive needs assessment to better understand the needs of the Department's clients and the behavioral health needs of County residents broadly, particularly those not yet served by the Department. A needs assessment is a process that would identify the key behavioral healthcare needs, as well as the barriers to service and modifications to resolve those barriers through systematic, comprehensive data collection and analysis. This assessment could build on the community planning process already undertaken as part of MHSA planning and leverage known data and stakeholder input that may be available from the EQRO audits.

In addition, this needs assessment should be augmented by a system of care performance assessment focused on reviewing capacity, access, quality, and outcomes across the Department's current service offerings and system of care. This performance assessment can leverage the work of the Department's Quality Control Management (QCM) Division, which monitors the quality of care that consumers receive by conducting regular audits and evaluations and developing strategies to meet performance goals.

Taken together, these reviews will support management decision-making in enhancing the overall system of care. The needs assessment will provide Department leadership with insight into the behavioral health needs of Santa Barbara residents, while the performance assessment will provide visibility into the extent to which the Department's current service offerings are meeting these needs. The findings generated by these reviews will help the Department to more optimally align service offerings to resident needs, to identify and resolve barriers to successful service delivery, and to make coordinated, informed, and strategic decisions regarding the investment of the Department's funds.

Action one: Establish a cross-divisional departmental Needs Assessment Committee to plan the needs assessment

The Needs Assessment Committee could build on the Department Action Teams who undertake the community planning process for the MHSA plan. The Committee should include representatives from Department divisions, clinics, and programs across medical operations, clinical operations, and alcohol and drug programming. The Needs Assessment Committee should have the following responsibilities as it relates to the development of the needs assessment plan as well as activities related to the needs assessment process outlined in action two below:

- Designate a suitable timeline for the needs assessment. Based on KPMG experience, typical needs assessments are undertaken over a three-to-six-month period.
- Consider whether the needs assessment should be performed by a third-party provider organization or whether the study should be undertaken directly by Department staff.
- Additionally, as an alternative to a department-specific needs assessment focused specifically on County residents with behavioral health needs, the Department in collaboration with the CEO's Office may consider conducting a cross-agency needs assessment. A targeted, department-specific needs assessment would provide Behavioral Wellness with a greater understanding of its clients which can assist with decision-making surrounding programs and services. However, individuals with serious and persistent mental illness often have complex needs that span County agencies under the County's current organizational structure. As a result, there is an opportunity for the County—though collaboration across Behavioral Wellness,

Social Services, CSD, Public Health, and the criminal justice agencies—to conduct a coordinated, cross-agency, cross-jurisdictional needs assessment, led by the CEO's Office. This process will provide the following benefits:

- Provide key needs assessment information to Behavioral Wellness
- Assist the County broadly in understanding the needs of Santa Barbara's residents across the continuum of services including behavioral health, public health, social services, criminal justice, housing, and homelessness
- Allow the County to better target cross-departmental service offerings
- Enhance the blending and braiding of countywide funds to better align with the multifaceted needs of the community.

Action two: Develop a process for data collection

Having developed a needs assessment plan, the Needs Assessment Committee, should consider how the data will be collected. There are a number of methods that can be used for data collection including:

- Surveys
- Interviews
- Focus groups
- Data analysis

Based on KPMG experience, needs assessments typically utilize multiple data collection methods such as those identified above to help ensure a more comprehensive approach to identifying community needs. Regardless of the data collection methods utilized, a number of questions should be developed for use within surveys, interviews and/or focus groups. Examples of questions that could be included within a survey and/or interview list include the following.

- What are your top three greatest behavioral health needs and/or service needs?
- What factors would increase willingness to accept behavioral health service and/or broader service offerings?
- What are the current factors that discourage service acceptance? (e.g., quality, access, lack of offerings)

In addition to developing surveys and holding interviews and/or focus groups, the Department should consider conducting analysis of available data across the County's systems, including Clinicians Gateway, to understand current levels of service utilization within the Department.

In determining the appropriate design for the needs assessment and data collection, if not conducted by an MHSA-funded third party consultant or contract provider, the Committee should develop a roadmap for completion, which may include action steps such as recruiting and training Department staff to survey and conduct the needs assessment, considering incentive(s) available for participation in the assessment (e.g., whether those with behavioral health issues experiencing homelessness will be compensated for their participation), and identifying appropriate staff to conduct data analysis and report writing.

Action three: Collect and analyze the data to identify community needs

Having collected the data, the next steps in the process will be to input and analyze the data to provide the required insights. The results of surveys, interviews, and focus groups could, for example, be

documented in a spreadsheet with dashboard outputs that would act as a central location for the data obtained. The data could then be analyzed to develop detailed insights into the needs of the community. This phase of analysis should also involve regular Committee meetings where analysis can be discussed. This process, for example, will allow the Department to identify:

- Current health status of its target population
- Primary areas of need
- Reasons behind service resistance and opportunities for process improvement and
- Service enhancement based on community engagement.

In addition to the data gathered from surveys, interviews, and focus groups as detailed above, the Department should review relevant data on the needs of the Department's current patients as captured in Clinicians Gateway and other existing technology systems.

Action four: Conduct a system of care performance assessment

Having identified the needs of the target population as a result of the steps taken under actions one through three above, the Department should conduct a system of care performance assessment. This assessment will allow the Department to understand how successful the current system is in meeting the needs of the target population across four broad areas: capacity, access, quality, and outcomes. This assessment will augment the quality performance evaluations undertaken by QCM and will assist the Department in answering the following questions:

- Is there sufficient capacity across the Department's service offerings to meet demand?
- Are individuals able to access the care they need at the right time and the right level?
- How long does it take to access care once referred and how well are clients case managed thereafter?
- When services are accessed, are they delivered at a high quality that leads to improvement, recovery, and successful outcomes?

In conducting this assessment, the Department should develop performance measures around each of the four areas of examination: capacity, access, quality, and outcomes. Examples of possible performance indicators to assess capacity, access, quality, and outcomes include the following (this list is not exhaustive):

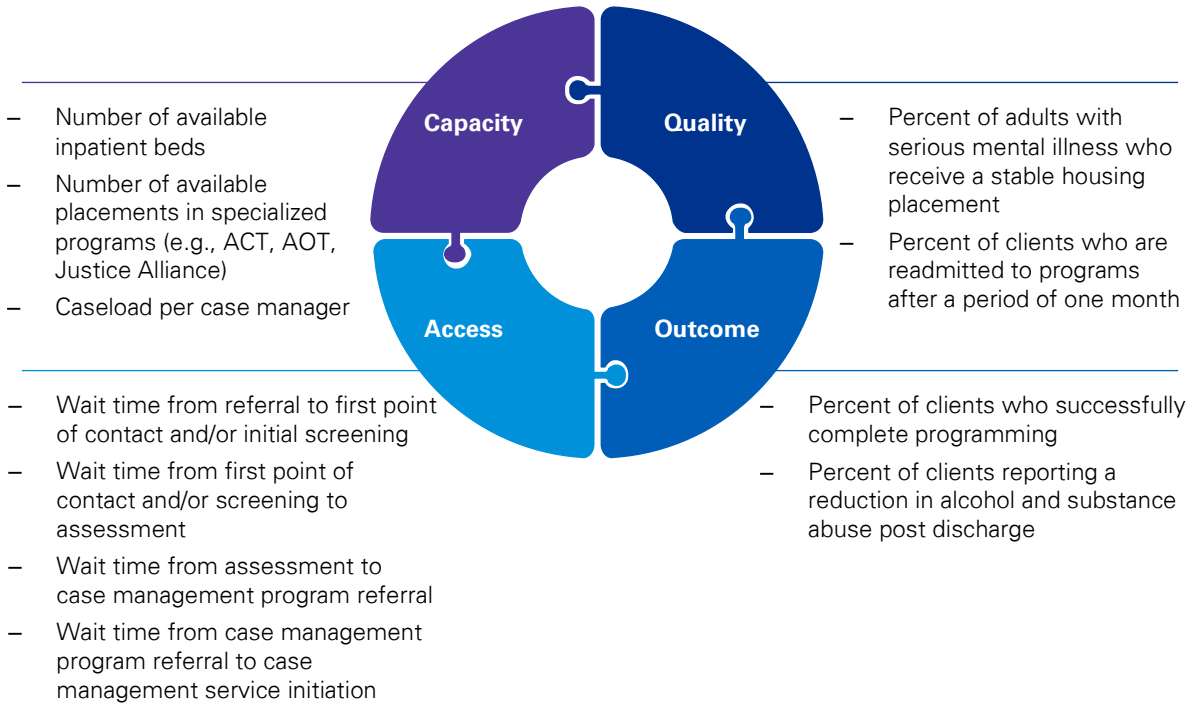


Figure 9: Source: KPMG

This analysis should be conducted annually going forward and will provide Department leadership with the analytics to help optimize the current system of care to best serve the residents of Santa Barbara.

Action five: Deploy needs assessment analysis and performance assessment to revise Department's strategy and service offerings to best meet the community's needs

Once the needs of the Department's clients have been identified and the system of care performance assessment completed, the data should be utilized to inform future decision-making surrounding the development of specific population cohorts, program and service offerings. This process could subsequently be linked with the grant management process discussed under recommendation 2.1 as it will assist in directing the Department toward the grant funding sources which may have the greatest impact on the community based on the distinct needs identified in Santa Barbara County.

The needs assessment should be undertaken every two to three years by the County or by a third party consultant if preferred and should be used as a mechanism to measure whether outcomes as they relate to the system of care performance assessment are being met. This process will allow the Department to understand whether any service offerings or other measures added as a result of the initial needs assessment are having the desired effect of reducing the unmet need across the community. The graphic below illustrates the needs assessment process.

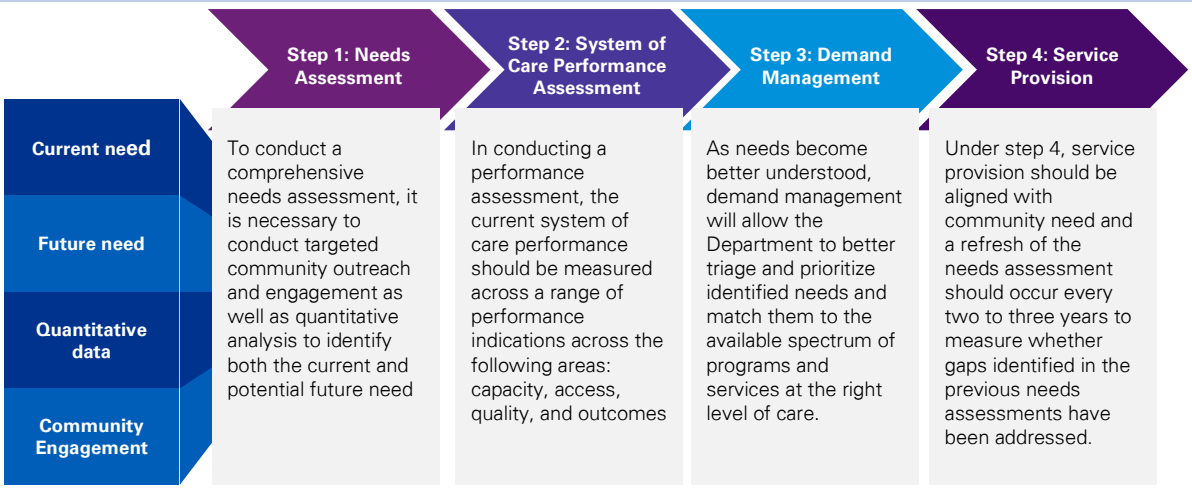


Figure10: Source: KPMG

1.2 Conduct an analysis of high utilizers of County behavioral health services to identify highest-needs population and address gaps in existing services

High utilizers are clients who impose a disproportionately high burden on the behavioral health system and/or other County services (such as public health, criminal justice, and social services) due to their complex and multifaceted needs. For example, it is common for chronically homeless persons to disproportionately interact with both crisis healthcare services in the form of emergency room visits, as well as criminal justice services in the form of welfare checks, 911 calls, or arrests for low-level charges such as public intoxication or criminal trespass. Additionally, some individuals with serious and persistent mental illness may disproportionately interact with County behavioral health, primary health, and criminal justice services.

As a result of these complex needs, such individuals often incur very high healthcare costs from potentially avoidable utilization of inpatient care and emergency room services. High utilizers typically move between various healthcare settings including emergency rooms, Institutions for Mental Disease (IMD), and other inpatient admissions and/or readmissions. Additionally, this high utilizer population may cycle in and out of the County jail and disproportionately make contact with law enforcement and the Emergency Medical Service (EMS), consuming criminal justice funding while, too often, failing to receive the services necessary to address their underlying needs.

Commendably, the Department has developed a Tableau report to monitor hospital re-admissions which identifies specific data about clients who re-admit within approximately 30 days and are likely high utilizers of service. Theis report allows the Department to development targeted interventions.

Additionally, the Department have developed a High Utilizer Working Group in order to commence analyzing department-wide high utilizers. This working ground functions more as a "complex case review," as the team reviews 1-2 clients per month by request. The High Utilizer List provided by the Department shows clients' most recent hospitalization, the number of PHF hospitalizations in the last two years, the number of crisis contacts in the last two years, and a yes/no if there are co-existing issues. This report, and the timeline of case reviews, does not allow for an accurate representation or analysis of the County's high utilizer population. The following actions will address the gaps with the current reporting methods. These actions would build on the community wide assessment discussed within Recommendation 1.1 and a previous examination conducted by the Sheriff's Office of high utilizers of the County's jail system.

Action one: Task the High Utilizer Working Group with inventorying the data sets necessary to identify department-wide high utilizers

The existing Working Group should be tasked with determining the data sets and analyses necessary to identify high utilizers across the Department's current systems and programs, as well as the departmental staff necessary to conduct this work. Based on the data analysis, the Working Group should also determine the definition of a high utilizer for the purposes of the study (e.g., a threshold for number and/or types of contacts over a fixed period).

Action two: Conduct data analysis of cross-agency systems to determine high utilizers

The Working Group, in collaboration with IT should subsequently conduct data analysis of the Electronic Health Record (EHR) system in order to validate the high utilizers identified as a result of the steps described within action one. This analysis may involve factors such as:

- Client demographics (age, race, sex, and ethnicity)
- Top utilized services
- Top attended programs

- Clients with the longest period of service within the system
- Most common diagnosis
- Most common co-occurring conditions
- Clients with the highest number of IMD stays
- Clients with the highest number of 5150 holds (A 5150 hold allows an individual with a mental illness in crisis to be involuntarily held for a 72-hour psychiatric hospitalization).

Action three: Conduct strategy design and problem-solving based on findings from departmental high utilizer data analysis to refine Behavioral Wellness service offerings

Based on the findings from the data analysis described above, the Working Group should lead strategy and problem-solving sessions to evaluate the extent to which the Department's current service offerings meet the needs of the identified high utilizer population, identify any gaps in services or barriers to access, and work with Department leadership to pilot and implement revised service offerings to better meet the needs of the Department's highest-need patients. Problem-solving sessions should also evaluate preventative or early intervention measures to prevent individuals entering the system before they become high utilizers. This work may include holding interviews, focus groups, and brainstorm sessions with line staff and those with lived experience of behavioral health issues across the service continuum in order to develop solutions to improve service delivery. This process could build on the Master Naming Index program being undertaken by the criminal justice agencies which focuses on developing high utilizers of the jail system. There are a number of strategies which can be implemented to revise and enhance service offerings some of which the Department has already commendably begun to implement, such as a multidisciplinary team approach to care in the form of ACT. Examples of such strategies include:

- Providing cross-departmental, coordinated care to a cohort population
- Increasing or reducing program capacity based on analysis of high utilizer needs
- Enhancing the level of warm hand-offs between cross-departmental service offerings
- Continuing to utilize a multidisciplinary teams of case workers with expertise across behavioral health, public health, housing and homelessness, social services and criminal justice to identify and address any gaps in service and provide coordinated services to the cohort population.

Action four: Utilize the data to develop strategic client cohorts who can be served by multiple agencies

Developing cohort strategies will require cooperation across all the relevant divisions. To achieve this, the Working Group established under action one should convene a number of subcommittees with representation from program managers within each Division. The Department's IT Division should also be included within these groups to advise on technology-related strategies. The subcommittees should be tasked with developing strategies for strategic cohorts for recommendation to the cross-divisional Working Group. Each subcommittee will be assigned one strategic cohort, based on the data review undertaken by action three above. The below on the following page illustrates a number of potential cohort types which could form the basis for future potential cohorts.

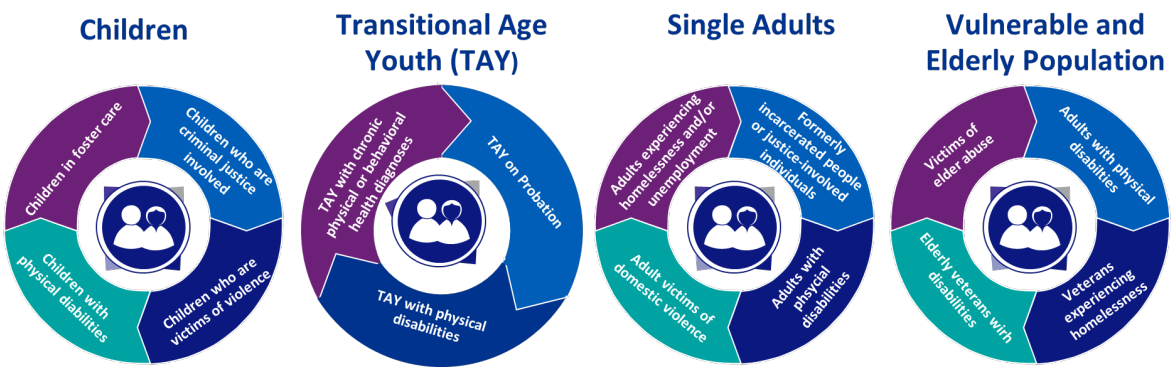


Figure 11: Source: KPMG

Action five: Enhance cross-departmental partnerships to promote a more coordinated system of care, particularly for shared clients

Having developed cohort strategies, the Department should enhance cross-departmental collaboration particularly for shared clients and clients identified as having wide-ranging needs. Collaboration could take the form of monthly meetings to discuss shared clients and refer others to cross-departmental services. This approach will reduce complexity for clients in navigating service across the continuum of care, promoting a "no wrong door" approach to the provision of services, a key focus of CalAIM. A key component of these partnerships will also involve collaborating with County Counsel and Compliance to ensure that departments can share the necessary data to enhance coordinated care while remaining in compliance with HIPPA and other federal regulations such as 42 CFR. This may also require an update to the protocols and workflows in place, legal or otherwise for sharing client data across departments, particularly as it relates to obtaining release of information (ROI) forms.

Action six: Pilot cohort programs and monitor impact

The Work Group in collaboration with its subcommittees should pilot programs to address the needs of high utilizer cohorts for a six- to nine-month period.

Outcomes for each specific cohort should be closely monitored during the pilot period with any issues with pilot program delivery identified and resolved, where possible. The following are examples of performance measures which could be employed to measure impact (this list is not all inclusive):

- Number of clients served
- Service utilization rate per cohort
- Number of clients who successfully receive behavioral health services
- Number of clients who accept shelter or transitional housing
- Number of clients who recidivate
- Number of clients who become justice involved during service delivery.

Based on continuous performance monitoring, cohorts should be refined where required and ultimately a decision made as to whether a cohort should be fully implemented based on overall impact.

Action seven: Collaborate with other County Departments to develop systemwide high utilizers

Leading practices to meet the needs of the high utilizer population typically involve collaboration between Behavioral Health, Public Health, Social Services, CSD, and criminal justice agencies such as the Sheriff's

Office, District Attorney, Probation Department, Public Defender, and the independent branch of Superior Courts. Having identified department-wide high utilizers, the Department should consider collaborating with the CEO's Office to deliver a cross-agency high utilizer study across agencies such as Public Health, CSD, Social Services, and the criminal justice agencies. This interagency study will allow the County to identify and better understand the individual circumstances of the highest-frequency users of County crisis services. Additionally, this review will allow the County to conduct cross-agency problem-solving to determine any gaps in service provision or identify the reasons these individuals have not received the services necessary to transition out of a cycle of crisis. Finally, it will allow the Department to identify high utilizer cohort profiles and correlating factors for high utilization, thereby helping departments determine which of their clients may be at risk of increased service utilization in the future without effective intervention.

The Departments, led by the CEO's Office, may consider developing an interdepartmental multidisciplinary team to manage this interagency process which would involve significant data-sharing and collaboration across agencies. The team would be responsible for managing data analysis, developing insights, and identifying high utilizers across multiple systems. Following analysis and cohort development, this team would be tasked with providing cross-departmental, coordinated services to the identified cohort populations. The team would be staffed by frontline subject matter experts across the Departments identified above who would work together to case manage and develop integrated care plans for each client within the identified cohorts. The approach will allow for increased cross-departmental data-sharing and allow for a more coordinated system of care, particularly for those clients with the highest need.

Commendably, the County's criminal justice agencies are collaborating on a naming index project to enhance cross-departmental data-sharing. Behavioral Wellness is now also part of this project and the project may be leveraged in developing systemwide high utilizers. As part of this process, the County may consider developing an integrated data tool to act as a cross-departmental data hub to allow for the sharing of data across agencies. This system would allow authorized staff across agencies to view client data across various systems, identify shared clients, and provide a more coordinated system of care. As noted in action five, in developing such a system, the Departments will likely need to consider privacy requirements under HIPAA, develop privacy agreements across system utilizers, and obtain release of information from clients where possible.

Financial management

2.1 Develop a utilization plan for existing grants and a prioritization and utilization plan for grant pursuits to align the pursuit and utilization of funding to the Department's strategy to meet the needs of its target population

The Department currently obtains funding from a total of 24 grants, each of which is linked to specific services across a range of areas including: behavioral health, diversion, substance use, housing and homelessness, and crisis services, among others. The Department's pursuit of and success in obtaining grant funding is commendable, allowing the Department to deliver expanded services to residents while minimizing costs to the County.

The Department aligns its grant funding with its 5-year plan, however, there is no formal prioritization and utilization plan in place for that ties the funding to the Department's strategy or the distinct needs of the Department's clients. This results in a number of challenges:

- There are no monthly spend targets for each grant, and the Department has at times risked having to return funding or request extensions for grant funding due to an inability to utilize the grant within the stipulated timeframe. However, it is important to note that in certain instances, the Department incorporates Med-Cal funding into grants in order to maximize program funding. Due to the cost reimbursement nature of Medi-Cal it is often challenging to predict Medi-Cal revenue to offset against grant funding to be drawn. In circumstances where more Medi-Cal funding than budgeted is earned during a grant period, an underspend of grant funding typically results. However, given the reforms to funding mechanisms proposed under CalAIM discussed further in recommendation 2.3, this challenge will likely be alleviated.
- Finally, interviewees report that costs reimbursable under certain grants may be unclear and staff reported lack of clarity on whether they can charge time to a grant code.

Commendably the Department have recently employed a Grants Coordinator to manage the oversite of all grant writing, meeting scheduling, minute taking and reporting to grantors. However, as detailed in the following pages, the Department would benefit from a formal prioritization and utilization plan for each grant that underscores alignment of funding to Department strategy and ties funding to community need. Future decisions surrounding grant pursuits should consider the results of the needs assessment discussed under recommendation 1.1. Aligning grant funding to community need will ensure that the County is adequately targeting the services required by the community at large which will in turn promote a faster pathway to recovery. Additionally, the development of this prioritization and utilization plan should involve collaboration with the Department's Fiscal Division, thereby allowing the Department to leverage information related to grant performance in future decisions about which grants should be pursued by the Department.

Action one: Establish a cross-divisional Grants Management Committee

The Department should consider establishing a Grants Management Committee, which would comprise representatives from all Divisions across the Department involved in the grant funding and management process including at a minimum:

- Grant Coordinator: The Department's Grant Coordinator should be tasked with coordinating meeting attendees, meeting scheduling, agenda development, minute taking, providing progress updates on pursuits, and overall committee and meeting management
- Executive Leadership: The Grant Committee should include representation from at least 2 / 3 Division Chiefs to chair meetings, ensure grant funding pursuits under consideration are in line with the prioritization and utilization plans and provide programmatic related input, particularly, surrounding implementation of grant funding and program need
- Fiscal representation: The Committee should have representation from the fiscal division who would be responsible for budgeting, managing and reporting on utilization and any related risks
- IT representation: IT should also be represented on the Committee to consider systems best placed to share and evaluate date as well as manage the development of the dashboard recommended in recommendation 2.2
- QCM and Research & Evaluation: A representative from both QCM and Research & Evaluation should form part of the Committee to report on any data collection issues and data analysis related to grant funding including alignment with grant funding requirements and performance measures.

Collectively, the Grants Management Committee would be responsible for:

- Identifying new funding sources (state, federal, and philanthropic) to find grant opportunities that support the Department's strategy for delivering behavioral health services
- Developing a prioritization plan and a utilization plan for each funding source to help ensure grant funding can be effectively and efficiently utilized within stipulated timeframe (see actions two and three for further discussion)
- Tracking the alignment of each funding source to the utilization plan on a recurring basis and reporting to Executive Leadership

The Committee should meet monthly to discuss potential grant pursuits as well as evaluate the performance of existing grants against the utilization plan.

Action two: Develop a strategic grant pursuits prioritization process

The Committee should be tasked with developing a grant-funding prioritization process for funding pursuits to identify grants which are most aligned to community need and department strategy. The development of grant applications requires a significant investment of time and resources. Developing a prioritization process will help ensure that the Department pursues funding which best aligns with need—reducing the risk of funding being returned to the grantor. There are a number of methods that can be incorporated to develop a prioritization process including the scoring model which involves scoring each potential funding pursuit against a range of criteria with the following being the development steps:

- Select three or four scoring criteria against which the funding pursuit can be scored (e.g., community impact, and alignment with community need, historical outcomes of similar funding sources)
- Assign ranges to the criteria to rank the pursuits (e.g., 0–5 or 0–10)
- Assign weights to each category (e.g., outcome may be a more significant deciding factor than impact)

Any prioritization criteria should be developed based on available data including the results of the needs assessment discussed under recommendation 1.1, as well as historical data related to grant performance. Funding should be pursued for services aligned with the greatest need and most successful outcomes (historically).

Action three: Develop a project utilization plan

In addition to a grant pursuits prioritization plan, the Grants Management Committee should be tasked with developing a utilization plan for each grant-funding source. The utilization plan should identify the following at a minimum:

- Timeframe within which the grant will be received
- Timeframe within which the grant must be utilized and related reporting and compliance requirements
- The number and expertise of staff that should be hired to deliver the services required under the grant
- Clear consensus on which services and programs the grant will support
- Amount of funding to be spent monthly to help ensure optimal usage of funds
- Performance of the grant to date (i.e., amount expended to date)

The Grants Coordinator should be tasked with coordinating, updating and reviewing the utilization plan monthly to help ensure optimal usage of funds. Any issues with fund utilization should be identified and presented by the Grants Coordinator during Grant Committee meetings. Subsequently, the issues should be discussed, and collaboratively resolved by the Grants Management Committee.

Action four: Implement a process to monitor progress toward achieving goals under the project prioritization and utilization plans

Project prioritization and utilization plans should be monitored regularly in order to evaluate progress toward achieving outcomes. These plans should be monitored and reviewed in line with the grant performance measures and performance dashboard discussed under recommendation 2.2. The performance measures should be analyzed against alignment to each plan. Regular project monitoring will ensure that underperforming projects can be course-corrected early on, with any issues resolved in an efficient and effective way. Any performance measurement process will require cadenced data analysis and reporting to Executive Leadership to allow results to be monitored and remediating actions undertaken.

2.2 Develop a grant performance dashboard to track the performance and usage of grant - funding on a regular basis to assist in decision-making surrounding funding pursuits

At present, the Department does not have a robust performance measurement reporting system related to grant funding. Each grant has a specific set of performance metrics and evaluation criteria; however, these measures tend to focus on programmatic outcomes rather than metrics related to funding utilization rates. Furthermore, given the differing nature and purpose of each grant, required performance measures are often not easily comparable across funding sources. This can result in difficulties in determining those grants with the greatest impact to inform decisions surrounding which grants should be pursued. While program outcomes are a key performance metric and should continue to be measured to inform outcomes and ensure compliance with state and federal funding regulations - effectively measuring fund utilization and overall performance across grants is also key to making data-driven decisions surrounding developing future grant applications, undertaking funding pursuits, and identifying and resolving poor performance and overall grant management. The Department currently tracks utilization performance based on amount of spend to date versus total grant funding. While this is a key metric, there is a need to develop a more consistent and balanced set of performance measures across each funding source such as costs incurred to date, staff time coded to the funding, and funding period remaining. These metrics will allow the Grants Management Committee and Executive Leadership to identify the grants at risk of not meeting the expected spend within the required timeframe and the potential reasons for this, e.g., staff not appropriately coding time to the grant. The dashboard should also be linked to performance outcomes which will allow one grant-funding source to be compared against another in terms of overall funding, number of positions provided, amount of services funded, number of clients served and identify those grant types that have the greatest impact and are best value-for-money. This process can in turn inform future decision-making and prioritization on which grants to apply for.

At the time of review, the Fiscal Division utilized a spreadsheet to track spend for each grant funding source received. The tracker is updated periodically and includes the name and description of the grant, award amount, grantor, period of receipt, program contact among other information. The spreadsheet provides a summary of each grant source; however, it is not automated or available for viewing in real time and creates a risk that all grants may not be included in the tracker. It also does not include factors such as utilization rate, cost incurred to date, and staff time coded to the grant, for example. Additionally, grant performance reporting to Executive Leadership is not undertaken on a regular basis to inform decision-making on grant pursuits ensuring that the Department targets and pursues the funding sources which most align with the needs of its target population.

However, commendably between initial review and the time of writing this report, the Department have developed an initiative to inventory all grant funding sources and has developed a Smartsheet form which will be distributed to all division chiefs. The smartsheet spreadsheet includes data surrounding grant name, focus area, target audience, grantor, award amount, fund, program, revenue account, start date, end date, claim frequency, description, program, fiscal, and grantor contacts, as well as baseline start and finish dates. However, similar to the initial excel spreadsheet discussed above, it does not include factors such as utilization rate, cost incurred to date, and staff time coded to the grant. A project management sheet has also been developed which includes automated alert emails to ensure relevant parties are aware when a particular grant deliverable is due. Once all necessary data has been collected the Department aims to develop a grant dashboard as recommended in the actions outlined below.

Action one: Develop a consistent set of grant performance measures

The County should task the cross-divisional, Grants Management Committee with developing a number of consistent and balanced grant performance measures. Examples of such performance measures, while not exhaustive, include:

— Number of programs/services funded by each grant

— Number of positions funded by each grant

— Number of clients served by each grant

— Utilization rate

— Services provided as a result of each grant

— Compliance with state and/or federal guidelines.

— Grant outcomes such as overall community impact and value-for-money

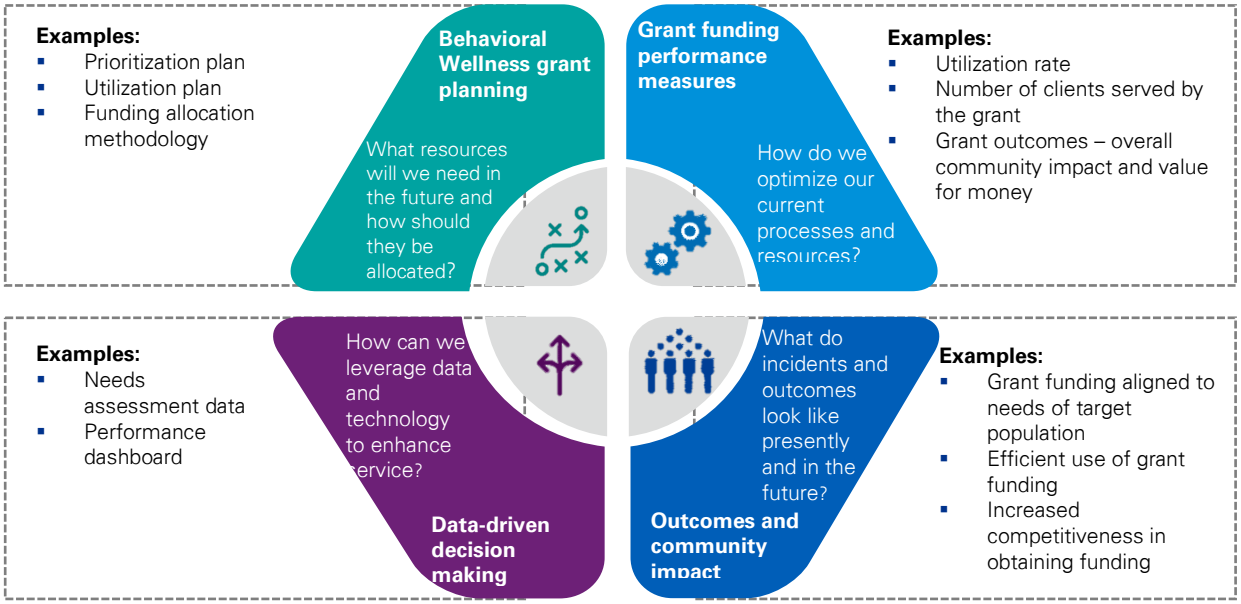


Figure 12: Source: KPMG

Action two: Develop a monthly dashboard of grant performance

The Department currently uses Tableau to visualize staff utilization data and should consider whether this platform could be utilized to develop a monthly dashboard to monitor grant performance. However, in advance of any upload to Tableau, data will need to be compiled, analyzed, and checked for data quality such as alignment to grant prerequisites. The Department will need to consider the staff best placed to compile the data and undertake analysis for subsequent issuance to Executive Leadership and other key stakeholders. QCM or the Fiscal Division, for example, may be best suited to conducting this analysis based on their current roles within the Department. The Grants Management Committee should be tasked with monitoring the dashboard on a monthly basis and identifying opportunities to improve performance in real time.

2.3 Commence departmental CalAIM readiness assessment to help ensure operational and fiscal alignment in conjunction with countywide efforts to prepare for this transition

In October 2019, the Department of Health Care Services (DHCS) published a set of Medi-Cal reforms referred to as California Advancing and Innovating Med-Cal (CalAIM). CalAIM was initially scheduled for implementation over a five-year period beginning in January 2021, however, commencement has been postponed until January 2022 given the impact of the COVID-19 pandemic on public health agencies across the State. CalAIM is intended to address long-standing challenges with Medi-Cal with key policy changes in the following areas:

- CalAIM proposes a number of reforms to improve service delivery for county behavioral health services, including streamlining its financing from cost reimbursement to an outcomes based approach, exploring new federal funding opportunities for residential care, integrating behavioral health services at the local level, and changing eligibility rules so more beneficiaries can receive behavioral health services
- Extending Components of a Current Federal Waiver (1115 Waiver) that allows the State to obtain federal funding that may not be otherwise available such as substance use disorder services
- Enhancing focus on Medi-Cal's high-cost, high-risk members by providing a more coordinated level of care and a broader suite of supportive service to high-needs clients
- Transforming and streamlining Medi-Cal Managed Care (managed by Cencal in Santa Barbara) by moving certain benefits from fee-for-service to Managed Care, considering a full-integration pilot whereby plans would offer an array of services including public health, mental health, substance use disorder services, and dental services, and setting payments for managed care plans on a more regional basis.

The area with the most significant implications for Department operations is in the area of Medi-Cal financing, as the State will transition away from a cost reimbursement approach. Currently, the Department funds behavioral health services locally and subsequently submits expenditure reports to the State. The Department receives reimbursements from the State on an interim basis until the completion of a cost reconciliation process that typically takes place annually. This current approach to cost reimbursement does not monitor outcomes or provide flexibility in empowering counties to offer incentives or take innovative approaches to increase productivity, effectiveness, or innovation.

Under the CalAIM initiative, the State is proposing a new funding mechanism known as Intergovernmental Transfer (IGT) and a transition away from the current cost reimbursement model. The IGT mechanism will identify an overall funding amount for the County for a defined period of time, which will likely involve the following steps:

- At the outset, the County will transfer funds to the State to cover the nonfederal share of costs
- The State will utilize the County-transferred funds to claim the federal funding
- Once federal funding is claimed, the State will return the local funds along with the federal funds to the County

This mechanism under IGT will eliminate the need for cost reconciliation under the cost reimbursement approach.

While many aspects of CalAIM continue to remain under development at state level, the eventual transition will have a significant and fundamental impact on the way the Department manages its operations. The initiative will impact decisions related to the County's EHR system as well as

productivity, billing, reimbursement and cross-departmental coordination, collaboration, and integration. For example:

- The transition will likely result in updated billing requirements which may impact the EHR capabilities required by the Department and should be considered when evaluating EHR functionality which is discussed further in recommendation 3.3.
- The shift toward a fixed rate of funding as opposed to cost reimbursement will require the Department to develop utilization targets based on financial considerations and enhance utilization management to ensure there is not a net financial impact to the Department following transition.

Department representatives have participated in statewide meetings with regard to CalAIM; however, to date, the Department has not commenced formal planning for the future implementation of CalAIM. At the Department level, conducting a fiscal and operational assessment of the expected impacts of CalAIM to facilitate the development of a short-term (one-year), medium-term (three-year), and long-term (five-year) strategic transition plan will help ensure a smooth transition and minimal disruption to client service delivery. The implementation of CalAIM will have an impact on multiple county departments including Behavioral Wellness, Public Health, Social Services, and Community Services, for example. Therefore, this work should take place as part of or in conjunction with a collaborative countywide, cross-agency CalAIM readiness assessment, which may assist County leadership in helping to ensure fiscal and operational alignment across agencies. This collaborative approach is discussed further in recommendation 7.3.

Action one: Task Executive Leadership to collaboratively evaluate the departmental changes required as a result of CalAIM

Commendably, Executive Leadership discuss CalAIM and its likely future impacts during their weekly meetings. Leadership are currently considering how to message the potential changes as a result of CalAIM to staff. Furthermore, they are collaborating with the QCM Department to discuss the expansion of medical necessity given this will be the first change to be implemented under CalAim. As CalAIM implementation becomes closer, the Department should consider establish bi-weekly or monthly meetings dedicated to CalAIM planning and progress tracking.

Furthermore, CalAIM aims to promote a more coordinated system of care for high-needs clients, which focuses on providing clients with a universal access point toward service. This may require a more comprehensive understanding of community need across the system of care (e.g., behavioral health needs, public health needs, housing needs, social services needs) which can be informed by a reoccurring needs assessment discussed under recommendation 1.1. Additionally, as discussed in recommendation 7.3, CalAIM may also require enhanced interdepartmental integration, particularly between Behavioral Wellness and Public Health which should be considered by Executive Leadership when evaluating potential department changes and conducting long-term planning under action four below.

Action two: Conduct a fiscal and operational assessment, with a particular focus on the impacts of CalAIM's cost reimbursement reforms

CalAIM will have a significant impact on the fiscal operations of the Department given the introduction of the IGT mechanism in place of full cost reimbursement. In order to preserve the Department's financial position and ensure cost-neutrality following CalAIM, the Department should conduct a fiscal and operational assessment. The assessment should clearly reflect the budget impact on funding for MHSA and other community services which will be affected as a result of the CalAIM reforms. This process will assist the Department in identifying strategies to maximize reimbursement and ensure the Department's financial position is not adversely impacted as a result of the CalAIM reforms. Examples of strategies which may be considered within the assessment include:

- Utilization targets which will need to be achieved at the position and program level as discussed in recommendation 3.1
- Number of appointments to be booked per day, week, month, and year
- Level of no-shows targeted
- Number of staff required to provide these services
- Staff mix required to be provide the required services

Action three: Collaborate with the CEO's Office and other County Departments to conduct a CalAIM readiness assessment

A key focus of CalAIM surrounds integrated service offerings and providing a more coordinated system of care to high-needs clients. As such, CalAIM will likely require changes to the way in which County Departments such as Behavioral Wellness, Public Health, Social Services, and HCD among others coordinate, collaborate, and integrate. As such, the Department should collaborate with other County Departments in an effort led by the CEO's Office to develop a countywide CalAIM readiness assessment. The readiness assessment should identify the operational and fiscal challenges that may arise cross-departmentally as a result of implementing the changes required by CalAIM and the mitigating factors that can be put in place to alleviate these challenges.

Action four: Develop a short, medium and long-term (one-to-five-year) transition plan for the implementation of CalAIM

Informed by the CalAIM fiscal and operational readiness assessment, Executive Leadership with support from management should lead the development of a short, medium, and long-term strategic transition plan. The plan will outline the steps which can be undertaken internally at the outset to achieve the fiscal and operational changes required under CalAIM. The plan should highlight departmental goals in implementation as well as a roadmap and timeline for implementation. Progress toward achieving plan steps, goals, timelines, and outcomes should be regularly monitored with the plan updated periodically to account for any changes to planned progress.

Utilization management

3.1 Develop role-specific utilization targets and implement leading practices to enhance staff utilization across positions

Staff utilization is a key metric for behavioral health providers to understand staff workload, to maximize service delivery to clients, and to manage staff performance and productivity. Regular tracking and discussion of utilization can also provide an opportunity for management to support staff in collaboratively problem-solving barriers to effective and consistent delivery of care, for example recurring client no-shows or time-consuming administrative tasks that divert staff time from patient-focused activities. Finally, utilization tracking will become more important with the transition to CalAIM, as the State will no longer reimburse the Department's for all billable services but will rather provide a fixed funding amount for service delivery for a defined period. For more information regarding the Department's preparations for the transition to CalAIM, please see recommendation 2.3.

The Department should be commended for its development of a Tableau dashboard to monitor and track utilization across service lines as well as by individual staff. The tool was developed during the COVID-19 pandemic in order to provide managers and Department leadership with a greater understanding of staff workload and service delivery. The Department's utilization dashboard reports two key metrics:

- An overall "staff activity percentage" for each staff member, which comprises the percentage of time spent on services considered to be "direct" client services by Executive Leadership in addition to time spent training and attending meetings.
- Average "client services utilization" which includes "direct" client services but excludes time spent on meetings and training as a share of total hours. Please refer to Appendix H to review the formulas utilized by the Department to calculate these utilization percentages.

To enable the calculation of these two utilization metrics, the Tableau system is linked to the Department's EHR system (Clinician's Gateway)—which provides information surrounding time coded to service activities—as well as the Department's timecard system, which identifies the time spent on training and meeting attendance.

The following pages provide an analysis of the Department's existing utilization data followed by recommendations to more proactively deploy this data to increase utilization Department-wide.

Utilization analysis

Average total staff activity utilization Department-wide for FY20–21 is 55 percent excluding administrative and supervisory staff. This total utilization percentage relates to time spent delivering direct client services as well as time spent in meetings and trainings. Average direct client service

utilization (total utilization less trainings and meetings) for the same period is 41 percent excluding supervisory and administrative staff.[2]

Given the wide-ranging services offered by the Department, which vary significantly by position in terms of the provision of direct client service, it is necessary to analyze utilization by position and/or program. For example, Department leadership may expect different utilization levels from a psychiatrist as compared to a recovery assistant or administrative staff. Additionally, as discussed in recommendation 3.2. below, limits to the Department's current time tracking processes result in "unaccounted time" in the current Tableau dashboard and further underscore the need for a role-specific utilization analysis, as discussed in action one below. The charts below identify the total staff activity utilization by position for FY20–21 as well as direct client services utilization by position for the same period. Please refer to Appendix H for charts related to utilization by position by program.

Finally, in reviewing the utilization data below, it is important to note that the Department has not established a formal utilization target for staff. Executive Leadership have considered implementing a 60 percent utilization target for direct service delivery and a 50 percent target for billable services across service lines based on assumptions previously issued by the State, although these targets do not reflect a state mandate.

Average Total Staff Activity Utilization Percentage:

Figure 13 illustrates the average total utilization per position for FY20-21 and the number of FTEs per filles position. In FY20–21, the Department's rehabilitation specialists, psychiatrists and clinical psychologists had the highest utilization percentage at 70 percent, 69 percent, and 66 percent respectively. However, given these utilization percentages include time spent in training and meetings, it is necessary to consider the average client services percentage in order to get a more comprehensive view of time spent by staff on client-related activities, as detailed on the following page.

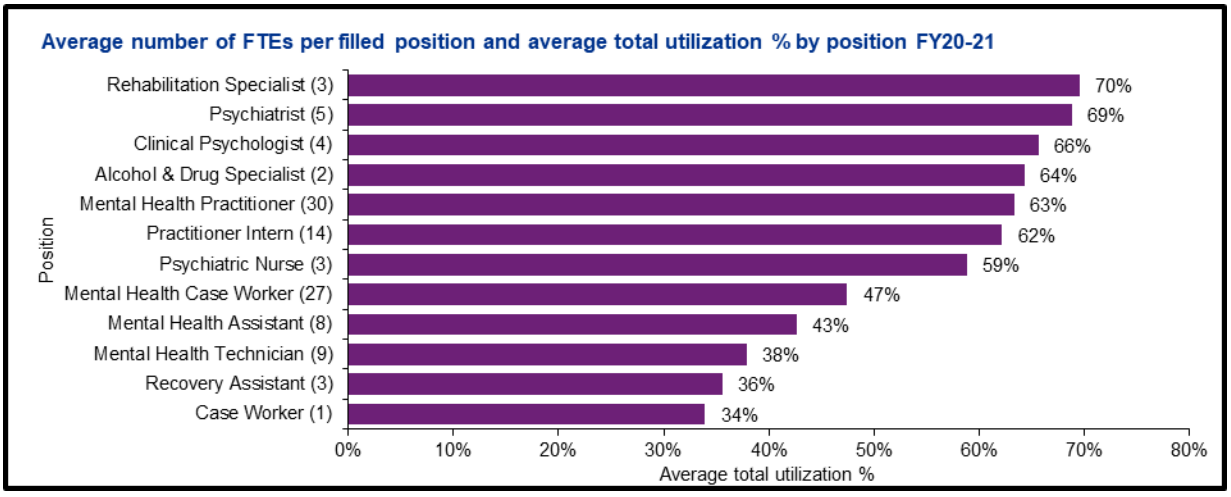


Figure 13: Source: KPMG analysis of utilization

As detailed in recommendation 3.2, lower utilization metrics for supervisory and administrative roles reflect limitations to the Department's current processes for tracking staff activities, as time spent on administrative and supervisory tasks may be reflected in the current Tableau dashboard as "unaccounted

[2] It is important to note, that based on data analysis 4 percent of entries for FY20-21 calculated a utilization percentage for certain staff in excess of 100 percent. Based on Department discussions, such instances largely relate to circumstances under which staff incorrectly coded their time sheets. Time sheet data is utilized to determine total hours worked per employee which in turn acts as the denominator in calculating utilization percentages. As a result of these errors, department-wide utilization may be artificially increased and these errors should be considered and rectified in conducting future analysis.

time." Recommendation 3.2. includes recommendations to resolve this challenge in the mid-term. In the near-term, the Department can work around these technological limitations by developing role-specific utilization targets, as discussed in action one below.

Average Client Services Utilization Percentage:
Figure 14 illustrates the average client service utilization per position for FY20-21 and the number of FTEs per filles position. The Department's clinical psychologists, psychiatrists and mental health practitioners had the highest client services utilization at 54 percent, 51 percent and 50 percent respectively. However, each of these percentages are below the 60 percent targeted utilization considered by Executive Leadership during analysis.

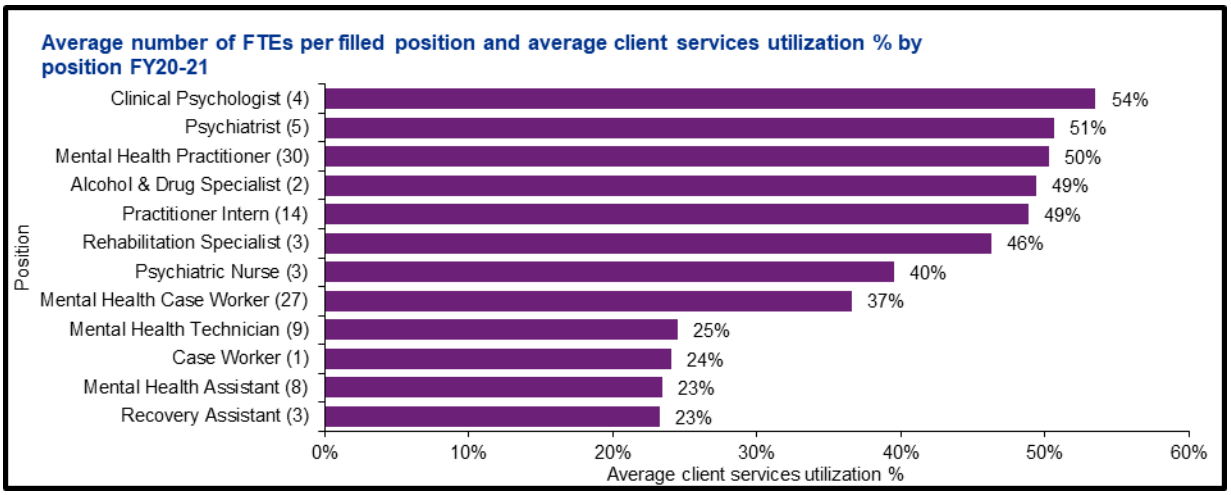


Figure 14: Source: KPMG analysis of utilization

Based on utilization analysis there are opportunities to increase overall staff utilization by developing role-specific utilization targets and adopting leading practices to manage staff utilization and maximize service delivery for County residents, as detailed below.

Action one: Develop role-specific utilization targets

To implement effective performance management of staff utilization, the Department should develop role-specific utilization targets. Role-specific targets will help ensure that staff are being given goals based on their roles and responsibilities and allow for a more tailored approach to utilization management as compared to a blanket Department-wide target. Riverside County for example, implemented role-specific targets for their staff with clinical psychologists within outpatient clinics having a utilization of 80 percent while peer specialists whose role involves less direct client service delivery were given a utilization target of 50 percent. Riverside County views utilization as direct billable hours, direct non-billable hours and direct client support hours as a percentage of total hours. Role-specific targets will also allow the Department to accommodate limitations with current activity tracking processes related to "unaccounted time" in the near-term, as the Department pursues a mid-term fix as detailed in recommendation 3.2.

As a first step in developing these targets, the Department should conduct a study of staff activities and outputs over a three-to-six-month period in order to obtain a greater understanding of the activities being undertaken by staff and the time taken to conduct each activity across various roles and programs. The study can be completed utilizing a formulated spreadsheet with drop-down fields to enhance efficiency in data entry on a daily basis. The spreadsheet would allow staff to list key activities undertaken each day and the amount of time consumed by each. The spreadsheet should be reviewed by staff supervisors weekly to identify staff activities being undertaken, reasons for low utilization, and instances

of unaccounted time. This process would enable Leadership to capture and understand a granularity of information not currently captured in the EHR and timecard systems. The data provided as a result of the study can be applied to not only identify the billable and nonbillable services being provided by staff but to identify the category and amount of unaccounted time per staff member discussed further within recommendation 3.2. This study can be completed alongside the time-tracking study for the Justice Alliance Program discussed under recommendation 4.2. If activity tracking over this length of time is not the desire of Department leadership or creates a significant administrative burden, the Department could consider utilizing periodic sampling (for example, a six-week activity study on an annual basis) to compile initial targets. Alternatively, Department leadership could work with supervisory staff to develop role-specific utilization targets qualitatively, and use weekly utilization meetings, as described in the action steps below, to refine these targets as needed.

Having completed the activity study, the Department should analyze the results and calculate a utilization target per program and subsequently per role. To undertake this process the following steps should be undertaken:

- A review of the current service buckets considered 'productive' should be undertaken to determine whether any additional services should be added or excluded. The Department should develop a formalized method for calculating utilization which is communicated to staff. An example of a calculation is as follow:

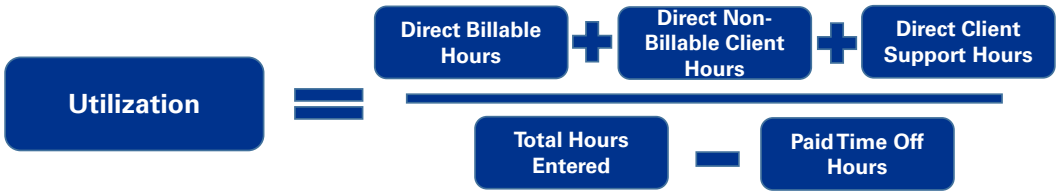


Figure 15: Source: KPMG

- Utilization range per program and role based on the study should be calculated using the formula identified above.
- Having calculated the average utilization percentages, the Department should develop a utilization percent target for each role and program. The target should be aligned to client needs to ensure that the target population is being effectively served. This target should also consider financial goals related to service delivery and whether a role currently devotes a significant amount of time to activities that fall into "unaccounted time" due to the limitations of current tracking processes—such as supervisory or administrative tasks. It is important that targets effectively challenge staff but are also considered achievable. In developing these targets, the Department may consider implementing a baseline utilization target and gradually increasing this over time as staff become more accustomed to these targets. Developing utilization targets informed by financial goals is particularly important given the pending transition to CalAIM. Under CalAIM, the Department will no longer be reimbursed for all billable services, but rather the State will provide a fixed funding amount to the Department for a defined period. As a result of this transition, the Department will need to conduct analysis to determine the utilization target that will need to be achieved in order to ensure financial and operational alignment so that the State reimbursement covers costs and there will be no net financial impact based on the transition as discussed within recommendation 2.3. Aligning utilization targets to financial goals will also allow the Department to align staffing to demand.
- Once the Department has implemented clear, role-based utilization targets, it would benefit from providing additional guidance to managers to deploy this utilization data as a performance management and accountability tool. Supervisors should formally communicate utilization targets to each staff member based on their role, and utilization-specific training should be

provided to staff and guidance developed to help ensure that they are aware of the categories of activity which are considered productive versus those which are non-productive. Supervisors should also be tasked with training, coaching and challenging staff to implement methods to increase their individual utilization, as detailed in action two below.

Action two: Task Supervisors to engage collaboratively with Clinical Staff on a weekly basis to develop a weekly scheduler and implement leading practices to enhance utilization

Once the Department has established role-specific utilization targets, Department leadership should provide guidance to instruct managers in working collaboratively with staff to support them in achieving these targets. At present, staff report confusion regarding the Department's utilization tracking processes and targets, which hinders existing efforts at utilization management.

- Staff reported confusion regarding which services are considered productive and non-productive, with many stating incorrectly that productive hours were only those which are billable.
- Staff commonly expressed frustration over the documentation requirements related to nonbillable services and appeared to lack an understanding that documentation of these services would increase their overall utilization. This lack of clarity is resulting in reduced staff morale as staff believe they are spending time documenting services for which they will not receive credit. Furthermore, the lack of clarity is preventing the Department from achieving its full utilization potential as staff may not document nonbillable services due to this communication breakdown.
- Managers appear to lack consistent guidance or processes for deploying utilization data to manage staff performance and collaboratively problem-solve dips in staff utilization. For example, the time frame within which Supervisors hold utilization discussions with their staff varies based on the service line or program–some Supervisors conduct discussions weekly and others bi-weekly or monthly.

Based on leading practices, there are several methods which can be implemented to increase staff utilization:

- First, in order to efficiently and effectively manage performance, utilization discussions should be held weekly between managers and their staff and should review a staff members utilization for the previous week or weeks. Weekly touchpoints will allow for a formal performance and accountability process allowing supervisors to identify opportunities for improvement and correct low utilization in a timely manner. For example, figure 16 below identifies two sequential pay periods between which average utilization for a clinical psychologist decreased by between 7 and 9 percent. Figure 17 illustrates a pay period for psychiatrists within which there is a 31 percent difference between total average activity utilization and average client services utilization which suggests that psychiatrists spent an average of 31 percent of their time attending meetings and training as opposed to providing client services in that period. Weekly utilization discussions, drawing on data such as that depicted in the charts below, would allow a supervisor to work with this psychologist to understand this dip in utilization and maximize productivity. Holding weekly discussions with staff will also allow for any time sheet errors and errors in utilization calculations to be identified and corrected in a more time efficient manner leading to more accurate data.

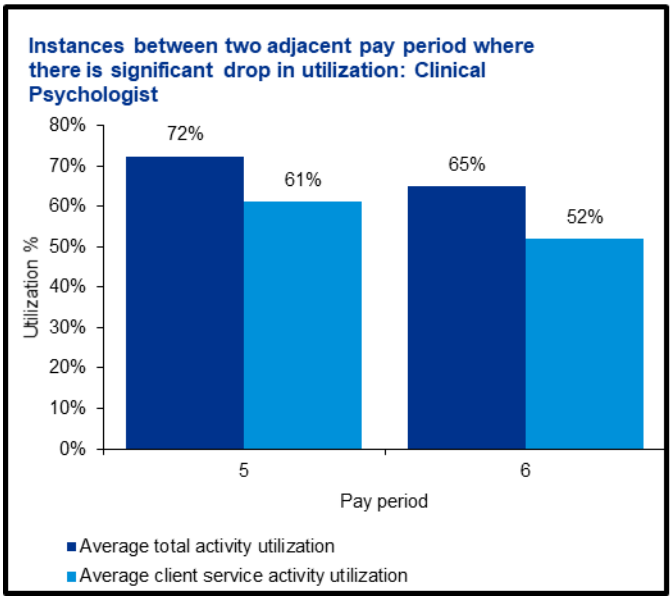


Figure 16: Source: KPMG analysis of utilization

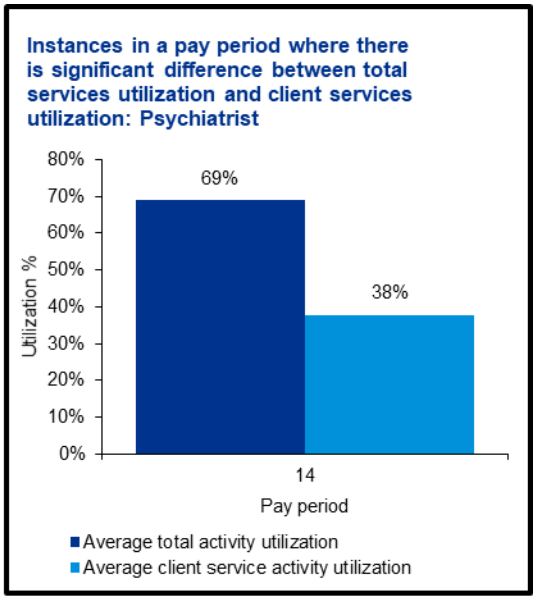


Figure 17: Source: KPMG analysis of utilization

- Second, clinical staff should be required to develop a weekly scheduler identifying their booked appointments and tasks for the upcoming week. These schedulers should be reviewed with supervisors during the weekly utilization meetings. Should staff be reporting utilization below the established target, supervisors can encourage them to undertake the following:
    - **Proactive outreach to reduce no-shows:** Regular communication and follow-ups with clients as well as sending appointment reminders for example, may reduce the level of appointment no-shows.
    - **Increasing group sessions:** Increasing the number of group sessions will help ensure that clinical staff can continue to provide services to the group even where one or more clients do not attend the session. Leading practice suggests that an optimal group session could include between six and fifteen participants, pending on diagnosis and treatment modality.
    - **Increasing field-based services:** Conducting regular outreach to and providing services "in the field" will allow clinical staff to increase utilization, particularly in circumstances where a significant portion of their clients are service resistant, justice involved or experience homelessness. This will also improve no-show and cancelation rates.
    - **Decreasing administrative time:** Clinical staff should redirect administrative tasks to non-clinical staff where possible, freeing up time for clinical staff to spend on direct client service delivery. This can be achieved for example by adopting a team-based model of care as discussed under recommendation 4.3.

- Third, in addition to developing a weekly scheduler, there are a number of other leading practices which can be employed by clinical staff in collaboration with their supervisors and Department leadership across service lines.
    - **Make a "no-show" plan:** Across interviews clinical staff reported that they regularly serve a significant number of justice-involved clients, or clients experiencing homelessness who are service resistant, lack transportation and often fail to attend their appointments. This in turn reduces staff utilization given no-shows cannot be

considered billable or productive. Staff should consider developing a no-show plan for such instances which would involve identifying clients or cohorts of clients who regularly fail to attend appointments and implementing preventative measures such as phoning the client the day before their appointment or adopting telemedicine. Furthermore, during days clinicians are scheduled to consecutively see clients who are regular no-shows, they should plan to conduct field-based services or implement scattered appointments. Another option that has yielded positive results, is to cluster the clients who have a high no-show rate for a 'drop-in' clinic where they can attend the office at any time during a specific day and range of time. Services are offered on a first come, first service basis, which improves clinician productivity. The drop-in clinics can also cluster services, such as nursing, case management, peer support and psychiatry.

- **Proactively schedule clients:** As a pre-requisite, clinicians should be encouraged to pro-actively schedule clients for appointments. For example, clients should be scheduled for the next appointment on the day of receiving service. A confirmation and reminders should be texted and / or emailed to clients.
- **Implement staggered appointments:** Implementing a process where a patient attends for an appointment every 30 minutes while appointments last 45 minutes for example, will help ensure that in the circumstances where certain clients are no shows, a clinician will only remain unutilized for 15 minutes as opposed to 45 minutes.

In Riverside County, employing similar methods to those above resulted in a 35 percent increase in productivity across all positions, a 95.5 percent average attainment of staff productivity targets as well as 225,000 hours (132 FTEs) in projected additional annual direct service hours. Patients experienced a 50 percent reduction in wait times with staff unaccounted time being reduced by 95 percent. Furthermore, due to a redesigned triage and intake pathway, approximately 450 hours of clinical therapist time freed up each month at one pilot clinic.

3.2 Update data systems to enhance the reporting accuracy and data quality related to utilization tracking and unaccounted time

At present, there are certain activities performed by staff—for example, those related to administrative tasks, managing social security checks, responding to emails, researching diagnosis, and best practices for treatment—that are not considered direct services and are not coded in either the EHR system or the timecard system. This results in unreported "unaccounted time" in the current Tableau dashboard.

Commendably, the Department is working to develop processes to better understand "unaccounted time" in the utilization dashboard. At present, the lack of detail around activities within this "unaccounted time" category makes it difficult for Leadership to gain a comprehensive understanding of staff activities and identify whether "unaccounted time" was spent on productive activities that are not tracked by current systems or whether the time was consumed by activities that do not further the Department's mission. This creates challenges in identifying opportunities to increase utilization and making data-driven decisions surrounding optimum staffing and staff mix across programs. Additionally, this "unaccounted time" has an impact on staff morale as an individual's utilization metrics may be low even if they are devoting their time to certain required activities that cannot be tracked under current processes.

The below graph shows average "unaccounted time" by position for FY20–21. In FY20–21, the average amount of "unaccounted time" across departmental positions was 47 percent, falling from 53 percent in FY19–20 and 55 percent in FY18–19. It is important to note that this "unaccounted time" likely includes both productive and nonproductive tasks. As would be expected, administrative and supervisory positions show the highest amounts of unaccounted time, as these roles perform less direct client services and more administrative and supervisory tasks which are not currently capable of being coded. This variation in "unaccounted time" by position type also underscores the need for position and program-level utilization targets, as discussed in recommendation 3.1.

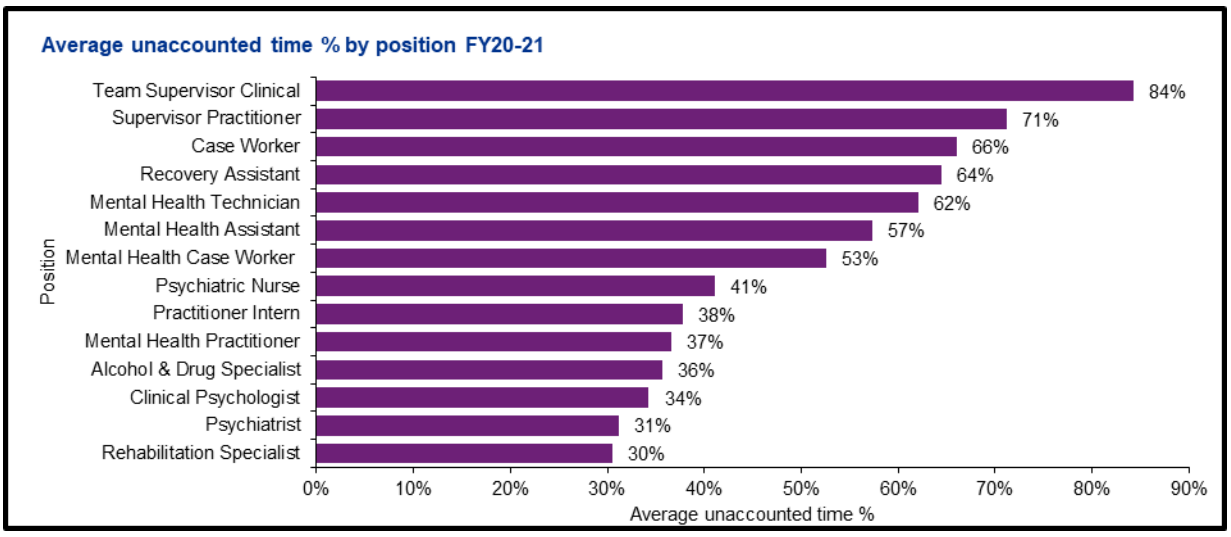


Figure 18: Source: KPMG analysis of unaccounted time

*Unaccounted time was calculated by deducting total activity hours from total hours (excluding vacation and leave) based on Department feedback.

When analyzed over the course of a year, staff time and activities that fall into the current "unaccounted time" category amount to significant personnel costs. In FY20–21, unaccounted time had an estimated

cost of $4.7 million across 127 positions with the Department's Mental Health Case Workers accounting for the highest cost related to unaccounted time at $1.3 million. The table below illustrates the cost of "unaccounted time" per position for FY20–21 which was calculated utilizing the following formulas:

1. Unaccounted hours / Number of hours worked per FTE per year = FTE equivalent of unaccounted for time[3]
2. Number of FTEs X Median salary per position type = Total cost of unaccounted time[4]

Please refer to Appendix I to view cost of "unaccounted time" for FY18–19 and FY19–20

Position	Median Salary	*Hours per FTE p.a.	Unaccounted hours	FTE equivalent unaccounted for time	FTE Cost
Psychiatrist	$260,346	1,660	2,822	1.7	$442,554
Mental Health Case Worker	$66,600	1,660	33,175	20.0	$1,331,005
Mental Health Practitioner	$81,738	1,660	20,665	12.4	$1,017,529
Mental Health Technician	$65,862	1,660	9,329	5.6	$370,131
Mental Health Assistant	$51,054	1,660	12,641	7.6	$388,793
Practitioner Intern	$67,302	1,660	9,750	5.9	$395,282
Supervisor Practitioner	$88,992	1,660	4,349	2.6	$233,127
Clinical Psychologist	$97,188	1,660	2,623	1.6	$153,566
Rehabilitation Specialist	$74,928	1,660	1,693	1.0	$76,412
Psychiatric Nurse	$93,942	1,660	1,597	1.0	$90,374
Recovery Assistant	$41,184	1,660	2,218	1.3	$55,017
Team Supervisor Clinical	$108,600	1,660	1,557	0.9	$101,830
Alcohol & Drug Specialist	$65,916	1,660	1,218	0.3	$48,368
Case Worker	$55,554	1,660	543	0.3	$18,175
Total	**$1,219,206**		**104,178**	**62.8**	**$4,722,154**

Figure 19: Source: KPMG analysis of unaccounted time

Finally, the utilization dashboard in its current state cannot be easily interpreted without a level of institutional knowledge. For example, in order to obtain an accurate view of program, division, or Department-wide utilization, users must manually filter out staff on leave, new staff undertaking training, administrative staff and certain program supervisors who do not typically provide direct client service

[3] Hours per FTE p.a. was calculated using the assumption that 1 FTE works 41.5 weeks per year allowing for 11.5 weeks of vacation sick or other leave in line with the Department's average productive hours based on FIN data

delivery. This increases the risk of inaccuracies in reporting Department-wide utilization and presents a risk to succession planning as information surrounding staff is not easily transferrable.

Action one: Establish system processes to allow for coding of unaccounted time

In order to track "unaccounted time" as a result of activities not being recorded, the Department should consider requiring staff to create a nonbill note for upload to the EHR system, which would in turn feed into the Tableau dashboard as nondirect client services. Alternatively, the Department could consider liaising with HR to develop time codes specifically related to lost time which could also be fed into the Tableau system. The latter approach may be more efficient from a staff point of view given it would not require a note write up. The level of unaccounted time should also form part of weekly supervisor discussions with staff and staff with a high level of unaccounted time should be supported in adopting some of the leading practice initiatives discussed within action two of recommendation 3.1.

Action two: Update systems to increase ease and accuracy of reporting

Executive Leadership, in collaboration with the IT Division, should consider updating the Tableau dashboard to allow for greater ease in display and filtering certain administrative information. The current system allows users to manually filter out utilization rates for certain staff who may not provide direct services or are on long-term leave and if included, would inaccurately skew the average utilization rate per program. However, in order to filter the data correctly, users must be aware of each staff members' specific role and status in terms of leave for example. In order to increase interpretation capabilities and transparency in review, the Department should consider updating the face of the Tableau dashboard to include staff roles, role in direct service delivery, and whether staff are on a specific type of leave. This will allow for a more accurate view of division, program, and Department-wide utilization.

3.3 Develop a strategy and timeline related to EHR tools to address legacy systems and increase functionality

At present, the Department utilizes Clinician's Gateway as its EHR system and Share Care as its medical billing system. Clinical and administrative staff across programs and services have access to both systems and are required to utilize these systems regularly to upload progress notes and other patient information. The EHR system is a legacy system and across interviews, staff identified numerous challenges with the system including:

- **Lack of interoperability:** While Clinician's Gateway and Share Care are integrated, they are not inter-operable. This lack of inter-operability results in duplication of effort and inefficiency as staff are required to enter data such as patient diagnosis into both systems.
- **Lack of multi-user updates:** Currently, the Access Team is required to complete an intake form within the EHR system each time they receive a call. The form identifies the date of the call, patient information as well as referral program or service. However, once submitted the staff to whom the client has been referred (typically outpatient clinics) cannot update the form to confirm date of service, services provided and diagnosis as well as other information required by the State. As such, the Access Team is required to follow up with the referral program or service for each and every call they take in order to obtain the relevant information to update the intake form after services have been provided. These follow up calls take a significant amount of time, reducing the amount of time the Access Team can spend on answering client calls. Furthermore, this process increases the likelihood of errors and incomplete information.
- **Character sensitivity:** The ADP utilizes the EHR system to develop and submit a CalOEMS report to the State each year. The report takes a significant amount of time to complete due to sensitivities and inefficiencies within the EHR system, for example, the system will produce a range of errors if a space is included after a word ("Mrs." versus Mrs. "). It takes a significant amount of time to check and update these errors to help ensure that the report is properly submitted to the State.
- **Lack of system capability:** The EHR system does not have the capabilities required by the PHF which would allow nurses to upload patient flow charts. As such, all flow charts are developed and stored via a paper process. However, the Department has procured an EHR system from Cerner to be utilized in the PHF which is to begin implementation in the coming months. It is not clear at present, as to how this new system will be integrated with the current EHR system to allow for the sharing of patient data between the PHF and other services and programs.
- **Lack of system training:** Across interviews, staff identified the lack of training in Clinician's Gateway as a challenge, for example, Clinician's Gateway has the ability to identify the number of direct client facing hours worked by a staff member in one week; however, staff are not clear on how to access this information.

As a result of the challenges identified above, Department Leadership and Management have spent a significant amount of time trying to find workarounds to resolve these challenges utilizing alternate software such as smart sheet. The implementation of a new EHR system would free up time for Executive leadership and Management to spend on more strategic and client facing matters.

Furthermore, as discussed in recommendation 2.3, the CalAIM initiative being developed by the State will likely require enhanced integration between both Behavioral Health, Public Health and other agencies in order to achieve a more coordinated system of client care which will inevitably require increased data sharing capabilities. However, currently, Behavioral Wellness and Public Health utilize differing EHR systems. Additionally, the CalAIM initiative is proposing a number of reforms to the current

billing methodology, which may also require updates to the current EHR system. Implementation of the action steps identified below should be taken in coordination with any countywide initiatives to prepare for CalAIM, including the countywide CalAIM readiness assessment as mentioned in recommendation 2.3, should that work be ongoing.

Action one: Establish a task group to evaluate the EHR functionality required by the Department

Commendably, the Department has developed many workaround processes to overcome certain shortcomings within the current EHR and is considering options with regard to the implementation of a new EHR system. However, the Department should establish a dedicated task group responsible for identifying a list of key challenges with the current EHR system, developing a set of essential capabilities for any new EHR, considering CalAIM implications and evaluating and assessing available EHR systems, and developing a timeline and strategy for implementation. Furthermore, EHR priorities should be aligned with the financial strategy of CalAIM to help ensure that any new EHR is capable of capturing the necessary data to allow for data-driven decision-making. The Task Group should be led by the IT Division and have representation from all Clinical Divisions.

Action two: Liaise with Public Health to discuss CalAIM reforms which may have an effect on County EHR

The Task Group should engage with the Public Health Division to consider the reforms proposed by CalAIM which may have an impact on the EHR functionalities and capabilities required cross-departmentally as a result of the reforms, particularly those surrounding enhanced integration and billing. The Public Health Division currently utilizes EPIC as its EHR system and discussions should consider whether implementing a Countywide EHR across Behavioral Wellness and Public Health is an option.

Action three: Conduct an analysis to assist in determining the most suitable timeframe to implement a new EHR system

As discussed in recommendation 2.3, the CalAIM initiative will likely have a significant impact on the operations of the Department including its EHR capabilities, particularly those related to the changes in cost reimbursement and billing. However, it is important to note that the Department will need to consider the most suitable time frame for the implementation of a new EHR system i.e. prior to or after the implementation of CalAIM. CalAIM is a Statewide initiative and therefore, it is likely that EHR providers will update their current systems and new providers may also come on the market which may increase the EHR systems available for selection by the Department which suggests that the Department should wait to transition to a new system until CalAIM have been implemented. Conversely, however, EHR systems typically require a significant amount of staff training and overall implementation may take some time, therefore, waiting to transition to a new EHR system until CalAIM implementation may put the Department at risk of losing funding if the EHR system is not updated correctly as staff continue to learn the system. The timeframe for implementation is a significant consideration and as such, the Task Group should be tasked with conducting an analysis to consider the optimal time frame within which they should evaluate, select and commence the implementation of a new EHR if the implementation of a new EHR is deemed necessary.

Action four: Evaluate EHR systems available to determine optimal solution for the Department

Once a suitable time frame has been identified, the Task Force should be responsible for evaluating potential EHR systems available to suit the Department's needs. As a first step in this process, the Task Force should initiate a Request for Information ("RFI") process in collaboration with the Purchasing Department. Issuing an RFI will allow the Department to gain familiarity about available EHR systems and their various capabilities. It will also help ensure that information can be gathered in a formal, structured, and comparable way to aid in the decision-making process. In order to initiate an RFI process,

the Task Force will be required to develop an RFI document for solicitation. The document should include the following at a minimum:

- Department background and current state systems
- Statement of need: The EHR capabilities required by the Department as recommended for development under action three.
- Qualifications: The desired skills and credentials of any vendor
- Information requested: The distinct information the Department would like to obtain on vendor perspectives and EHR systems such as their respective capabilities, vendor perspective on risks and opportunities of implementation based on the Department's current state, anticipated concerns and/or timelines that the Department can use to craft a focused procurement process
- Submission deadline

Once all RFIs have been submitted, each submission should be assessed with the intention of helping to inform the Department's formal procurement process. This method will allow the Department to identify the most suitable system for the needs of the Department whether it be adopted pre or post CalAIM

The Department is commencing the implementation of a new EHR system in the PHF which was developed by Cerner. Closely evaluating the performance of this system will allow the Department to identify any issues and/or lessons learned as a result of implementation which can in addition to the RFI process, inform future considerations and requirements for the implementation of a department-wide EHR system. In order to monitor performance, the Department should obtain regular feedback from clinician's and daily users of the system by way of surveys and focus groups.

Staffing and service delivery

4.1	Review client acuity across ACT programs to assess viability of combining ACT Teams and transitioning to a FACT Model to better tailor service delivery to the needs of the target population

ACT is an evidence-based program which aims to provide mental healthcare to individuals with serious mental illness (SMI) or serious and persistent mental illness (SPMI). ACT typically focuses on the most vulnerable 20 percent of individuals with SMI and/or SPMI and targets persons who are high utilizers of behavioral health services, frequently booked into the jail, homeless, or suffering from co-occurring conditions that impairs their ability to live in the community[5].

The ACT model provides the highest level of care aside from inpatient and day treatment services. The model calls for a low client to staff ratio with 100 clients receiving care from a multidisciplinary team of 10 staff who are available on a 24-7 basis. The multidisciplinary team should have expertise surrounding psychiatry, social work, nursing, substance abuse and vocational rehabilitation and offers integrated treatment, rehabilitative and support services. The model is intensive: ACT Teams should average two to four contacts with each client per week. Teams visit clients in their community to deliver wraparound services — including psychiatric services, counseling, medication management, and substance abuse treatment, as well as housing, employment, and case management services. Effective treatment may include early identification of challenges to functioning that could lead to crisis, recognition and quick follow-up on medication effects or side effects, assistance to individuals with symptoms, self-management, rehabilitation and support. Please refer to Appendix F for further detail on the ACT model.

Currently, Behavioral Wellness operates three regional ACT programs: in Santa Barbara, Santa Maria, and Lompoc, which are funded primarily through a combination of Mental Health Services ACT (MHSA) funding and Medi-Cal. The Santa Barbara ACT program is operated directly by the Department, while the ACT programs at Santa Maria and Lompoc are run by contract providers, Telecare Corporation and Transitions Mental Health Association (TMHA) respectively. In reviewing Department data related to the ACT program, the project team analyzed the number of clients served per program as well as the number of visits received by each client to assess whether they are in line with the ACT program's standards of care. It is important to note that a number of potential discrepancies in the data were identified, particularly related to the transfer of clients between programs as well as the readmission of clients to the same program. These nuances are discussed further under action one below; however, they necessitated significant manual data manipulation, making it difficult to accurately ascertain the number of clients served per program per month as well as the number of client sessions offered per program.

5 https://www.researchgate.net/profile/J_Van_Veldhuizen/publication/281115683_Manual_Flexible_Assertive_Community_Treatment_FACT/links/55d6f20008ae9d65948c0a2f/Manual-Flexible-Assertive-Community-Treatment-FACT.pdf?origin=publication_detail

Number of clients served per program

Across each of the three programs, the Department served an average of 89 clients per program per month between 2018 and May 2021, below the 100 clients which each ACT Team is expected to serve under the standards of care. The below table illustrates the average clients served per program per year for 2018, 2019, and 2020 as well as the first five months of 2021.

Program	County Target	Average clients 2018	Average clients 2019	Average clients 2020	Average clients Jan 2021– May 2021	Number of clients at May 2021
Santa Barbara ACT	100	93	97	98	87	82
Lompoc ACT	80	78	80	80	77	75
Santa Maria ACT	100	93	95	92	90	88

Figure 20: Source: KPMG analysis of ACT data

The Santa Barbara ACT Team served an average of 95 clients between 2018 and May 2021 with the average number of clients served monthly falling from a high of 98 in 2020 to 87 in the first five months of 2021. Across interviews, staff noted that reductions in monthly client numbers often result from difficulties in recruiting and retaining adequate staff to serve a caseload of 100, the standard of care.

The Lompoc ACT Team provided services to an average of 79 clients between 2018 and May 2021 with the average number of clients served monthly falling from a high of 80 in 2020 to an average of 77 in the five months to May 2021. Similar to the County-operated ACT team in Santa Barbara, TMHA, the Lompoc contract provider, indicated they have had trouble maintaining sufficient staff to operate a full ACT team. As a result, TMHA negotiated a contract amendment with the Department to reduce client placements to 80, allowing them to operate the program with less than 10 staff. However, it is important to note two implications of this shift:

- The reduction to less than 100 clients and less than 10 staff is a deviation from the evidence-based ACT model, and it may be challenging for a team of less than 10 staff to provide 24-7 coverage which is an imperative aspect of the ACT model.
- Additionally, based on data analysis, the program at times serves less than even this reduced target of 80 clients, which is not in line with ACT standards of care.

Between 2018 and May 2021, the Santa Maria ACT Team provided services to 93 clients on average, with the average number of clients served monthly falling from a high of 95 in 2019 to 90 in the five months to May 2021. The Santa Maria program's contract provider reported that they have not suffered from challenges recruiting or retaining staff and have capacity to treat 100 clients. However, staff noted during interviews that the program has not received adequate referrals from the Department in order to operate at full capacity.

The following charts illustrate the number of clients served per program per month between 2018 and May 2021.

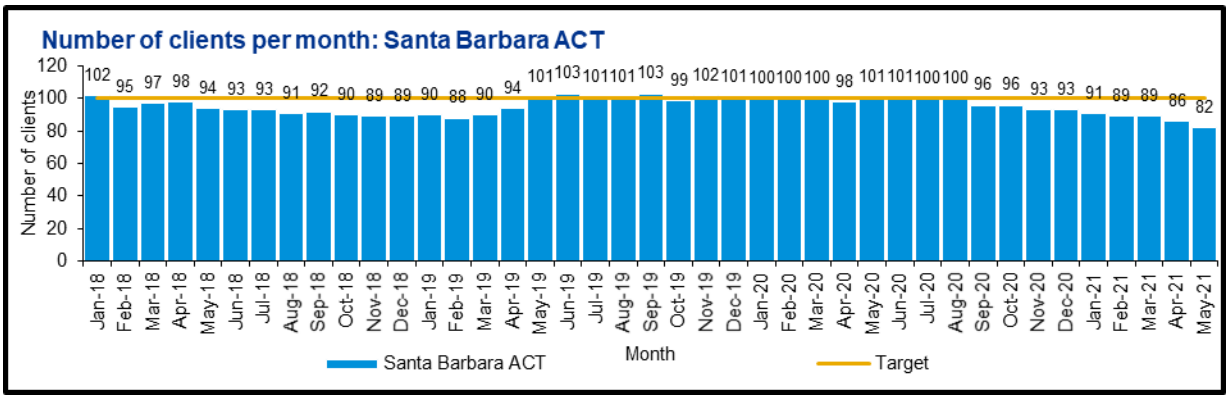


Figure 21: Source: KPMG analysis of ACT data

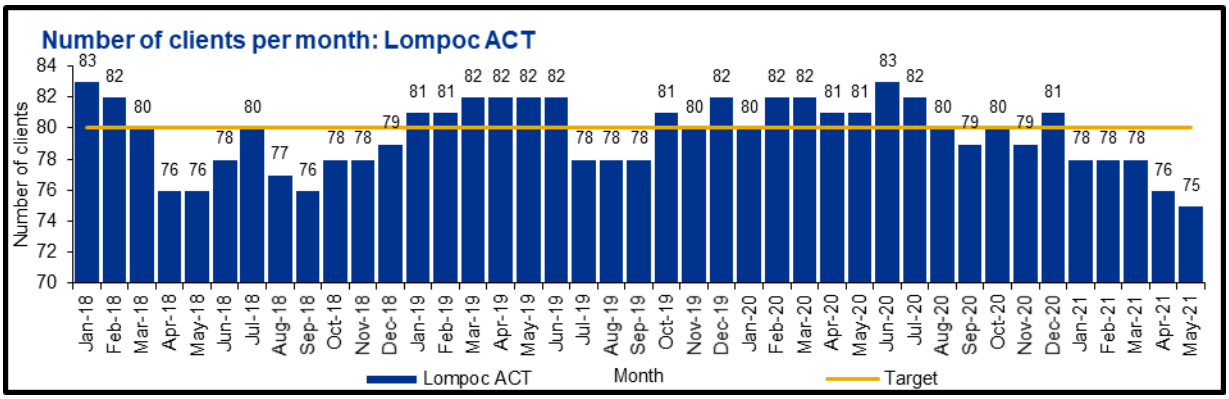


Figure 22: Source: KPMG analysis of ACT data

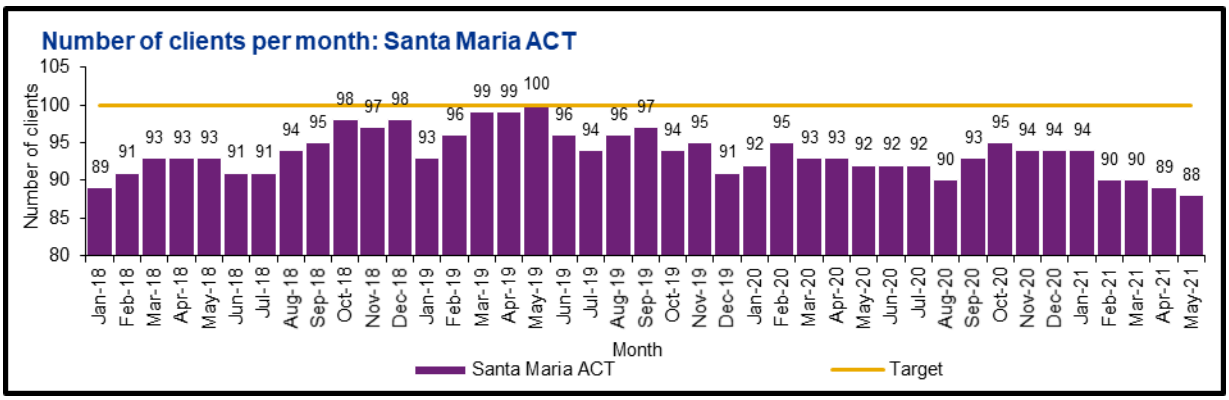


Figure 23: Source: KPMG analysis of ACT data

Number of sessions provided per patient per month

The ACT model recommends that clients should receive two to four contacts per week, although successful clients may be transitioned to a lower level of contact as they prepare to exit the program. As a result, adherence with the ACT model would result in at least 8–16 client visits per month. Across programs, data analysis illustrates that a significant portion of clients receive less visits than that recommended under the ACT Model, as illustrated below. The following chart illustrates the average number of sessions provided to each client served per program per month between 2018 and May 2021.

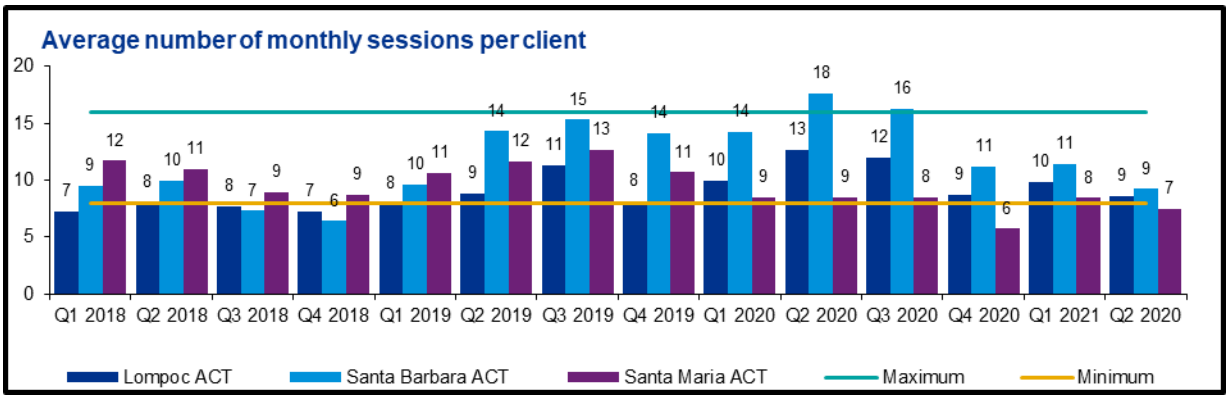


Figure 24: Source: KPMG analysis of ACT data

The Santa Barbara program has historically provided the greatest number of average monthly sessions per client at 12; however, it is important to note that this has fallen to an average of nine in Q2 2020. Lompoc and Santa Maria both provided an average of nine sessions monthly between 2018 and May 2021. However, across all programs averages are often artificially increased as a result of a small portion of clients receiving a disproportionately high number of monthly sessions. For example, from 2018 to May 2021, an average of sixteen clients received at least 20 sessions per month in the Santa Barbara program, this figure was eight for Santa Maria and five for Lompoc.

To more accurately evaluate how closely each program conforms with the monthly number of sessions recommended under the standards of care, the project team evaluated the percentage of clients per program who received less than the recommended minimum of eight interactions per month as compared to those who receive eight or more. The following table identifies the annual average percentage of clients under each of these buckets across 2018, 2019, 2020 and the five months to May 2021.

Program	Number of interactions	Average % of clients 2018	Average % of clients 2019	Average % of clients 2020	Average % of clients Jan 2021– May 2021
Santa Barbara ACT	<8 interactions	59%	35%	33%	49%
	8+ interactions	41%	65%	67%	51%
Lompoc ACT	<8 interactions	58%	48%	35%	46%
	8+ interactions	42%	52%	65%	54%
Santa Maria ACT	<8 interactions	40%	36%	58%	54%
	8+ interactions	60%	64%	42%	46%

Figure 25: Source: KPMG analysis of ACT data

On average, between 2018 and May 2021, 43 percent of clients within the Santa Barbara program received less than eight interactions per month. This percentage has fallen from a high of 59 percent in 2018 to a low of 33 percent in 2020, increasing to 49 percent in the five months to May 2021.

The Lompoc ACT program provided less than eight interactions to an average of 47 percent of clients between 2018 and May 2021. This fell from a high of 58 percent in 2018 to a low of 35 percent in 2020, rising to 46 percent in the five months to May 2021.

Between 2018 and May 2021, the Santa Maria ACT program provided less than eight interactions to 46 percent of its clients, rising from a low of 36 percent in 2019 to 54 percent in the five months to May 2021. The high percentage of clients across programs who receive less than the recommended eight interactions per month suggests that the clients being served by these programs may not be the targeted population or may not meet the acuity required to be served by an ACT team.

Given that the number of clients across ACT programs falls below the recommended 100 client caseload, as well as the fact that subsets of this population are receiving less than the recommended contacts per month, the Department may consider reviewing the acuity of the ACT client population to assess the feasibility of transitioning the model can be transitioned to one ACT program and one FACT program. As detailed in the action steps on the following pages, this assessment is an option to be evaluated based on the analysis of caseload data which was the only data available at the time of review.

It was also noted by the Department that ACT outcomes are tracked in multiple different programs, without clarity from ACT providers on the accuracy of data, limiting the ability to drill down to a single point-of-truth dataset.

Action one: Conduct an analysis of ACT data quality

The Department utilizes its EHR system to input and track caseload data related to the ACT program. Interviewees reported numerous challenges with the system related to connectivity and data input, which can lead to potential issues surrounding data accuracy. Additionally, there are inconsistencies in the performance indicators, tracking mechanisms, and related reporting for performance outcomes across each program. The Department should consider conducting a review of data quality for the ACT program to help ensure accurate and meaningful analysis by the Department is possible. The following data gaps were identified during data analysis:

- There are 13 instances where a client is recorded as receiving services by two programs in the same month. In many cases, this appears to occur when a client is discharged from one program and admitted into another and may represent an administrative delay or midmonth transfer. However, in 6 instances, clients appear in multiple programs for more than one month, with the longest overlap reaching five months.
- Five staff members identified as direct service providers per staffing schedules were not included as service providers within the reported ACT data.
- During data analysis, 100 instances were identified where a client had multiple dates of admission and/or discharge during the same admission period. In order to help ensure a client was not double counted in identifying the number of clients served per program, the project team analyzed each specific instance and manually updated the date of admission where necessary. The ability to accurately identify the number of clients being served per program is key to determining whether the program is performing in compliance with standards, as well as identifying available places per program. In order to help facilitate accurate program analysis in the future, the Department should consider implementing a system prompt where a staff member changes a date of admission and/or discharge to ensure the change is not an error.
- Between 2018 and May 2021, a secondary diagnosis has not been entered for 75 percent of clients. While a percentage of clients may not suffer from a secondary condition, which may account for the lack of entry, given that the ACT program often has a focus on clients with co-

occurring conditions, it is somewhat unusual that only 25 percent of clients have a documented secondary diagnosis.

- There are instances of inconsistent diagnosis entry by multiple staff members attending a single client within the same time period, for example, in sessions provided to one particular client by one staff member, primary diagnosis is identified as "*Schizoaffective disorder, depressive type"* and secondary diagnosis is updated as "*Cannabis abuse, uncomplicated.*". However, in sessions undertaken by another staff member during the same period, the client's primary diagnosis is identified as "*bipolar disorder, unspecified*" with no secondary diagnosis. Throughout data analysis, similar instances were identified for 86 clients or 19 percent of clients across the entire data set. The inaccuracy and inconsistency among staff data entry requires further analysis, development of an improvement plan, and accountability on behalf of the ACT Team. If staff are unclear of what the primary diagnosis or secondary diagnosis is, the assessment of client's presentation, subsequent treatment plans and follow-up may be adversely impacted.
- The data identifies 59 different diagnosis categories between 2018 and May 2021 across the ACT Program. The number of diagnosis categories increase the likelihood of error in documenting diagnosis. The Department should consider implementing a system to prompt users when they wish to change a client's primary diagnosis to help ensure that change is not an error.
- As noted above, there are inconsistent performance indicators tracked across programs, for example, the Santa Barbara ACT Team does not track incarcerations, but does track jail admissions using a specific report developed by their IT Department. Lompoc and Santa Maria do not track an indicator noted as "Physical Health admitted"; however, instead track "Emergency Care for Physical Health". Please refer to Figure 26 for an analysis of the specific indicators tracked across each program.
- Across interviews, staff expressed concern that there are inconsistent tracking mechanisms in place to calculate performance outcomes. For example, each program may utilize a different report or calculation metric to develop the same indicator outcome measure. This can result in challenges in making comparisons between ACT programs for the purpose of analyzing performance.

The Department should task QCM with conducting a review of the ACT data quality. This will involve liaising closely with each ACT Team and identifying inconsistencies and inaccuracies within the data based on review.

Action two: Conduct an analysis of client acuity per program to determine most suitable treatment model

Initial analysis suggests that some ACT clients may be eligible for treatment through other programs for two reasons:

- In interviews, staff noted that certain clients are not suitable for ACT due to a violent or service resistant nature and may be better suited to the County's AOT program, in which individuals are legally required by Courts to receive treatment.
- Additionally, data analysis suggests that a portion of ACT clients may not have a sufficiently acute diagnosis for inclusion in ACT based on the number of weekly sessions provided. If clients are able to function with just one to two sessions per week, month over month and for a prolonged period of time, they should be considered for transition to a lower level of care, such as outpatient treatment.

In order to accurately analyze the number of ACT-appropriate clients across the three programs, the Department should task each of the ACT Teams with conducting a detailed client-by-client analysis

against the requirements to receive ACT services in order to determine suitability for inclusion in ACT. The analysis should be reported back to the QCM Division and Executive Leadership for validation and compilation. The analysis will involve evaluating the following data points on a client-by-client basis against the criteria to access ACT which can include:

- Persons with severe symptoms of mental illness including schizophrenia
- Persons with high rates of substance abuse
- Individuals experiencing homelessness due to mental illness
- Persons with frequent hospitalizations
- Persons who have not responded well to traditional outpatient care.

These data points for each client should be analyzed against the ACT standards of care. It is recommended that the Department pay particular attention to two considerations at this point:

- Across the three programs, an average of 45 percent of clients received less than eight visits per month between 2018 and May 2021. These clients who receive less than two contacts a week should be considered for transition to a lower level of care. The Department should conduct a review of clients who receive less than the minimum number of visits per month on a recurring basis to confirm that these individuals need to remain in the ACT program. Should data quality issues prevent the regular and efficient reporting of this analysis, the Department should reassess its process for assessing ACT data.
- Additionally, the Department should analyze the number of no-shows or instances of violence per client to determine those clients who may benefit from a referral to the AOT program. Referrals to AOT are discussed further in action three, which recommends the creation of a decision tree to guide these referrals.

In addition to analyzing acuity of current ACT clients, the Department should also evaluate the results of the community needs assessment discussed under recommendation 1.1 to determine whether there are clients who may be eligible for inclusion within the ACT program, but do not currently receive service. The Department should establish referral pathways to reach these clients via outreach, warm hand-offs or other methods.

While the Department undertakes weekly and monthly reports related to ACT programs, the purpose of these reports is largely to create Medi-Cal claim records and identify the services being performed. There does not appear to be any analysis undertaken to determine whether the ACT program aligns with the ACT standards. The above analysis should be conducted at least quarterly and will allow the Department to identify the number of clients who meet ACT standards across the County and will help ensure that ACT clients meet the required acuity for participation in the program.

Commendably, the Department requires its contract ACT providers to submit quarterly reports, which include progress toward specific program outcome targets. Additionally, the Department meets with providers annually to discuss their performance against these targets and should be commended for this implementation of performance-based contracting. However, based on interviews, there is an opportunity for the Department to provide more regular feedback, guidance, and support for providers to help maximize their service delivery. For example, implementing a meeting with providers quarterly to collaboratively discuss progress toward achieving performance outcomes will increase provider accountability, foster an environment of continual improvement and ensure best outcomes and value-for-money. These quarterly meetings can also act as a forum for both the Department and providers to discuss any barriers to meeting performance targets and then collaboratively problem-solve. This will

help ensure that performance-related issues can be correct in a timely manner, yielding more efficient and effective client service delivery.

Action three: Develop a decision tree to transition service resistance clients to AOT

Santa Barbara ACT experienced an average of 36 client no-shows and customer cancellations per month based on data from 2018 to May 2021, while Lompoc and Santa Maria experienced 13 and 7 respectively. While ACT clients are expected to be service resistant, in interviews, staff noted that some clients may be better suited to the County's AOT program given they may be justice involved, prone to violence and take up a disproportionate amount of the team's time.

The Department launched its AOT program in January 2017 and received 138 referrals between January 2017 and December 2019. AOT provides court ordered outpatient treatment for adults with SMI and SPMI who are experiencing repeated crisis events and who are not engaging in treatment on a voluntary basis. A patient ordered into AOT is required to follow a treatment plan approved by the court and determined through consultation between the patient, the mental health system, and a physician.

A client can be referred to an AOT program in circumstances where the person has a history of lack of compliance with treatment mental illness and has recent instances of hospitalization, serious and violent behavior toward himself or herself or others or needs AOT to prevent relapse or deterioration which may have significant consequences. Please refer to Appendix F for further detail on the criteria for AOT.

The Department should develop a specific decision tree to guide referrals from ACT to AOT to facilitate clients who may be severely service resistant or violent. This will allow for a more accurate determination of the number of ACT Teams that are truly required. A decision tree could be developed in the format of a questionnaire, survey or form and could consider the following client characteristics across a three-to-six-month period:

- Number of no-shows or cancellations
- Acts of violence toward staff or others
- Number of incidents involving crisis services
- incidents of criminal justice involvement
- Noncompliance with medication as prescribed

Furthermore, the Department may need to enhance its processes related to data tracking and analysis in order to consider this information, for example, currently it is not clear based on the data provided whether ACT Teams track the number of violent or crisis service involved incidents per client.

Action four A: Conduct a deep dive quantitative and qualitative analysis of Santa Barbara, Santa Maria, and Lompoc ACT programs to assess the efficacy of contracting out ACT programs versus operating ACT programs directly

Based on quarterly ACT data provided per program by the Department during the course of this review, a comparative analysis was undertaken to consider the performance of each ACT team against the standards of care. Based on this comparative analysis, all programs, whether contracted or operated directly by the Department, reported low performance in certain indicators while high in others. (See Figure 27 for performance detail). As such, the Department may consider conducting a deep dive qualitative and quantitative analysis to understand the underlying drivers behind each performance indicator. This analysis will provide the Department with a deeper understanding of the root causes that result in low performance against an indicator, as well as the best practices being adopted by teams to

achieve high performance against an indicator. This understanding will allow Department leadership to enhance data-driven decision making as it relates to ACT programs.

The table on the following page seeks to act as a comparative analysis across programs for fiscal years FY18-19, FY19-20, and FY20-21. In analyzing the table below, rates that appear to indicate high performance have been highlighted in green, while rates that indicate lower performance in comparison to other teams are highlighted in red. Additionally, certain other data namely, *clients who showed improvement on the MORS* and clients *engaged in purposeful activity* are not tracked by the Santa Barbara ACT team, these indicators are noted as N/A and highlighted in red given they are key measures to understand client outcomes and the effectiveness of the ACT model. Therefore, these metrics should be analyzed and tracked as a priority in the future. Finally, in some instances, certain data was identified as not collected by a particular ACT team, however, it is understood that this data is being collected under a different indicator and as such, it has been noted as N/A and highlighted in grey.

It is important to note, that the differing performance indicators being tracked across programs can make analysis challenging, given it is important that an "apples to apples" comparison can be made between programs. In the future, the Department should develop a key set of performance indicators which should be tracked across all ACT programs that is operated and/or funded by the County. Furthermore, across interviews, staff expressed concern that the outcome metrics for certain indicators being reported by provider programs may not align with the processes used to calculate outcome metrics by Santa Barbara ACT. In the future state, having developed a key set of performance indicators the Department should also provide training to all ACT teams to provide guidance on the exact process to be adopted in analyzing each performance indicator.

ACT Program Annual Outcomes Percentage by Fiscal Year									
Category	Santa Barbara ACT Average Percentage			Lompoc ACT Average Percentage			Santa Maria ACT Average Percentage		
	FY 18-19	FY 19-20	FY 20-21	FY 18-19	FY 19-20	FY 20-21	FY 18-19	FY 19-20	FY 20-21
Proportion of clients with 0-7 service interactions	54%	30%	42%	54%	40%	42%	42%	45%	60%
Proportion of clients with 7+ service interactions	46%	70%	58%	46%	60%	58%	58%	55%	40%
Incarceration	6%	N/A	N/A	6%	2%	1%	9%	13%	13%
Jail stay admissions	15%	9%	4%	2%	1%	2%	5%	2%	1%
Medical Hospital Admitted	8%	5%	7%	N/A	N/A	N/A	N/A	N/A	N/A
Psychiatric hospital admissions	5%	4%	3%	5%	4%	4%	7%	10%	4%
Physical Health Emergency Care	4%	6%	7%	N/A	N/A	N/A	N/A	N/A	N/A
Emergency care for physical health	N/A	N/A	N/A	4%	10%	10%	4%	6%	7%
Hospitalizations for physical health	N/A	N/A	N/A	3%	4%	3%	4%	3%	3%
Crisis Services	7%	6%	3%	24%	11%	12%	13%	10%	20%
Stable/Permanent Housing	93%	96%	92%	86%	75%	71%	90%	85%	89%
Engaged in purposeful activity	N/A	N/A	N/A	30%	23%	39%	18%	19%	22%
Higher LOC*	1%	1%	2%	7%	0%	0%	0%	1%	2%
Lower LOC*	0%	1%	1%	1%	5%	2%	2%	2%	2%

Clients who showed improvement on the MORS	N/A	N/A	N/A	N/A	33%	32%	2%	5%	11%

Figure 26: Source: KPMG analysis of ACT data

The table on the following page seeks to analyze each ACT program across each indicator based on the results identified in the table above.

Indicator	Analysis
Proportion of Interactions of clients	— Each team has one year where their average interaction with clients does not meet the minimum requirement of the ACT standards of care, namely two visits per week. — In general, each team's frequency of interactions with clients appears to demonstrate that approximately half of the clients need the level of intervention required under the ACT standards on a regular basis.
Incarceration	— Santa Maria ACT had a significantly higher proportion of incarceration rates than other ACT Teams across each year analyzed. Santa Barbara ACT did not track incarceration rates for the years FY19-20 and FY20-21.
Jail stay admissions	— Santa Barbara ACT demonstrated significantly higher jail stay admissions in comparison to the other teams across all years. However, this percentage has reduced significantly in FY20-21.
Medical Hospital Admitted/ Hospitalizations for physical health	— Two different categories are reported for outcomes related to physical health: (1) Medical hospitalization admissions and (2) Hospitalization for physical health. These measures are reported separately across the three teams; however, these measures were compared for the purposes of analysis as it is understood that they seek to report the same indicator. — Medical hospitalization rates for the Santa Barbara ACT team were more than double the rates of the other ACT programs across all years analyzed. — Lompoc and Santa Maria ACT reported similar results across all years.
Psychiatric hospital admissions	— Santa Maria rates were significantly higher than the other two teams for both FY18-19 and FY19-20. In FY20-21, admission rates across all three teams appear to be similar.
Physical Health Emergency Care/ Emergency care for physical health	— Two different categories are reported for outcomes related to emergency care for physical health: (1) Physical Health Emergency Care and (2) Emergency Care for Physical Health; however, these measures were compared for the purposes of analysis as it is understood that they seek to report the same indicator. — Santa Barbara ACT does not separately report emergency care for physical health and as such, appears to report all outcomes related to physical health under the Medical Hospital Admitted category. This may explain the significantly higher rates of medical hospital admissions for Santa Barbara ACT discussed above. — In FY19-20 and FY20-21, Lompoc ACT experienced significantly higher rates of emergency care for physical health when compared to Santa Maria.
Crisis Services	— Lompoc ACT reported significantly higher rates of crisis services than Santa Barbara and Santa Maria in FY18-19. Both Santa Maria and Lompoc have higher rates of crisis services interaction than Santa Barbara across FY19-20 and FY20-21.

	— As ACT Teams are designed to operate 24/7/ 365 to provide client care, clients should only be attending crisis services, such as CSU when the team deems it necessary. The involvement of crisis services at these rates indicate that the model requires further analysis to determine where the gap of care is occurring.
Stable/Permanent Housing	— Santa Barbara ACT has the highest rate of clients that have housing stability averaging approximately 94 percent across the three years analyzed. In FY19-20 and FY20-21, Lompoc ACT reported two consecutive years of low stabilization in housing averaging 73 percent across these years. — Housing Stabilization is a key mechanism to stabilize a client's circumstances and/or situation. There may be a link between the lack of stable housing and high use of crisis services in Lompoc ACT.
Engaged in purposeful activity	— Lompoc ACT appears to have the highest percentage of engagement in purposeful activity; however, based on best practices each team should be aiming for higher linkage of purposeful activity among clients. — Santa Barbara ACT did not track engagement in purposeful activity across each of the three years analyzed. This is a key indicator to understand client outcomes and the effectiveness of the ACT model. Therefore, this metric should be analyzed and tracked as a priority in the future.
Higher LOC*	— With the exception of Lompoc ACT in FY 2018-19, the data appears to indicate that those admitted to the program are receiving the correct level of care and are being maintained at that level. — The spike in FY18-19 for Lompoc ACT may be due to admissions that should not have been diverted to this level of care; however, this appears to have been resolved in the following years.
Lower LOC*	— With the exception of Lompoc ACT in FY19-20, the data indicates little movement to lower levels of care. — While the primary program goal is to stabilize clients at this level, ultimately the longer team goal should be to decrease the level of intervention; thus, allowing clients to transition to lower levels of care, otherwise, the flow of clients to each program will be impacted.
Clients who showed improvement on the MORS	— There is very low to minimal improvement demonstrated for clients receiving service from Santa Maria ACT. Although, Lompoc did not track this data for FY18-19, clients receiving service from this team did demonstrate improvement over a two-year period. — Santa Barbara ACT did not track clients who showed improvement on the MORS across each of the three years analyzed. This is a key indicator to understand client outcomes and the effectiveness of the ACT model/ services offered. Therefore, this metric should be analyzed and tracked as a priority in the future.

Figure 27: Source: KPMG analysis of ACT data

In undertaking this action, the Department should conduct the following key steps:

— **Step one:** As noted above, there are inconsistencies in the indicators being collected across programs with concern expressed over the data sources being utilized to develop these indicators. As such, the Department should develop a consistent set of performance indicators and tracking mechanisms across all ACT programs. This will allow for greater ease and accuracy in comparison, allowing for an "apples to apples "comparison each and every time.

These updated indicators should include metrics related to clients engaged in purposeful activity and clients who show improvement on the MORS that are not currently tracked by Santa Barbara ACT.

- **Step two:** It is important that each ACT team is utilizing the same tracking mechanisms, sources, reports, and calculations to identify performance against indicators. As noted in the body of this recommendation, each ACT team may be utilizing differing mechanisms to calculate performance against indicators with Santa Barbara having a separate reporting mechanism for crisis services and psychiatric hospitalizations, for example. As such, the Department should provide training to ACT teams on the process to calculate, track, and measure each performance indicator to help ensure consistency and accuracy in data analysis and comparison.
- **Step three:** Conduct a qualitative analysis of each ACT program based on the comparative analysis outlined above. This may involve conducting interviews and focus groups with members of each ACT team to identify the specific reasons for high or low performance across each performance indicator. This analysis will subsequently allow Department leadership to make more informed decisions surrounding the performance of both County operated and provider programs. However, it is understood that the ACT provider in Lompoc has recently changed, as such, the Department may consider completing a comparative analysis, similar to the above quarterly, bi-yearly, or annually for FY21-22 in order to get a more representative view of the performance of the new provider against the existing program provider and County. The Department may also choose to complete its qualitative analysis on this updated data.
- **Step four:** Share the results of the comparative and qualitative analysis outlined under step three with each ACT team. The Department may consider developing a quarterly forum for all ACT teams to discuss performance outcomes, share best practices, as well as concerns and areas of poor performance. This will promote an environment of continuous improvement and collaborative problem solving.
- **Step five:** Determine if the County needs three ACT teams versus one ACT team and a Flexible ACT team based on the quantitative and qualitative outcomes.

Action four B: Assess the feasibility of combining two ACT caseloads and transitioning these clients to a FACT model

This action is based on caseload data provided by the Department during the course of the review. Based on the analysis undertaken under Action four A above, the Department may consider assessing the feasibility of combining two ACT programs to one FACT program as an alternative approach to assessing whether ACT programs should be contracted out or operated directly by the Department.

As of May 2021, Santa Barbara, Santa Maria, and Lompoc, served 82, 75, and 88 clients respectively, which on average is approximately 22 percent lower than the 100 patients recommended under the ACT model. The analysis recommended under actions two and three may identify additional opportunities to transition clients to AOT or to a lower level of care, further reducing active client numbers across each team.

Given that the County's ACT teams currently are not operating at full capacity, and that a number of these clients may be eligible for transition to different programs, there may be an opportunity for the Department to modify its service offerings – transitioning to offering one ACT program and one FACT program across the County.

The ACT model focuses on the most vulnerable 20 percent of people with SMI and SPMI accompanied by multiple hospital admissions and at times prolonged admissions. Care for the remaining 80 percent, who tend to have significant issues in several areas of life such as physical health, lack of training and unemployment, functioning in the community and maintaining personal relationships, is provided through less intensive models of care, such as FACT. FACT was developed to meet the needs of this 80 percent who meet the following criteria:

- Suffer from a psychiatric disorder requiring care and treatment (≈ is not in symptomatic remission)
- Have severe limitations in social and community functioning (≈ not in functional remission)
- These two criteria are related to each other (the limitations are the cause and consequence of the psychopathology)
- Problems are not transient in character (they are systematic and long-term)
- Coordinated care provided by care networks or healthcare practitioners is needed to implement the treatment plan.

Like ACT, FACT is a multidisciplinary team, however, it provides a more flexible model than other Full Service Partnerships in that is allows participants to switch back and forth between two modes of care delivery while remaining in the one program:

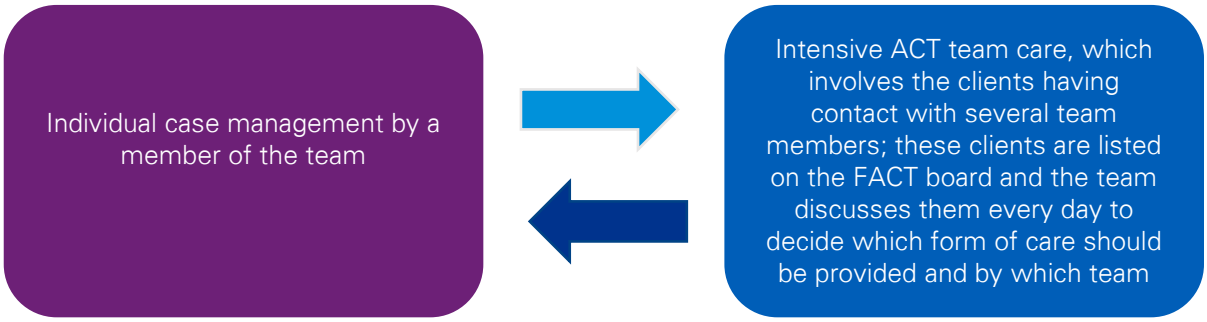


Figure 28: Source: KPMG

In both situations, the care is provided at the client's place of residence. As a result, the care is more personal and the client's care needs become more specific. For most clients, individual supervision offered through individual case management suffices. But if acuity arises or if hospitalization is imminent, the care is then provided by the intensive ACT team model. Once the crisis is over, the team switches back to individual case management care. This flexible switching seems to be the response needed for the natural course of SMI with its remissions and relapses.

While ACT is based on a team of 10 multidisciplinary members who serve approximately 100 clients, FACT is a multidisciplinary team of 11–12 FTE who care for approximate 180 to 220 clients. The target population is individuals with SMI in a dedicated catchment area who fluctuate between the 20 percent for whom ACT serves but can be stabilized through intensive treatment and be supported through less intensive means. To combine care for these two groups, the FACT team employs a "flexible switching system" as previously stated. The client group that requires the most intensive care is discussed daily and the team adopts a shared caseload approach. For the clients requiring less intensive care, the same team provides individual case management with multidisciplinary treatment and support as required. When clients become more stable, they do not have to be transferred (as is the case with ACT) to a

different team; they stay with the same FACT team. This flexibility to switch between the two modes of service delivery in the same team enhances continuity of care and reduces drop-out.

Reducing the number of ACT programs and/or transitioning to a FACT model, while referring clients to AOT where appropriate, may allow the Department to provide care to the population currently enrolled in ACT in a more cost-effective manner. It is important to note that across the three ACT programs, the Department currently has a maximum capacity of 280 clients, 100 clients in Santa Barbara and Santa Maria and 80 in Lompoc. The combination of one ACT program and one FACT program would provide the capacity to provide care to 280 to 320, 100 in the ACT program and 180 to 220 in the FACT program. During 2020, a combined 93 percent of clients in Santa Maria and Lompoc received less than eight contacts which would suggest that these clients may be more suited to a FACT model. This transition would deliver cost savings to the Department and may alleviate some of the Department's challenges in recruiting and retaining ACT staff, as FACT has lower staffing requirements than the ACT program.

As FACT Teams are required to perform a significant amount of their contacts in the field, it would likely be more feasible to combine and transition the Santa Maria and Lompoc Teams to a FACT model given that there is just 27 miles between these locations which should allow for appropriate coverage across geographical locations. Additionally, the Lompoc program does not currently adhere to the ACT model's recommended caseload of 100, and based on data analysis, Santa Maria and Lompoc have historically provided a lower average number of monthly sessions per client per month, averaging nine sessions per client as compared to Santa Barbara's twelve. Furthermore,46 percent of clients in Santa Maria and 47 percent of clients in Lompoc are seen less than eight times per month, compared to 43 percent in Santa Barbara. This would suggest that the clients served by Lompoc and Santa Maria have a slightly lower acuity and as such, may be more suited to the FACT model.

4.2 Implement demand-driven staffing and develop program-specific performance measures for Forensic Services programs to enable effective service delivery and track program outcomes and cost benefit

The Department's Forensic Services programs provide services to justice-involved adults with SMI or SPMI, including both individuals in the jail and in the community. These programs allow licensed mental health professionals in each region of the County to link eligible persons involved with the justice system to behavioral health and recovery-oriented services. Clinicians conduct outreach and assessments in the jail, courts, and community, and provide a wide range of services to justice-involved individuals until they can be linked to longer-term Full-Service Partnership programs such as ACT or Community Support Services. In addition, Forensic Services staff provide competency restoration services to defendants found Incompetent to Stand Trial (IST) in both the inpatient PHF and outpatient settings.

Across interviews, Forensic Services staff and management stated that staffing ratios were insufficient for effective service delivery, particularly related to case management and administrative services for the Justice Alliance and AB 109 programs. Key takeaways included:

- Currently, the Justice Alliance program, which falls within Forensic Services and offers services in both Santa Maria and Santa Barbara, has two dedicated case workers which are funded via AB1810, a mental health diversion funding stream. The Department's AB109 program, which provides outpatient behavioral health services to individuals released from prison, does not have a dedicated case manager. As a result, case management for the AB109 program falls to psychiatrists or to the case managers for the Justice Alliance program. Staff reported that this level of case worker staffing is insufficient to meet demand; however, the Department does not currently possess a data-driven method to validate this assertion
- There are two administrative staff assigned to Forensic Services. However, one of these staff is located in the North County Outpatient Clinic and is often pulled into clinic-related responsibilities. In interviews, staff noted a need for expanded administrative assistance related to tracking referrals and outcomes. However, staff indicated they may not have capacity for this work in addition to their current responsibilities
- Finally, interviewees reported that case management and administrative work may fall to psychiatrists or other clinicians due to a lack of specialized staffing

To develop a sustainable, efficient staffing model for Forensic Services that allows staff to function to the top of their license and enables effective performance management, the Department should undertake the following actions:

Action one: Establish role-specific guidelines to more clearly delegate responsibilities across staff levels

Job classifications identify the broad activities to be undertaken by psychiatrists, case managers and administrators countywide; however, the programs offered by Forensic Services are unique in nature given the populations they serve. As a result, the standard, countywide job classifications may not provide a sufficiently nuanced job description to efficiently delegate work across staff levels. As such, the Department should consider developing role-specific guidelines for the programs offered by Forensic Services to more clearly articulate the activities within the responsibility of each position. These updated guidelines will right-size the activities being undertaken across programs and help ensure that each staff member is performing activities appropriate to his or her role and working to the top of their license.

Action two: Implement a time-tracking study to assess the time required to conduct the above role-specific activities

Following the implementation of enhanced activity guidelines to help ensure staff is conducting activities within their remit, the Department should use time tracking to develop a data-driven understanding of the time and workload associated with these activities. The time-tracking study should also be supplemented by outcome tracking to help verify that current workload, caseloads, and activities enable successful case management and program outcomes. This workload data can be used to assess, for example, whether current caseload per caseworker or administrative staff is feasible.

Forensic Services does not currently have recommended caseload guidelines for caseworkers or clinicians. As a result, it is difficult to verify staff assertions that current caseloads provide an unmanageable workload or whether they can complete all expected activities to a high quality for each individual on their caseload in their typical working hours.

To answer questions such as this, the Department should develop a low-barrier pilot program for Forensic Services staff to enter time spent on client contacts, attending court, attending jails, training, scheduling and administration, and other work demands. This program can be facilitated via a simple spreadsheet with prepopulated drop-down fields to reduce the time it takes to enter information. This time-tracking exercise should be conducted for three-to-six months, and then analyzed to enhance the understanding of how staff is spending their time in the field.

If time tracking over this length of time is not the desire of Department leadership or creates a significant administrative burden, the Department can consider utilizing periodic sampling (e.g., a six-week time study on an annual basis) to compile initial workload estimates. Alternatively, the Department can consider asking caseworkers to work collaboratively with Department leadership to identify appropriate caseload targets qualitatively, which can be piloted, refined, and deployed to determine the appropriate staffing for the Forensic Services programs.

Action three: Utilize caseload guidelines, workload data, and population size to develop a data-driven staffing model

Based on the time and workload analysis detailed in action two, the workload-based caseload guidelines can be deployed to produce a data-driven estimate of the number of staff needed for Forensic Services to complete its responsibilities. The data produced from existing processes and the steps above will allow Department leadership to make a quantitative case for the number of staff required based on demand for service.

Action four: Expand program performance measures to assess outcomes and the cost-benefit of Forensic Services programs

Finally, given that many Forensic Services activities are not billable, Department leadership would benefit from additional information on the effectiveness and outcomes of these programs. It is important to note that some of these programs may produce long-term savings by preventing the use of crisis services such as the PHF and the jail. Department and County leadership would benefit from an understanding of the magnitude of these savings.

The Department currently conducts outcome tracking related to Forensic Services programs that are grant-funded, as many of these grants carry evaluation requirements. However, the Department would benefit from expanding this outcome tracking across all Forensic Services programs and expanding performance measures to allow for a cost-benefit analysis of the impacts of these programs. Performance measures should be developed with input from Executive Leadership, program management as well as case staff to help ensure feasibility and buy-in. The establishment of these expanded performance

measures will allow Executive Leadership to understand how effective the program is in terms of service delivery, cost savings and achieving successful outcomes.

Examples of such performance measures by program include but are not limited to the following:

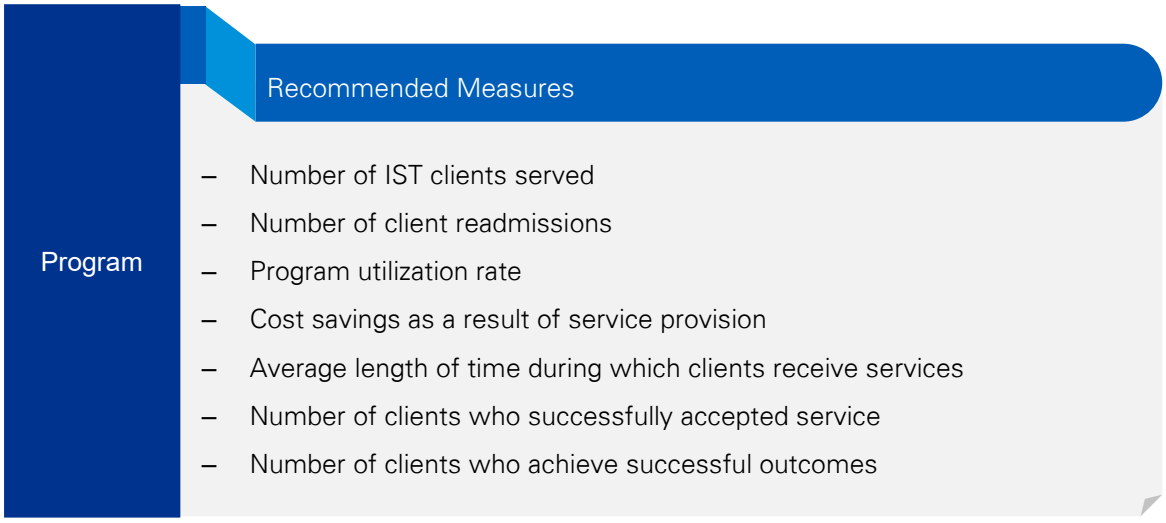


Figure 29: Source: KPMG

The establishment of these performance metrics may require modifications to the way Forensic Services manages and records current data. However, establishing policies to track and manage this data will enable Leadership to enhance data-driven performance management and develop a culture of continuous improvement. The Department currently utilizes Tableau to track and monitor utilization and should identify whether Tableau can be utilized to develop a monthly dashboard of program performance for Forensic Services programs. Executive Leadership should be engaged in performance management and should utilize Tableau to monitor performance on a rolling schedule, based on performance against the measures or KPIs. Where the program is consistently not trending against its performance measures it will be subject to closer monitoring and a systematic review cycle until performance issues are identified, addressed, and resolved.

4.3 Collaborate with County HR to review pay differentials for PHF nursing staff and adopt a team-based model of care to reduce recruitment and retention challenges

Throughout interviews, Department leadership and staff identified challenges related to staff recruitment, retention, and scheduling within the PHF. As a Medicare reimbursable facility, the PHF is one of only two Super-PHFs in the State and is licensed as both a PHF and an acute psychiatric inpatient hospital. As such, Santa Barbara's PHF is more heavily regulated than other PHFs. Based on State requirements, for example, the PHF must meet a staffing minimum of one registered nurse for every six patients. Challenges related to recruitment, retention, and scheduling have had a significant impact on the Department's ability to maintain this staffing minimum and the facility's operations over the past year:

- There have been instances in which the PHF was not able to operate at its full patient capacity as the facility lacked sufficient staff to meet State-mandated staffing minimums.
- There have been circumstances under which the Crisis Stabilization Unit (CSU) has been closed in order to transition staff from the CSU to the PHF to adhere to PHF staffing minimums.
- Staffing shortages present a risk to staff morale and increase the likelihood of additional turnover as night shift staff report being denied vacation in an effort to maintain staffing minimums. In addition to the below recommendations on recruiting, recommendation 5.2 also includes actions to improve retention across the Department, which may also assist with staffing shortages in the PHF.
- Due to staffing shortages, night shift staff are at times transitioned to the day shift, which in turn reduces the staff available to work on the night shift. Staffing minimums are higher during the day shift due to increased activity related to admissions, discharges, and recreational activities that do not occur with the same level of frequency on the night shift.

A review of staffing trends at the PHF suggests that a key staffing challenge stems in part from the County's compensation package for nurses as the PHF is not competitive with the market or competing facilities. This recommendation includes benchmarking analysis of pay for psychiatric nurses as well as an action to mitigate staffing shortages at the facility broadly.

Action one: Consult with County HR and CEO's office to increase pay differential for PHF-related nursing roles

Interviewees report that the County's compensation for PHF nurses is not competitive with the market and is not aligned at the educational level based on whether a nurse has a bachelor's degree, master's degree, or other specialty degree or certification. This assertion is backed up by benchmarking as noted in the table on the following page. In Ventura County, a senior registered mental health nurse receives an average salary of $107,000 and a nursing supervisor earns an average salary of $158,000, while in Santa Barbara, these figures are approximately 4.6% and 24% lower respectively at $103,000 and $119,000, respectively. This disparity is heightened by the fact that the cost of living in Ventura County is lower than that of Santa Barbara County by 13 percent. While nursing salaries in San Luis Obispo County are on average 14 percent lower than those offered in Santa Barbara, the cost of living in San Luis Obispo is 31 percent lower than that of Santa Barbara.

County	Role classification	Night shift pay differential	Average salary (annual)	**Cost of living[6]
Santa Barbara County	Psychiatric Nurse I	$1.50	$91,771	47.6%
Santa Barbara County	Psychiatric Nurse II		$96,129	47.6%
Santa Barbara County	Psychiatric Nurse, Senior		$103,096	47.6%
Santa Barbara County	Psychiatric Nurse, Supervisor		$118,687	47.6%
Ventura County	Registered Nurse, Mental Health	*$3.19–$6.38	$99,132	34.9%
Ventura County	Senior Registered Nurse, Mental Health		$106,808	34.9%
Ventura County	Nursing Supervisor, Mental Health		$157,962	34.9%
San Luis Obispo County	M.H. Nurse I	*$1.74–$3.48	$80,278	16.5%
San Luis Obispo County	M.H. Nurse II		$89,190	16.5%
San Luis Obispo County	M.H. Nurse III		$96,720	16.5%
San Luis Obispo County	M.H. Supervising Nurse		$111,207	16.5%

Figure 30: Source: KPMG

**Differentials represent minimum amounts given pay differentials are calculated based on percentage of hourly rates.*
***Cost of living information compares each county's cost of living as compared to the national average, for example, Santa Barbara's cost of living is 47.6 percent higher than the national average.*

Interviewees also highlighted challenges with salaries related to extra help and night staff positions:

- The County's salary for extra help nurses is on average 15 percent below the salary for permanent nursing positions. As a result, the PHF often experiences challenges in recruiting extra help to cover vacation time, sick leave, or other short-term staffing shortages. Commendably, the PHF has highlighted this issue to County leadership and has been given the approval of the CEO's office to liaise with County HR to bring extra help salaries in line with that of permanent positions, which should help remedy this issue in the future.
- Furthermore, night shift staff receive a pay differential of $1.50 per hour more than nurses who work the day shift. This differential is lower than that offered by neighboring Ventura and San Luis Obispo Counties: For example, Ventura County offers nurses a 7.5 percent differential for evening shifts (3:00 p.m.–11:00 p.m.) and 15 percent for night shifts (11:00 p.m.–7:00 a.m.),

[6] Cost of Living Calculator | Salary.com

which based on hourly rates represents a minimum evening differential of $3.19 and night differential of $6.38. In San Luis Obispo County, nurses receive a 5 percent differential for evening shifts and a 10 percent differential for night shifts, which represents a minimum evening differential of $1.74 and night differential of $3.48 based on nursing hourly rates. As mentioned previously, it is important to note that both Ventura and San Luis Obispo Counties have a lower cost of living than Santa Barbara, which may further increase the impact of this higher pay differential. Finally, interviewees also report that the County's pay and night shift differential are lower than that offered by private hospitals in the region.

Salaries and benefits for County positions are set on a countywide basis. Given the importance of the PHF to the wellbeing of residents of Santa Barbara County—as it is the only acute psychiatric inpatient hospital that accepts Medi-Cal in Santa Barbara County—the Department's Executive Leadership should collaborate with the CEO's office and County HR to implement a pay scale differential that offers a competitive salary for nurses at the PHF, compensates for educational level, and offers a competitive differential for staff on the night shift.

Action two: Transition to a team-based model of care

In order to continue providing effective, patient-centered care in the face of current nursing shortages, the PHF could consider adopting a team-based care model. Team-based care uses multidisciplinary teams to provide coordinated care; these teams can include clinicians, nurses, pharmacists, counselors, social workers, nutritionists, community health workers, or others. A team-based model of care also strives to actively engage patients as full participants in their care to enhance patient education and promote a faster recovery. According to the National Academy of Medicine (NAM), team-based care acknowledges that there are multiple key players treating a patient and that each of them must work with one another in order to drive optimal care outcomes.[7] Commendably, the PHF has already begun to implement team-based care by recruiting recovery assistants to assist nursing staff. The recruitment of these positions allows the diversion of some less specialized and complex tasks that would otherwise be conducted by nurses to a lower-cost staff member and a position that may be easier to fill due to lower education and experience requirements.

Adopting a team-based care model typically involves both the shifting of tasks and the strategic redistribution of workload across the team, ensuring that each member of the team plays a key role in client recovery:

- **Task shifting** involves the reassignment of clinical and nonclinical tasks from one level or type of health worker to another so that behavioral health services can be provided more efficiently and effectively. For example, in the PHF where nursing staff can be in short supply, some services can be effectively shifted to equipped and well-trained unlicensed staff while maintaining quality.
- **Workload redistribution**: Team-based care can also involve a strategic redistribution of work among members of a practice team. In the model, all members of the team play an integral role in providing patient care. The clinician and a team of nurses and/or other healthcare assistants share responsibilities for better patient care.

The model is adaptable and can be tailored to meet the needs of each particular institution. Based on leading practice research, the advantages of a team-based approach, having adopted the above operational and strategic changes, include the following:[8]

[7] https://patientengagementhit.com/news/how-to-use-team-based-care-to-improve-the-patient-experience
[8] WHO-NMH-NVI-18.4-eng.pdf;jsessionid=011387AD090CE7005A4DFD00D711D15E

- Expanded access to care (more hours of coverage, shorter admission wait times)
- Better patient support, knowledge, satisfaction, and adherence to medication as patients become involved in treatment decisions
- Enhanced team member collaboration as the model promotes a coordinated approach to discuss patient diagnosis and treatment
- Time saving for patient and healthcare team.

Please refer to Appendix I for further detail on implementing a team-based model of care.

It is important to note, that regardless of whether a team-based care is adopted, the PHF will continue to be required to meet the 1:6 nurse to patient staffing ratio based on the requirements of a Super-PHF. However, adopting such a model will increase efficiency in the use of existing resources and can help prevent instances where the PHF cannot operate at full capacity. Challenges specifically related to nursing shortages may be best solved by considering recommendation increasing pay differential for PHF-related nursing roles as discussed in action one of this recommendation.

4.4 Collaboratively engage with Department HR to establish a policy for managing sick leave and implement methods to reduce instances of sick leave

Over the past year the PHF has experienced significant instances of sick leave—excluding COVID-19-related illness—among its employees. These sick leave occurrences are adding to the staffing challenges faced by the PHF.

In 2020, the PHF reported an average of 12 sick leave instances per month. In the months from January 2021 to May 2021, this figure rose to an average of 19 instances per month. Given the high level of sick leave experienced at the facility, management reported scheduling above staffing minimums, so the facility can continue to operate at full capacity even if staff call out sick. The high level of sick leave is adding to the staffing shortages being experienced by the PHF, given scheduling above staffing minimums means a higher pool of staff are required at the facility.

As illustrated in the chart below, sick leave days among staff continued to rise between December 2020 and March 2021, with the highest figure to date experienced in May 2021 at 25 sick leave days.

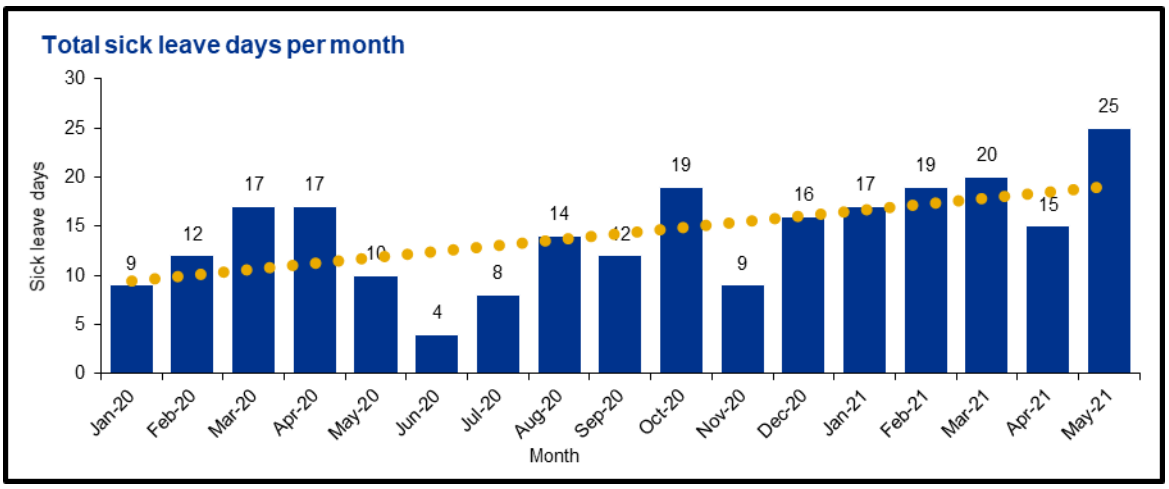


Figure 31: Source: KPMG analysis of PHF sick leave data

Based on data analysis, a large portion of sick leave occurrences are concentrated among a small number of staff. For example, 65 percent (96 instances) of all sick days were taken by 14 employees in 2020, while 14 employees accounted for 68 percent of all sick leave days between January 2021 and May 2021. Historically, licensed staff and recovery assistants take the highest amount of sick leave with licensed staff accounting for 48 percent of all sick leave between January 2020 and May 2021 and recovery assistants responsible for 46 percent of sick days in 2020 and 45 percent in the five months to May 2021.

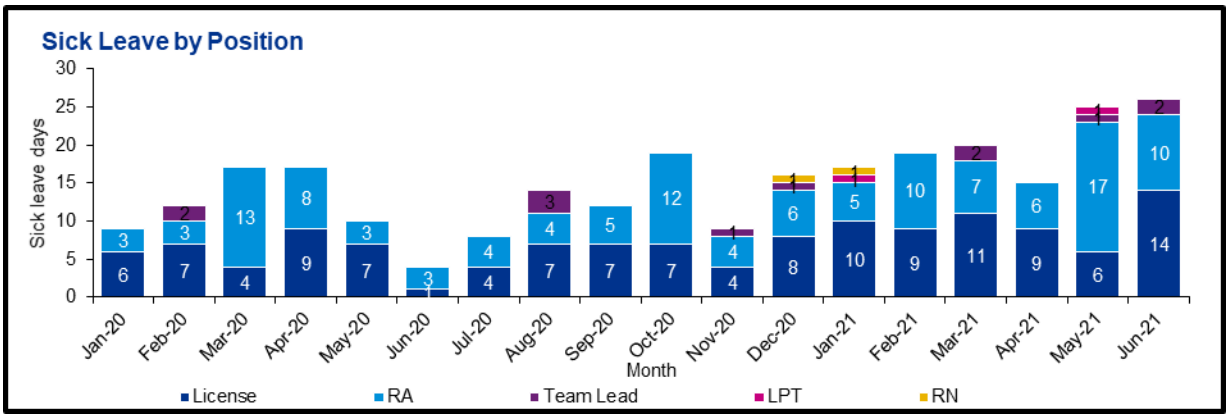


Figure 32: Source: KPMG analysis of PHF sick leave data

Behavioral Wellness does not have a formal sick leave policy. Instead, the provisions for utilizing sick leave are outlined in MOUs with various labor organizations. The MOUs outline the process surrounding sick leave accruals, utilizing sick leave for death or illness of immediate family members, and the right of the Department to request a physician's certificate. The PHF internally developed attendance guidelines that were updated in July 2019 and outline the process that must be followed by employees when calling out sick. Specifically, the protocols state that all staff must call the team lead and supervisor or manager two hours before the scheduled shift. However, neither the MOU nor the sick leave guidelines outline how sick leave should be managed at the Facility or Department level.

The current level of sick leave is having a significant impact on PHF staffing; however, there are a number of initiatives that can be considered to better support employees and manage sick leave, such as the following:

- **Liaise with Department HR to develop a policy for managing sick leave:** The PHF should liaise with Department HR to discuss the current level of sick leave and determine the feasibility of developing a policy to better manage sick leave, while ensuring continued compliance with State and federal laws as well as agreements with labor organizations. A policy to manage sick leave could include the following, for example:
    - Circumstances under which an occurrence can be issued
    - Process which must be undertaken to report sick leave and implications for not following processes
    - Process that must be undertaken to report sick leave and implications for not following processes
    - Process for employee grievances as it relates to sick leave.

It is important to note that the development of any sick leave policy would require significant collaboration and agreement between Department HR and County HR. Any change of current practices with regard to sick leave would also require engagement and negotiation with labor unions.

- **Track patterns of employees:** The PHF should track sick leave patterns per employee and regularly monitor the number of accrued sick leave hours remaining for each staff member. The PHF should liaise with Department HR and County HR to determine the appropriateness of issuing an occurrence for an employee who has exceeded the amount of his or her accrued sick leave but continues to take leave. Furthermore, the PHF should also regularly analyze patterns

of sick leave at a facility level by liaising with both HR and the Fiscal Divisions to identify rate of absenteeism, cost of absenteeism, as well as the shift, day of the week, and position that accounts for the highest percentage of sick leave instances. This analysis should be conducted and reported to executive leadership monthly to increase transparency, investigate reasons for high rates of sick leave on a particular day or shift, and collectively develop and implement practices to mitigate instances of sick leave.

- **Request physician's certificates:** Under MOUs in place with labor organizations, the Department has the right to request physician's certificates for each and every instance of sick leave. Currently, these certificates are not consistently requested across divisions and facilities. The Department, including the PHF, should implement a process for determining when managers should request a physician's certificate from employees upon their return from sick leave—perhaps utilizing the sick leave tracking mentioned in the bullet above. This process will increase accountability and transparency, allowing the PHF, as well as other behavioral wellness clinics, to assess the gravity of an employee's illness and determine any potential support that can be provided to the employee to prevent future illness. Furthermore, it will allow the PHF to identify whether the illness is in line with that identified under the paid sick leave law.
- **Hold return-to-work meetings:** The Department including the PHF should consider establishing informal return-to-work meetings with an employee returning from sick leave. The meeting would be facilitated by the employee's supervisor and would act as an informal forum to discuss how the employee is feeling and whether he or she needs any support from the Department. Undertaking return-to-work meetings will allow the PHF to better understand the reasons behind staff illness and will help ensure that the employee feels supported upon return to work, which may reduce the instances of future sick leave.
- **Conduct employee pulse surveys:** Given the level of sick leave being experienced by the PHF, management should consider issuing regular pulse surveys to its staff. Pulse surveys will allow management to understand employee satisfaction and can identify areas for improvement, which may lead to a reduction in sick leave. Based on KPMG experience, pulse surveys are between 5 and 10 questions in length and can be issued on a monthly or quarterly basis. Examples of survey questions include:
  - What are the challenges you are currently facing?
  - Were you able to achieve your goals during this period?
  - Do you have the resources you need to achieve your goals?
  - Are you clear on your roles and responsibilities?
  - Is there anything further the PHF could be doing to improve your employee experience and ability to optimally perform your job?

Succession planning

5.1 Collaborate with County HR to review human resource processes to speed recruitment timelines and develop recruiting pipelines

Across interviews, staff and Department leadership cited chronic vacancies as a key challenge in delivering day-to-day services to clients across the system of care. Challenges that contribute to the Department's unfilled vacancies include a protracted recruitment timeline and the lack of a robust, proactive recruitment pipeline.

Staff reported extended timelines to recruit and fill vacancies, with the timeframe between posting and filling a position often taking two to three months. While extended timelines for hiring are not unusual at local government agencies, these delays cause operational challenges as the Department attempts to deliver services while below its allocated staffing. Operating with vacancies requires Department staff to take on responsibilities beyond those typically assigned to their positions, resulting in workloads that negatively impact staff morale or quality. Additionally, the extended hiring timeline leads to an increased risk that qualified candidates receive offers from other employers before completing the County's process.

The recruitment process involves coordination between the hiring Division within Behavioral Wellness, department-level HR, County HR, and upon occasion, the CEO's Office. The following pages outline action steps that will enable the above parties to collaborate to accelerate the recruiting timeline, develop a proactive recruiting pipeline, and strengthen relationships with local universities. These action steps combined with those outlined in recommendation 5.2 which relate to implementing competitive pay (with a particular focus on high-priority, chronically vacant roles) and enhancing processes surrounding succession planning will assist in expediting recruitment timelines, promoting staff retention and improving department resiliency.

Action one: Review existing processes with County HR including MOU and determine viability of implementing two process pathways (standard versus expedited)

Currently, the Department has a Memorandum of Understanding (MOU) with County HR; however, it is not regularly referred to or reviewed. As such, there is an opportunity to collaborate with County HR to review this agreement to outline the specific turnaround times for recruiting to better meet Behavioral Wellness's business needs. In particular, the Department should consider working with County HR to implement an expedited hiring process for high-priority positions in order to shorten recruitment timelines in areas where understaffing is significantly impacting the Department's operations.

First, the Department should review the current MOU with County HR to determine whether turnaround timelines can be reduced across each step of the process.

Second, the Department should work with County HR to develop guidelines for defining and initiating an expedited hiring process for high-priority situations as defined by the Department with concurrence from the CEO's Office. This process would allow Behavioral Wellness Leadership to collaborate with County HR to initiate an expedited hiring process in instances in which vacancies may significantly or adversely

disrupt Department operations. In determining whether to initiate this expedited process, the Department and County HR should consider the following elements:

- Number of related positions vacant in the particular Division/Program/Clinic/IMD
- Impact on direct client service delivery should the position remain vacant for a protracted period
- Potential cost of any overtime related to existing staff taking on additional responsibility during recruitment period
- Impact on state/federal requirements should position remains vacant for a protracted period

Should the Department and County HR agree to the implementation of an expedited process pathway, the MOU should be updated to outline the expedited timelines and circumstances under which the process can be initiated.

Third, the Department should collaborate with County HR to monitor adherence to the MOU on an annual basis. This may involve tracking the average length of the recruiting process (both standard and expedited timelines), and meeting with County HR to review and problem-solve should there be instances in which the terms or timelines of the MOU are not being met.

Action two: Strengthen relationships with local universities

The Department should increase outreach to local universities to strengthen the Department's proactive recruiting pipeline. As a first step in this process, Department HR should review the degrees offered at local universities in order identify the roles for which the university graduates may be well qualified. Once key universities and degree programs have been identified, the Department subsequently should liaise with each target program to hold recruiting events and post job notices. Department HR should also consider attending recruitment fares and speaking at university events in order to increase awareness of the Department's programs, services, and opportunities for employment.

Action three: Enhance utilization of telemedicine for chronic vacancies

During the COVID-19 pandemic, the Department commendably increased its utilization of telemedicine to allow it to continue providing critical services to County residents in as safe a manner as possible. Interviewees noted that this shift to telemedicine particularly in outpatient clinics, while not appropriate for every client, in many cases did not decrease the quality of service provided and, in fact, enabled increased staff productivity. Building on this work and going forward, the Department should identify services that can continue to be delivered using telemedicine. The hiring pool for these remote services can then be expanded to include remote staff. This approach will allow the Department to expand its pool of candidates beyond the boundaries of Santa Barbara County. The flexibility for remote working and providing remote services may be attractive to potential candidates in terms of travel and living arrangements, for example, and may also differentiate Santa Barbara from other counties, increasing the County's ability to attract highly talented candidates.

Action four: Develop a proactive, continuous recruitment pipeline for "difficult to fill" positions

Following the implementation of competitive pay scales, the Department should develop a proactive, continuous recruitment pipeline under which they would continually advertise for "difficult to fill" positions to build a pipeline of eligible, interested applicants, with the expectation that candidates will be contacted for final interview once a position becomes vacant. The initial process would screen candidates for suitability, with unsuccessful candidates being informed following screening and successful candidates remaining in the pipeline ready for a final interview once a position becomes vacant. This process could significantly reduce recruitment timelines by helping to ensure that the Department has a reservoir of potential qualified candidates at all times.

5.2 Develop a proactive strategy to enhance succession planning and department resiliency

Updating the Department's recruiting processes, as detailed in the above recommendation, is just a first step toward developing sustainable staffing levels that meet the Department's business needs. Interviewees report challenges related to succession planning, training new staff, and creating robust promotion pathways that incentivize promotion and retention:

- Across the Department, staff noted that the lack of documented standard operating procedures (SOPs) poses a challenge to onboarding, training, and succession planning. As detailed in recommendation 5.1, the Department experiences extended timelines for hiring. As a result, departing staff may not overlap with their successors and, thus, lack a window to train their successors in person. Given this dynamic, proactive succession planning and codified, standard practices become even more important so that attrition does not consistently result in a loss of institutional knowledge at the Department. Having codified SOPs will help ensure that new staff has the materials necessary to learn to conduct their new responsibilities, even if in-person shadowing is not possible before their predecessor departs.

- Additionally, interviewees noted that current pay scale differentials do not incentivize staff promotion. The maximum salary of a supervisor position can only be between 5 and 7 percent higher than the maximum salary for the line staff role for certain positions, even though promotion to a supervisory position typically entails a significant increase in responsibility. This pay scale does not provide an adequate incentive for internal promotion and may exacerbate the Department's challenges with external hiring. For example, the average pay of a Behavioral Wellness Practitioner II is approximately $83,435 while the starting pay for a Clinical Psychologist Team Supervisor is approximately $80,795— over 3 percent below the average pay for a supervisor. While the starting pay for a program/business leader (the equivalent of a manager) is approximately $99,000, newly promoted managers may be at the lower end of manager pay range, meaning they would receive significant additional responsibilities without a commensurate pay increase. As shown below, when compared to neighboring Ventura and San Luis Obispo Counties, Santa Barbara ranks the lowest in the different pay differentials between the equivalent of senior line staff, supervisor and manager. The difference between the maximum pay at the senior line staff level is on average 10 percent higher than the minimum pay at the supervisor level. Furthermore, the difference between the maximum at the supervisor level is on average 13 percent higher than the minimum pay the program lead level. While most supervisors would not promote into the bottom of the manager salary range, there is not a likelihood that they would promote into the high side either, creating a disincentive that is compounded by the difference in the amount of work a manager is expected to perform as compared to a supervisor.

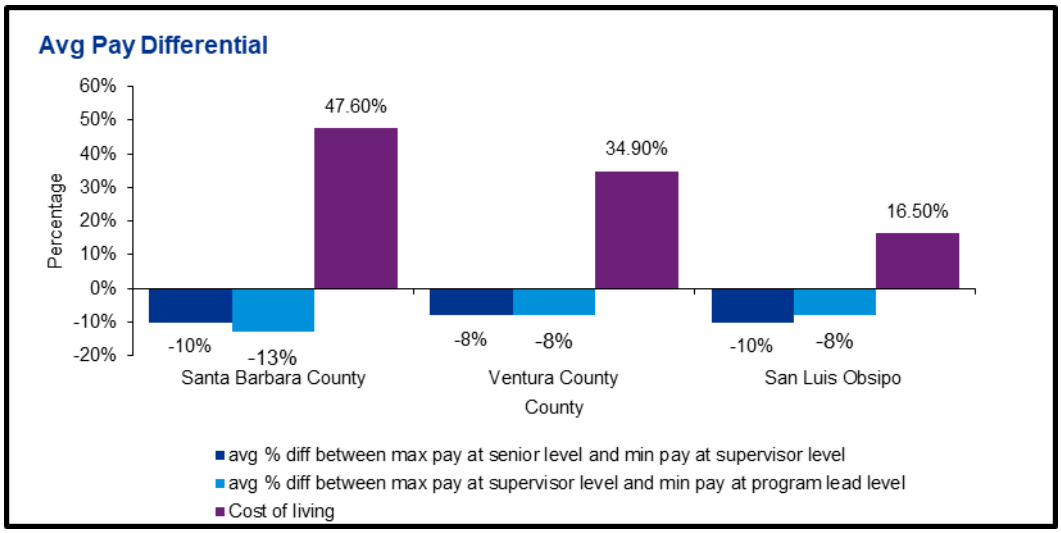


Figure 33 Source: KPMG

Succession planning is a priority area countywide, and robust succession and workforce planning strategies are key to reducing the risks associated with staff attrition. This recommendation builds upon those outlined in the firm's review of the County HR Department, which recommends that the County develop a shared service strategy to create a more structured workforce development and succession plan across all Departments. By dedicating staff time to succession planning, and leveraging the support of County HR, the Department can build resiliency while adopting a more proactive approach to workforce planning and development. Outlined below are a series of iterative steps to improve succession planning across the Department.

Figure 34: Source: KPMG

Action one: Develop SOPs to document critical information and transfer across staff

To prepare to more efficiently navigate staff turnover, the Department should develop and codify SOPs to the document critical processes at the position level that are required to maintain efficient operations. In developing these SOPs, the Department should begin by determining which positions lack adequate succession planning at present—most significantly, positions that currently represent single points of failure because staff lacks a replacement should they depart. The Department should prioritize the development of SOPs for these roles to help ensure attrition does not result in a loss of institutional knowledge. To achieve this, Division managers and supervisors should identify key tasks and processes performed by each unit and prioritize the documentation of relevant instructions and key pieces of information (e.g., data dictionaries, policies and procedures). These SOPs should be codified and stored on the Department's intranet.

Action two: Utilize cross-training to improve resilience and flexibility

Cross-training is a critical aspect of organizational resilience and a key component of succession planning. Examples of this are teamwork, rotational positions, job sharing, job shadowing, interviewing, and mentoring. Commendably, the Department has demonstrated its resiliency by assigning nursing staff from the CSU to work at the PHF during periods of chronic understaffing in order to maintain

staffing minimums. However, Department leadership should further strengthen collaboration with supervisors to help train and identify staff to provide resiliency to any positions that are currently single points of failure and lack an adequate succession plan.

As discussed in action one, the development of SOPs and consistent operations may also facilitate cross-training and the flexing of staff. For example, interviewees report that procedures related to client transfer may vary across clinics and programs. Standardizing these processes would allow staff to more easily flex across clinics or programs, if permanently or temporarily transferred.

Action three: Collaborate with County HR to modify pay and incentives to create a promotion pathway that encourages recruiting, retention, and advancement

Interviewees noted that current pay scales may not incentivize promotion, due to a disconnect between pay and responsibilities from the line staff to supervisor level. Supervisor and manager positions were viewed as requiring a significant increase in responsibility without a commensurate increase in pay. Salary analysis supports the assertion that these promotions may not result in a financial reward commensurate with the increase in responsibility. Department leadership should work with County HR to assess the manager salary range to create a monetary incentive for supervisors to promote to manager and fill funded vacancies.

Contract processes

6.1 Engage with County Counsel to increase specificity of expectation around turnaround times and scope of review to increase efficiency

Currently, the Department has over 303 active contracts in place with a range of providers across the system of care with a total contract value of approximately $98 million. Maintaining these contracts with care providers requires regular coordination and collaboration both cross-divisionally and cross-departmentally. Given the number of contracts in place, the Department has a dedicated Contracts Division responsible for drafting contracts and coordinating the overall contract process from submission of a contract request form to contract execution. County Counsel is a key partner in this process, as they are responsible for reviewing each contract to identify any area of legal risk for the County.

Interviewees in both the Department and County Counsel report that the contracting process, which begins with the submission of a contract request and ends with execution, often experiences delays and inefficiencies related to coordination and hand-offs between the Department and County Counsel. In particular, Board contracts—contracts that amount to over $200,000—must go through multilayer reviews across 10 process partners including County Counsel and can take three months to execute. Given that many of Behavioral Wellness's contracts are Medi-Cal-funded or relate to other specific grant-related funding and must be executed by a specific date, delays may put the Department at risk of losing funding sources which would have a direct impact on the ability to provide client service.

Interviewees report a series of frustrations with the current process:

- Agreed-upon timelines for delivery and handling are not consistently met, making it difficult for parties to manage their workload internally and resulting in delays and inefficiencies in the contracting process.
- The parties share incomplete drafts, which then creates a need for repeated reviews as language is updated.
- The parties disagree on the scope of County Counsel's review and whether County Counsel should be providing feedback on issues such as grammar.

The core challenge appears to be a need to establish a review timeline that works for both parties as well as gaining adherence to the deadlines established in this timeline. The following actions allow for the establishment of a formal agreement to clarify roles and responsibilities or specific areas of review, performance tracking to monitor adherence to established turnaround timelines as well as the implementation of an expedited process for time-sensitive contracts. These actions taken together with recommendation 6.2 below which relates to the implementation of a contracts management system will help reduce turnaround times and increase efficiency in review across process partners.

Action one: Establish a service level agreement (SLA) with County Counsel outlining turnaround times and specific areas of review to increase efficiency in review

The Department should consider negotiating with County Counsel to develop an SLA which would formalize the service relationship between both agencies. The SLA would define the level of service to be provided by County Counsel and should include the following elements at a minimum:

- Description of the services to be provided
- Role and responsibilities of County Counsel, including specific areas of review
- Role and responsibilities of Behavioral Wellness in engaging with County Counsel
- Turnaround timelines at each stage of review (initial review, secondary review, and final review)
- Number of hours assigned to Behavioral Wellness per week/month
- Annual cost
- An expedited review process, if appropriate, as detailed in action two.

It is important to note that any SLA should be developed in collaboration with County Counsel to help ensure buy-in from both departments.

Establishing an SLA will increase the efficiency of workflows by helping to ensure there are formalized roles and responsibilities for each Department, an expedited review process as well as agreed upon review timelines and related performance measures to enhance transparency and accountability across both Departments.

Action two: Track turnaround timelines and monitor and review County Counsel performance against the SLA periodically to promote accountability and enhance efficiency

The Department should begin tracking contract development and review timelines across its internal process partners to understand the average time taken to develop and review a contract during each level of review. In order to track review timelines, the Department could develop a spreadsheet which identifies each contract and tracks turnaround timelines, hours spent on review, number of iterations per Behavioral Wellness process partner for example. The Department should also consider whether this tracking process could be implemented via smartsheet. County Counsel has already implemented performance tracking for review timelines and report an average timeline of two to seven business days over the past number of years. Understanding the average time taken to both develop and review contracts at each level of review will allow the Department to identify those levels of review which take the longest period of time. Once identified, the Department can develop measures and supports across process partners in order to increase efficiencies in review.

Furthermore, performance against the SLA established with County Counsel should be monitored quarterly by Behavioral Wellness with Key Performance Indicators (KPIs) developed to allow for performance analysis. KPIs should be developed in collaboration with County Counsel during SLA negotiations as a cross-agency effort and should include performance measures related to turnaround timelines, workload hours, cost, and number of expedited reviews undertaken for example. The two departments should coordinate to evaluate whether KPIs are being met, and update processes or the SLA as needed in instances in which KPIs are not adhered to.

Action three: Implement two process pathways to allow for a typical contract review process and an expedited process for time-sensitive contracts

The Department has certain time-sensitive contracts related to Medi-Cal or grant funding that must be executed by a specific date in order to meet funding requirements. The Department should consider implementing an expedited process for these time-sensitive contacts in order to reduce the risk of potentially losing funding. Implementing this process will require the development of guidelines to be met in order for the expedited process to be initiated. Guidelines should be developed in collaboration with all internal process partners and should consider the following elements:

- Contract amount
- Timeline for execution
- Funding source
- Impact of failure to meet contract specific timeline

The expedited process would reduce the timeframe under which each process partner is required to review and/or require for concurrent reviews. Any SLA with County Counsel should include a term related to this expedited process.

Action four: Liaise with County Counsel to develop standardized boilerplate contracts per program to reduce review timelines

The Department has standard contracts related to certain programs; however, County Counsel holds that these standard contracts must be updated and reviewed annually as they often require some modifications. In order to increase efficiency of review, the Contracts Division should collaborate with its assigned County Counsel representative at the earliest point possible each year, to review updated standardized boilerplate contracts per program which help expedite the review period by County Counsel for each contract due to early implementation of the standard template. The SLA should also include a term surrounding the review of these boilerplate contracts with the goal of conducting this review during a low workload period.

Action five: Establish formalized onboarding training for County Counsel staff

Behavioral Wellness contracts have many nuances given the nature and the array of the services they offer as well as the varying state, federal and grant funding sources received. Many of these contracts require specific state or federal terms or clauses, for example, which are not an element of other departmental contracts. The various requirements and business need of Behavioral Wellness take time to become accustomed to. However, Behavioral Wellness can be assigned a new County Counsel representative after a period of time as a result of a reallocation of workload at the County Counsel level. To reduce the learning curve for newly assigned County Counsel representatives, the Contracts Division should develop a formalized onboarding process. The onboarding at a minimum should provide an overview of the role of the contracts division, the role of County Counsel based on the SLA, the various funding sources received, and related contracts requirements under these funding sources, as well as a sample of boilerplate contracts and a sample of contracts already in place.

6.2 Implement an electronic contract management system to better coordinate workflows and streamline the contract review and approval process

At present, there are 10 review groups involved in the contracts process including internal and external parties. Internal review groups include: Program Managers, Fiscal Division, Research and Evaluation, Contracts Division, and Behavioral Wellness Executive Leadership while external review groups include County Counsel, Auditor-Controller, Risk Management, CEO's Office, and the Contractor. Reviews are not conducted concurrently and timelines from request through to contract execution are lengthy, often taking more than three months.

The Department commendably implemented an electronic contract request form and approval process via ServiceNow and recently developed a workflow to implement DocuSign, however, the overall process remains largely unautomated. The Division utilizes email to coordinate the process, provide contracts to each process partner, and respond to comments and requests for clarification. This lack of automation creates a version control risk, does not allow for a centralized hub of cross-partner commentary, and reduces overall efficiency due to linear reviews and manual processes in coordinating reviews.

Implementing an electronic management system, which acts as a centralized location for access to contracts, streamlines workflows, allows for concurrent review, update, and commentary, will increase efficiency in review, reduce workflow timelines, and ensure that the Division meets the contracting deadlines required under Medi-Cal and other funding sources.

Action one: Establish a Task Force with IT representation dedicated to assessing potential electronic management system solutions

The Department should establish a Task Force with representation from the Department leadership, the Contracts Division, Department Process Partners, and IT to consider the functionality required by the Department in considering any contracts management system. Given that any contract management system will need to align with countywide contracting processes and other systems under development including BANA, the Taskforce should also include representation from the County's IT Department. The Task Force should develop a shortlist of system "must haves" and utilize this in assessing and evaluating potential electronic management system solutions. At a minimum the solution should manage the contract process from step one (contract request) through to the final step which involves board docketing and contract execution. This shortlist should also consider the varying nuances of Behavioral Wellness specific contracts.

Action two: Analyze contract management solutions available to determine optimal solution for the Department

The Department should assign responsibility to the cross-department Task Force to evaluate potential contract management systems available. In evaluating each potential solution, the Task Force should consider the short list of required functions under action one, as well as the cost and potential timeline for implementation of each option. A scoring methodology could be developed to analyze alignment to required functionality for each potential system and identify the most suitable option for the specific needs of the Department. There may be an opportunity for the County to pilot this solution at Behavioral Wellness and potentially adopt countywide in time. It should be noted that the County is currently undertaking a Business Applications Needs Assessment (BANA) project which should enable a more integrated ERP suite and should be considered by the Task Force when assessing potential electronic management system.

Action three: Consult with the CEO's Office and Department leadership to identify funding sources

Once a potential system has been identified, the Task Force should develop a cost-benefit analysis and business case for the implementation of the electronic management system and present this to Department leadership and the CEO's Office. In collaboration with the CEO's Office, the Department should identify potential funding sources for the procurement of the electronic contracts management system such as general fund dollars or other potential funding sources.

Interagency collaboration

7.1 Enhance collaboration between homeless outreach efforts within Behavioral Wellness (homeless outreach team and clinic staffing) and between Behavioral Wellness and CSD to streamline and enhance service offerings

Outreach is a key factor in building trust and developing relationships with persons experiencing homelessness to direct clients to the appropriate level of care and achieve successful outcomes. At present, the County conducts homeless outreach through multiple teams across Behavioral Wellness as well as through programs funded by the CSD. Based on the population and locations served by these outreach teams, similar services are often provided to the same shared client by numerous teams. However, there is no consistent coordination and collaboration between them that would allow for greater streamlining of service offerings:

- Behavioral Wellness outreach teams under the Mental Health Outpatient and Community Division runs three homeless outreach teams across Santa Barbara, Lompoc, and Santa Maria. These teams are tasked with providing homeless outreach exclusively to those with SMI. Interviewees report, however, that it often takes months of outreach to build rapport with individuals experiencing homelessness in order to determine whether they suffer from SMI
- City Net, a third-party service provider engaged by the CoC conducts outreach to the entire homeless population across the County regardless of health diagnosis. Given City Net does not offer behavioral health service, it refers many of its clients experiencing SMI to Behavioral Wellness
- In addition, patients served by the Department's outpatient clinics experience homelessness. Behavioral Wellness' clinics report conducting their own outreach to engage and provide services to their distinct clients, who are at times service resistance

By enhancing collaboration across the three entities conducting outreach, the Department can streamline service offerings, more strategically allocate workload, and achieve more successful outcomes.

Action one: Establish weekly touchpoints between homeless outreach teams operating in each region

The Department should implement consistent weekly touchpoint meetings to be attended by all street outreach teams in a virtual setting. These meetings will act as a forum for sharing knowledge and data on clients, identifying gaps in service and successful practices adopted, and reducing potential duplication of outreach and service particularly between Behavioral Wellness and provider-funded teams.

Action two: Reassign outreach conducted by outpatient clinics to clients experiencing homelessness to homeless outreach teams

The Department would benefit from a more coordinated relationship between outpatient clinics and street outreach teams in which clinics delegate outreach services to the Department's homeless outreach teams. Clinics may choose to enlist outreach services in circumstances which clients with unstable housing fail to attend at appointments, for example. This delegation will reduce the amount of

time spent by highly trained outpatient clinicians on nonbillable, outreach services and increase availability to provide direct client services to dedicated homeless outreach staff who are more accustomed to this type of outreach work.

Action three: Enhance performance tracking to assess the impact of outreach services

Currently, Behavioral Wellness' outreach teams are funded by a variety of funding sources, including Homeless Emergency Aid Program (HEAP), Projects for Assistance in Transition of Homelessness (PATH), MHSA among others. The performance measures reported by each outreach team are specifically tied to the varying regulations or requirements of these particular funding source(s) and the Department reports performance measures to the State based on these funding requirements. While it is necessary to comply with all funding regulations, there is a need to develop a consistent and balanced set of performance measures across outreach teams to allow for an evaluation of the efficacy across each outreach team. This performance data should be reported to the Department's Executive Leadership on a recurring basis. Examples of such performance measures, while not exhaustive, include:

- Number of clients served monthly versus benchmark
- Number of clients per case manager
- Length of time taken to determine diagnose a client with "SMI"
- Number of clients with co-occurring conditions
- Number of clients who refuse to engage with outreach teams
- Length of time taken for client to obtain housing and/or supportive services
- Number of clients who became justice-involved during service provision
- Number of clients using emergency room services during service provider
- Cost of outreach services per client
- Compliance with state and/or federal guidelines

The Department should begin to report performance measures monthly to increase performance visibility, incentivize performance, and address nonalignment with target performance measures in a more timely fashion. The Department should also compare performance across locations and, where significant discrepancies arise, identify the reasoning behind such discrepancies and mitigating factors such as enhanced training, outreach methods, and adoption of best practices.

Action four: Collaborate with the CEO's Office to conduct a review of homeless services funding

A key impediment to enhancing collaboration between cross departmental homeless service providers is funding, particularly given that the Behavioral Wellness, for example, cannot receive Medi-Cal reimbursement for homeless services. Currently, homeless services are funded and delivered by a variety of sources across multiple agencies including Behavioral Wellness and CSD. However, these agencies may provide similar services such as outreach to overlapping client populations.

For example, the Housing and Community Development Division of CSD manage Countywide homeless services and funding, acting as the lead agency for CoC. Behavioral Wellness receives funding from the CoC as well as from other sources including PATH, Homeless Mentally Ill Outreach Treatment (HMIOT), HEAP, MHSA among others to provide its services. There is an opportunity to streamline collaboration across agencies in delivering services to persons experiencing homelessness and to clarify the roles and responsibility of each agency based on its place in the system of care. Furthermore, there is an opportunity to quantify and review the amount of countywide funds available for homeless services to

provide County leadership with a coordinated view of cross-agency funding and assess whether funding aligns to the need for supportive services.

This process could be undertaken by developing an Excel spreadsheet detailing the amount of each funding source, the services which can be funded under that funding source, the length of each funding source, and whether the funding falls within the authority of the CoC, for example. This process will also promote a more coordinated approach to funding decisions by identifying funding which can be blended and braided across agencies to more strategically fund programs and service offerings to meet the needs of the target population. The effort to clarify roles and responsibilities and review funding sources should be led by the CEO's Office with collaboration from each agency providing services to those experiencing homelessness. Clarifying roles and responsibilities and establishing a countywide view of available funding sources will help ensure each program in the County's system of care is funded appropriately, delegated strategically, has a clear owner and oversight, and coordinates with other relevant stakeholders.

In addition to funding constraints, staffing is also a key impediment to enhancing cross departmental collaboration for homeless services. Due to the time bounded nature of certain grant funding sources, extra help staff are often hired to provide the services funded. This results in increased staff turnover and continuous on-boarding which can be time consuming. In evaluating and considering funds, the Department in collaboration with the CEO's Office should consider developing a consistent team to build relationships and enhance service delivery to those clients experiencing homelessness.

7.2 Strengthen and expand partnerships with criminal justice agencies to connect eligible justice-involved residents to behavioral health services

The American Jail Association estimates that more than 650,000 bookings each year involve persons with mental illness. This translates into at least 16-25 percent of the national jail population. A vast majority of these mentally ill inmates are arrested for simple peculiar behavior or nonviolent minor crimes, and yet, they spend an average of 15 months longer in jail for the same charges as compared to incarcerated people without mental illness[9].

Commendably, the Department operates a number of programs to support justice-involved people in Santa Barbara County who have a behavioral health need, including, but not limited to, the Justice Alliance program, Forensic Action Team, Stepping Up, and mental health diversion courts, as well as a mobile crisis team. The Department's crisis service team responds to 911 calls when requested by law enforcement. The team is responsible for writing 5150 holds when appropriate, and work to connect clients with severe mental health issues to follow-up services should they not meet the criteria for a hold. Additionally, the Department has collaborated with the Sheriff to develop a countywide co-response program. This program consists of a Crisis Intervention Team (CIT) trained deputy and a mental health clinician or case worker from County Behavioral Wellness who are partnered up to respond together to mental health crises. Additionally, the County operates a Crisis Hub which includes a Sobering Center, a Walk-in Mental Health Crisis Center, and a Crisis Stabilization Center.

The Department should continue to expand its collaboration with criminal justice agencies in the County to provide services to residents whose justice involvement may stem from untreated behavioral health issues. This recommendation focuses on three key opportunities to expand partnerships between Behavioral Wellness and the County's criminal justice agencies.

- First, there is an opportunity for enhanced collaboration between Behavioral Wellness and the Sheriff regarding Behavioral Wellness clients who are booked into the jail. Although, Well Path discharge planners are funded in the jail, interviewees report that the Department may be unaware when a client is released from custody.This limits the Department's abilty to maintain service to clients as they transition out of the jail and connect them to the appropriate level of care in the community.
- Second, the Department should evaluate funding opportunities to maintain the Department's co-response program with the Sheriff's Office. Across interviews, staff has lauded the success of the co-response program, which provides law enforcement officers with the support and tools needed to divert individuals whose justice involvement may stem from behavioral health issues. However, funding for these teams is set to expire at the end of 2022. There may be potential for the Department to convert its existing mobile crisis team to a co-response model which could be funded using MHSA dollars ensuring the program continues in existence. Sonoma County for example, operates one crisis response team – the Mobile Support Team, which is a partnership with the police departments across its cities as well as the Sheriff's Office.
- Third, Behavioral Wellness Leadership should continue working with County criminal justice agencies and the CEO's Office to continue expanding diversion options within the County. The COVID-19 pandemic, and resulting zero bail emergency rule, resulted in significant reductions to the County's jail population. As the County reopens, there may be an opportunity to evaluate opportunities for prearrest diversion. For example, Sheriff's Officers often report repeated interactions with residents with multiple bookings for low-level charges such as drug possession,

[9] The Bexar Model (naco.org)

possession of paraphernalia, public intoxication, or trespassing. In many cases, these charges may be related to an unmanaged mental illness and/or substance abuse disorder that is most effectively addressed outside of the criminal justice system. To empower law enforcement to best respond to this type of incident, localities such as Harris County and Indianapolis-Marion County have established intake facilities—separate from the jail and other emergency service providers that enable 24-7 diversion by law enforcement to emergency medical services for individuals experiencing addiction and/or behavioral health distress. At these centers, behavioral health staff are available to assess and stabilize individuals in crisis. Other supportive service providers, including but not limited to housing and healthcare, may be located on site to enable referrals for individuals with complex needs. While Santa Barbara County does not currently have a diversion center with colocated services, there may be opportunities for Behavioral Wellness to support the County's criminal justice agencies. This can be undertaken by diverting justice-involved individuals to community-based service providers or case management programs where appropriate, rather than the traditional justice system-focused response of arrest, booking, and detention.

Action one: In collaboration with the Sheriff, enhance integration with service offerings for those released from custody to better meet the behavioral health needs of offenders

There is an opportunity to improve navigation and transition services for clients with SMI as they are released from jail. While the jail has a discharge planner, which is overseen by the Sheriff, interviewees report that Behavioral Wellness has little collaboration with this resource. The discharge planner is not part of the weekly Community Treatment and Supports (CTS) meeting held by the Department. CTS is a collaborative countywide meeting with all Behavioral Wellness services providers which is held to discuss clients referrals across the various levels of care.

As a first step toward enhanced collaboration, the Department should invite the jail discharge planner to attend these weekly meeting and advise upon the clients with SMI who are scheduled for release in the upcoming week. This will allow the Department to effectively plan for the individual's release and direct them to the approprtiate level of care at the outset.

Action two: Analyze the performance of co-response and crisis services teams and assess feasibility of combining the two to achieve sustainable funding

Based on interviews, Executive Leadership does not receive sufficient peformance-related data for both the co-response and crisis service teams to allow them to monitor and track outcomes and make data-driven decisions related to these outcomes. Currently, Executive Leadership is considering how the co-response teams can be funded following the expiration of the Proposition 47 funding in late 2022. One option available to Executive Leadership is converting the current crisis services teams to this co-respose team model and utilizing MHSA funding to cover a portion of the cost of these services with criminal justice also covering a portion of the cost. However, in order to consider this approach, the Department will need to understand the performance of co-reponse relative to crisis services teams. The analysis should consider and compare the following performance measures at a minimum:

- Number of incidents responded to
- Number of clients successfully diverted
- Average length of time at each incident
- Total cost of opperating the program
- Cost savings as a result of programming
- Number of clients referred to the PHF or CSU

- Number of clients referred to the Emergency Room (ER)
- Number of client stabilized with no referrals.

Any analysis and decision-making related to any future transition from a crisis services team model to a co-response model should be made in collaboration with the Sheriff's Office and law enforcement including the County's Police Departments, given that under any enhanced co-response model, law enforcement will have an increased role and the approach will likely require the training of additional officers in addition to the commitment of funding.

Action three: Implement a multidisciplinary team approach to promoting a collaborative approach to diversion

The interdepartmental multidisciplinary team recommended under recommendation 1.2 (action seven) could also be tasked with identifying opportunities to enhance diversion strategies across the system of care. The high utilizers analysis which this team would conduct under recommendation 1.2 could inform decisions surrounding the cohort population who would best benefit from enhanced diversion strategies and the strategies which would best suit the needs of this population. Transitioning to a more data-driven, needs informed, cohort-oriented team will ensure strategies are aligned with need, enhancing successful outcomes. The team should also be tasked with researching potential funding opportunities which could be leveraged by the collective departments to increase and develop the range of diversion programs available. The team could also act as a forum for department representatives to discuss and collectively resolve any challenges identified within the current cross-agency diversion programs to foster an environment of continual improvement

7.3 Conduct CalAIM reform planning to increase integration between Regional Health Authority and complementary County Departments including Public Health

As part of the CalAIM initiative, the State is promoting a more coordinated system of care for its high-needs clients, allowing for a broader suite of supportive services to be offered to clients under a "no wrong door" policy. This approach focuses on providing clients with a universal gateway toward service access regardless of condition. In the future, this may require enhanced interdepartmental integration, particularly between Behavioral Wellness and Public Health.

Mental health and physical health are fundamentally intertwined. Persons living with a serious mental illness are often at higher risk of experiencing a wide range of chronic physical conditions[10]. Furthermore, based on research referenced by the Canadian Association of Mental Health, those living with chronic physical health conditions experience depression and anxiety at twice the rate of the general population. Co-occurring mental and physical conditions can reduce quality of life and lead to longer illness duration and worse health outcomes.

In the current state, Behavioral Wellness and Public Health operate as stand-alone departments with separate administrative functions including IT, HR, Fiscal, and Contracts. There is some collaboration between the departments, however, each utilize a separate EHR system, serving their clients separately with little communication, data-sharing, or proactive care coordination regarding shared clients. However, commendably, at the time of writing this report, the Department are in discussions with the Public Health Department to progress towards allowing each Department to access the other Department's EHR.

At the clinic level, the outpatient clinics run by Behavioral Wellness do not screen for physical health issues. Community Health Clinics run by Public Health do employ behavioral health staff to try to facilitate a warm hand-off between public and behavioral health services for those clients requiring a higher acuity than can be offered by Public Health, however, these services are not well utilized. This structure for delivering care at times requires clients with co-occurring conditions to attend separate clinics in separate locations to receive care. The two departments have developed processes to implement some level of care coordination. For example, the Behavioral Health Clinics at Lompoc, Santa Maria, and Santa Barbara hold weekly meetings with their counterpart Community Health Clinics to discuss weekly referrals and the specific needs of certain clients. However, given the future reforms that may be required as a result of CalAIM and the benefits of providing co-occurring clients with a more coordinated system of care, the Department, should begin collaborating with Public Health to identify opportunities for enhanced integration.

Action one: Executive Leadership should continue to engage with the Regional Health Authority, Public Health and consider engaging with other complementary departments to consider integration scenarios

Executive Leadership should continue to meet with both the Regional Health Authority and Public Health Leadership monthly to consider the future impacts of CalAIM. In the future, as the State continues to refine and provide additional information on the implementation of CalAIM, the Department should consider using these meetings as a forum to consider potential integration scenarios and opportunities. In time, leadership from other complementary agencies such as Social Services and CSD may also become involved in these discussions, in the event a shift toward a more superagency structure is considered. The meetings should discuss the development, delegation and delivery of tasks with meeting agendas and minutes provided to all attendees prior to and after each meeting, respectively.

[10] Connection Between Mental and Physical Health (cmha.ca)

Action two: Liaise with the CEO Office's to establish a formalized cross-department collaborative approach to CalAIM planning

As a result of CalAIM, there are over 65 major project initiatives which will be implemented over the next six years. Many of these initiatives will affect multiple departments, for example, rate setting undertaken by Behavioral Wellness may affect Public Health, while homeless and housing related funding to be received under CalAim will require significant cross-departmental collaboration for successful implementation. Furthermore, CalAIM will require for enhanced information sharing across departments, while ensuring alignment with HIPPA requirements. Given the countywide coordination which will be required under CalAIM, the Department should liaise with the CEO's office to establish a cross-department collaborative to include departments such as Behavioral Wellness, Public Health, Social Services, and Community Development. The following key steps should be considered in establishing and operationalizing the recommended collaborative:

- **Step one:** Liase with the CEO'Office to establish a cross-department committee led by the CEO's Office. The commitee should meet monthly to consider and plan for all upcoming intitiatives under CalAIM. The meetings should be utilized to develop and assign tasks across departments, as well as discuss progress on pre-assigned tasks. The CEO's Office should act as the meeting chair and should issue monthly agendas to participants with input from each department. The committee should include division chiefs from Behavioral Wellness, Public Health, Social Services, Community Services, as well as County Counsel. The Committee should also have repersentation from IT and fiscal leaders across each department.
- **Step two:** On the basis that each intitiative may require varying departmental expertise, the committee discussed under step one, should develop a number of subcommitees to manage initiatives. Depending on the initiative type the committee should consider the subject matter expertise which will be required for implementation. For example, under certain intitiatives fiscal expertise across departments will be required, requiring input from cross-departmental fiscal leaders and line staff, while under other initiatives, IT repersentation may be required across departments. All sub-committees should be assigned tasks by the committee established under step one and as required, should report and attend the primary committee's monthly meetings to provide updates on progress.
- **Step four:** As noted in the body of this action, cross-departmental information sharing will be a key component for sucessful implementation and operationalization of CalAIM. As such, the committee should coordinate with County Counsel and Compliance to develop procedures for information sharing while remaining in compliance with HIPPA and other federal regulations. This may also require an update to the protocols and workflows in place, legal or otherwise for sharing client data across departments, particularly as it relates to obtaining release of information (ROI) forms.
- **Step three:** Having developed commitees and considered HIPPA requirements, the Department should liaise with the CEO's Office and other complementary departments to develop formal and written communication strandards and workflows to ensure that tasks are completed as effectively and efficiently as possible. Following development, all committee and sub-committee members should be trained on the requirements of works flows and communication standards.

Action three: Evaluate the range of options for integrated services looking at both clinical integration (outpatient clinics) and integration at the organization level

This action includes recommendations related to integration at the clinical level (outpatient clinics) as well as the broader operational level (interagency/Department-level) given that clinical level coordination and integration can be undertaken without a broader organizational restructure.

Models of clinical integration

The Working Group should conduct an evaluation of a range of models available for clinical integration. Organizations such as the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Health & Medicine Policy Research Group, a not-for-profit policy center have proposed a number of models for integration across behavioral health and public health services, upon which the below recommendations are based. SAMHSA proposes six levels of collaboration/integration across three broad models (coordination, colocation, and integration) at the clinical level.[11]. While the Health & Medicine Policy Research Group proposes eight potential models for enhanced clinical integration.[12] It is important to note that significant analysis must be undertaken to assess which if any changes in organizational model are appropriate for Behavioral Wellness. This assessment at a minimum should consider the impact on staffing needs, union and other legal agreements, EHR and other technological systems, back-office functions, Medi-Cal billing, client service delivery, as well as level of investment and timeline to implement. The following are examples of the three overarching structures that most align to the Department's status which could be implemented to increase integration and collaboration at the clinic level across the spectrum:

Model 1: Coordination – Improving collaboration between Behavioral Health Outpatient Clinics and Community Health Clinics

- This model represents the smallest amount of change from the current state and could be undertaken as a first step toward enhanced future integration. Under this model, Behavioral Health Clinics would collaborate with Community Health Care Clinics to provide initial physical health screening to their clients using telemedicine and vice versa. Riverside County has adopted this model across a portion of its clinics.

Model 2: Colocation – Co-located Behavioral Health Outpatient Clinics and Community Health Clinics

- This model also represents enhanced collaboration at the clinic level requiring behavioral and physical health services to be provided at one location. The two providers share space, however, run as separate services. Emerging literature on co-located substance abuse treatment and primary care has shown that patients have better outcomes, with the most significant improvement for those with poorer health. In addition, research suggests that medical costs may be reduced as patients utilize less medical care because of the simultaneous provision of mental health services. This model would require much consideration for the County, particularly related to facility space and location. Riverside County have also implemented this model across some more of its healthcare clinics.

Model 3: Integration – Unified Primary Care and Behavioral Health

- This model targets persons with SMI and is similar to Model 2; however, the hallmark of this model is the fact that not only are clinical services combined, but the administration and financing are also well integrated. At the clinical level, behavioral health and primary care staff interact regularly and on an administrative level, they have an integrated medical record and single treatment plan. This model typically offers full-service primary care and full-service psychiatric care in one place. Based on research undertaken, this model typically resulted in patients having reduced ER visits, better physical health status, and were less likely to report a problem with continuity of care. Leadership from Inland Empire Health Plan, a Medi-Cal Managed care plan and San Bernardino County Department of Behavioral Health convened in April 2019 and agreed to proceed with planning a comprehensive integration pilot to fully integrate physical and behavioral health. These integrated pilot clinics offer all mental health and substance use disorder outpatient

services (including case management and a standardized referral process was created for access to specialty physical health services.[13]

In addition to the three clinical models identified above, the Department may also wish to consider a Certified Community Behavioral Health Clinic (CCBHC) model. CCBHCs are a new provider type under Medicaid and are designed to provide a range of mental health and substance use disorder services to vulnerable clients. In doing so, they receive an enhanced Medicaid reimbursement rate based on the anticipated cost of expanding services to meet these high-needs clients. CCBHCs must provide nine types of services, with an emphasis on the provision of 24-hour crisis care through mobile crisis teams, evidence-based practices, care coordination with local primary care and hospital partners, and integration with physical healthcare. A number of providers across California have already implemented this model including the Santa Barbara Neighborhood Clinics which are run by a not-for profit. In Texas, the Harris Center, the County's local mental health authority has adopted the CCBHC model to provide more coordinated service to its high-needs clients.

Models of organizational integration

At the broader organizational level, based on a benchmarking study of organizational models across a range of comparable counties in California, the following structures were found to be representative of Departmental organizational models in place throughout the State of California:

Model 4: Combined Public Health and Behavioral Health

- San Luis Obispo operates a Health Agency which comprises the Behavioral Health Department, Public Health Department, Animal Services Division and the Office of the Public Guardian. The Health Agency is the largest Department in the County with over 600 employees and an FY20–21 budget of $87 million.

Model 5: Combined Public Health, Behavioral Health and Social Services

- Placer County operates a Health and Human Services Department which includes six divisions: Public Health, Environmental Health, Animal Services, Adult System of Care (mental health), Children's Support Service, and Human Services. The Department has over 743 employees and an FY20–21 budget of $234 million.

Model 6: Superagency

- San Diego County has a superagency structure, which comprises Behavioral Health, Public Health, Social Services, Children's Services and Housing and Community Development Services. The Department has 6,773 employees and an FY20–21 budget of $2.5 billion.

The models above are not intended to be exhaustive and the County should consider integration and collaboration models that best suits the distinct needs of both its Behavioral Health, Public Health and other potential complementary Departments such as Social Services and Community Services and their collective clients.

Transitioning to a new organization model is not a simple process whether at the clinical or the departmental level. Depending on the level of integration, the process can take many years and requires a significant amount of evaluation and planning particularly as it relates to staffing and direct client service

[11] SAMHSA-HRSA Center for Integrated Health Solutions (CIHS) | SAMHSA
[12] Behavioral-health-integration-working-paper.pdf (d3s8k6ajh82rah.cloudfront.net)

[13] Behavioral Health Integration in Medi-Cal | CHCF

delivery which can be significantly disrupted as a result of any organizational restructure. Given the nature of the services offered by Behavioral Wellness and Public Health, there are also significant considerations as they relate to the Departments' EHR systems which are not current aligned, the sharing of information as well as the billing process.

A robust assessment and evaluation of available organizational models should be undertaken by the Department prior to considering any transition in order to determine the most suitable model (if any) for Santa Barbara based on its current state. This assessment should also include a deep analysis of areas of operations which will be considerably affected by an organizational restructure (staffing, service delivery, billing, technology and tools, among others) and the measures which can be put in place (if any) to minimize disruption in implementation.

Appendix A: Benchmarks

	Budgets in $'000	Santa Barbara	Average	Monterey	Solano	Sonoma	Tulare	Placer	SLO	Marin	Santa Cruz	San Bernardino County	Lake County
FY 18	Department FTE	370	773	425	206	651	2,060	786	318	723	1,156	1,328	82
	% of Enterprise	9.07%	14.89%	8.00%	6.70%	15.68%	41.16%	27.07%	11.41%	31.66%	47.40%	5.77%	8.26%
	Department Budget	$121,812	$195,555	$135,932	$85,904	$254,777	$462,022	$185,728	$71,010	$184,084	$151,163	$414,071	$10,854
	% of Enterprise	11.31%	14.73%	9.09%	8.18%	15.86%	40.13%	21.44%	11.62%	25.01%	25.87%	8.21%	8.62%
FY19	Department FTE	387	771	426	206	573	2,070	791	313	735	1,155	1,364	80
	% of Enterprise	9.30%	14.86%	8.14%	6.80%	14.12%	41.11%	27.26%	11.21%	32.23%	46.52%	5.91%	7.97%
	Department Budget	$134,763	$208,320	$139,880	$91,563	$253,583	$482,260	$213,186	$74,645	$196,487	$176,837	$442,903	$11,858
	% of Enterprise	12.21%	13.98%	9.21%	8.55%	14.98%	41.21%	21.96%	11.81%	25.63%	27.61%	7.03%	8.97%
FY20	Department FTE	404	795	461	216	554	2,125	797	313	752	1,201	1,452	84
	% of Enterprise	9.49%	15.01%	8.59%	7.01%	13.64%	41.61%	27.37%	11.18%	32.51%	46.99%	6.10%	8.29%
	Department Budget	$142,705	$226,108	$158,747	$100,712	$251,369	$513,543	$220,369	$80,109	$207,621	$190,938	$523,936	$13,733
	% of Enterprise	12.51%	14.12%	10.28%	8.91%	14.02%	39.91%	21.33%	12.36%	25.23%	28.39%	7.55%	10.17%
FY21	Department FTE	404	690	471	216	548	2,075	743	288	763	265	1,447	86
	% of Enterprise	9.38%	13.02%	8.71%	6.91%	13.34%	41.44%	27.69%	10.25%	32.50%	10.53%	6.03%	8.43%
	Department Budget	$146,349	$241,436	$169,084	$106,985	$269,931	$560,678	$233,741	$86,295	$208,905	$197,530	$565,342	$15,867
	% of Enterprise	12.33%	14.49%	10.31%	8.93%	13.91%	41.59%	22.91%	12.70%	26.13%	26.55%	8.01%	6.54%

Figure 35: Source: KPMG

Appendix B: Meeting tracker

This section provides detail on the meetings held with the Department of Behavioral Wellness during the review. Throughout the review period the KPMG Team held over 50 interviews with Department staff and providers to understand the organizational structure, roles and responsibilities, operations, and processes of the Department.

Name	KPMG Attendees	Client Attendees	Date
Santa Barbara County BeWell Departmental Review with KPMG	Bill Zizic, Catherine Singer, Alexander Rothman, Lauren Coble, Olivia Rabbitte	Lindsay Walter, Alice Gleghorn, Marshall Ramsey, Waseem Kadada, Joshua Woody and Terri Maus-Nisich	Wednesday, March 31, 2021
KPMG Interview: Ole Behrendtsen, Medical Director	Bill Zizic, Vivian Demian, Alexander Rothman, Lauren Coble, Olivia Rabbitte	Ole Behrendtsen	Wednesday, April 7, 2021
KPMG Interview: Susan Grimmsey, Chief Quality Care & Strategy Officer	Vivian Demian, Alexander Rothman, Lauren Coble	Susan Grimmsey	Wednesday, April 7, 2021
KPMG Interview: John Winckler, Division Chief of Clinical Operations	Bill Zizic, Vivian Demian, Alexander Rothman, Lauren Coble, Olivia Rabbitte	John Winckler	Thursday, April 8, 2021
KPMG Interview: John Doyel, Drug & Alcohol Programs	Bill Zizic, Vivian Demian, Alexander Rothman, Lauren Coble, Olivia Rabbitte	John Doyel	Friday, April 9, 2021
KPMG Interview: Celeste Andersen, Chief of Compliance	Alexander Rothman, Lauren Coble, Olivia Rabbitte	Celeste Andersen	Friday, April 9, 2021
KPMG Interview: Lindsay Walter, Department of Admin & Operations	Alexander Rothman, Cate Singer, Olivia Rabbitte	Lindsay Walter	Wednesday, April 21, 2021
KPMG Interview: Laura Zeitz, Division Chief: Placement & Housing	Alexander Rothman, Cate Singer, Olivia Rabbitte	Laura Zeitz	Wednesday, April 21, 2021
KPMG Interview: Marshall Ramsey, CIO	Alexander Rothman, Cate Singer, Olivia Rabbitte	Marshall Ramsey	Thursday, April 22, 2021
KPMG Interview: Elodie Patarias: Adult Program Team Supervisor (SM Region)	Alexander Rothman, Lauren Coble, Olivia Rabbitte	Elodie Patarias	Monday, April 26, 2021

Name	KPMG Attendees	Client Attendees	Date
KPMG Interview: Tony Hollenback: Regional Manager Lompoc	Alexander Rothman, Lauren Coble, Olivia Rabbitte	Tony Hollenback	Wednesday, April 28, 2021
KPMG Interview: Chris Ribeiro, CFO	Alexander Rothman, Cate Singer, Lauren Coble, Olivia Rabbitte	Chris Ribeiro	Wednesday, April 28, 2021
KPMG Interview: Veronica Heinzelmann: Regional Program Manager	Alexander Rothman, Lauren Coble, Olivia Rabbitte	Veronica Heinzelmann	Thursday, April 29, 2021
KPMG Interview: Shauna Burns: Forensic Service Manager	Alexander Rothman, Lauren Coble, Olivia Rabbitte	Shauna Burns	Thursday, April 29, 2021
KPMG Interview: Geoffrey Bernard: Adult Program Team Supervisor	Alexander Rothman, Lauren Coble, Olivia Rabbitte	Geoffrey Bernard	Friday, April 30, 2021
KPMG Interview: Roberto Rodriguez: Adult Program Team Supervisor	Alexander Rothman, Lauren Coble, Olivia Rabbitte	Roberto Rodriguez	Friday, April 30, 2021
KPMG Follow-up Interview: Laura Zeitz, Division Chief: Placement & Housing	Alexander Rothman and Olivia Rabbitte	Laura Zeitz	Friday, April 30, 2021
KPMG Interview: Chris Shurland: Contracts Supervisor	Alexander Rothman, Lauren Coble, Olivia Rabbitte	Chris Shurland	Monday, May 3, 2021
KPMG Interview: Melanie Johnson, Contracts Manager	Alexander Rothman, Lauren Coble, Olivia Rabbitte	Melanie Johnson	Tuesday, May 4, 2021
KPMG Interview: Jennifer Hidrobo, PHF Manager	Alexander Rothman, Lauren Coble, Olivia Rabbitte	Jennifer Hidrobo	Tuesday, May 4, 2021
KPMG Interview: Matthew Nguyen, Pharmacist in Charge	Alexander Rothman and Olivia Rabbitte	Matthew Nguyen	Wednesday, May 5, 2021
KPMG Follow-up Interview: Lindsay Walter, Department of Admin & Operations	Cate Singer, Alex Rothman and Olivia Rabbitte	Lindsay Walter	Thursday, May 6, 2021
KPMG Interview: Jon Masuda, Homeless Services Manager	Alexander Rothman and Olivia Rabbitte	Jon Masuda	Friday, May 7, 2021
KPMG Interview: Katie McBain, Practitioner / Waiver Psychologist	Alexander Rothman, Lauren Coble, Olivia Rabbitte	Katie McBain	Monday, May 10, 2021

Name	KPMG Attendees	Client Attendees	Date
KPMG Interview: Rae Vargas, Santa Maria, Children's Clinic	Alexander Rothman, Lauren Coble, Olivia Rabbitte	Rae Vargas	Monday, May 10, 2021
KPMG Focus Group: SB Adult Outpatient Clinic and SB Children's Outpatient Clinic	Alexander Rothman, Lauren Coble, Olivia Rabbitte	Natalie Garcia, Christina Relis, and Sara Bazan	Monday, May 10, 2021
KPMG Focus Group: ADP Program Managers	Alex Rothman and Olivia Rabbitte	Amy Lopez and Melissa Wilkins	Wednesday, May 12, 2021
KPMG Follow-up Interview: Marshall Ramsey	Cate Singer, Vivienne Demian, Alex Rothman, Lauren Coble and Olivia Rabbitte	Marshall Ramsey	Wednesday, May 12, 2021
KPMG Interview: Alesha Silva, PHF Nurse Supervisor	Olivia Rabbitte	Alesha Silva	Wednesday, May 12, 2021
KPMG Interview, Marjorie McCarthy, Clinical Psychologist II	Alexander Rothman, Lauren Coble, Olivia Rabbitte	Marjorie McCarthy	Thursday, May 13, 2021
KPMG Interview: AJ Quinoveva, Behavioral Wellness Analyst	Alexander Rothman, Lauren Coble, Olivia Rabbitte	AJ Quinoveva	Thursday, May 13, 2021
KPMG Focus Group: Josh Woody and Jaime Huthsing, QCM Managers	Alexander Rothman, Lauren Coble, Olivia Rabbitte	Josh Woody and Jaime Huthsing	Friday, May 14, 2021
KPMG Follow-up Interview: Shana Burns, Forensic Services Manager	Alex Rothman and Olivia Rabbitte	Shana Burns	Friday, May 14, 2021
KPMG Interview: Dr. Fisher, Deputy Director	Cate Singer, Alex Rothman, Lauren Coble and Olivia Rabbitte	Pam Fisher	Friday, May 14, 2021
KPMG Focus Group: Christie Boyer and Josue Sanchez, Finance Division	Lauren Coble and Olivia Rabbitte	Christie Boyer and Josue Sanchez	Monday, May 17, 2021
KPMG Interview: Dr. Gleghorn, Director of Behavioral Wellness	Cate Singer, Vivienne Demian, Lauren Coble and Olivia Rabbitte	Dr. Alice Gleghorn	Monday, May 17, 2021
KPMG Interview: Dr. Leslie Lundt, QCM Psychiatrist	Lauren Coble and Olivia Rabbitte	Dr. Leslie Lundt	Tuesday, May 18, 2021

Name	KPMG Attendees	Client Attendees	Date
KPMG Interview: Ana Bello, Behavioral Wellness Contracts Division	Lauren Coble and Olivia Rabbitte	Ana Bello	Tuesday, May 18, 2021
KPMG Focus Group: Lompoc Clinic Supervisors	Lauren Coble and Olivia Rabbitte	Thelma Macias and Nicole Becker	Wednesday, May 19, 2021
KPMG Interview: Kim Albers, Homeless Services, HCD	Cate Singer and Olivia Rabbitte	Kim Albers	Wednesday, May 19, 2021
KPMG Interview: Luiz Alvarado Diaz, Homeless Services Division	Cate Singer and Olivia Rabbitte	Luiz Alvarado Diaz	Thursday, May 20, 2021
KPMG Follow-up Interview: QCM Team	Lauren Coble and Olivia Rabbitte	Josh Woody and Jaime Huthsing	Thursday, May 20, 2021
KPMG Follow-up Interview John Winckler, Mental Health Outpatient & Community Chief	Lauren Coble and Olivia Rabbitte	John Winckler	Friday, May 21, 2021
KPMG Follow-up Interview: Elodie Patarias, Supervisor Santa Maria Clinic	Lauren Coble and Olivia Rabbitte	Elodie Patarias	Friday, May 21, 2021
KPMG Interview: Rey Guillen, Be-Well HR Manager	Alex Rothman and Olivia Rabbitte	Rey Guillen	Thursday May 27, 2021
KPMG Interview: Christina Harney, Transitions Mental Health (Lompoc ACT)	Alex Rothman and Olivia Rabbitte	Christina Harney	Thursday May 27, 2021
KPMG Interview: Alessandra Snavely, Santa Barbara ACT Team	Lauren Coble and Olivia Rabbitte	Alessandra Snavely	Friday, May 28, 2021
KPMG Interview: Evie Zuroske, Grants Management	Lauren Coble and Olivia Rabbitte	Evie Zuroske	Thursday June 3, 2021
KPMG Focus Group: Santa Maria ACT Program (Telecare Corporation)	Alex Rothman and Olivia Rabbitte	Cynthia Doutt and Kali Tanguay	Thursday June 3, 2021
KPMG Follow-up Interview: Alesha Silva, Nurse Supervisor	Alex Rothman, Lauren Coble and Olivia Rabbitte	Alesha Silva	Tuesday June 8, 2021
KPMG Follow-up Interview: Lindsay Walter and Laura Zeitz	Alex Rothman and Olivia Rabbitte	Lindsay Walter and Laura Zeitz	Thursday June 10, 2021

Name	KPMG Attendees	Client Attendees	Date
KPMG Follow-up Interview: Staff Activity Report (Utilization Data)	Cate Singer, Alex Rothman, Lauren Coble and Olivia Rabbitte	Marshall Ramsey, John Winckler, and Whitney Perry	Monday June 14, 2021
KPMG Follow-up Interview: Melanie Johnson, Contracts Division	Olivia Rabbitte	Melanie Johnson	Tuesday June 15, 2021
KPMG Follow-up Interview: Laura Zeitz, PHF	Vivienne Demian, Alex Rothman, Lauren Coble and Olivia Rabbitte	Laura Zeitz	Tuesday, June 15, 2021
KPMG Focus Group: Serena Cyr and Caitlin Lepore	Alex Rothman, Lauren Coble and Olivia Rabbitte	Serena Cyr and Caitlin Lepore	Wednesday June 16, 2021
KPMG Interview: Behavioral Wellness Contracts Review Process	Alex Rothman, Lauren Coble and Olivia Rabbitte	Rachel Van Mullem and Teresa Martinez	Wednesday June 30, 2021
KPMG Utilization Data Discussion	Caoimhe Thornton, Alex Rothman, Lauren Coble and Olivia Rabbitte	Pam Fisher, Marshal Ramsey, John Winckler, Josh Woody, and Whitney Perry	Tuesday July 13, 2021
KPMG Utilization Data Discussion	Cate Singer, Alex Rothman, Lauren Coble and Olivia Rabbitte	Marshal Ramsey and Whitney Perry	Tuesday July 20, 2021

Figure 36: Source: KPMG

Appendix C: Data tracker

This section provides detail on data received throughout the Department of Behavioral Wellness Review.

Data Item	File Name
Department Organizational Chart	Organizational Chart 2021 Exec Team Highlight 4.5.2021
Department Organizational Chart	Provider Directory Drug Medi-Cal Organized Delivery System March 2021
Department Organizational Chart	Provider Directory Mental Health Plan March 2021
Schedule samples for Alcohol & Drug Programs	ADP Staffing – KPMG Mar 2021
Schedule samples for Alcohol & Drug Programs	Alcohol and Drug Programs clinic hours and contact
Schedule samples for Contracts Division	Contracts Division – Table of Organization March 2021
Fiscal Schedule	Fiscal Schedule
Schedule samples for Mental Health Plan Clinical	Behavioral Wellness Clinical Operations
Schedule samples for Mental Health Plan Clinical	Capture
Schedule samples for Mental Health Plan Clinical	LompocMobileCrisisFeb2021
Schedule samples for Mental Health Plan Clinical	LompocMobileCrisisMar2021
Schedule samples for Mental Health Plan Clinical	SCCS Schedule February 2021
Schedule samples for Mental Health Plan Clinical	SCCS Schedule March 2021
Schedule samples for Mental Health Plan Clinical	SMMobileCrisisFeb2021
Schedule samples for Mental Health Plan Clinical	SMMobileCrisisMar2021
Assertive Community Treatment (ACT) Contracts	Telecare FY 19–22 BC 19219 Executed
Assertive Community Treatment (ACT) Contracts	TMHA FY 20–21 BC 20-028.
Assertive Community Treatment (ACT) Requests for Proposals (RFP)	FINAL – ACT & Supportive Community Services RFP (1.14.21) w bookmarks2
Contracts Division – BWell Items for BOS Statistics 2017-2021	Contracts Division – BWell Items for BOS Statistics 2017–2020

Data Item	File Name
Contracts Division – Board Contract Process Overview	Contracts Division – Board Contract Process Overview
Contracts Division – BOS Contract Renewal Season 2021 (3.16.21)	Contracts Division – BOS Contract Renewal Season 2021 (3.16.21)
Contracts Division – Checklist, Board Letter Review	Contracts Division – Checklist_Board Letter Review
Contracts Division – Checklist, Contract Review	Contracts Division – Checklist_Contract Review
Contracts Division – Checklist, Subcontractor and Provider Determination	Contracts Division – Checklist_Subcontractor and Provider Determination
Contracts Division – DocuSign Process Guide v.1	Contracts Division – DocuSign Process Guide V.1
Contracts Division – Example of Weekly Mtg with County Counsel	Contracts Division – Example of Weekly Mtg w County Counsel (1)
Contracts Division – Statistics (Jan – Dec 2020)	Contracts Division – Statistics (Jan–Dec 2020)
Contracts Division – Table of Organization March 2021	Contracts Division – Table of
Contracts Division – Work plan 2021	Contracts Division – Work plan 2021
Doctor Contracts – Contractors on Payroll (COPs)	Berge FY 20–21 BC executed
Doctor Contracts – Contractors on Payroll (COPs)	Edwin Feliciano M.D. FY 20–21 Contractor on Payroll Agreement Executed
Doctor Contracts – Contractors on Payroll (COPs)	Irwin Lunianski M.D. FY 20–21 Contractor on Payroll Agreement executed
Doctor Contracts – Contractors on Payroll (COPs)	JSA FY 19–20 PO and contract executed (CN23472)
Doctor Contracts – Contractors on Payroll (COPs)	Mary Pat Sweeney FY 20–21 Minute Order & BC Executed
Doctor Contracts – Contractors on Payroll (COPs)	Sterling Care Psychiatric Group FY 19–22 BC19354 – Executed
Drug Medi-Cal Organized Delivery System (DMC-ODS) Contract and Provider templ	ADP Template FY 21-22 (March 15_ 2021)
Drug Medi-Cal Organized Delivery System (DMC-ODS) Contract and Provider template	DHCS DMC-ODS Agreement FY 18-22 #18-95148
Good Samaritan Contract	Good Sam FY 18-21 BC 19-152 AM 4
Good Samaritan Contract	Good Sam FY 18-21 BC 19-152 AM1
Good Samaritan Contract	Good Sam FY 18-21 BC 19-152 AM2.docx
Good Samaritan Contract	Good Sam FY 18-21 BC 19-152 AM3

Data Item	File Name
Good Samaritan Contract	Good Sam FY 18-21 BC 19-152 AM5
Good Samaritan Contract	Good Sam FY 18-21 BC 19-152 AM6
Good Samaritan Contract	Good Sam FY 18-21 BC 19-152
Mental Health Plan Contract and our Mental Health Plan Contract Provider temp	DHCS – Mental Health Plan State 17-94613 executed
Mental Health Plan Contract and our Mental Health Plan Contract Provider temp	MH Template FY 21-22 (March 18 2021)
Mental Wellness Center for short-term housing programs	Mental Wellness Center FY18–19 Executed.
Mental Wellness Center for short-term housing programs	MWC FY18–19 And 2 into 19-20 executed (compressed)
Mental Wellness Center for short-term housing programs	MWC FY 18-21 BC 19-029 AM3 executed
Substance Abuse Prevention and Treatment Block Grant (SABG)Mental Health Serv	State Performance Agreement FY 18-21 #18-95274
Temporary Staffing Contracts – Psychiatric Health Facility	Barton & Associates FY 18-21 BC 18-216 AM2
Temporary Staffing Contracts – Psychiatric Health Facility	Barton & Associates FY18–19 BC18216
Temporary Staffing Contracts – Psychiatric Health Facility	Barton & Associates FY 18-20 BC 18-216 AM1 executed
Temporary Staffing Contracts – Psychiatric Health Facility	Crossroads FY20–21 Board Contract executed
Temporary Staffing Contracts – Psychiatric Health Facility	Jackson & Coker FY20–21 BC 20-030 executed
Temporary Staffing Contracts – Psychiatric Health Facility	Locumtemens FY 20-22 BC executed
Temporary Staffing Contracts – Psychiatric Health Facility	Maxim FY 18-21 BC 18-217 AM 2 executed
Temporary Staffing Contracts – Psychiatric Health Facility	Maxim Healthcare Services FY 18-20 BC 18-217 AM1
Temporary Staffing Contracts – Psychiatric Health Facility	Office Team FY20–21 Board Contract executed
Temporary Staffing Contracts – Psychiatric Health Facility	TBH FY 20-22 BC executed
Department Funded, Unfunded, and Vacant position breakdown	FY1819 to 2021 Funded and Unfunded Positions
Department Job Descriptions	Position Details Sheet-MED OT
Department Recruitment and Attrition data	BEWELL PP01 2018 – PP26 2020 HIRES

Data Item	File Name
Department Recruitment and Attrition data	BEWELL PP01 2018 – PP26 2020 SEPARATIONS
Department Staffing Reports (current and historical staffing breakdown)	Staffing Analysis PP06 – ServiceNow data
Department Time Allocation breakdown by staff member	Lost Time Summary
Department Union Agreements	management-classification-and-salary-plan
Department Union Agreements	mou-local-620-2018-2021
Department Union Agreements	mou-uapd-2018-2022
Department Union Agreements	resolution-managers
BWell Housing Projects 20-21	Capital report and housing 2021
BWell Housing Projects 20-21	Housing Projects through BWell 20-21
Depot Street MOU with County Housing Authority	HACSB FY 16-30 MOU CDM executed
Depot Street MOU with County Housing Authority	Support Services Agreement (1)
Depot Street MOU with County Housing Authority	Support Services Agreement
Homeless Emergency Aid Program (HEAP) MOU	CSD BeWell HEAP MOU Executed (1)
Homeless Emergency Aid Program (HEAP) MOU	CSD BeWell HEAP MOU Executed
Staffing Assignments Alcohol & Drug Programs	Alcohol and Drug Program Staffing
Staffing Assignments Contracts Division	Contracts Division – Table of Organization March 20
Staffing Assignments Fiscal	Fiscal Org Chart
Staffing Assignments Information Technology	Information Technology Division
Staffing Assignments Information Technology	Information Technology Division St
Staffing Assignments Mental Health Plan Clinical	Forensic Services February 202
Staffing Assignments Mental Health Plan Clinical	Homeless Services February 202
Staffing Assignments Mental Health Plan Clinical	Lompoc Adult Services February
Staffing Assignments Mental Health Plan Clinical	Lompoc Children Outpatient Ser

Data Item	File Name
Staffing Assignments Mental Health Plan Clinical	Lompoc Crisis Services February
Staffing Assignments Mental Health Plan Clinical	North County Crisis Services F
Staffing Assignments Mental Health Plan Clinical	Santa Barbara Adult Outpatient
Staffing Assignments Mental Health Plan Clinical	Santa Barbara Children Outpatient
Staffing Assignments Mental Health Plan Clinical	SB ACT February 2021 No Infor
Staffing Assignments Mental Health Plan Clinical	SM Children's February 2021 Updated
Staffing Assignments Mental Health Plan Clinical	SM TAY February 2021 Updates
Staffing Assignments Mental Health Plan Clinical	South County Crisis Se
Staffing Assignments Psychiatric Health Facility	Copy of PHF OT Analysis
Staffing Assignments Psychiatric Health Facility	Maxim PHF Analysis
Staffing Assignments Psychiatric Health Facility	Staffing Project 3.2021 – draft
Staffing Assignments Quality Care & Strategic Management	Office of Quality Care & Strategic Ma
Director's Reports 2021	Director's Report February 2021
Director's Reports 2021	Director's Report January 2021
Director's Reports 2021	Director's Report March 2021
Previous Studies & Review Reports	SB AOT Year 3 Report Final 5.15.20
Previous Studies & Review Reports	Annual Report FY19-20
Previous Studies & Review Reports	DMC-ODS EQRO Report FY19-20
Previous Studies & Review Reports	SANTA BARBARA FY 2020-21 DMC-ODS Final Report 03-22-21_suppressed
Previous Studies & Review Reports	Santa Barbara DMC-ODS 19-20 CCU Report FINAL
Previous Studies & Review Reports	Santa Barbara SABG 19-20 CCU Report FINAL
Previous Studies & Review Reports	FY17 18 MHP EQRO Report
Previous Studies & Review Reports	FY18 19 MHP EQRO Report

Data Item	File Name
Previous Studies & Review Reports	MHP EQRO Report FY19-20
Previous Studies & Review Reports	Santa Barbara System Review Findings Report FY19_20 FINAL
Previous Studies & Review Reports	Santa Barbara MHSA Performance Contract Review Report 2020
Previous Studies & Review Reports	Santa Barbara MHSA Plan of Correction Completed 10.26.2020 (1)
Previous Studies & Review Reports	A Tag CMS Plan of Correction 10.2.2019
Previous Studies & Review Reports	B Tag CMS Plan of Correction 9.17.19
Previous Studies & Review Reports	BOS Sys Update 12-8-15_411pm
Previous Studies & Review Reports	Health Management Associates Report on Inpatient Services October 2012
Previous Studies & Review Reports	9-17-14 System Change Outcome Tracking
Previous Studies & Review Reports	TriWest Report
Department Budget Breakdowns and Actual Expenditures Revenues	Expenditure Breakdown
Department Compensation Data by position classification	Department Compensation
Department Division fund level balance sheets	Fund Balance Levels
Department Division funding structures and revenue streams	BWell Grants – FY2021 Summary
Department Division funding structures and revenue streams	Funding Sources
Contract service provider staff utilization and productivity data: Alcohol & Drug Programs	Network Adequacy for the Drug Medi-Cal Organized Delivery System
Contract service provider staff utilization and productivity data: Mental Health Plan Clinical	Network Adequacy for the Mental Health Plan Licensed Staff 2020
Department and Division Programs Services overview: Mental Health Plan Adult	Outpatient Manual-Team Care Based updated 1_2000.docx (003)
Department and Division Programs Services overview: Mental Health Plan Children	Outpatient Manual-Team Care based updated 1_2000.docx (003)
Department Division Performance Metrics Targets: Alcohol & Drug Programs	Alcohol and Drug Program Master Evaluation Tables
Department Division Performance Metrics Targets: Contracts Division	Contracts Division – BOS Contract Renewal Season 2021 (3.16.21)
Department Division Performance Metrics Targets: Contracts Division	Contracts Division – BWell Items for BOS Statistics 2017 – 2020

Data Item	File Name
Department Division Performance Metrics Targets: Contracts Division	Contracts Division – Statistics (Jan–Dec 2020)
Department Division Performance Metrics Targets: Fiscal	FIN Documents Processed
Department Division Performance Metrics Targets: Psychiatric Health Facility	PHF Quality Assurance Performance Improvement Indicator List 11.20.2020
Department Division Performance Metrics Targets: Quality Care & Strategic Management	BWell QIC Work Plan FY20–21 6.30.20
Department Division Performance Metrics Targets: Quality Care & Strategic Management	Final Cultural Competency Plan Update fiscal year 2019-2020
Department Division Performance Reports: Alcohol & Drug Programs	Alcohol and Drug Program – Treatment Perception Survey Summary
Department Division Performance Reports: Alcohol & Drug Programs	Behavioral Wellness Annual Report FY18–19
Department Division Performance Reports: Contracts Division	Contracts Division – Work plan 2021
Department Division Performance Reports: Fiscal	Performance Report
Department Division Performance Reports: Psychiatric Health Facility	Medical Care Evaluation Study-Admin Days FY2021 FINAL
Department Division Performance Reports: Psychiatric Health Facility	Monthly QAPI Indicator Outcomes for January 2020
Department Division Performance Reports: Quality Care & Strategic Management	Drug Medi-Cal-Organized Delivery System Performance Improvement Project 3.5.21
Department Division Performance Reports: Quality Care & Strategic Management	Mental Health Plan Clinical Polypharmacy Performance Improvement Project 2020
Department Division Performance Reports: Quality Care & Strategic Management	Mental Health Plan Crisis Services Performance Improvement Project 2017
Department Division Performance Reports: Quality Care & Strategic Management	Mental Health Plan Psychiatry Performance Improvement Project 2018 Final
Department Division Performance Reports: Quality Care & Strategic Management	QIC Work plan Evaluation FY 19–20 6.30.20
Department Division Workload Reports: Alcohol & Drug Programs	Alcohol and Drug Program Staff Core Functions FY 20–21
Department Division Workload Reports: Fiscal	Staff Workload
Department Division Workload Reports: Quality Care & Strategic Management	Quality Care & Strategic Management Core Functions FY 20–21
Department Strategic Plans or Business Operating Plan Documents	Compliance Plan Revision – November 2019 (1)
Department Strategic Plans or Business Operating Plan Documents	FY 18-20 Strategic Plan

Data Item	File Name
Department Strategic Plans or Business Operating Plan Documents	FY 20-22 Strategic Plan
Department Vendor Contracts List	MASTER LIST ACTIVE CONTRACTS 032621
Map and List of Department Locations including clinic or other health facility locations	DMC-ODS Adult Clinics
Map and List of Department Locations including clinic or other health facility locations	DMC-ODS Children's Clinics
Map and List of Department Locations including clinic or other health facility locations	DMC-ODS NTP Providers
Map and List of Department Locations including clinic or other health facility locations	MHP Adult Clinics
Map and List of Department Locations including clinic or other health facility locations	MHP Children's Clinics
Mental Health External Quality Review	FY17 18 MHP EQRO Report
Mental Health External Quality Review	FY18 19 MHP EQRO Report
Mental Health External Quality Review	FY19 20 MHP EQRO Report
ACT and AOT Reporting	SB AOT Year 3 Report Final 5.15.20
ACT Data	ACT Data Request Data 5.24.21
ACT Data	ACT Staffing Da
ACT Reports	ACT Monthly Reports 4.2.2021
ACT Staffing Data	ACT Staffing Data with names 6.6.21
Update ACT Data	KPMG June 3 New Program Data
Update ACT Data	KPMG June 3 New Patient Data
Update ACT Data	KPMG June 3 New Data Dump – Parts 2
PHF Data	KPMG PHF Data V2
PHF Acuity Data	Acuity May–June 2021
PHF Staffing	Schedule May–June
PHF Staffing	Copy of PHF sick call tracking May 1-June 16 2021
Utilization Data	Average Activity Percentages 2021 – 6-14

Data Item	File Name
Utilization Data	Average Activity Percentages 2020
Utilization Data	Average Activity Percentages 2019
Utilization Data	Average Activity Percentages 2018
Utilization Data	Average Activity Percentage Details
Utilization Codes	ShareCare Service Codes
Time sheet earn codes	Timesheet Earn Code Cheat Sheet.pdf
Combined utilization data for FY18, FY19 and FY20	Average Activity Percentages (2)(1).xlsx
Lost Time	043 BW Lost Time FY17-19.xlsx
Earn codes	043 BW Earn Codes Used FY17-19.xlsx
Behavioral Wellness Programs	043 BW Programs.xlsx
Financial Trend data	043 BW Financial Trend FY17-19.xlsx

Figure 37: Source: KPMG

Appendix D: Operating model maturity scale

The figure below describes a continuum of maturity related to optimal service delivery across six areas of analysis. The purple boxes indicate the Department's capabilities at the time of the review, and the gold boxes illustrate the level of maturity that KPMG believe is attainable through the recommendations in this report.

Service Delivery Model	Lack of formalized utilization targets and cadenced staff communication	1	Utilization targets are not formalized or consistently monitored and communicated to staff to help ensure commitment to achieving targets	3	4	Utilization formalized across the County and tracked on a weekly basis	Optimized staff utilization
Education and Training	Lack of coordination	1	Little documented, coordinated and cadenced training surrounding systems, processes and utilization	3	Documented processes and regular staff trainings at the Divisional and program level	5	Robust
Technology	Incompatible systems	1	The EHR system is not compatible with the needs of the Department	3	4	EHR system is utilized across the Department to connect and facilitate strategic delivery of service	Enterprise system
Process	Lack of strategical alignment and consistent adoption	1	2	Internal and high-priority interagency processes do not consistently align with the Departments needs while others are not consistently adopted (e.g., HR policies, contract processes	4	Both internal and high-priority interagency processes align with Department vision and strategy and are consistently communicated to staff to help ensure adoption as intended	Consistently adoption and in line with vision and strategy
Governance and Controls	Lack of automation	1	2	3	Controls and compliance processes in place and regularly reviewed, but automation could be enhanced	Fully automated control and compliance processes across the department	Automated and preventative
Data and Reporting	Inconsistent or decentralized data models and reporting structures	1	2	Data is recorded, reviewed, and updated, but communicated to staff on an irregular basis	4	Data is recorded, reviewed, and updated on a regular basis. Reporting is accurate, consistent, and regularly shared across the Department	Established processes for sharing and analysis

Figure 38: Source: KPMG

Appendix E: Operating model framework

This section describes the operating model framework that was developed to articulate how a function should be designed, structured, and operated to improve operational efficiency, effectiveness, and service delivery. It consists of six interacting layers that need to be considered in conjunction with each other to determine how to optimally deliver services to the public.

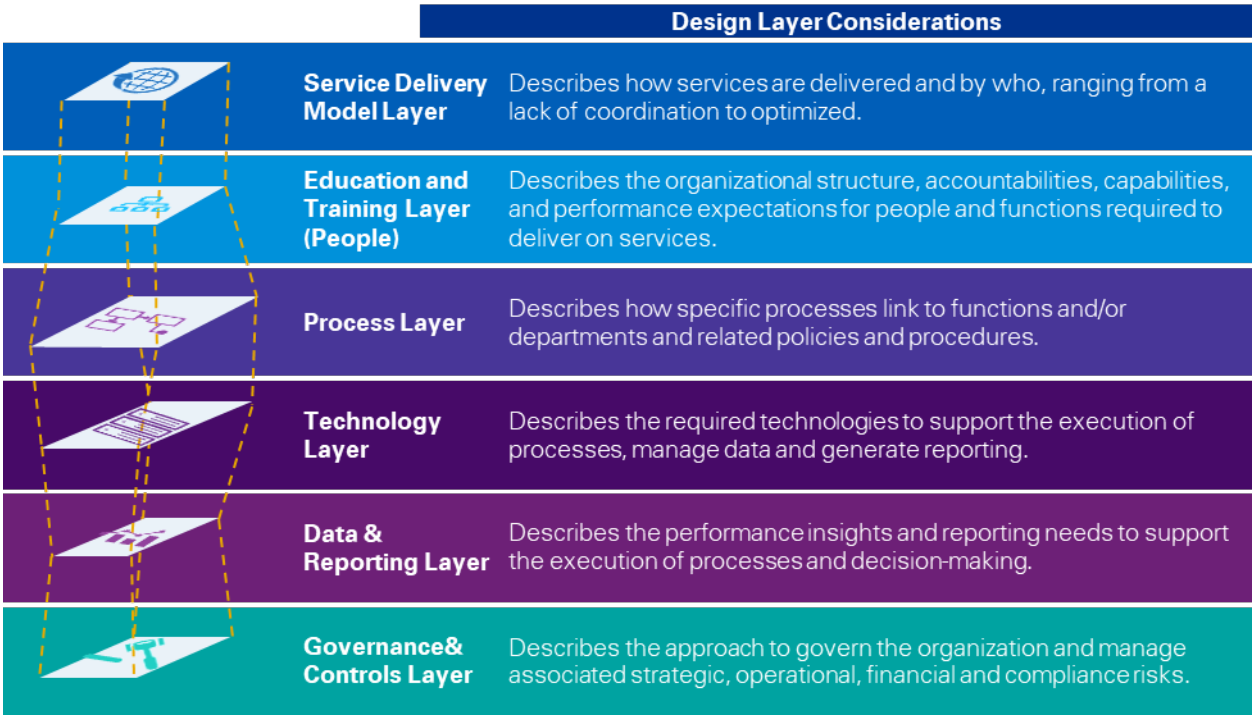


Figure 39: Source: KPMG

Appendix F: ACT and AOT program criteria

ACT:

The California Institute for Mental Health cites the ACT model as having the following standards of care:

- **Multidisciplinary staffing including full-time psychiatrist:** Teams should have expertise surrounding psychiatry, social work, nursing, substance abuse and vocational rehabilitation and should be staffed by a least one full-time psychiatrist program, which provides services to 100 clients.
- **Ready access in times of crisis (24-7):** Program is responsible for providing services 24 hours a day, seven days a week.
- **Team approach with shared caseloads**: The ACT program functions as a team staffing model rather than as an individual staffing model. The team specialists know and work with all clients. The entire team shares responsibility for each member: each clinician and behavioral health technician contributes expertise as appropriate.
- **Integrated and individualized services**: ACT directly provides psychiatric services, medication management, counseling, housing support, substance abuse treatment, employment and rehabilitative services in addition to case management service.
- **Low client-staff ratios (from 10 to 1):** ACT Teams should maintain a low member to staff ratio in the range of 10:1 to help ensure adequate and individualization of services.
- **Maximum team size of 100 clients:** It is critical that the ACT Program maintains adequate staff size and disciplinary background to provide comprehensive, individualized service to each client.
- **More than 75 percent of contacts in the community**: The Team should endeavor to provide more than 75 percent of its contact touchpoints with a given client, in a face to face format in the community.
- **At least 2-4 contacts with clients per week:** ACT Teams should provide a high amount of face to face service contacts. ACT clients should have high acute service needs, resulting in ACT staff engaging with them frequently throughout the week. Where clients do not require this level of service the reason should be documented and a review of the client's level of care should also be reviewed, as detailed in the actions below
- **Assertive outreach including delivering medications:** ACT programs should use outreach and other techniques to ensure ongoing engagement and compliance of treatment plans.
- **Time-unlimited services:** There is no time limit on the services provided under ACT, however, clients should be regularly monitored in order to determine progression in their overall care plan

and consideration for transitioning clients to a step down or lower level of care given when deemed clinically appropriate.

AOT:

A client can be referred to an AOT program in circumstances where the person has a history of lack of compliance with treatment mental illness, in that at least one of the following is true:

- The person's mental illness has, at least twice within the last 36 months, necessitated hospitalization or receipt of services in a forensic or other mental health unit of a state correctional facility or local correctional facility.
- The person's mental illness has resulted in one or more acts of serious and violent behavior toward himself or herself or another within the last 48 months.
- The person's condition is substantially deteriorating and participation in AOT Program would be the least restrictive placement necessary to ensure the person's recovery and stability.
- The person needs AOT in order to prevent a relapse or deterioration that would likely result in grave disability or serious harm to himself or herself, or to others.

Appendix G: ACT charts

The following visualizations were completed based on ACT data provided by the Department and relate to number of clients served per ACT program, average number of client sessions undertaken per program per month, top 5 diagnosis per program as well as number of no shows and cancellations per program It is important to note that a number of potential discrepancies in the data were identified, particularly related to the transfer of clients between programs as well as the readmission of clients to the same program. These nuances are discussed further under action one of recommendation 4.1; however, they necessitated significant manual data manipulation, making it difficult to accurately ascertain the number of clients served per program per month as well as the number of client sessions offered per program.

Number of clients per ACT program per month

The below charts illustrate the number of clients served by each of the three ACT programs per month from 2018 to May 2021. The Santa Barbara ACT Team typically served the highest number of clients on a monthly basis during this period at an average of 95 with the highest number of clients being served between Sep-19 and Aug-20. Santa Maria and Lompoc Programs typically served an average of 93 and 79 clients per month over the three-and-a-half-year period

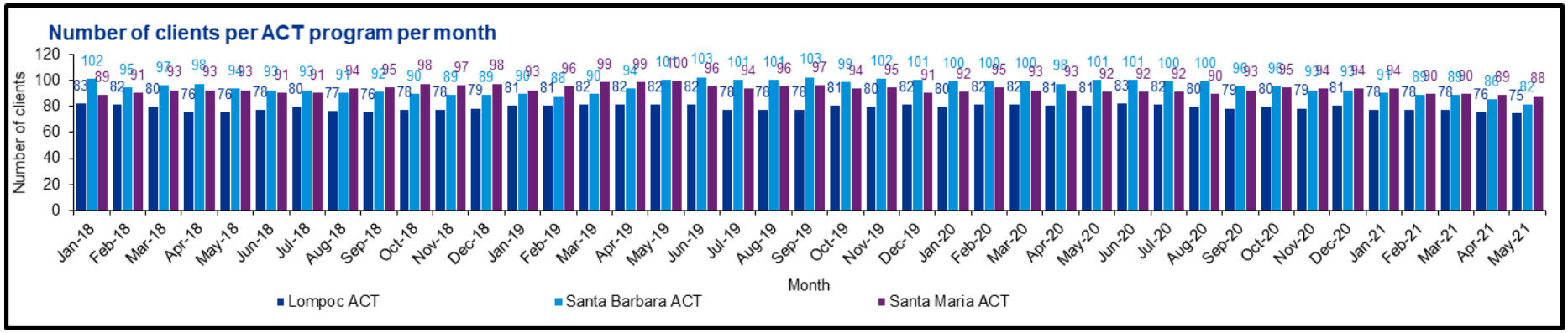


Figure 40: Source KPMG analysis of ACT data

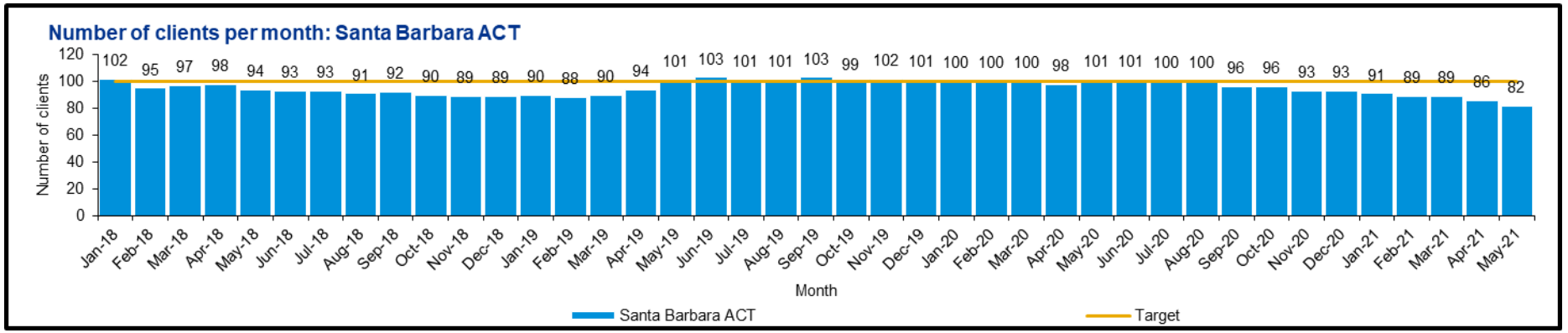


Figure 41: Source KPMG analysis of ACT data

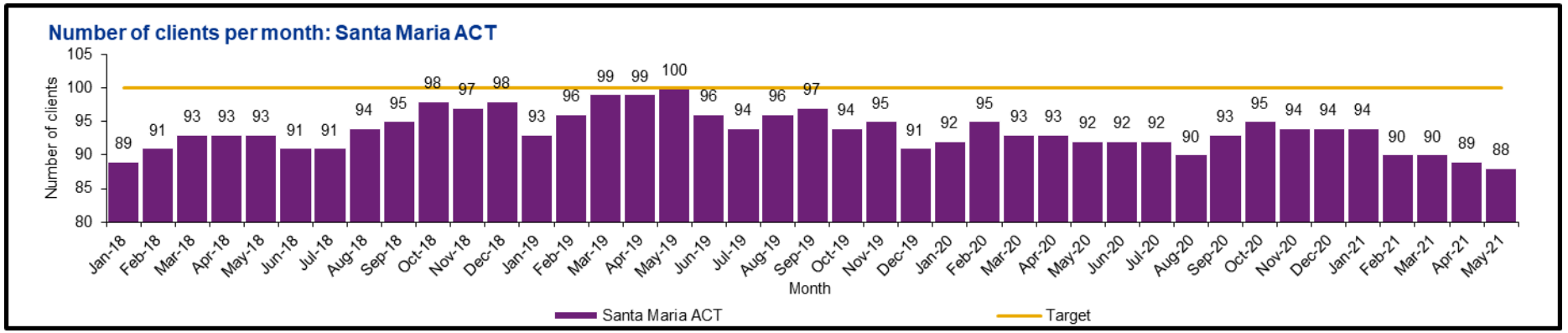


Figure 42: Source KPMG analysis of ACT data

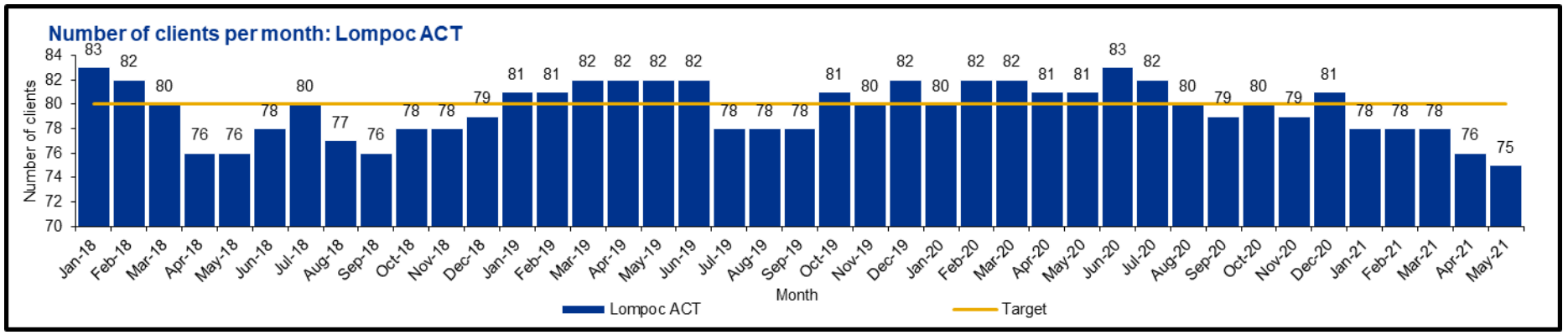


Figure 43: Source KPMG analysis of ACT data

Average length of time (in months) a client receives services

Between 2018 and May 2021, the Santa Barbara ACT program provided services to its clients for an average of 36 months, which was between 6 and 8 months shorter than the Santa Maria and Lompoc programs who provided services for an average of 42 and 44 months respectively.

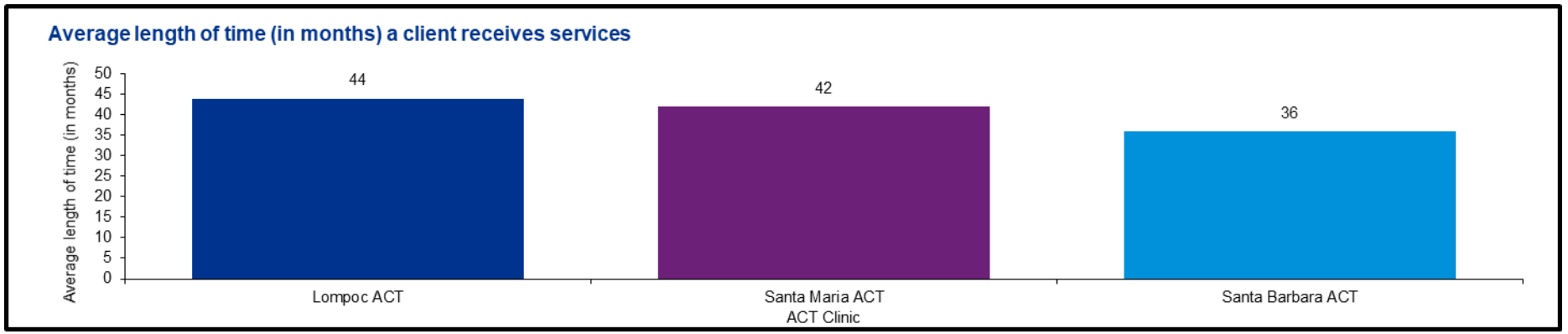


Figure 44: Source KPMG analysis of ACT data

Average number of monthly sessions per client per program

The below charts outline the average number of sessions provided to each client per program per month.with the target lines identifying the recommended minimum and maximum number of sessions which should be provided to clients under the ACT model (8-16). The Santa Barbara program has historically provided the greatest number of monhtly sessions, on average at 12, although this has fallen to nine in Q2 2020. Santa Maria and Lompoc both provided an average of nine sessions monthly between 2018 and May 2021. However, it is important to note that these averages disproportionately increased due to a small concentration of clients receiving in excess of 20 sessions per month, for example.

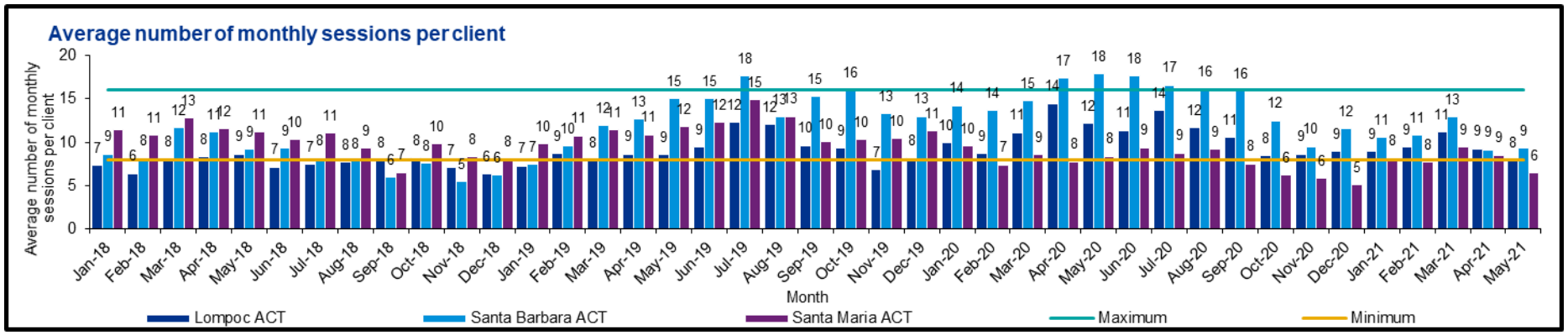


Figure 45: Source KPMG analysis of ACT data

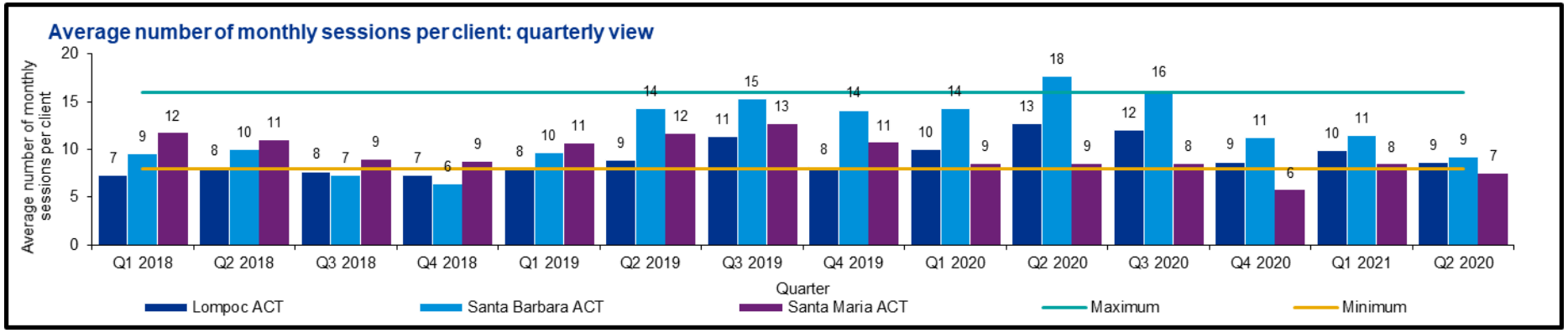


Figure 46: Source KPMG analysis of ACT data

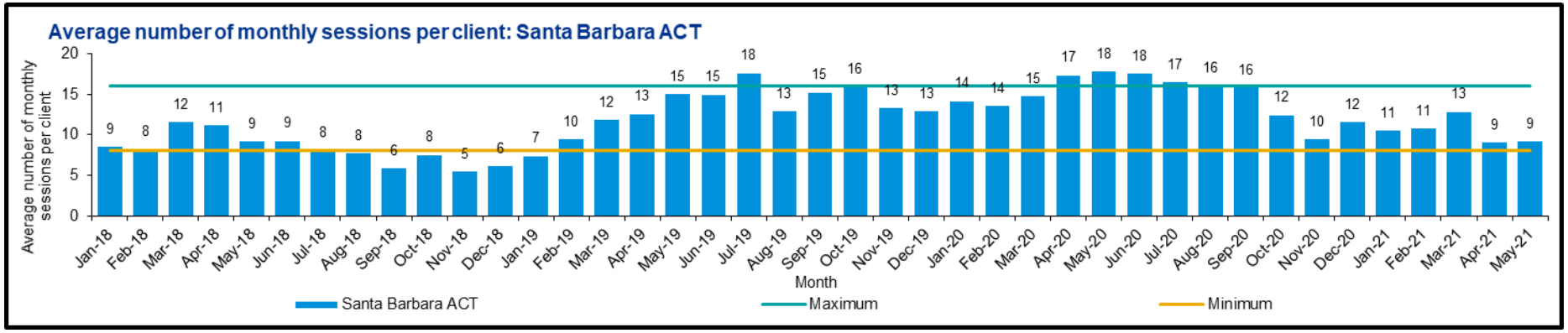


Figure 47: Source KPMG analysis of ACT data

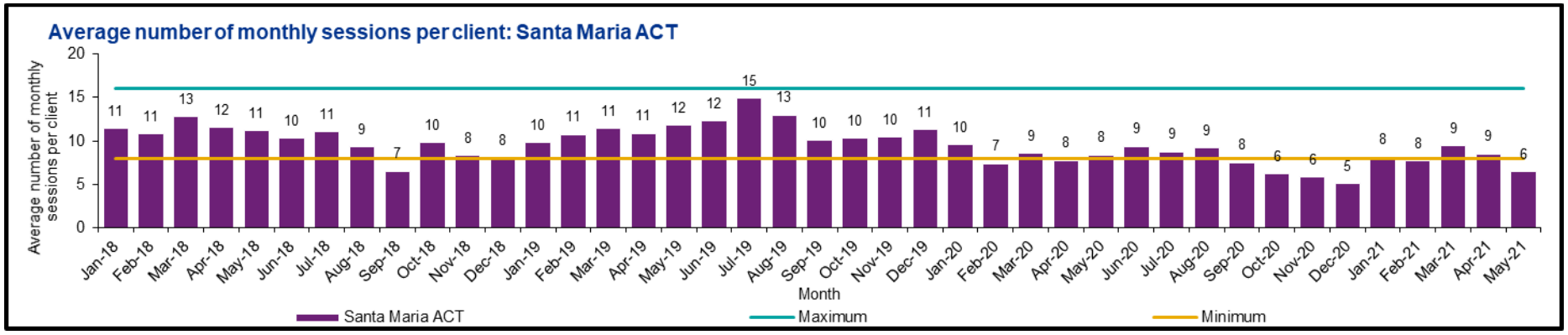


Figure 48: Source KPMG analysis of ACT data

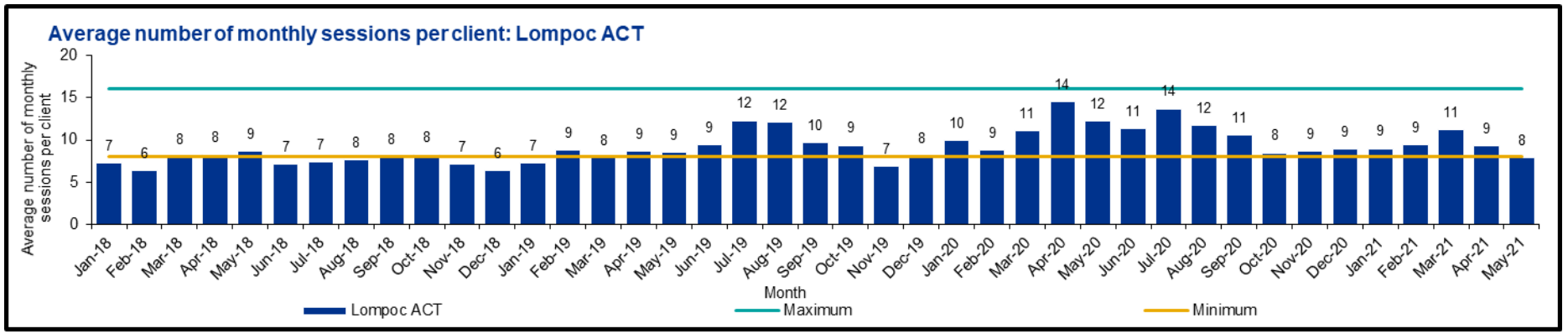


Figure 49: Source KPMG analysis of ACT data

Number of service interactions

The charts below illustrate the percentage of clients who received less than eight sessions per month (0-7 interactions) and the average number of clients who received eight or more sessions per month (7+ interactions). On average, between 2018 and the five months to May 2021, 43 percent of clients within the Santa Barbara program received less than eight interactions per month, this percentage was 47 percent in Lompoc and 46 percent in Santa Maria

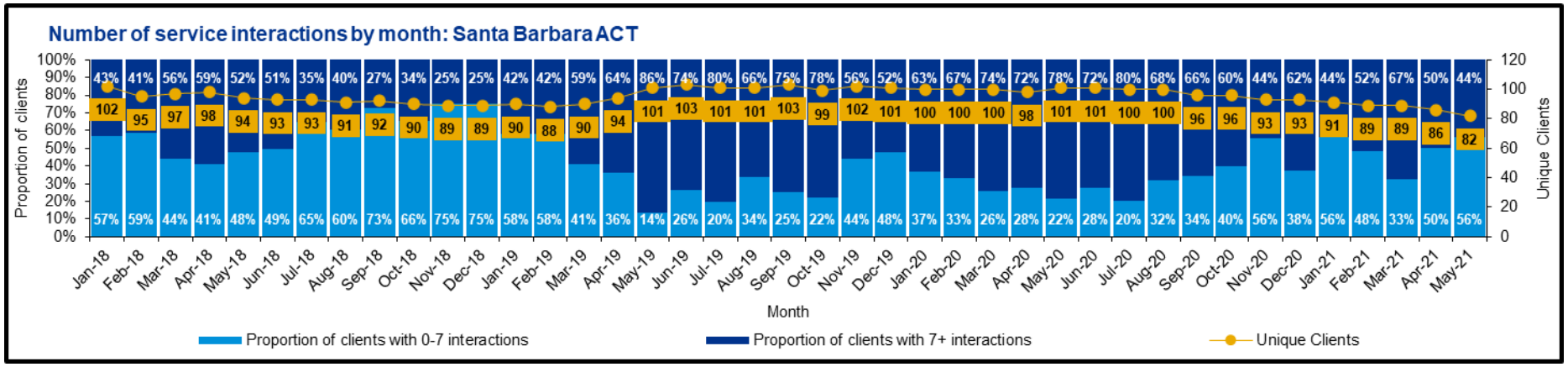


Figure 50: Source KPMG analysis of ACT data

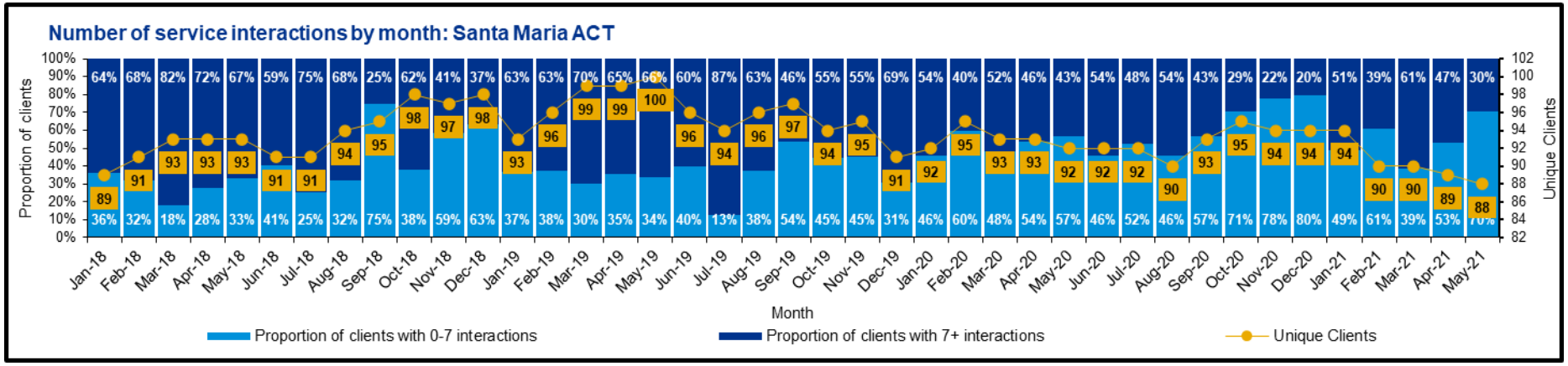


Figure 51: Source KPMG analysis of ACT data

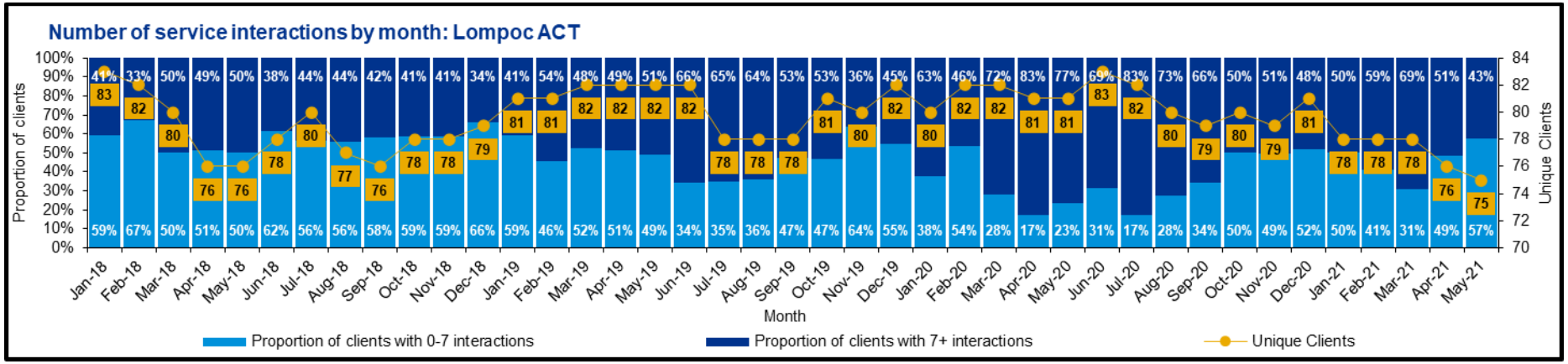


Figure 52: Source KPMG analysis of ACT data

Diagnosis

The charts below outline the top five primary client diagnosis across each program. Schizophrenia related illnesses consistently represented the top diagnosis across programs. Between 2018 and May 2021, 75 percent of clients in the Santa Barbara ACT program suffered from a schizophrenic related disorder, 81 percent in Santa Maria and 54 percent in Lompoc.

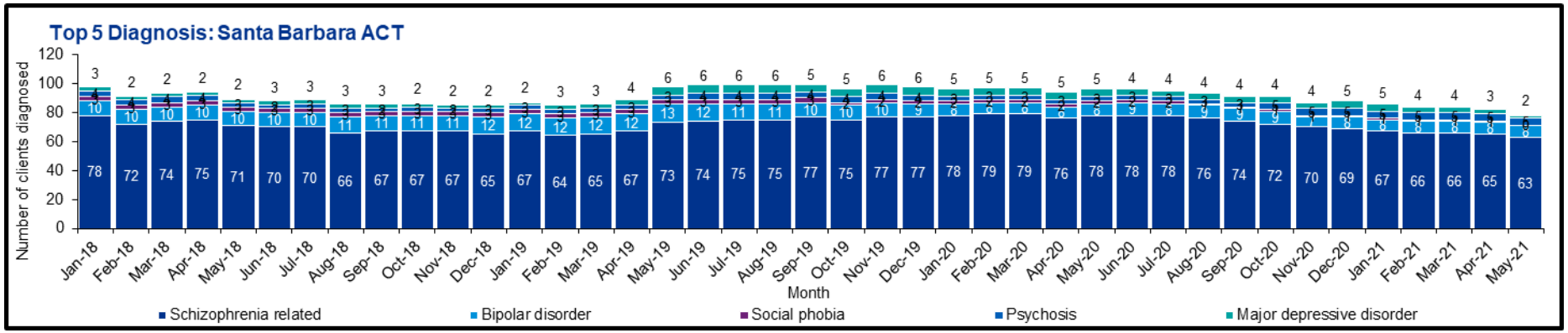


Figure 53: Source KPMG analysis of ACT data

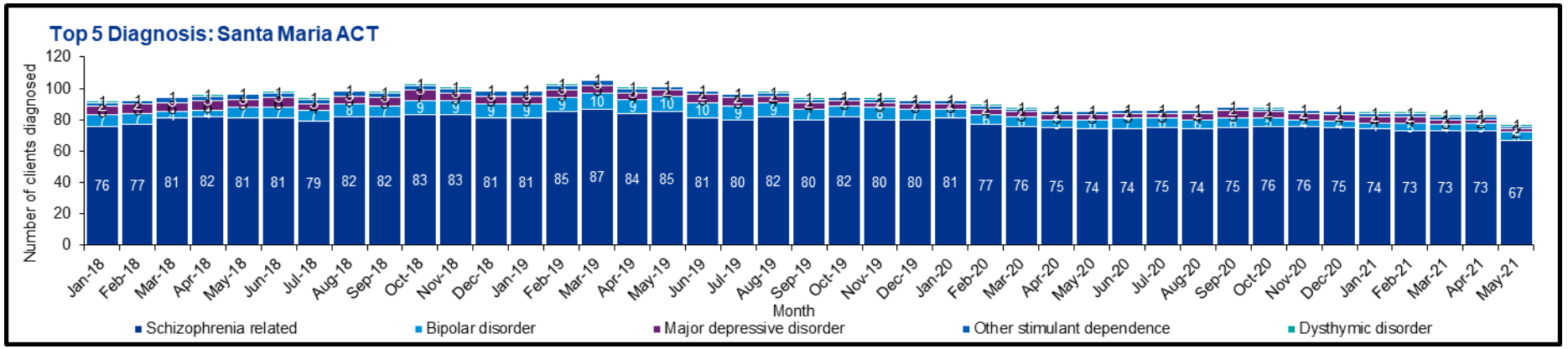


Figure 54: Source KPMG analysis of ACT data

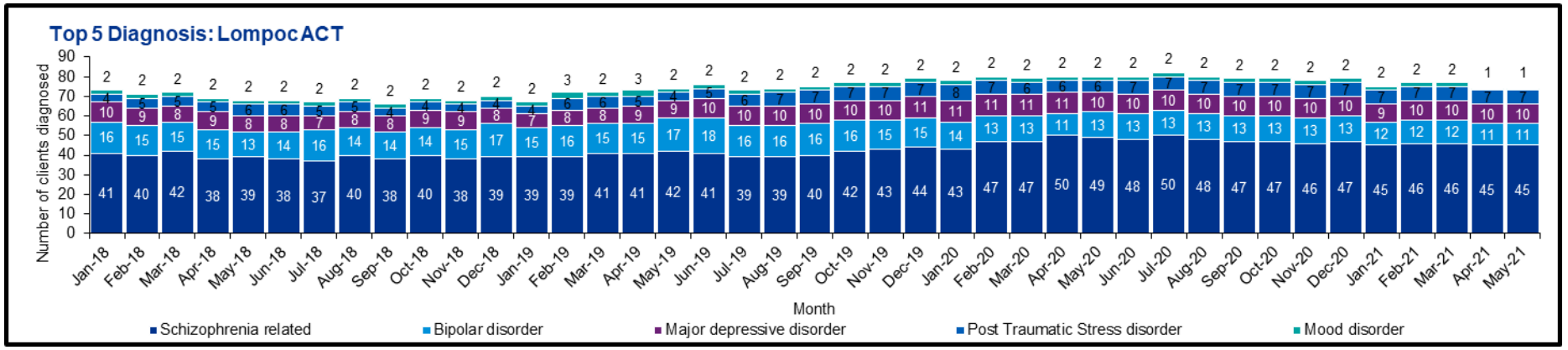


Figure 55: Source KPMG analysis of ACT data

No shows

The charts below identify the number of client no shows and cancellations as well as the number of staff cancellations per program per quarter between 2018 and the five months to May 2021. Over the period, the Santa Barbara program experienced the highest number of client no shows and cancellations at an average of 108 per quarter (36 per month), while Lompoc experienced 39 (13 per month) and Santa Maria 21 (7.per month)

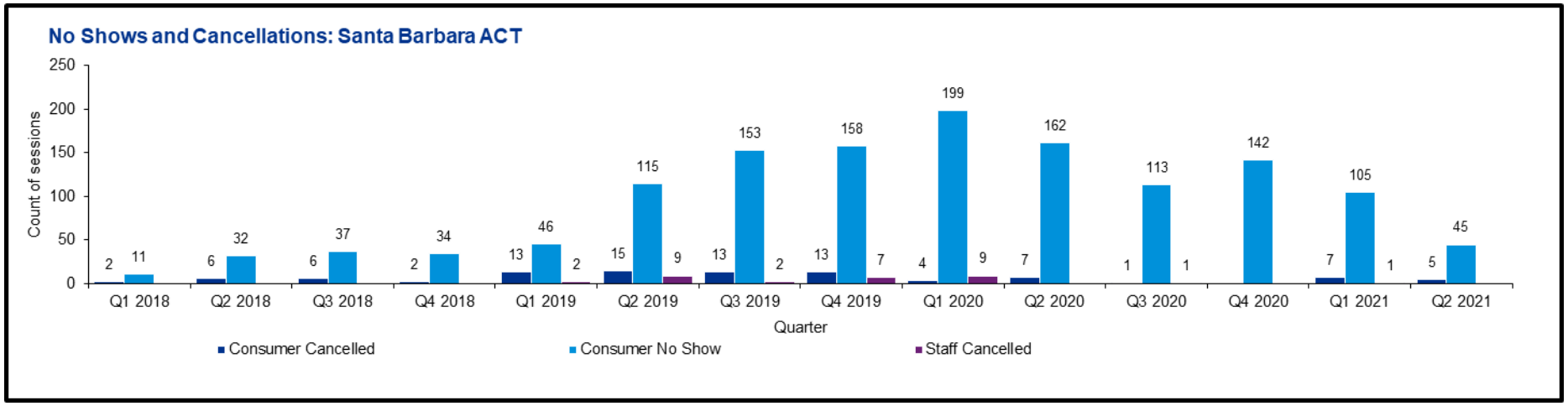


Figure 56: Source KPMG analysis of ACT data

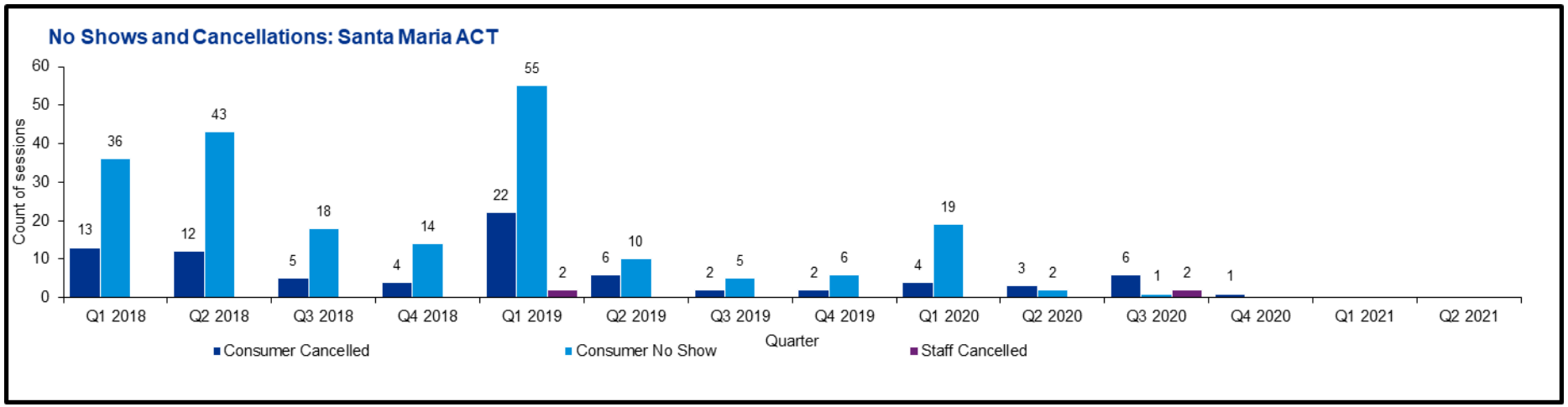


Figure 57: Source KPMG analysis of ACT data

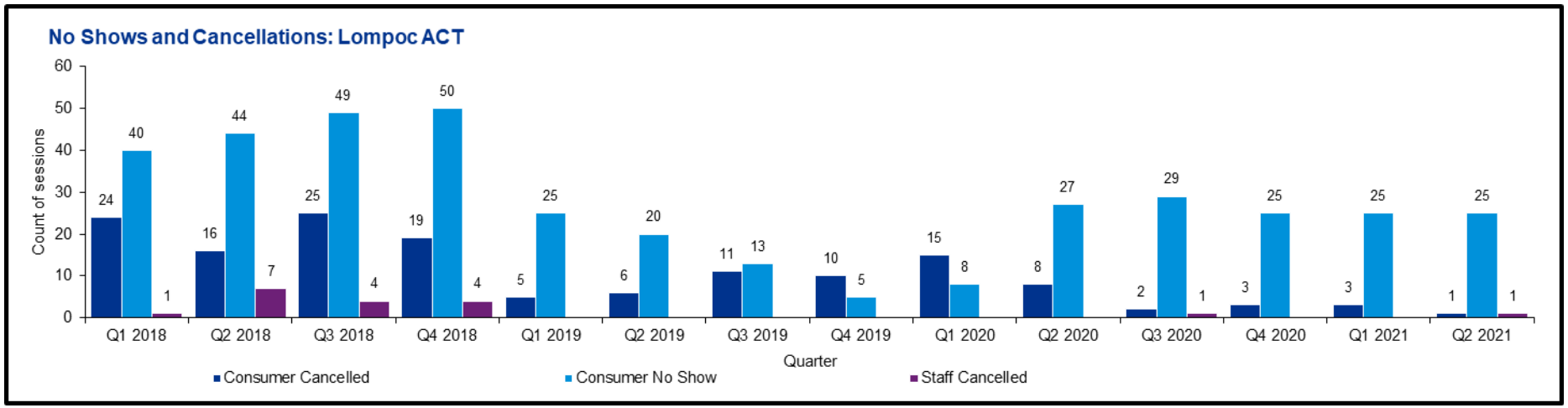


Figure 58: Source KPMG analysis of ACT data

Appendix H: Utilization charts

The Department developed a Tableau dashboard to monitor and track utilization across service lines as well as by individual staff member to provide managers and Department leadership with a greater understanding of staff workload and service delivery. The Department's utilization dashboard reports two key metrics:

1. An overall **"total activity utilization"** for each staff member, which comprises the percentage of time spent on services considered to be "direct" client services by Executive Leadership in addition to time spent training and attending meetings. The formula to calculate this staff activity utilization is illustrated in the following graphic:

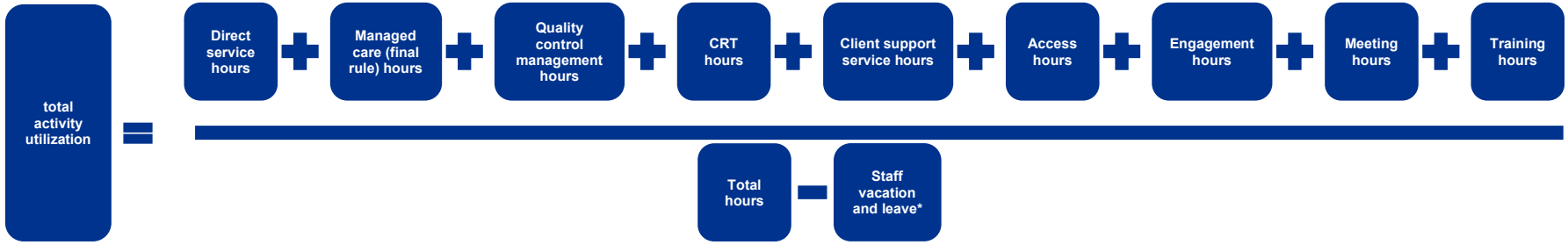


Figure 59: Source KPMG analysis of utilization

2. Average **"client services utilization"** which includes activities related to the provision of client services but excludes time spent on meetings and training as a share of total hours. The formula to calculate client services utilization is illustrated in the following graphic:

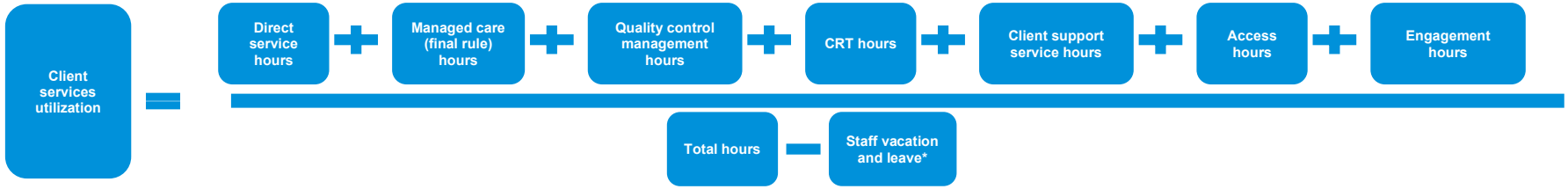


Figure 60: Source KPMG analysis of utilization

* Leave includes public holidays, sick leave, family leave, administrative leave among other forms of leave offered by the Department

The below table provides a description of the types of activity category that the Department includes in its calculation of total activity utilization and client services utilization percentages:

Activity category per utilization data	Activity category description
Direct service hours	Billable activities
Managed Care ("MCO") hours	MCO is a Managed Care Final Rule from Department of Health Services (DHCS). MCO is used as a project code on timesheets for activities associated with the MCO. For example, instances when clinical staff engage in care coordination to refer or step-down clients not eligible for services or activities related to contract monitoring of community-based organizations.
Quality control management hours	Activities dedicated to quality control including chart reviews, utilization reviews, quality improvement committee meetings, clerical time gathering chart and billing documentation, activities related to developing and evaluating clerical practice guidelines, plan development activities among other activities related to quality improvement.
CRT hours	Activities associated with attending at Court on behalf of clients
Client support	Services provided to clients which cannot be billed.
Access hours	Activities related to answering the Department's Access Line.
Engagement hours	Services typically provided by Homeless Outreach, Justice Alliance or Mobile Crisis Teams. These services are provided prior to the individual consenting to treatment and becoming an open client in the Department's system.
Meeting hours	Time spent attending departmental meetings.
Training hours	Time spent undertaking training.

Figure 61: Source KPMG analysis of utilization

Utilization Charts

The following visualizations were developed based on utilization data provided by the Department which encompass staff activity utilization and client services utilization. They provide a view of average total activity utilization by position and program as well as average client services utilization by position and program for FY18–19, FY18–19, and FY20–21. Program mappings for each position were provided directly by the Department.

However, it is important to note, that based on data analysis 4 percent of entries for FY20–21 calculated a utilization percentage for certain staff in excess of 100 percent. Based on Department discussions, such instances largely relate to circumstances under which staff incorrectly coded their time sheets. Time sheet data is utilized to determine total hours worked per employee which in turn acts as the denominator in calculating utilization percentages. As a result of these errors, department-wide utilization may be artificially increased and these errors should be considered and rectified in conducting future analysis.

Average total activity utilization by position per fiscal year

The below charts illustrate average total activity utilization by position per fiscal year from FY18–19

During FY18–19 and FY19–20 psychiatrists accounted for the highest utilization percentages at 71 percent and 70 percent respectively. In FY20–21, the Department's rehabilitation specialists had the highest utilization at 70 percent. Historically, team supervisor positions and administrative staff have the lowest utilization given that these positions do not typically provide a significant amount of direct client service.

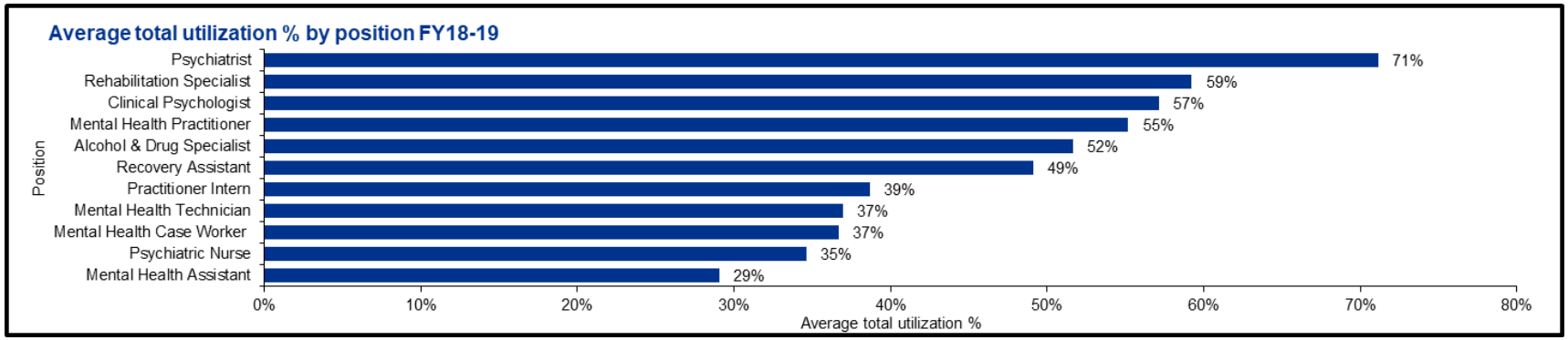


Figure 62: Source KPMG analysis of utilization

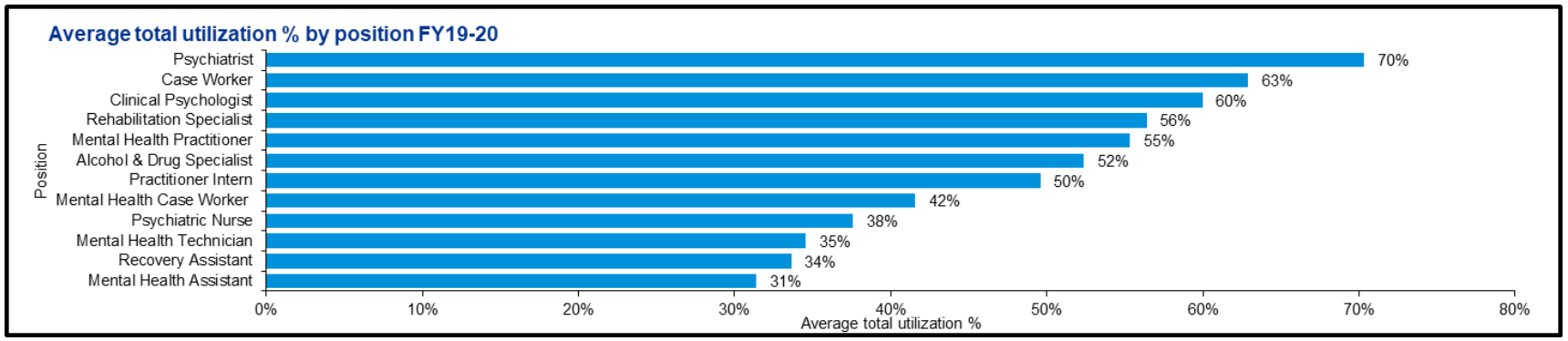


Figure 63: Source KPMG analysis of utilization

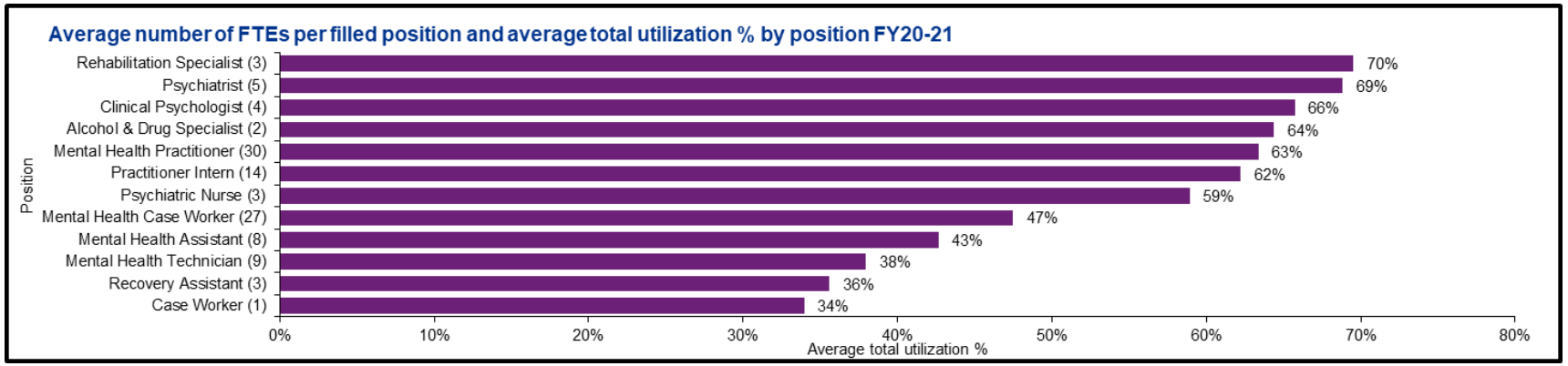


Figure 64: Source KPMG analysis of utilization

Average client services utilization by position per fiscal year

The below charts illustrate average client services utilization by position per fiscal year from FY18–19 to FY20–21. Similar to total activity utilization the Department's psychiatrists had the highest utilization in FY18–19 and FY19–20 at 55 percent and 50 percent, respectively. However, in FY20–21, clinical psychologists accounted for the highest utilization percentage at 54 percent with psychiatrist utilization increasing by 1 percent to 51 percent in that year. As is the case with total utilization percentage, team supervisors and administrative staff had the lowest utilization, given their respective roles.

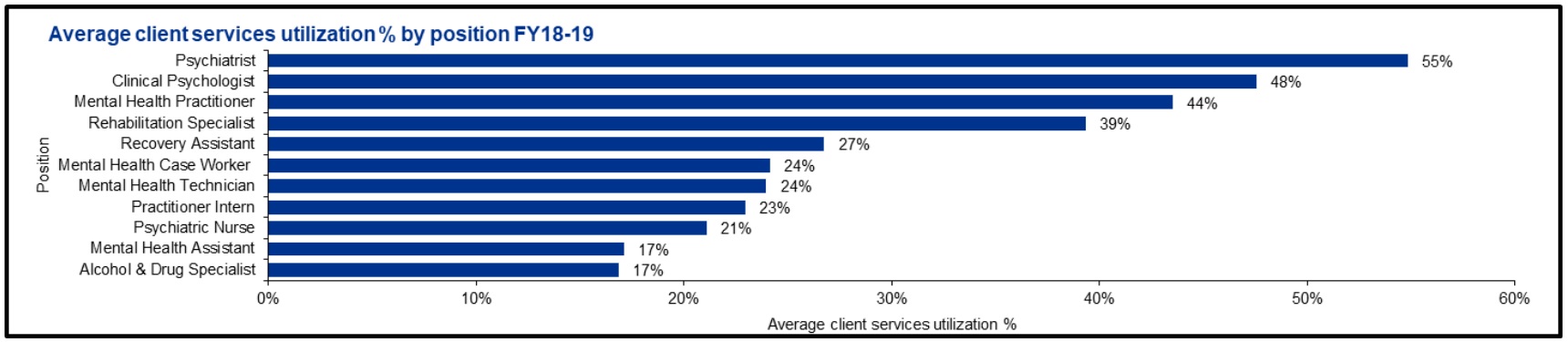


Figure 65: Source KPMG analysis of utilization

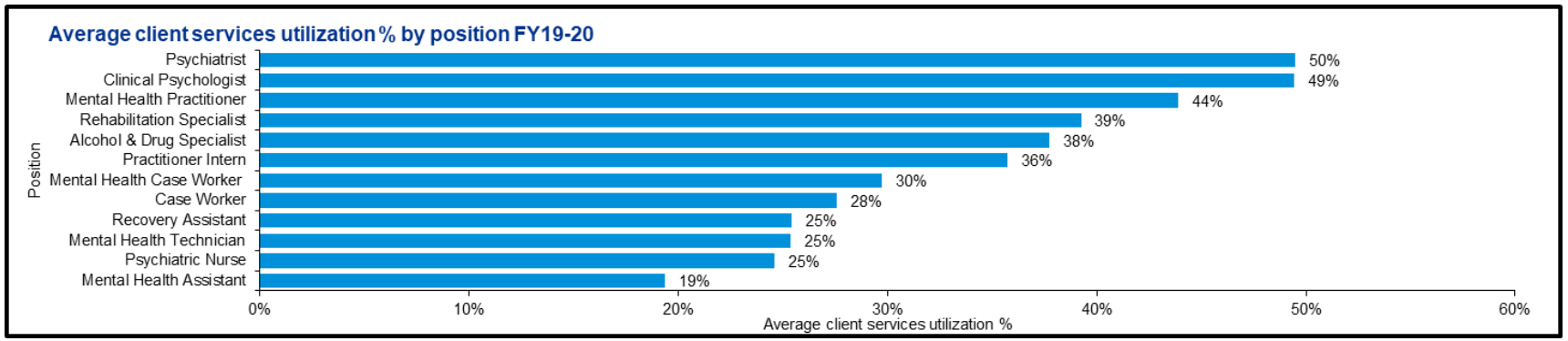


Figure 66: Source KPMG analysis of utilization

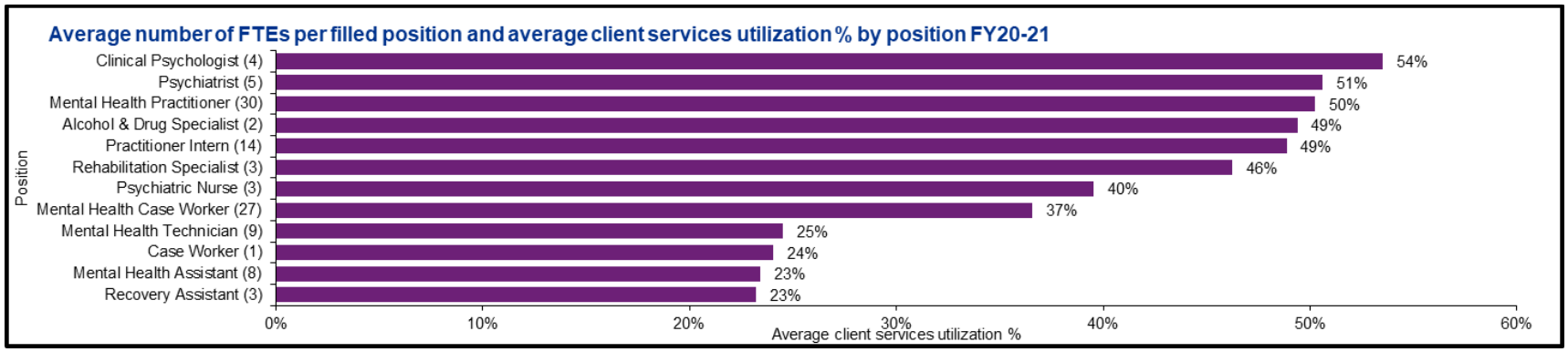


Figure 67: Source KPMG analysis of utilization

Average total activity utilization percentage and average client services utilization by position

The below bar charts outline average total activity utilization and average client services utilization by position from FY18–19 to FY20–21 with the former depicted by the blue bar and the later depicted by the green bar.

For FY18–19, difference between total activity utilization and client service utilization is the smallest for clinical psychologists at 9 percent. This suggests that clinical psychologists spent less time attending trainings and meetings and more of their time providing client services than other departmental positions in that year. On average, psychiatrists accounted for the highest difference between total activity utilization and client service utilization at 16 percent which suggests that psychiatrists spent approximately 29 percent of their time attending meetings and training in FY18–19.

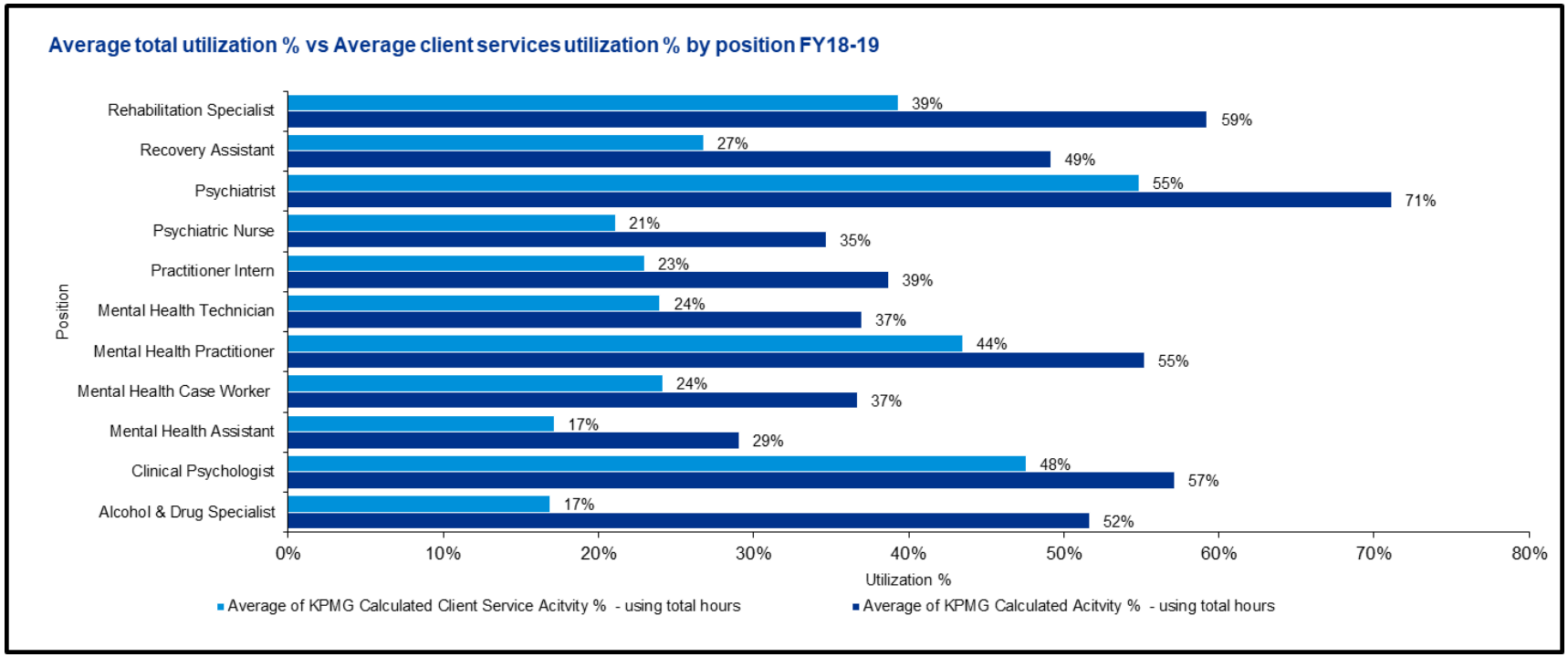


Figure 68: Source KPMG analysis of utilization

In FY19–20, recovery assistants and mental health technicians on average accounted for the smallest difference between total activity utilization and client services utilization at 9 percent. Case workers accounted for the largest difference between total activity utilization and client services utilization, spending 56 percent of their time undertaking training or attending meetings in FY19–20.

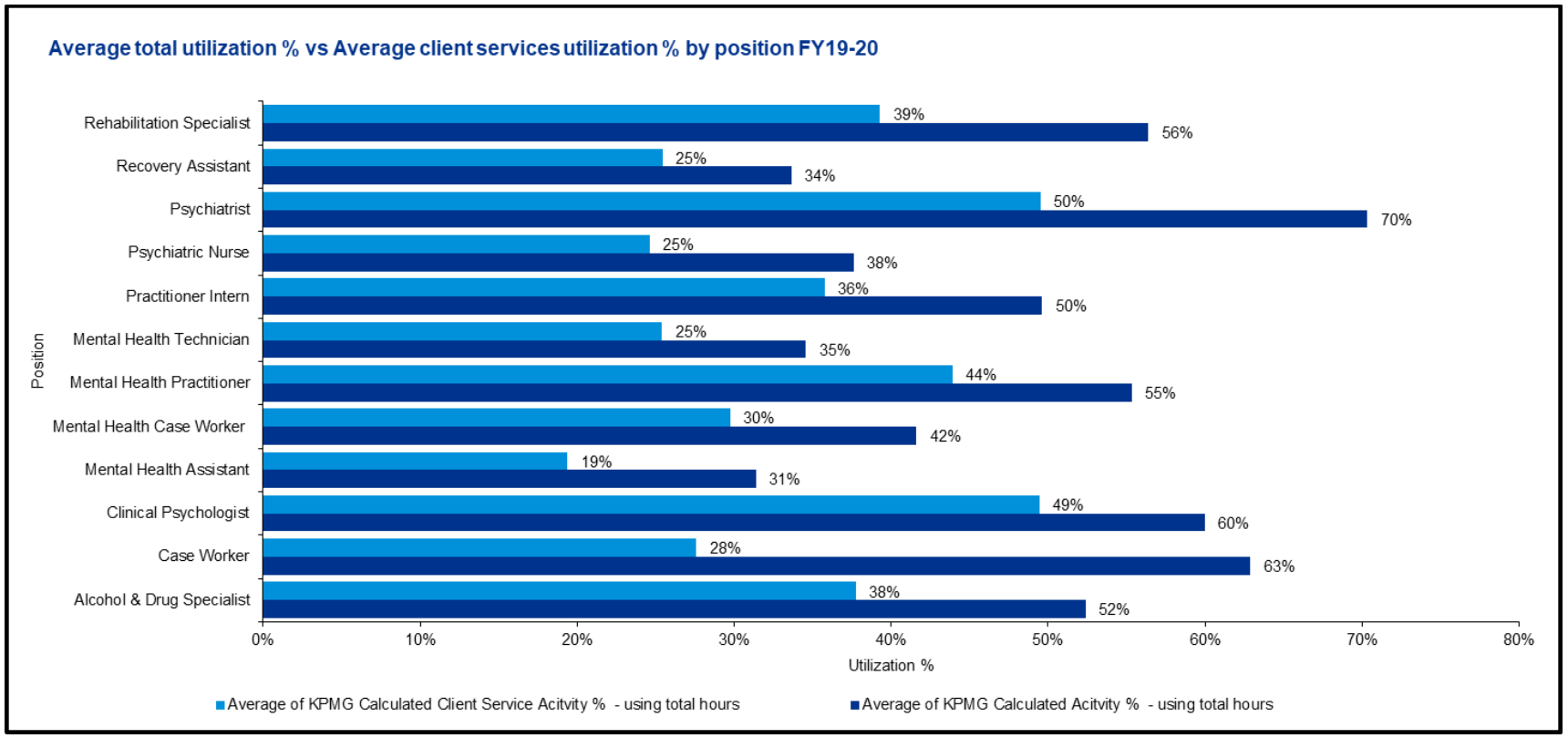


Figure 69: Source KPMG analysis of utilization

Conversely as compared to FY19–20, mental health case workers accounted for the lowest difference between total activity utilization and average client services utilization. Rehabilitation specialists had largest difference between total activity utilization and client services utilization, spending 35 percent of their time undertaking training or attending meetings as compared to providing client services.

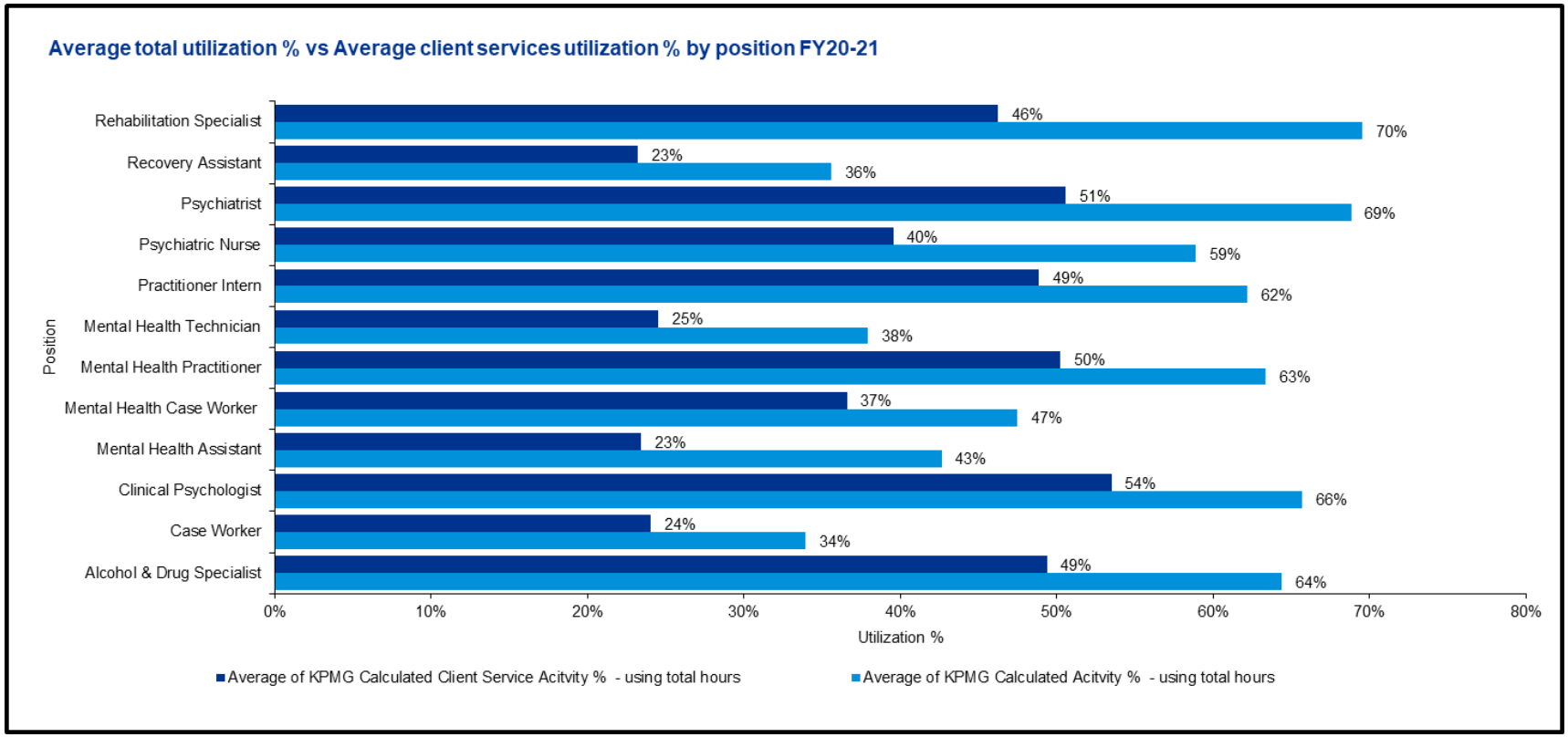


Figure 70: Source KPMG analysis of utilization

Average total utilization by position by fiscal year per program

The below charts illustrate the average total activity utilization percentage by position per program from FY18–19 to FY20–21. These charts were developed based on data and program mappings provided by the Department.

Across the three-year period, total activity utilization has increased at the Lompoc Clinic by approximately 15 percent. Recovery assistants accounted for the highest average total activity utilization at 66 percent during this period.

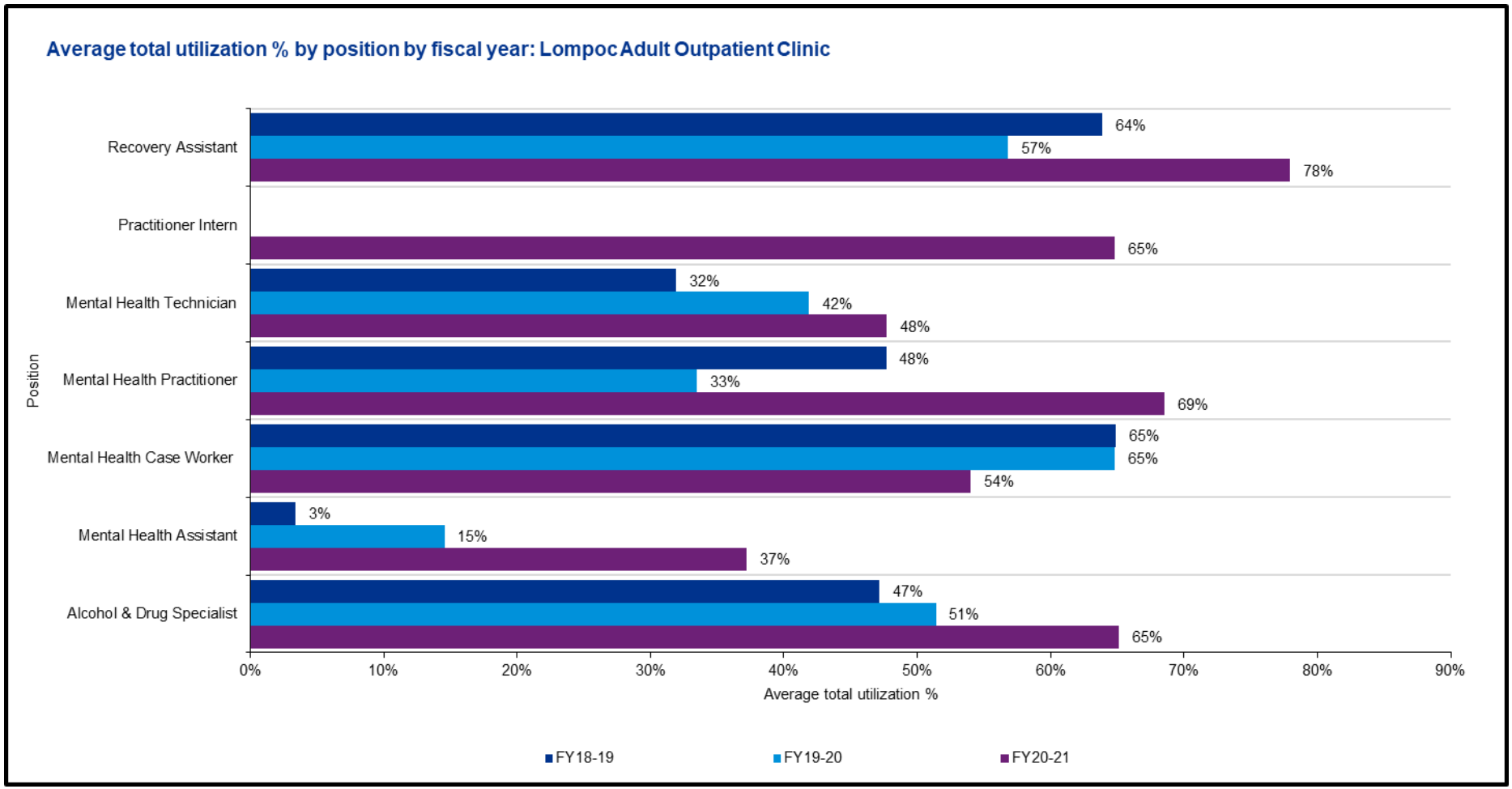


Figure 71: Source KPMG analysis of utilization

Average total activity utilization at the Santa Barbara Outpatient Clinic has increased from 50 percent in FY19–20 to 61 percent in FY20–21..

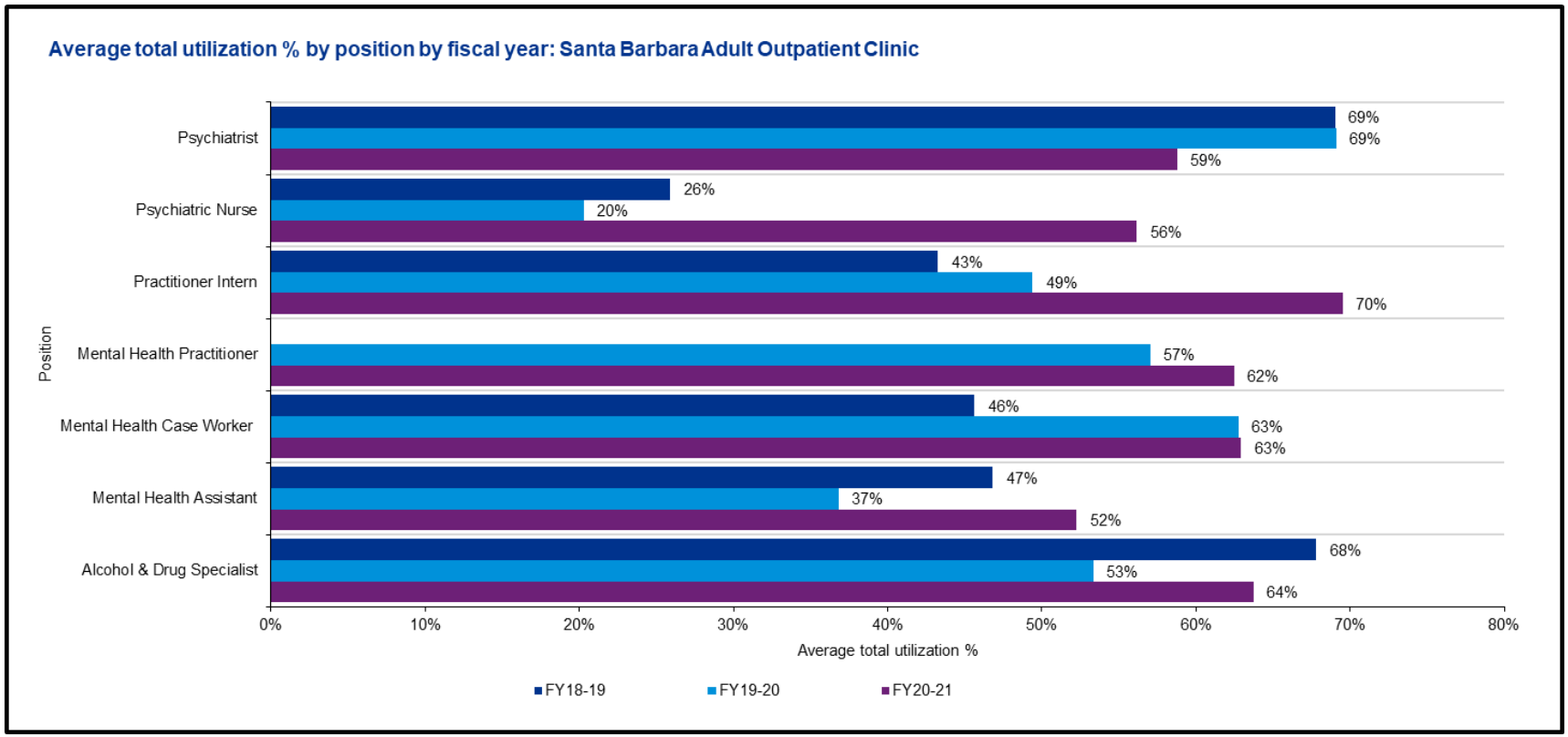


Figure 72: Source KPMG analysis of utilization

Across the three-year period, average total activity utilization at the Santa Maria Transitional Age Youth (TAY) Outpatient Clinic has increased by 4 percent from approximately 58 percent in FY18–19 to 62 percent in FY20–21. During this period Rehabilitation Specialists had the highest average total activity utilization at 82 percent.

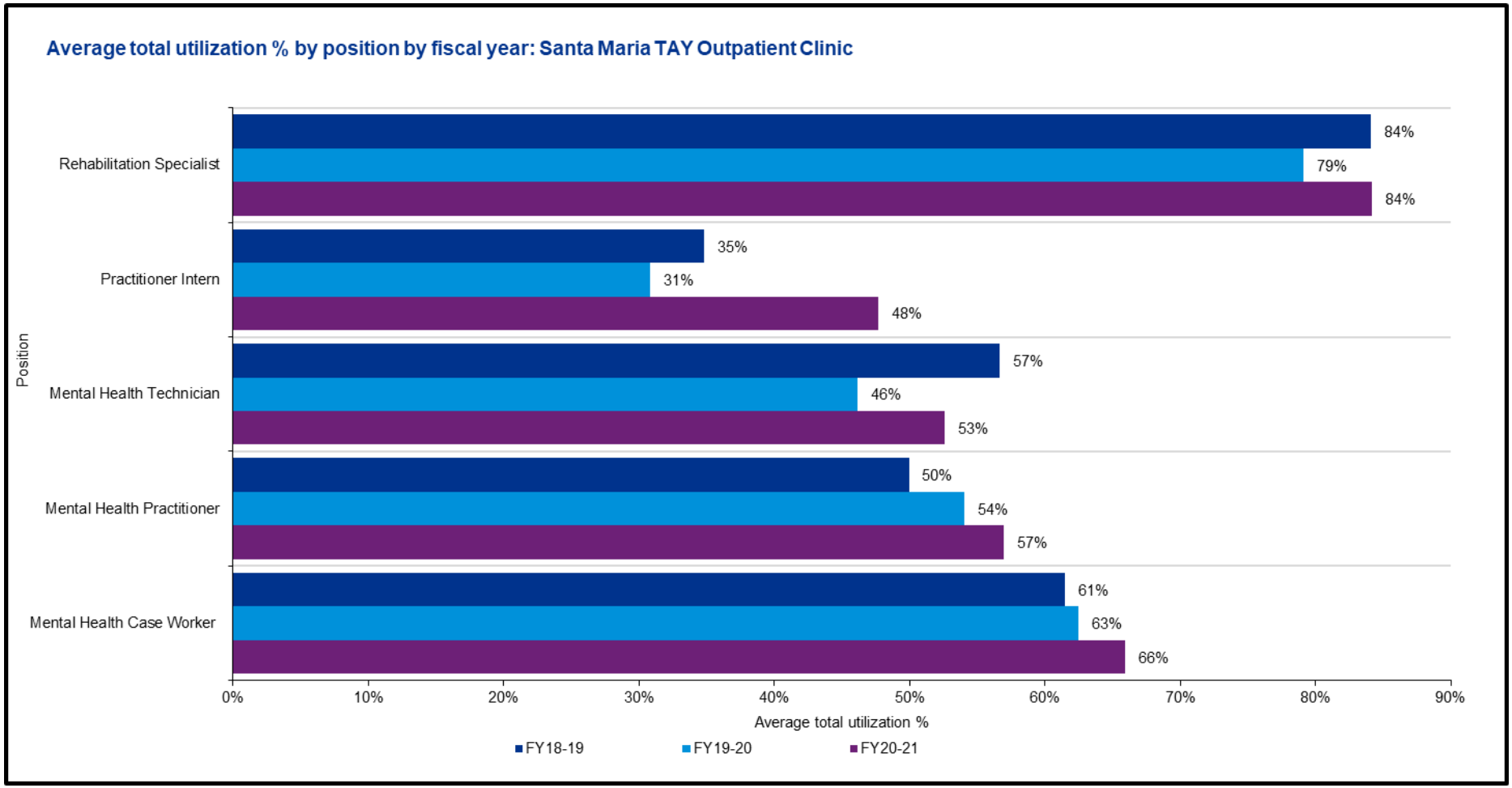


Figure 73: Source KPMG analysis of utilization

Total average activity utilization for mental health practitioners within the Santa Barbara Children's Clinic has fallen by 15 percent from 81 percent in FY18–19 to 66 percent in FY20–21.

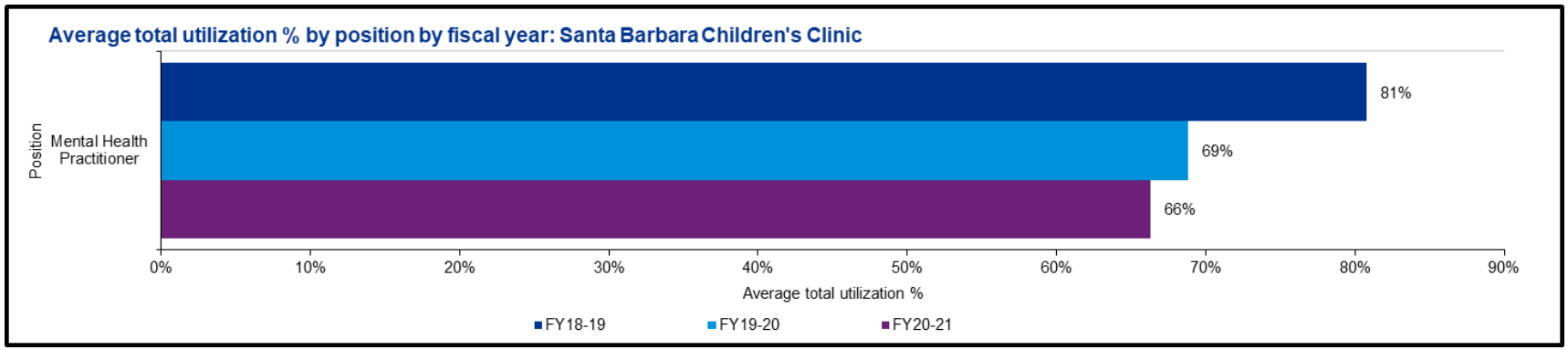


Figure 74: Source KPMG analysis of utilization

Total average activity utilization has increased for the Santa Maria Children's Clinic by approximately 13 percent from 46 percent in FY18–19 to 59 percent in FY20–21. Psychiatrists accounted for the highest average total activity utilization during that period at an average of 70 percent.

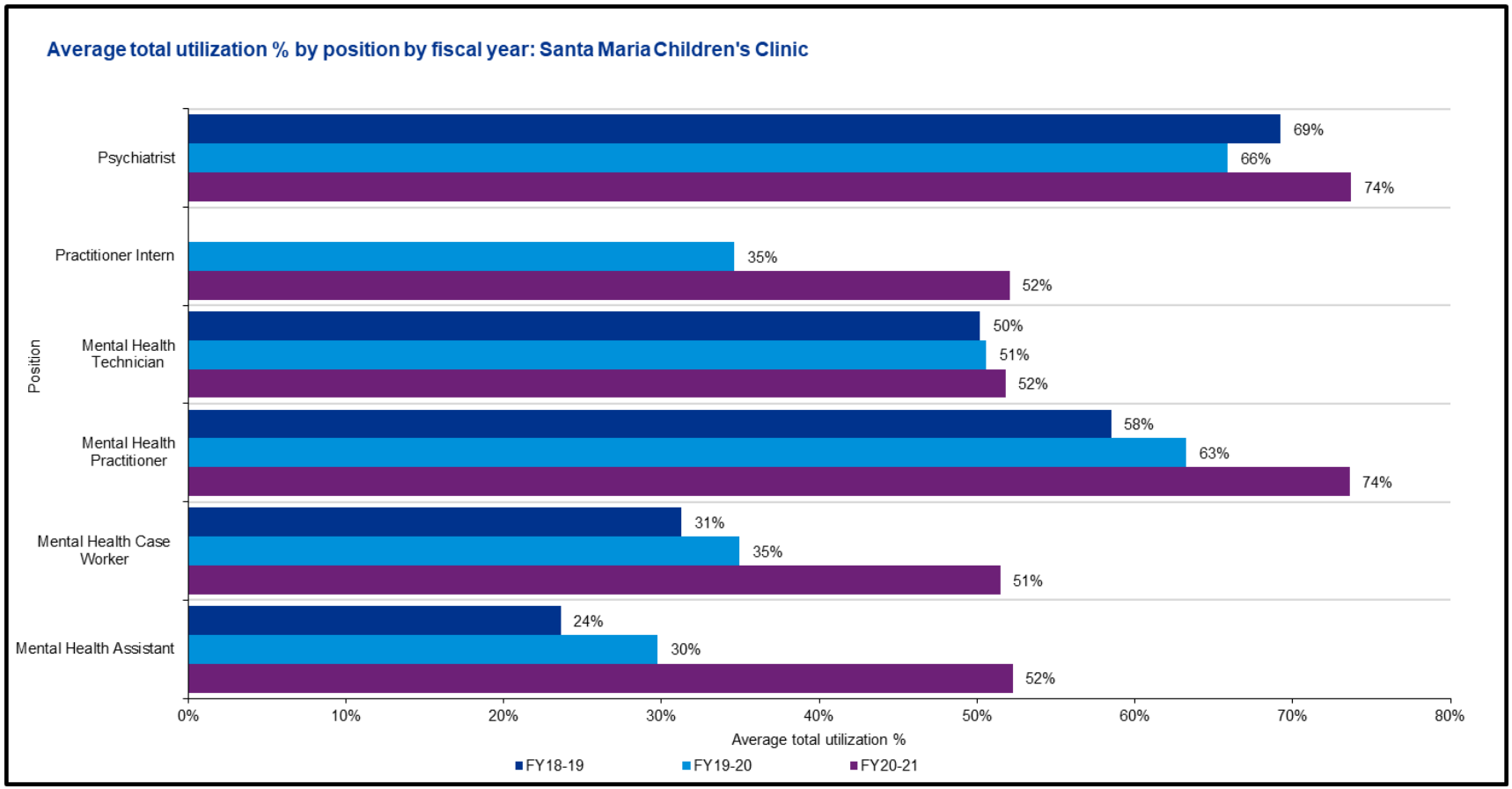


Figure 75: Source KPMG analysis of utilization

Across the three-year period, total average activity utilization has increased for Lompoc Regional Programs by approximately 6 percent from 52 percent in FY18–19 to 60 percent in FY20–21. Practitioner interns accounted for the highest average total activity utilization at 66 percent during the same period.

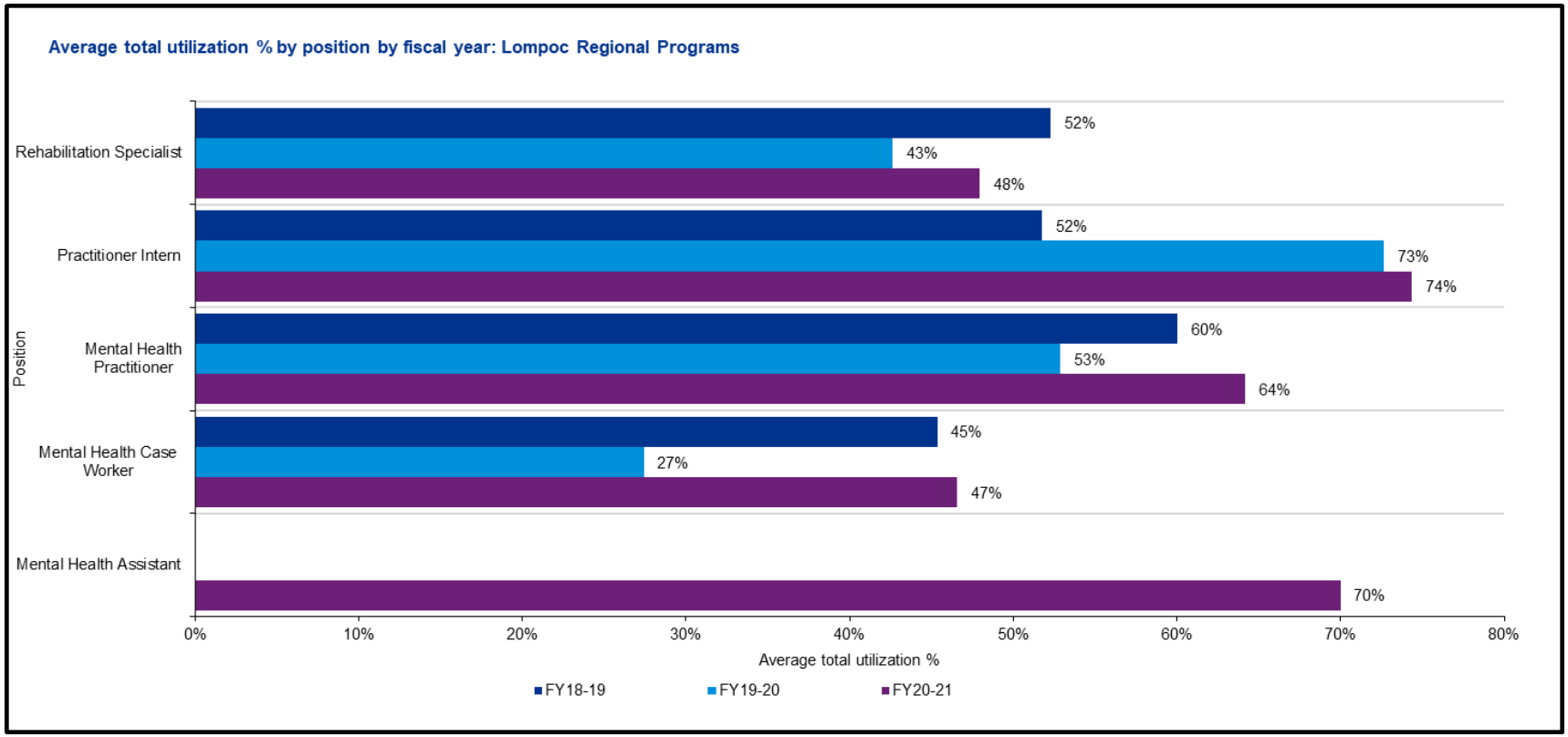


Figure 76: Source KPMG analysis of utilization

Total average activity utilization increased for Santa Barbara Regional Programs by approximately 20 percent over the three-year period from 47 percent in FY18–19 to 62 percent in FY20–21. Psychiatrists and clinical psychologist both accounted for the highest average total activity utilization at 77 percent during the same period.

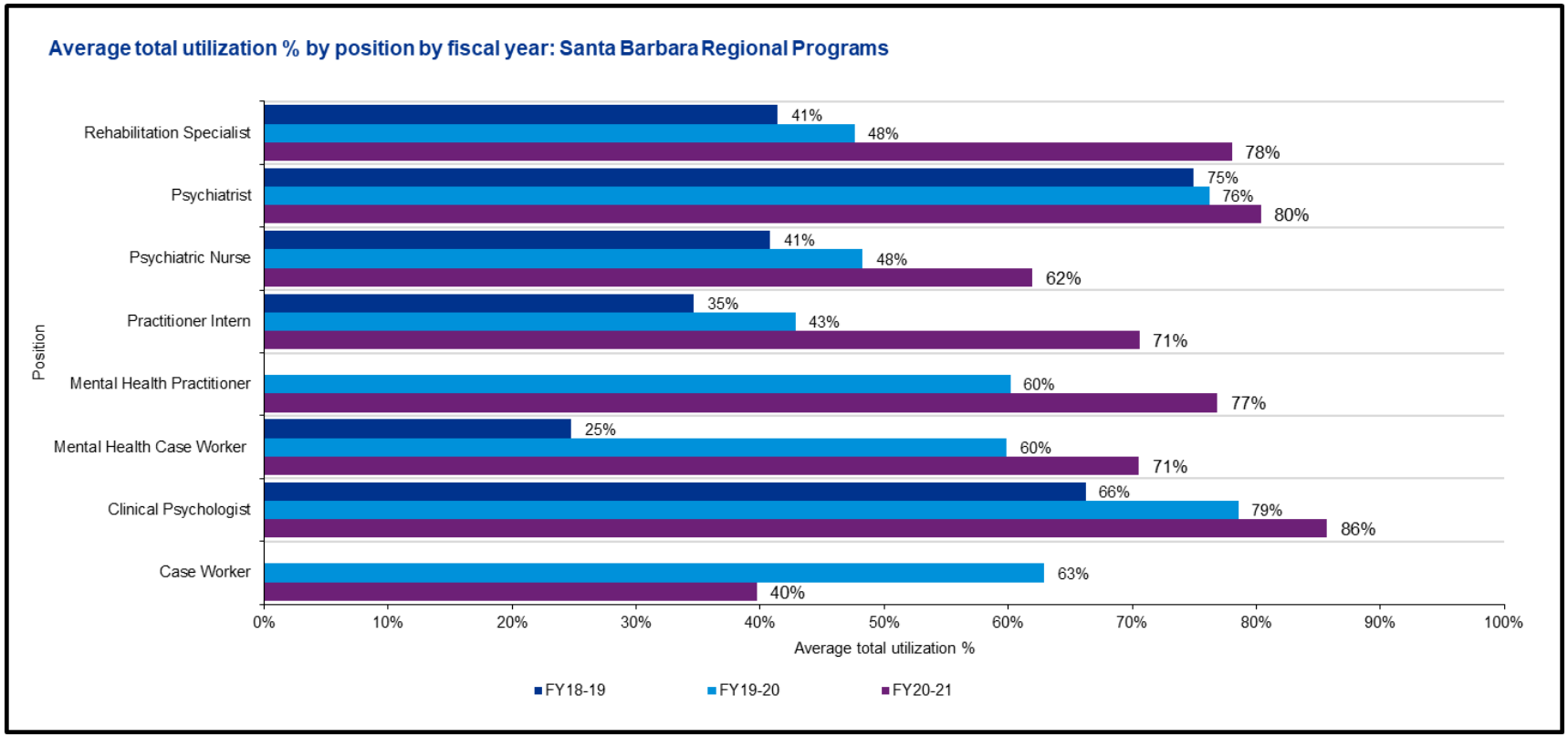


Figure 77: Source KPMG analysis of utilization

Across the three-year period, total activity utilization has increased for West and North County Crisis Services by approximately 2 percent from 37 percent in FY18–19 to 39 percent in FY20–21. Total average activity utilization for mental health technicians increased by 18 percent over the same period, while utilization for recovery assistant fell by approximately 4 percent between FY18–19 and FY20–21.

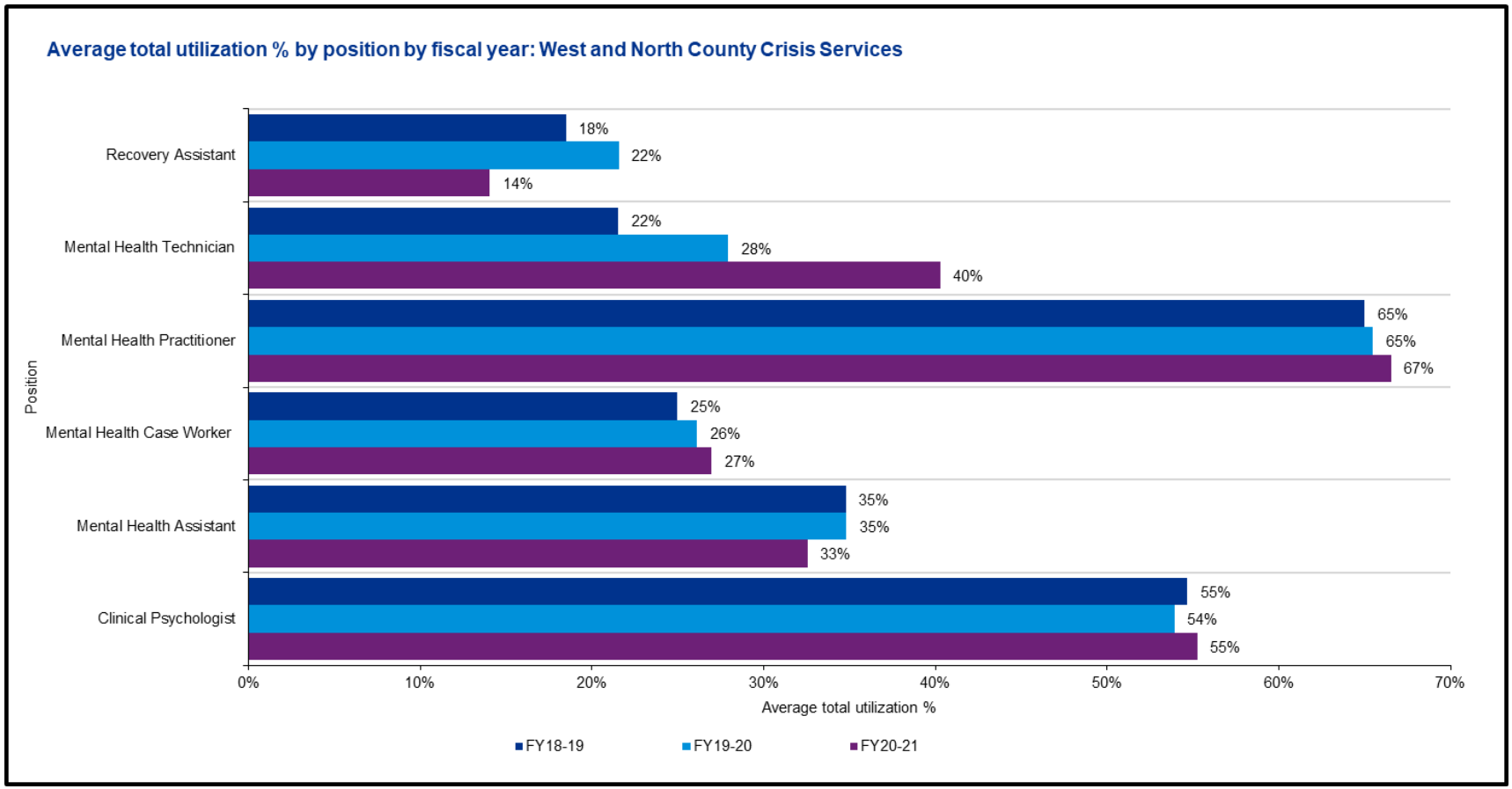


Figure 78: Source KPMG analysis of utilization

In FY20–21, the caseworker position within Forensic Services had average total activity utilization of 18 percent, while the mental health technician had an average utilization of 1 percent.

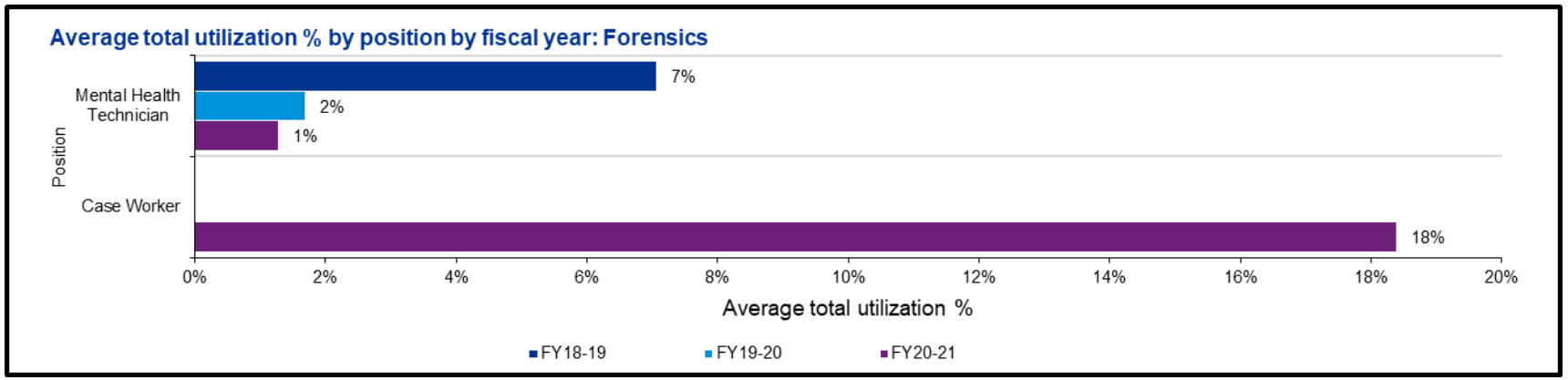


Figure 79: Source KPMG analysis of utilization

Between FY18–19 and FY20–21, average total activity utilization increased by 19 percent for mental health case workers from 41 percent to 60 percent.

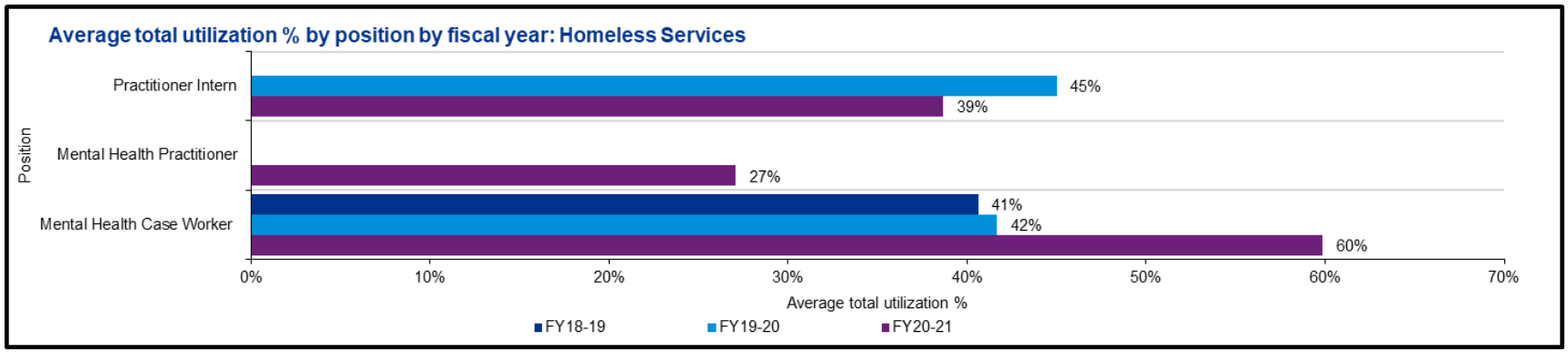


Figure 80: Source KPMG analysis of utilization

Between FY18–19 and FY20–21, average total activity utilization for the Justice Alliance program has fallen by 6.5 percent from 45.5 percent to 38 percent with average utilization for mental health technicians falling by 24 percent between FY19–20 and FY20-21 alone.

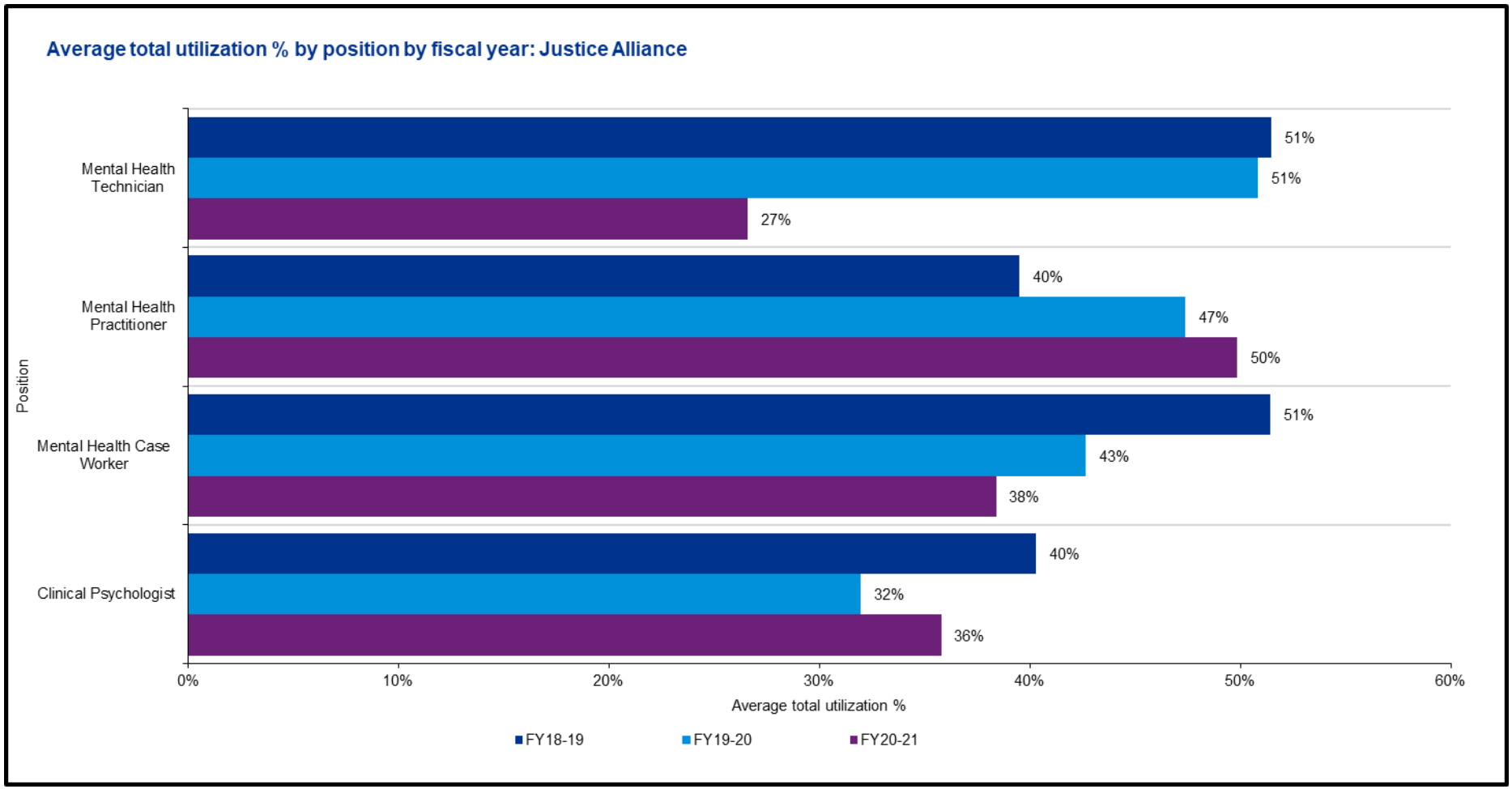


Figure 81: Source KPMG analysis of utilization

In FY20–21, psychiatrists within Juvenile Justice Mental Health Services accounted for the highest average total activity utilization at 73 percent, followed by mental health practitioners at 54 percent.

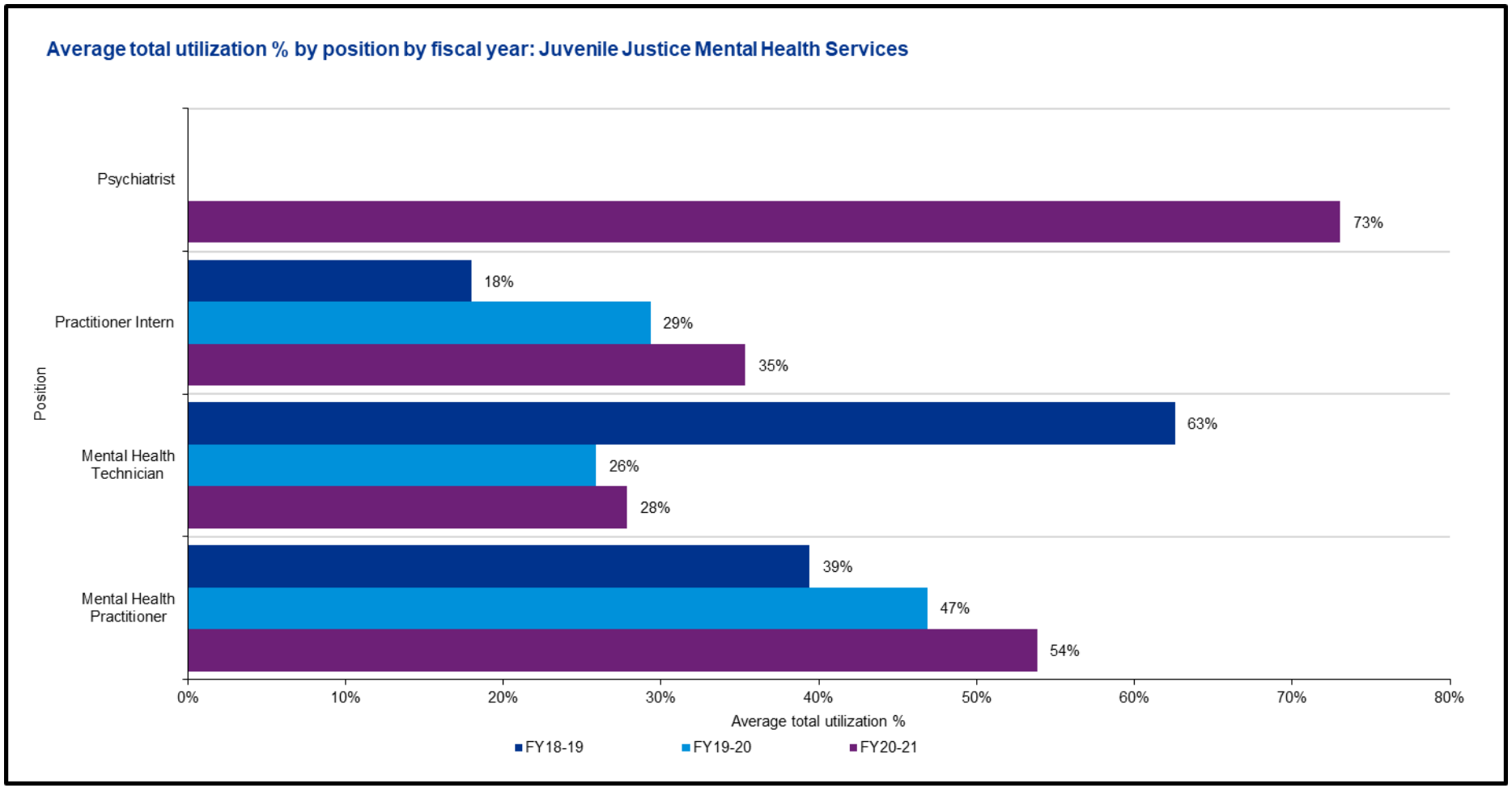


Figure 82: Source KPMG analysis of utilization

Instances between two adjacent pay periods in 2021 where there is a significant drop in utilization

The below charts illustrate instances between two adjacent pay periods in 2021 where there is a significant drop in utilization for the following positions: clinical psychologists, mental health practitioners and psychiatrists. As discussed in recommendation 3.1, weekly utilization discussions, drawing on data such as that depicted in the tables below, would allow a supervisor to work with their staff to understand dips in utilization between periods and maximize productivity.

For clinical psychologists, a greater than 7 percent drop in either total activity utilization or client services utilization is observed in pay periods 2–3, 5–6, 12–14, 16–17, 19–20, and 25–26. For mental health practitioners, a greater than 6 percent drop in either total activity utilization or client services utilization is observed in pay periods 13–15, 17–18, 20–21, and 25–26. For psychiatrists a greater than 10 percent drop in either total activity utilization or client services utilization is observed in pay periods 8–10, 13–14, and 18–22.

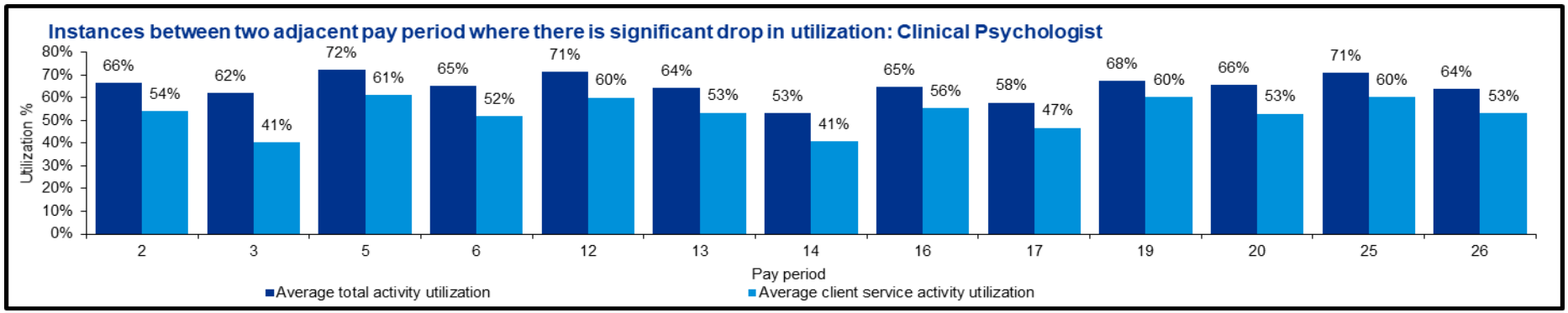


Figure 83: Source KPMG analysis of utilization

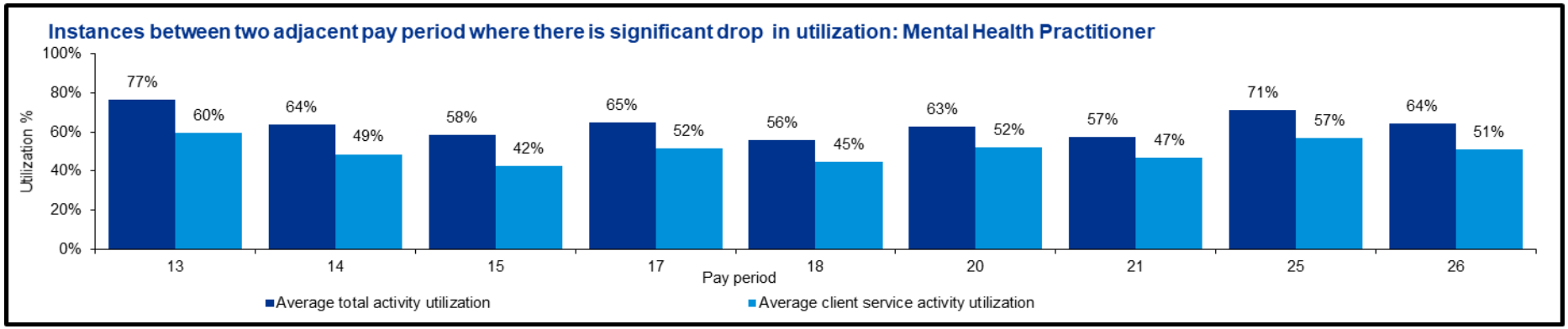


Figure 84: Source KPMG analysis of utilization

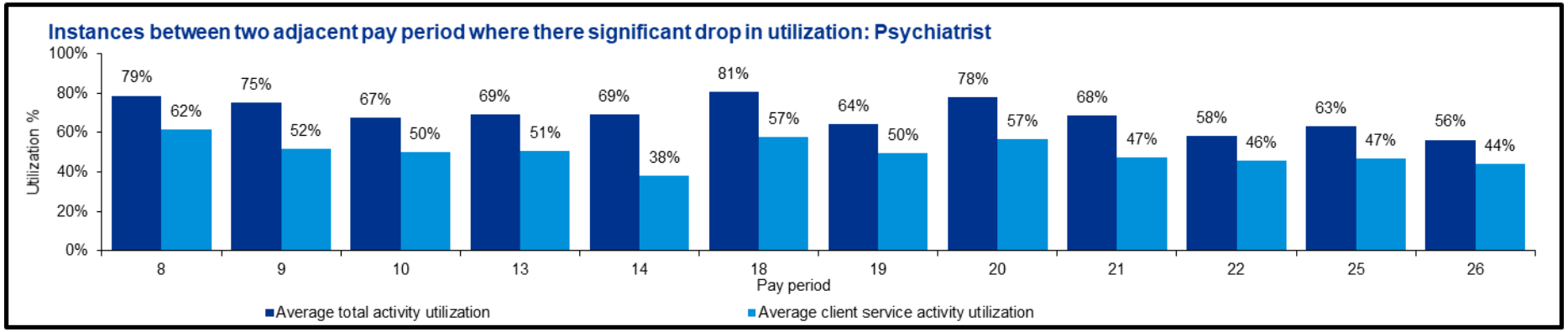


Figure 85: Source KPMG analysis of utilization

Unaccounted time

Presently, there are certain activities performed by staff—for example, those related to administrative tasks, managing social security checks, responding to emails, researching diagnosis, and best practices for treatment—that are not considered direct services and are not coded in either the EHR system or the timecard system. This results in unreported "unaccounted time". Unaccounted time was calculating as follows based on Department feedback:

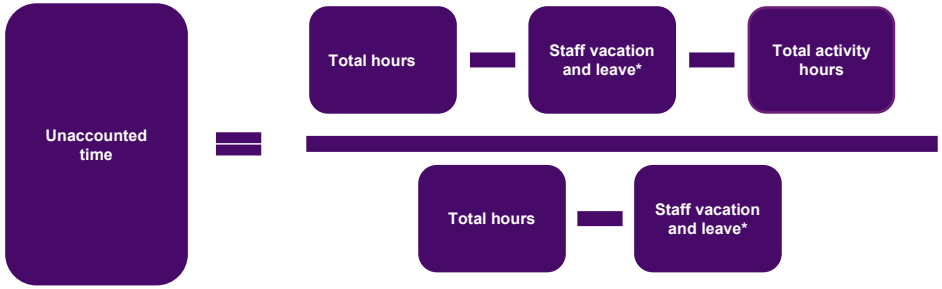


Figure 86: Source KPMG analysis of unaccounted time

Average percentage unaccounted time by position per fiscal year

The below charts illustrate the average percentage unaccounted time by position per fiscal year from FY18–19 to FY20–21. During that period supervisor and administrative staff accounted for the highest percentage unaccounted time at between 73 percent and 95 percent. Staff tasked with providing direct client services such as psychiatrists, psychologists, and rehabilitation specialists, typically had a much lower percentage of unaccounted time at between 30 and 40 percent over the same period, as illustrated in the below charts. However, there is a significant opportunity to reduce this unaccounted time, particularly for those staff involved in the provision of direct client service as discussed in recommendation 3.2 and illustrated further in Appendix I.

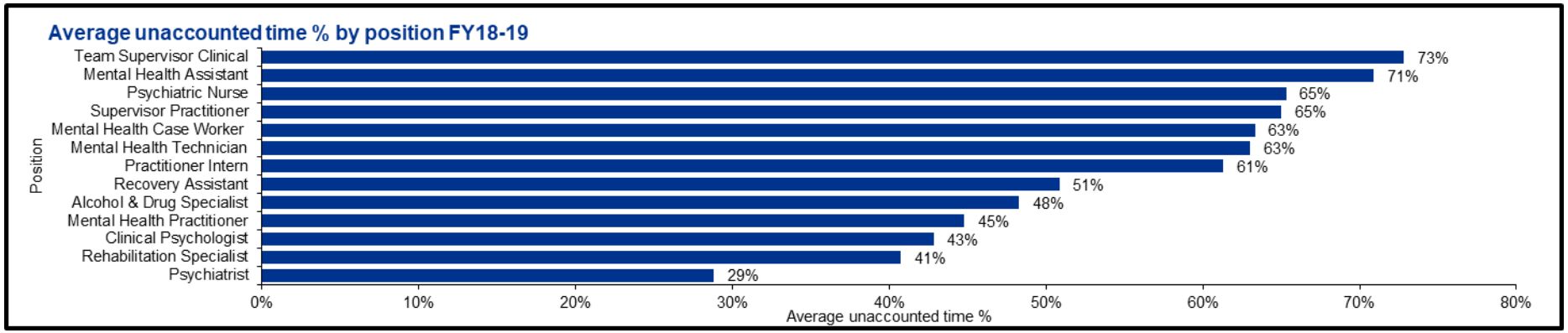


Figure 87: Source KPMG analysis of unaccounted time

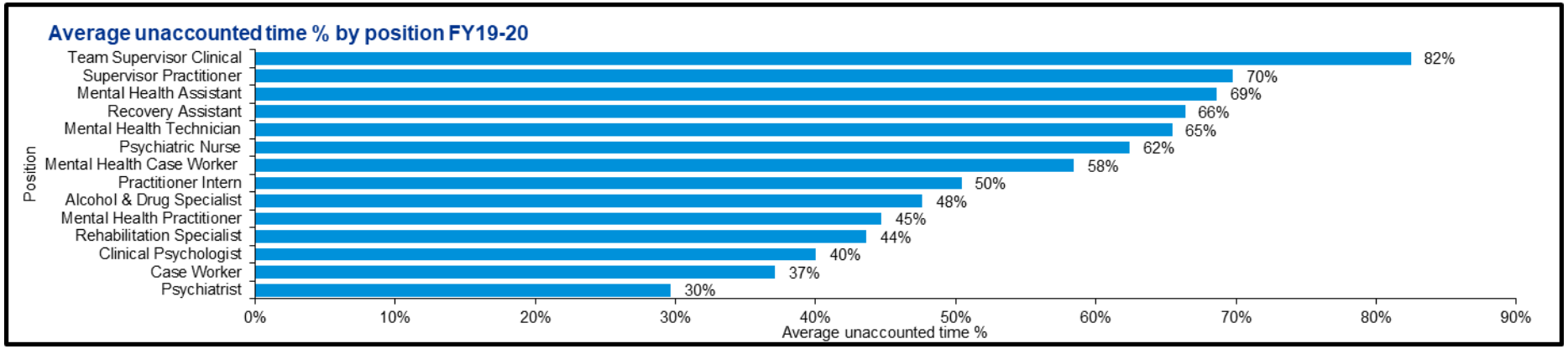


Figure 88: Source KPMG analysis of unaccounted time

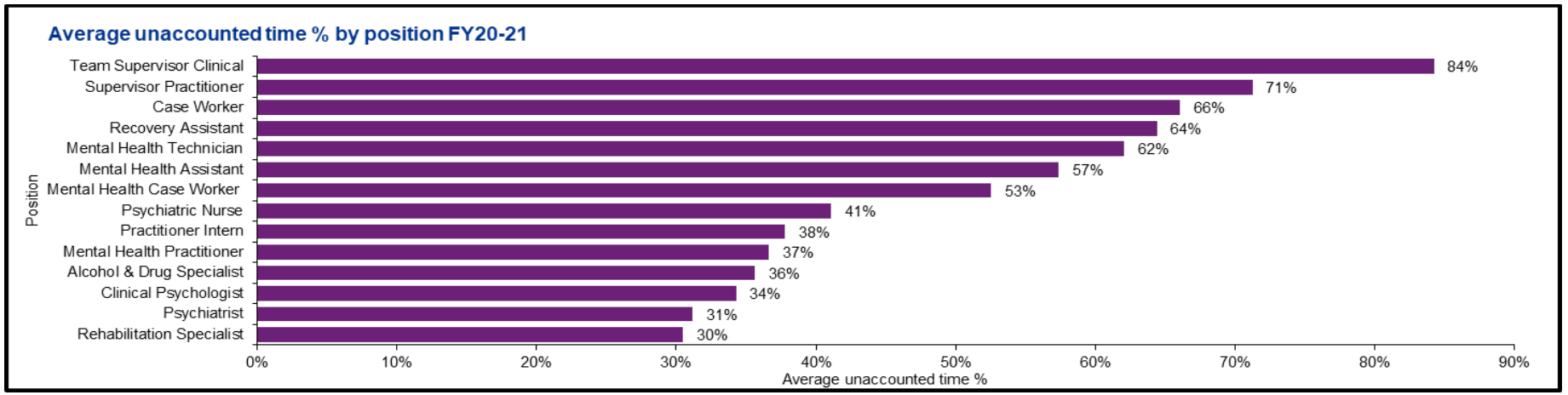


Figure 89: Source KPMG analysis of unaccounted time

Appendix I: Unaccounted Time Cost

The following table provides a summary of the cost of unaccounted by position for FY18–19, FY19–20 and FY20–21. The cost of unaccounted time was calculated as follows:

1. Unaccounted hours were identified based on utilization data provided by the Department.
2. Hours per FTE per annum was calculated using the assumption that 1 FTE works 41.5 weeks per year, allowing for 11.5 weeks of vacation, sick or other leave in line with the Department's average productive hours based on FIN data provided by the Department.
3. Median salary was calculated for each position category based on publicly available information. Please refer to the position mappings table on the following page which outlines how job titles were grouped into position categories.
4. An FTE equivalent for unaccounted time was calculated by dividing unaccounted hours by hours per FTE per annum. This was multiplied by median salary to determine cost.

			Unaccounted hours			FTE equivalent			Cost		
Position	Median Salary Annual	*Hours per FTE p.a.	FY 18-19	FY 19-20	FY 20-21	FY 18-19	FY 19-20	FY 20-21	FY 18-19	FY 19-20	FY 20-21
Psychiatrist	$260,346	1,660	1,411	1,685	2,822	0.8	1.0	1.7	$221,278	$264,217	$442,554
Mental Health Case Worker	$66,600	1,660	29,204	30,021	33,175	17.6	18.1	20.0	$1,171,670	$1,204,471	$1,331,005
Mental Health Practitioner	$81,738	1,660	19,557	22,219	20,665	11.8	13.4	12.4	$963,002	$1,094,043	$1,017,529
Mental Health Technician	$65,862	1,660	8,961	9,591	9,329	5.4	5.8	5.6	$355,516	$380,529	$370,131
Mental Health Assistant	$51,054	1,660	5,020	9,719	12,641	3.0	5.9	7.6	$154,393	$298,924	$388,793
Practitioner Intern	$67,302	1,660	7,136	8,906	9,750	4.3	5.4	5.9	$289,305	$361,075	$395,282
Supervisor Practitioner	$88,992	1,660	2,286	2,458	4,349	1.4	1.5	2.6	$122,534	$131,772	$233,127
Clinical Psychologist	$97,188	1,660	2,453	2,699	2,623	1.5	1.6	1.6	$143,588	$158,013	$153,556
Rehabilitation Specialist	$74,928	1,660	2,172	2,239	1,693	1.3	1.3	1.0	$98,028	$101,054	$76,412
Psychiatric Nurse	$93,942	1,660	1,660	1,739	1,597	1.0	1.0	1.0	$93,923	$98,401	$90,374
Recovery Assistant	$41,184	1,660	683	1,815	2,218	0.4	1.1	1.3	$16,935	$45,030	$55,017
Team Supervisor Clinical	$108,600	1,660	1,313	1,432	1,557	0.8	0.9	0.9	$85,914	$93,670	$101,830
Alcohol & Drug Specialist	$65,916	1,660	977	1,650	1,218	0.6	1.0	0.7	$38,807	$65,532	$48,368
Case Worker	$55,554	1,660	-	133	543	-	0.1	0.3	$0	$4,441	$18,175
Total	**$1,219,206**		**82,831**	**96,305**	**104,178**	**49.9**	**58.0**	**62.8**	**$3,754,893**	**$4,301,174**	**$4,722,154**

Figure 90: Source KPMG

Position Mappings

The following table identifies the position category to which certain job titles were mapped as well as the job class utilized to identified salary per the County's salary table report.

Job title	Position category	Annual minimum salary	Annual maximum salary	Annual median salary	Annual median salary per position	Job class title used from salary table report
ALCOHOL & DRUG PROG SPEC	Alcohol & Drug Specialist	$65,148	$78,108	$71,628	$65,916	ALCOHOL & DRUG SERVICE SPEC
EXH ALCOHOL & DRUG SERVICE SPEC		$54,216	$66,192	$60,204		ALCOHOL & DRUG SERVICE SPEC - EXH
EXH ADMHS CASE WORKER	Case Worker	$50,028	$61,080	$55,554	$55,554	ADMHS CASE WORKER - EXH
CLIN PSYCHOLOGIST II	Clinical Psychologist	$92,244	$111,180	$101,712	$97,188	CLIN PSYCHOLOGIST II
CLIN PSYCHOLOGIST I		$84,096	$101,232	$92,664		CLIN PSYCHOLOGIST I
MENTAL HEALTH ASSIST	Mental Health Assistant	$46,620	$55,488	$51,054	$51,054	ADMHS RECOVERY ASSISTANT
MENTAL HEALTH CASE WORKER	Mental Health Case Worker	$60,624	$72,576	$66,600	$66,600	ADMHS CASE WORKER
MH PRACTITIONER I	Mental Health Practitioner	$72,732	$87,360	$80,046	$81,738	ADMHS PRACTITIONER I
MH PRACTITIONER II		$75,780	$91,080	$83,430		ADMHS PRACTITIONER II
MENTAL HEALTH TECH I	Mental Health Technician	$56,892	$68,028	$62,460	$65,862	ADMHS PSYCHIATRIC TECH I
MENTAL HEALTH TECH II		$63,024	$75,504	$69,264		ADMHS PSYCHIATRIC TECH II
EXH ADMHS PRACTITIONER INTERN	Practitioner Intern	$55,416	$67,656	$61,536	$67,302	ADMHS PRACTITIONER INTERN - EXH
MH PRACTITIONER INTERN		$66,444	$79,692	$73,068		ADMHS PRACTITIONER INTERN
PSYCHIATRIC NURSE I	Psychiatric Nurse	$83,280	$100,248	$91,764	$93,942	PSYCHIATRIC NURSE I
PSYCHIATRIC NURSE II		$87,204	$105,036	$96,120		PSYCHIATRIC NURSE II
Psychiatrist II Board Certified	Psychiatrist	$234,360	$286,332	$260,346	$260,346	PSYCHIATRIST II
PSYCHIATRIST II		$234,360	$286,332	$260,346		PSYCHIATRIST II
EXH ADMHS RECOVERY ASSISTANT	Recovery Assistant	$37,092	$45,276	$41,184	$41,184	ADMHS RECOVERY ASSISTANT - EXH
MENTAL HEALTH REHAB SPEC	Rehabilitation Specialist	$68,124	$81,732	$74,928	$74,928	ADMHS REHABILITATION SPEC
MH TEAM SUPV-PRACTITIONER	Supervisor Practitioner	$80,784	$97,200	$88,992	$88,992	ADMHS TEAM SUPV-PRACTITIONER
MHTEAM SUPV-CLIN PSYCH	Team Supervisor Clinical	$98,448	$118,752	$108,600	$108,600	ADMHS TEAM SUPV-CLIN PSYCH

Figure 91: Source KPMG

Appendix J: Implementing team-based care

The following steps should be undertaken in implementing a team-based care model:

Step 1: Establish a multidisciplinary care team, which may include nurses, recovery assistants, clinicians, pharmacists, community health workers, therapists, social workers, case managers, nutritionists, administrators, and information technology staff members. Management should also define the identity of the care team and emphasize that identity with patients. This will ensure the patient knows he or she is being treated by a team.

Optimizing the care team is also critical to maximizing the supply of the care setting and improving the daily flow of work. The specific mix of staff (number of clinicians, nurses, assistants, technicians, clerks, etc.) determines the extent and type of work that can be driven away from the nurses (the constraint). The care team composition emerges from a discussion of how the facility decides to balance its supply and demand. The facility has to understand the types of services it provides and then decide who should be involved in the work and how the work should be divided among the care team. This approach begins with demand and adjusts supply to meet the demand. This is different from an approach that sets an arbitrary care team mix and then tries to fit the demand into the supply. For example, if nurses are freed from tasks traditionally assigned to them but for which their skills are not necessary, they can have more time to do the work they find more challenging and satisfying as professionals and that is ultimately more important to patients.

Step 2: Define the roles of different care team members to help ensure that each team member is clear on his or her responsibility in providing patient-centered care. Management should also consider tasks that can potentially be reassigned to other team members and whether those team members will require additional training to complete such tasks. Arranging close supervision, mentoring, and support following training will also help ensure staff excel in completing such tasks.

Furthermore, the role patients and their family caregivers play as members of the care team should be considered. Using shared decision-making and patient education, clinicians can integrate patients into treatment decisions. This will tap the patient as the expert on his or her own care and lifestyle preferences that must be considered before ordering certain therapies.

The table on the following page may assist with identifying the best approach to implementing a team-based care strategy taking account of current staff capacity[14]:

[14] (http://www.ihi.org/resources/Pages/Tools/SelfManagementToolkitforClinicians.aspx, accessed October 17, 2017)

A. Task	B. Who does it now?	C. In a perfect world, who would do it?	D. Does this person need additional training to complete this task?	E. If answer to D is yes, then what kind of training is best (training to role or as a team)?
Take patient history				
Diagnosis				
Regular evaluation for secondary causes				
Highly complex patients				
Identify barriers				
Perform lifestyle counseling				
Refill medications				
Adjust medications				
Refer or discharge patient				
Data entry				

Figure 92: Source KPMG

Step 3: Design workflows to reflect the new model of care. Clinical workflows refer to patterns of activities undertaken by healthcare professionals that are enabled by a systematic organization of resources. Workflows can be designed for an entire clinical process (including preadmission, admission, and discharge), or for individual tasks such as dispensing and administering medicine, completing charts, and providing therapy, for example. As a starting point, facilities can look to existing standard work and adapt existing workflows based on position roles and responsibilities or cocreate new ones. The process of developing a workflow should include:

- Creating a workflow diagram with specific tasks and responsibilities associated with each step in the patient journey
- Bringing the team together to discuss the workflow and validating which role is most appropriate for each duty.

Step 4: Increase communication among the team, practice, and patients. Effective communication is key to helping ensure the successful implementation of team-based care. Examples of communication tactics that can be adopted include:

- Scheduling regular team meetings to discuss patient cases and issues, so that the team can work together to solve problems
- Facilitating regular dialogue between staff about how to improve tasks in order to increase service efficiency and quality
- Communicating the team's work to patients to integrate patients into treatment decisions.

Management should also create processes for sharing both written and verbal information about the patient, ensuring that each care team member has all of the data needed to make informed care decisions. Effective team communication can help ensure better care outcomes thus leading to a better patient experience.

Step 5: Use a gradual approach to implement the model. Management should encourage and instill commitment to the model. Staff commitment is of key importance as it may take several months for the team to adapt to the model. Based on leading practice research, the model can take 2–3 months to fully implement. However, as the model expands, experienced staff can mentor or assist with training new staff.

Step 6: Optimize the care model. The facility should seek to continually optimize the care model. This can be done by cross-training staff, using standard protocols, and using huddles to improve communication. Performance measures should also be developed and adopted to measure, track, and influence team effectiveness. Examples of such measures include but are not limited to average length of patient stay and average cost of service per patient.

Outcomes

Leading practice research suggests that team-based care has a number of successful outcomes:[15]

- **Enhanced patient experience:** Patients who think their care team works well together tend to report better experiences and feel safer. Experts from patient experience and healthcare consultant Press Ganey report that patients perceive their care as higher quality when they perceive their providers as all working well together.
- **Increased staff morale:** Some evidence indicates that team-based care makes providers happier or less stressed, which in turn can result in better relationships with patients and potentially lower rates of physician burnout. Although evidence is currently limited, researchers at NAM say team-based care may be one key solution to physician burnout.
- **Patient quality of care:** Reducing physician burnout can improve the quality of care patients receive because their physicians will be less tired, more attuned to patient needs, and able to create better relationships with patients.

[15] WHO-NMH-NVI-18.4-eng.pdf;jsessionid=011387AD090CE7005A4DFD00D711D15E

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