KPMG

Santa Barbara County: Crisis Services Review

September 19, 2023

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Project Scope:

Santa Barbara Behavioral Wellness (BWell) engaged KPMG from July to September 2023 to conduct an assessment of the County's crisis services operating model including strategy, program delivery operations and performance, program costs, and resource alignment.

Project Objective:

The purpose of this review is to identify opportunities to enhance workflows and levels of service, potential overlap/duplication in service offerings between the various crisis services offered and recommend evidence-based practices.

Project Methodology:

As part of this task, KPMG performed the following key activities:

- Reviewed current operations to identify opportunities for improvement within operational processes, workflows, and procedures.
- Conducted interviews with key stakeholders including County staff, community hospital partners, Law Enforcement, individuals with lived experiences, and recipients of the services in order to inform current state.
- Facilitated onsite workshops to develop flow maps for the flow of Crisis Services clients from (1) the Access Line to crisis teams, (2) from the jails into the crisis system, (3) from the County Hospital Emergency Departments into hospital beds/placements via the crisis teams; and (4) to and from youth crisis service.
- Developed key data points and data collection methodology in order to conduct data analysis over a four-week period.
- Researched new Mobile Crisis Medi-cal Benefits guidelines against current practice and the impact new guidelines will have on mobile crisis operations.
- Provided opportunities for consideration that would redesign staffing structure/teams to better align with new guidelines, optimize human resources, address stakeholder feedback and align with evidence-based practices.
- Recommended priorities and phasing of improvements for the department to consider.

Overview of Santa Barbara County Crisis Services

Santa Barbara County's Crisis Services provides crisis response for clients across the County. The program is comprised of Mobile Crisis teams, Crisis Clinics, and Co-response teams. The County also contracts with Casa Pacifica to provide Youth Crisis Services through Safe Alternatives for Treating Youth (SAFTY). In addition, the County has a designated Access Line where individuals can reach out to access crisis care or coordination of services. Each teams function is outlined below.

	Mobile Crisis	SAFTY	Co-Response	Crisis Clinic	Access
Overview	Response to individuals experiencing crisis. Engaged by Law Enforcement, hospitals, jails and the community.	Response to individuals under the age of 20 experiencing crisis. Engaged by Law Enforcement, hospitals and the community.	Response to active behavioral health crises in the community. Primarily engaged by other Law Enforcement.	Support individuals in crisis that require urgent level of care. Referrals are conducted by any professional or Citizen in need.	Responds to incoming calls from individuals seeking mental health and/or addiction services.
Team Composition	Behavioral health clinicians and case managers	Behavioral health clinicians	Non-uniformed sheriff or police deputy and BWell behavioral health clinicians.	Behavioral health clinicians, prescribers, peer support and case managers	Master level behavioral health clinicians
Population	Ages 20+, however all ages when SAFTY is unavailable	Ages 20 and under	All ages	Ages 18+	All ages
Location	Hospitals/emergency departments, jails, office/telephone & community	Hospitals/emergency departments, office/telephone and community	Community based/telephone	Office based/telephone	Office based/telephone
Number of Teams	Three Teams: One team per region across North, South, and West County.	One Team with staff located across two office: one in Santa Maria and another in Lompoc	Two Teams operated in collaboration with the Sheriff Two Teams operated in collaboration with Santa Maria (SMPD) and Santa Barbara Police Departments (SBPD)	Three Teams: One team per region across North, South, and West County. Prescribers are shared across regions.	One team that services the entire County.
Hours of Operation	24/7/365	Monday to Sunday, 8 AM to 8 PM	Hours: 8 AM to 6 PM South: Mon-Sun, Sherriff/SBPD North: Mon-Thurs, Sherriff/ SMPD West: Tues-Fri, Sheriff	Monday to Friday, 8 AM to 6 PM	Monday to Friday 8 AM to 5 PM
Services Offered	Assessments, 5150/5585 evaluations,, de-escalation and safety planning, referrals, Lanterman-Petris-Short Act (LPS) placement, follow ups	Assessments, 5150/5585 evaluations, safety planning, information sharing, referrals, and coordination of care, crisis hotline service	Assessments, 5150/5585 evaluations, information sharing, de-escalation and safety planning, referrals, follow ups and coordination of care	Intake, assessments, case management, peer support, rehabilitation counseling, medication support, and linkage to longer-term care	State directed standardized screening tools, information sharing, triage and referrals

Crisis Services Commendations

1

Operation of Crisis Clinics
The Department's commitment to operating walk-in crisis clinics across each of the three regions of Santa Barbara County (North, South, and West) aligns with leading practice. Studies show that this model has demonstrated a decrease of emergency department visits, psychiatric in patient admissions, and decrease in justice involvement. It also elevates pressure on other behavioral health systems as some clients stabilize once rapid crisis services are received.

2

Establishment of Co-response
The establishment of co-response teams across the County in collaboration with both the Sheriff and the Police Departments is a leading practice for supporting individuals in crisis. Furthermore, across stakeholder engagements, stakeholders consistently commended the co-response teams for their responsiveness and service delivery in providing care to vulnerable clients.

3

Utilization of Peer Support
Crisis clinics teams include recovery assistants who are designated peer support for individuals experiencing mental health crisis. The utilization of peer support across crisis services is viewed as a key leading practice and has been proven to have a transformative effect on both individuals and systems*.

4

Commitment to Innovation:
Ahead of the implementation of the Medi-Cal Crisis Services Benefit, the Department is in the process of developing a detailed implementation plan and have already begun making a number of changes to Department operations, including the reorganization of staffing structure across crisis services.

5

Mobile Crisis and Crisis Services Response Times
Based on an analysis of available data, both mobile crisis and co-response have call response times of less than 30 minutes (21 and 18 minutes respectively). This is well below the 60 minute target in urban areas and 120 minute target in rural areas which will be required following the implementation of the Medi-Cal Crisis Benefit.

6

Deep Commitment to Client Service Delivery
Across interviews, it was clear that staff across crisis services teams have a strong commitment to providing critical mental health services to high-needs and vulnerable members of the community across Santa Barbara County.

* https://www.mhanational.org/peer-support-research-and-reports#:~:text=Peer%20support%20empowers%20people%20to, settings%20and%20stages%20of%20recovery.

Crisis Services Stakeholder Engagement Key Insights

As required by the scope of work, KPMG conducted a number of interviews with community partners to obtain feedback on experience in engaging crisis services. These interviews included:

- **Seven roundtables** with stakeholders across Law Enforcement, Hospital Emergency Departments, NAMI, Jail Mental Health, Public Defender, and individuals and their families who have had direct experience with crisis services. Roundtables were **attended by 23 individuals** who provided key insights into experience in collaborating, engaging, and/or accessing crisis services. Key insights were considered in the development of opportunities for consideration for Crisis Services. A high-level overview of the key themes identified during this stakeholder engagement outlined in the table below.

Access to Services	• There is an opportunity for greater consistency and standardization for service access. Response to requests should not be based on an individual clinician's perspective but rather on the Department's Crisis Service mission. • There is an opportunity for the Access Line to enhance collaboration with professionals referring clients, which should include collecting information based on their involvement. • Crisis Clinic marketing and advertising should be enhanced, especially as it relates to availability of Prescribers. • The lack of Crisis Stabilization beds and Psychiatric beds is significantly impacting access to appropriate levels of care, leaving clients in the Emergency Departments for prolonged periods.
Roles and Responsibilities	There is an opportunity for Department leadership to formalize roles and responsibilities for Crisis Services staff. This should include expectations surrounding client engagement, response time, documentation, and handover to others services.
Target Population Served:	For mobile crisis and co-response teams, there is a lack of clarity on the target population of each team and whether they are truly serving the population in most need of their specific service. For example: • All stakeholder groups indicated that a mobile crisis response is based on an individual clinician's perspective. Declining to engage with a client they do not believe meets criteria, leaves those reaching out with limited to no service. • A consumer in active drug use should not be disqualified from being eligible for Crisis Services. This may require development and training by the Department for all crisis staff in recognizing co-occurring disorders.
Outcome Measures	Co-Response team outcome measures require clear definition and calculation that is agreed upon by Law Enforcement and BWell. Metrics should include the evaluation of the partnership and effectiveness of the model.
Limited Authority to Issue a Hold	Law Enforcement, NAMI, and Emergency Departments outlined the limitation of only BWell and SAFTY being able to issue a 5150/5585, given in other parts of the State and Country, Law Enforcement and hospital personnel can issue holds.

Summary Key Takeaways

The following two pages summarize the key data points identified following detailed analysis undertaken during this review. It is important to note that a large number of data integrity issues were identified during analysis and they have been outlined in further detail in the performance analysis section of this report. A detailed regional analysis of each program has been included in the Appendix to this report.

Productivity Data (Q3 FY21-22 – Q3 FY22-23)	Mobile Crisis North County Average Quarterly Productivity	Mobile Crisis South County Average Quarterly Productivity	Mobile Crisis West County Average Quarterly Productivity	Co-response North & West County Average Quarterly Productivity	Co-response South County Average Quarterly Productivity	Crisis Clinics North County Average Quarterly Productivity	Crisis Clinics South County Average Quarterly Productivity	Crisis Clinics West County Average Quarterly Productivity
	27%	12%	24%	23%	20%	33%	24%	11%

Mobile Crisis (Aug 7 2023 – Sep 3 2023)	Total Mobile Crisis FTES*	Average Weekly/Daily Call Volume per Team	Busiest Day of the Week/Time of Day	Most common Service Location	% Face- to Face Contact	Average Response Time	Average Time Spent of Call
	17	16/2	Sat/8am-9am	ER(50%)	87%	21 mins	98 mins

Co-response (Aug 7 2023 – Sep 3 2023)	Total Mobile Crisis FTES*	Average Weekly/Daily Call Volume per Team	Busiest Day of the Week/Time of Day	Most common Service Location	Average % Face-to Face Contact	Average Response Time	Average Time Spent of Call
	5	5/1	Wed, Thurs/11am – 12pm	Community (53%)	86%	15 mins	77 mins

Crisis Clinics (Aug 7 2023 – Sep 3 2023)	Total Crisis Clinic FTES*	Total Crisis Clinic Prescriber FTE	Average Weekly Service Interaction Volume	Average Daily Service Interactions	Average Daily Prescriber Service Interactions	Average No Show Rate/Cancellation Rate	Average Service Minutes
	16	1.25	55	11	2	6%/1%	27 minutes

*FTEs were identified based on staffing charts provided by the Department. However, Division leadership notes that in many cases, staff work across a variety of programs including Crisis Services (i.e. Mobile Crisis, Co-response, Crisis Clinics). Therefore, FTE numbers may vary based on demand at any specific time.

Summary Key Takeaways

Youth Crisis Services (SAFTY) (FY21-23)	Number of FTEs funded	Annual Average Call Volume	Average Call volume per month	Average Call Volume per 12-hr. shift ex. Bed Search*	Average Bed Search Call 12-hr. shift	Percentage Calls considered Crisis	Percentage Face-to-Face Contacts
	8.5	2,118	177	5	1	26%	27%
Access Line (FY20-22)	Number of FTEs funded	Annual Average Incoming and Outgoing Calls	Annual Average Incoming Calls Answered and Outgoing Calls	Average Call Received/Answered per day*	Average Call Received/Answered per hour	Min-Max Talk Time (FY20-22)	Min-Max Call Handling Time (FY20-22)
	5.5 FTEs	18,346	17,256	71/66	8/7	4 secs – 1 hr. 22 mins	30 secs – 4.5 hrs.

Protocall (FY20-22)	Annual Average Call Volume (FY21-23)	Average Call volume per month (FY21-23)	Average Call Volume per day (FY21-23)	Average Call Volume per hour (Apr – Jun 2023)/ (FY21-23)	Busiest Month of Day of Week (Apr – Jun 2023)	Time Period with Lowest Volume Apr – Jun 2023)
	7,095	592	19	1.2 – 1.4	Monday	1 0 pm– 7am

Current State versus Future State

Current State

Team	SAFTY	Mobile Crisis	Co-response	Crisis Clinic	Access	Protocall	Total Crisis Services Current FTEs
No. of Teams	2	3	4	3	1	1	53.25 * ex management, supervisory and admin staff
FTE Count	8.5	17	5	17.25	5.5	*After hours contract service	
Hours of Operation	8 am – 8pm daily	24/7/365	8am – 6pm*	8am – 6pm (Mon – Fri)	8am – 5pm (Mon – Fri)	5 pm – 8am (Mon – Fri) and 24/7 during weekends	

The County's Crisis Services Program is managed by 1 FTE Division Chief, 1 FTE Manager, and 3 FTE supervisors and supported by 3 administrative FTEs

Proposed Future State System Redesign for Consideration

Future State

Team	SAFTY and Mobile Crisis	Crisis Team	Co-response	Crisis Clinic	Access and Protocall	Total Crisis Services Future FTEs
Model Redesign	Respond to community calls only (i.e. excluding Jails and Eds, and other Medi-Cal restricted settings)	Stationed in ED/Jail and collaborate with hospital/jail staff and boarder crisis services teams to provide support to clients in these settings	No change to current model	No change to current multidisciplinary team model as this models leading practice; however greater utilization can be achieved through marketing*	Collapse Access and Protocall to create a 24/7/365 line to include calls for all ages seeking information and services. Create a separate dedicated Crisis Line that operates 24/7/365, and answered by dedicated personnel.	47.35 * ex management, supervisory, and admin staff It is important to note that based on the proposed future state system redesign will require the Department to redirect 5.9 FTE to other areas of need within BWell.
No. of Teams	1	2	4	3	1	
FTE Count	8.4 (2 staff per shift)	8.4 (4.2 per jail/ED)	5	17.25	5.5 + 2.8 (8.3 FTE)	
Hours of Operation	24/7/365	24/7/365	8am – 6pm*	8am – 6pm (Mon – Fri)	24/7/365	

Opportunities for Consideration

The following pages will provide an overview of opportunities for consideration that BWell may consider for a more efficient and effective crisis operational service for County residents.

Opportunity Areas	#	Opportunity Overview	Decision to Move Forward (Y, N)	Timeline (Short, Medium, Long)
Co-response	1.1	Establish joint metrics and targets with clear definitions, calculations, inclusionary and exclusionary criteria, and sources to extrapolate data from. Display outcomes on a joint dashboard that is reviewed on a weekly and monthly basis. ▪ Develop a Minimum dataset (MDS) ▪ Develop a shared dashboard of agreed upon performance metrics across departments ▪ Establish joint weekly meetings between BWell and Law Enforcement middle management ▪ Establish monthly meetings between BWell and Law Enforcement senior management (or add to already established agenda) ▪ Develop clear expectations for co-response teams including physical location, hours of operation, community engagement, technology advancement, documentation, as well as a roster of staff to provide coverage for co-response team members	Y	Short
Mobile Crisis	2.1	Revamp Mobile Crisis Services to align with the new Medi-Cal Crisis Benefits requirement, while establishing crisis worker roles in high referral volume areas, such as emergency departments and jails. ▪ Consider the feasibility of developing one mobile crisis team ▪ Establish Crisis Team structure ▪ Establish training and safety protocols ▪ Establish and station a crisis worker role in the emergency departments ▪ Establish a crisis worker role in the jails ▪ Engage with clients while in the Emergency Department ▪ Expand Access Line to include a new Mobile Crisis Line ▪ Establish roles and responsibilities for the new Mobile Crisis Team	Y	Short

Opportunities for Consideration

Opportunity Areas	#	Opportunity Overview	Decision to Move Forward (Y, N)	Timeline (Short, Medium, Long)
Crisis Clinics	3.1	Optimize Crisis Clinic capacity and capabilities through an effective marketing and communication plan developed by BWell and issued among key stakeholders. Shifting the model of care to be more fluid based on client need and engagement. ▪ Develop a marketing strategy and communicate crisis clinic capabilities ▪ Shift crisis clinic staffing structure from office based to field based ▪ Provide availability for same day or next day appointments for all referrals ▪ Establish a round table among key stakeholders ▪ Establish targets *(Direct therapeutic interactions)* in line with Ambulatory Services ▪ Establish average length of service for crisis clinic and transition planning for ongoing treatment ▪ Establish metrics and develop dashboards to be shared with front line staff and management	Y	Medium
Youth Services	4.1	Recognizing the requirements for the new Medi-Cal Crisis Benefit, in order to have the team financially sustainable, consider merging youth crisis services with adult crisis services to create a central team that services the County. ▪ Consider creating a single mobile crisis team that services all age groups across the County	Y	Medium
Access Line	5.1	Enhance Access Line features to include a designated Crisis Line that operates 24/7/365 for Child, Adolescents, Adults, and Older Adults. ▪ Consider designating a specific line within the Access Line to Crisis Services	This opportunity will be revisited for feasibility in the future, following the implementation of opportunities 1.1 through 4.1.	

Opportunities for Consideration

Opportunity Areas	#	Opportunity Overview	Decision to Move Forward (Y, N)	Timeline (Short, Medium, Long)
Cross-programmatic opportunities	6.1	Collaborate with Law Enforcement and establish a triage protocol that outlines which crisis team is most suited to attend crisis calls within the community. Develop triage protocol documentation and conduct County wide education with key stakeholders. ▪ Triage crisis calls to determine mobile crisis versus co-response teams	Y	Short
	6.1 a	Establish a Safety Protocol for the Mobile Crisis Team that aligns with the new Medi-Cal Crisis Benefit requirements	Y	Short
	7.1	Implement standardized documentation for mobile crisis teams as issued by DHCS. Develop standardized documentation and training for all other crisis staff. Conduct routine evaluation of clinicians' documentation. Develop improvement plans as required. ▪ Regularly evaluate the content and value of current documentation and provide training, where necessary	Y	Medium
	7,1 a	Standardization documentation and Handover Framework between Mobile Crisis/Co-Response Team and others, such as Emergency Departments. ▪ Develop and implement a standardized documentation and handover framework between teams	Y	Medium
	8.1	Streamline data input and collection to one source of truth that will allow for effective analysis and decision making by management. In addition to aligning financial reimbursement by team to determine financial suitability. ▪ Develop customized reports in Smartcare to track key data points and allow for a single source of truth ▪ Update EHR system to require staff to document the team that responded to a client ▪ Consider tracking cost by individual crisis services team and region	Y	Medium/Long

Stakeholder Engagement

Stakeholder Overview

As part of this review and as identified by the Department, KPMG conducted four key stakeholder engagement roundtables with Law Enforcement, Hospital Emergency Departments, NAMI, and Jail Mental Health to obtain insights and perspectives on crisis program operations and opportunities for improvement. The following key themes were identified across roundtables.

Law Enforcement

System Strengths

- Stakeholders (NAMI and Hospital Emergency Departments) identified the co-response team as a key strength of the system. Law Enforcement expressed much success with the model and wish to continue to expand the teams and hours of operations.

Collaboration with Crisis Service – Challenges

- **Lack of Co-location:** Currently, the co-response assigned deputy and BWell clinician are not co-located. Rather, the co-response deputy is located at the Sheriff's Office, while the BWell clinician works from the designated BWell Office. As a result, the co-response deputy must call the clinician when a call is received, the deputy then goes to pick up the clinician at the BWell office and they travel together to the scene. The current process results in a longer response time than would be necessary if the co-response team were co-located.
- **Reduced Staffing and Backfill:** BWell does not backfill for co-response assigned clinicians and there has been periods during which the co-response deputy does not have a partner. In one instance, one of the deputies did not have a partner for over a year. This results in a misalignment with the co-response model and limits the effectiveness of the team.
- **Law Enforcement Engagement and Limitations:** Mobile Crisis calls Law Enforcement to all mental health calls in the community, excluding jails or locked facilities. Mobile Crisis often request that Law Enforcement attend the scene first, confirm it's safe, prior to mobile crisis engagement with the client, resulting in an increase in Law Enforcement workload. However, Law Enforcement believes this is required due to the potential risk of violence.
- Furthermore, Law Enforcement cannot write 5150/5585 holds in Santa Barbara County. As a result, they must call Mobile Crisis or Co-response to assist in these instances. While co-response deputies can in special circumstances write holds, it is not encouraged by BWell.
- **Lack of metrics and formal evaluation of the Collaboration:** Law Enforcement and BWell have not established joint metrics to formally evaluate the co-response teams at the initiation of the partnership.

Client Service Delivery – Challenges

- **Prolonged Response Times:** In Lompoc, Mobile Crisis take between 45 minutes and an hour to respond. In these circumstances, it is quicker for Law Enforcement to transport the client to the Emergency Department or jail.
- **Limited Response to Substance Use Calls:** Mobile Crisis Teams will not respond to calls where an individual is experiencing a crisis as a result of substance abuse. In the past, Law Enforcement spent a significant amount of time dealing with these calls and this was one of the reasons why the co-response team model was developed. Law Enforcement believe it is critical for deputies to have the necessary skills to deal with these type of calls and developing the co-response team has allowed them to designate deputies to crisis intervention and provide them with the appropriate training.

Stakeholder Overview

- Mobile Crisis teams continue to not respond to calls where the primary issue is substance use. There was limited acknowledgement that a high percentage of these consumers may be presenting with co-occurring disorders.

Access to Services – Challenges

- **Lack of Crisis Stabilization Unit:** The Crisis Stabilization Unit (CSU) has recently closed and there are limited sobering center and facilities to which a client can be referred to for ongoing treatment. In any case, when the CSU was in place, it was necessary to have a client medically cleared before referral to the CSU. However, often times, the CSU would refuse to take a client if they were heavily intoxicated. As a result, when they qualified, it was faster to take them to jail than the CSU.
- **Lack of Psychiatric bed availability:** There is limited inpatient psychiatric beds to refer a client to. The PHF often has no capacity to accept referrals due to their beds being utilized by those in conservatorship and awaiting housing.

Collaboration with SAFTY – Challenges

- **Prolonged Response Times:** Stakeholders reported that Youth Services (SAFTY) response times are worse than Mobile Crisis. For example, if they are based in Santa Maria; SAFTY have to drive an hour to the scene. In these instances it is quicker for Law Enforcement to transport the client to the Emergency Department or Jail/Juvenile Hall.
- **Limited Face to Face Assessments:** Law Enforcement work with SAFTY at the schools and the vast majority of instances, SAFTY respond via telephone, noting that it has been a challenge to have them respond in-person.
- **Decision making Authority:** Finally, SAFTY staff must consistently consult with a supervisor each time a decision is required. For example, they must engage a supervisor to confirm whether they can respond in-person or whether a hold should be written. This increases the call handling times.

Hospital Emergency Departments

System Strengths

- Stakeholders identified the co-response team as a key strength of the system. Emergency Departments have experienced quick response times and effective communication with the co-response teams vs. the mobile crisis teams.

Access to Care – Challenges

- **Limited Crisis Services Availability:** Despite the existence of County Crisis Clinics, stakeholders reported limited available walk-in crisis services, and in-voluntary CSUs, for clients in crisis. While the County previously operated an CSU, it was voluntary in nature and therefore, did not have high volumes, resulting in its closure. Clients experiencing crisis continue to the cycle through Emergency Departments. For future state, stakeholders noted that the Department should consider outsourcing such services to Hospitals.

Stakeholder Overview

- **Lack of Medication Support:** There were key challenges identified related to coordinating medication supports and follow up care for clients. For example, stakeholders noted that clients referred to crisis clinics experience challenges in engaging a prescriber. For example, many report that in the majority of instances, there is no prescriber scheduled to provide service when a client needs medication support. Clients are provided with 3-7 day of medication from the Emergency Department, therefore, if a client does not connect with a prescriber and receive ongoing medication, they again cycle back to the Emergency Department.
- **Lack of Psychiatric Bed Availability:** Once a client is on a 5150/ 5585 hold and is medically cleared, coordination of services becomes challenging as there is a lack of psychiatric facility bed availability to which a client can be referred. For example, the County operates an 16-bed PHF; however, due to staffing challenges, it is rare that a bed is available. Exclusion criteria for admission to the PHF consists of patients with diabetes or mobility issues. The lack of bed availability results in clients remaining in the Emergency Department for a prolonged period of time without accessing the care they need.
- **High Medi-Cal Insurance Wait Times:** Stakeholders reported a notable difference in timeframe to obtain psychiatric bed placement based on whether an individual has Medi-Cal insurance, with placement taking a couple of weeks versus private insurance, where placement can be within a few days.

Collaboration and Communication across Service – Challenges

- **Lack of Warm Hand-off:** There is limited communication and warm hand-off from the Mobile Crisis Team to Emergency Department staff. For example, Mobile Crisis staff do not typically attend the Emergency Department or call to provide a warm hand-off. Emergency Department staff often require additional information from Mobile Crisis; however, experience challenges in both identifying and communicating with the staff member who wrote the hold.
- **Lack of Detail on Hold Documentation:** Hold documentation often lacks detail surrounding criteria for detainment. However, includes a lot of additional information not relevant for Emergency Department staff. In the future, there is an opportunity for Mobile Crisis and Co-response to collaborate with the Emergency Department to consider the key information that the Emergency Department requires and providing staff training to help ensure it is consistently provided in hold documentation.
- **Limited Mobile Crisis Presence in Emergency Department:** In addition, stakeholders noted due to high volume of crisis clients in the Emergency Department, there is an opportunity for a Mobile Crisis staff member to be stationed in the Emergency Department.

Stakeholder Overview

NAMI

Access to Care – Challenges

- **Poor Service Navigation:** Stakeholders reported that obtaining support and access to service via the Access Line can be challenging. Furthermore, callers are required to answer a significant amount of questions that can take up to 45 minutes and this process is not suitable for individuals in crisis who require immediate support.
- **Lack of Psychiatric bed availability:** Stakeholders reported that there is a lack of psychiatric beds in the County resulting in clients continuing to cycle through emergency departments or crisis services or being placed out of county.
- **Limited Effective Service Coordination: Access to appropriate services** In the future, stakeholders reported that there is an opportunity to enhance the number of Full Service Partnerships (FSPs) available. FSPs would play a key role in building relationships with psychiatry programs and other programs for more efficient and effective referrals resulting in better patient treatment outcomes.

Staffing and Hours of Operations – Challenges

Misaligned Staffing levels: Mobile crisis teams often appear to be understaffed and experience high turnover. This reduces the ability to provide quality service timely.

- **Limited Hours of Operations for Co-response:** Stakeholders noted that co-response teams are only available between 8 a.m. and 6 p.m. and in one particular region, there is no BWell clinician post 5 p.m. Stakeholders noted that given that Co-response often provide a faster response, they should be available 24/7.

Roles and Responsibilities – Challenges

- **Limited Law Enforcement Authority to Write 5150/5585 Holds:** Santa Barbara is the only county in the State which does not allow Law Enforcement to write holds. To increase response times, there is opportunity for the County to consider Law Enforcement updating policy and ordinance to allow Law Enforcement to write 5150/5585 holds in the field. This can minimize non-value added time and/or reduce patients unnecessarily going into custody.

Jail Mental Health (WellPath)

Access to Care – Challenges

- **Lack of facilities and services for acute clients:** Stakeholders noted that the key gap in the system relates to the shortage of behavioral health facilities capable of providing a higher level of care, particularly for individuals experiencing psychosis. WellPath cannot medicate individuals that are in an acute state of psychosis and they typically require a higher level of care than what WellPath can support. The County previously operated a CSU; however, this was closed over a year ago. There are limited other facilities in which an individual experiencing psychosis can be referred to and often times, there is no option but to refer the individual to the Emergency Department.
- **Lack of PHF Bed availability:** Additionally, there is limited bed availability in the PHF to meet the needs of the Jail. For example, Mobile Crisis cannot write a 5150 hold until a PHF bed becomes available. As a result, an individual in crisis must remain in a safety cell until they receive a bed placement. However, interviewees reported that a client cannot remain in a safety cell for more than 24 hours. As such, in instances where a bed does not become available within the

Stakeholder Overview

- 24-hour period and the situation is not capable of de-escalation, the Jail must transport the individual to the Cottage Hospital Emergency Department. Cottage Hospital typically do not write holds for these individuals. Rather, they conduct medical clearance, medicate the individual, if needed, and return them to the Jail to connect them to service.
- **Connection to Care:** Clients can be booked and transported to the jail by Law Enforcement. However, in certain instances, these clients require connection to behavioral health services rather than jail booking. For example, the jail can receive a high number of “Cite and Release” cases. In these instances, the client is not held in the jail for a long enough period to result in engagement with WellPath given they typically have high caseloads (57% of jail inmates suffer from behavioral health issues). In these cases, a client is not connected to service, but instead released back into the community and continues to cycle in and out of the jail.

Collaboration with Crisis Services– Challenges

- **Unwillingness to respond:** Stakeholders reported that often times, the jail must “embellish” a client’s presenting condition in order for Mobile Crisis to respond. Although willingness to respond has increased in recent months due to greater engagement with Crisis Services Management and BWell leadership, challenges continue to exist. For example, a recent incident was cited in which an individual was experiencing a behavioral health crisis outside the grounds of the South County Jail. The Jail called Mobile Crisis to respond. The individual in question was known to Mobile Crisis due to frequent engagement. Mobile Crisis considered the client to be malingering and resultantly, refused to respond. In order to best serve the needs of this individual, the Jail subsequently contacted Co-response. Co-response attended the scene and wrote a 5150 hold.

  Limited opportunity to share data: WellPath and BWell utilize differing Electronic Health Records (EHRs) which are not capable of integration. As a result, it is extremely challenging to share information on client history, pre-existing conditions, connected providers etc. Rather, WellPath is required to make multiple calls to BWell, Public Health, and other stakeholders to identify whether a client has been connected to care. In certain instances, this can result in a client being released from jail without their provider being advised. For example, stakeholders described a recent incident in which a client required a higher level of care than what WellPath can support. The client experienced behavioral health challenges and was already connected to a local service provider. However, WellPath were unaware of the connection until two days post client release. Furthermore, the client had an appointment with the provider on the day of release; given client presentation, WellPath considered it unlikely that the client attended. However, given this key information was not provided until post release, WellPath could not proactively engage the provider to ensure the client obtained the needed support.

Stakeholder Overview

Public Defender

The Public Defender indicates there is a great need for crisis services in order to adequately serve the needs of individuals with severe mental illness. The Public Defender serves a large portion of individuals who are mentally ill and unhoused.

The Public Defender practices holistic defense, as opposed to criminal defense, which acknowledges the familiar faces cycling through the system and works to address the factors and barriers that cause them to enter into the criminal justice system. Hence, the Public Defender aims to get individuals housed and mental health care. The Office relies on crisis services regularly since many clients are severely mentally ill.

Crisis Clinics:

- **Lack of Awareness** with Regards to Crisis Clinics, their roles and how they can be accessed by both professionals and clients.
- **Lack of Alignment between Service and Population Served:** Hours of operations do not align with when clients require crisis services; therefore, the service is not seen as a resource for the population that Public Defenders service. In addition, clients in crisis would not typically be able to bring themselves to a physical clinic; therefore, not aligning with the needs of the population served.
- Clients typically experience crisis outside clinic hours, resulting in being taken to an Emergency Department to access crisis care.
- **Access Line:** Many clients do not share all the information necessary due to active criminal cases. Screening is conducted over the telephone, missing key factors that may be observed if the screening is conducted in-person.
- **Lack of Ability to Share Crucial Client Information:** Public Defender cannot share the extensive history that they may have on the client as Access Line staff will only speak to the consumer. Information sharing would be valuable in better understanding client needs. Public Defender cannot speak on behalf of a client as Access line staff do not welcome additional information.
- **Mobile Crisis:** While there has been recent improvement, mobile crisis teams training can be enhanced when dealing with those with a serious and persistent mental illness (SPMI). As a result of the teams current skill set, the teams approach is seen as ineffective.
- **Enhancement of Skills Set is Required:** The mobile crisis team's training needs to incorporate effective de-escalation skills. Those that are part of mobile crisis care must want to deal with those with a SPMI.
- **Co-response:** Co-response is viewed positively; however, there are some issues with data accuracy/integrity and who is being served.
- There is a perception that co-response teams are generally responding to "easier" calls and not calls for high-need/complex individuals, resulting in that population being arrested.
- The co-response teams do a better job in de-escalating crisis situations. There has been a slight decrease of arrest charges, diverting some clients to more effective services.
- **Lack of Data Integrity:** The data presented for co-response teams is not seen as accurate. It is recommended that a deeper examination of how the data is calculated and presented and who is being served be conducted. Demonstrating that the team is doing great work when key

Stakeholder Overview

- partners are not observing it, is not helpful for a population in need of this much desired service.
- **Youth Crisis Services:** The Public Defender is impressed with the collaboration and skills of Youth Crisis Services; the Public Defender feels that as a County they are excelling within the youth side.
- The excellent service by the team can be attributed to low volumes, but work is done very well. Public Defender views volumes as artificially low since it is often the parent calling crisis services seeking support for their children.
- There may be gaps in serving people of color, migrants, and those with varying immigration status, either due to lack of knowledge or fear of the system.
- **Overrepresentation of Law Enforcement among Crisis Calls:** The Public Defender does not believe Law Enforcement should be involved in crisis calls/situations since it is largely within a clinicians skills set.

Crisis Services System Workflows

Crisis Services System Workflow Overview

As required by the scope of work, KPMG developed four workflows to visually depict the flow of clients in and out of the County's Crisis Services Program. These workflows include:

- The flow of clients from the Access Line to crisis teams, including Mobile Crisis, Co-response, and Crisis Clinics
- The flow of clients from the County's jails to Mobile Crisis
- The flow of clients to and from Youth Services Safe Alternatives for Treating Youth (SAFTY) program, operated by Casa Pacifica
- The flow of clients to and from County's Emergency Departments as well as into hospital/bed placements via Mobile Crisis

In developing these workflows, KPMG undertook the following key steps to help ensure that workflows were accurately documented, visualized and validated:

01 Facilitated 12 in-person workshops and focus groups with management, supervisors, and line staff across each program (Mobile Crisis, Co-response, Youth Services, and Crisis Clinics) and region to develop a thorough understanding of the flow of clients in and out of the County's crisis programs.

02 Based on the information provided during the in-person workshops, KPMG developed an initial workflow draft for staff consideration.

03 Facilitated four follow up validation sessions with staff across each team to present the draft workflow and confirm accuracy. These sessions included representation from management, supervisors, and front line staff across each region.

04 Following validation sessions, each workflow was updated for feedback provided and issued to supervisors for review and distribution to staff.

05 KPMG provided supervisors with a timeframe to review the workflow with staff and provide any further feedback in writing.

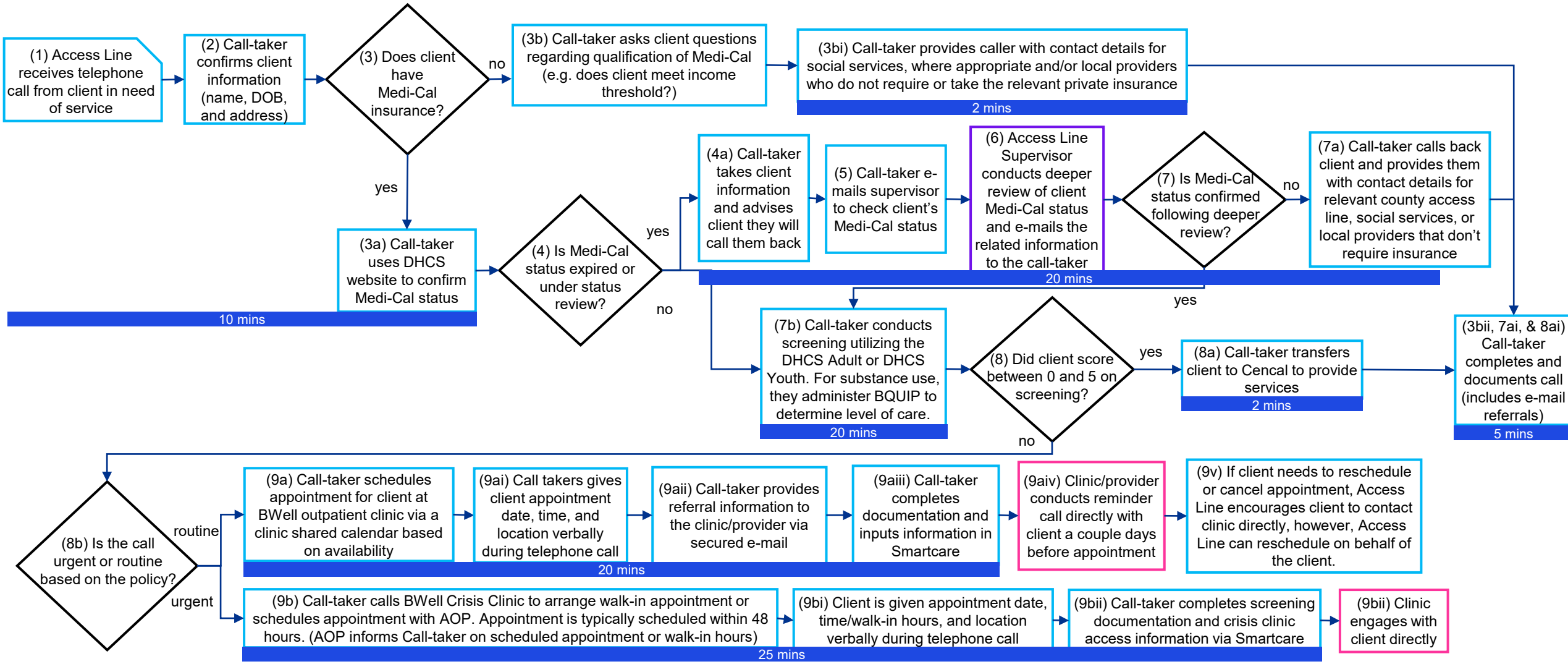
06 KPMG updated each workflow based on the feedback received. The final workflow was issued to management and supervisory staff for reference.

Workflow – Access Line Routine and Urgent Calls

Legend
- Access Line Call-taker
- Clinic/provider
- Access Line Supervisor
- Average time frame for task

one COUNTY one FUTURE

This following workflow relates to the flow of Access Line routine calls into services as well as a step-by-step guide explaining the workflow.



*Usage of language line can double all timeframes listed.

Workflow – Access Line Routine and Urgent Calls

Step 1: The Access Line receives a telephone call from a community member in need of service or a family member or case manager requesting service on behalf of client.

Step 2: The Access Line call-taker confirms the client's name, date of birth, and address.

Step 3: The Access Line call-taker asks client or client family/case manager to confirm if the client has Medi-Cal insurance.

- **Step 3a:** If the client advises that he/she has Medi-Cal insurance, the call-taker logs onto the Department Health Care Service (DHCS) website, searches the client using the client's identifying information, and confirms the client's Medi-Cal status. **Workflow proceeds to step 4.**
- **Step 3b:** If the client confirms that they do not have Medi-Cal insurance, the call-taker asks the client a number of questions regarding possible eligibility of insurance. (i.e. Do you have a job? Do you have income? etc.)
    i. Based on information provided by the client, they may be eligible for Medi-Cal insurance; therefore, the call-taker provides the client with contact details for Social Services, and/or local providers who do not require insurance. If the client is not be eligible for Medi-Cal insurance, the call-taker provides the client with contact details for local providers who do not require insurance or who may take the relevant private insurance.
    ii. The call-taker subsequently completes and documents the telephone call in Smartcare (including e-mails and referrals). The workflow based on this call outcome is subsequently complete.

Step 4: The next step is dependent on whether the client's Medi-Cal insurance is expired or continues in place.

- **Step 4a:** If the client's insurance is expired or under review, the call-taker confirms with the client, requests the client's phone number, and advises the client that they will receive a call back.
- **Step 4b:** If the client's insurance is not expired, workflow moves to **step 7b.**

Step 5: The call-taker e-mails the client's information to the Access Line supervisor and requests that a deeper review of client Medi-Cal status is undertaken.

Step 6: The Access Line supervisor conducts an in-depth review of the client's Medi-Cal status on the DHCS website and e-mails the results of the in-depth review to the call-taker.

Workflow – Access Line Routine and Urgent Calls

Step 7: This step is contingent on if the client's Medi-Cal status is confirmed by the supervisor's review.

- **Step 7a:** If the client's Medi-Cal status is not confirmed after the supervisor's review, the call-taker calls the client back, confirms the results of the status review, and provides the client with contact details for relevant county Access Line, Social Services, or local providers that do not require insurance based on review outcome.
    i. The call-taker subsequently completes and documents the telephone call (including e-mails and referrals). The workflow based on this call outcome is thereby complete.
- **Step 7b:** If the client's Medi-Cal status is confirmed after the supervisor's review, the call-taker conducts a screening utilizing DHCS Adult or DHCS Youth Behavioral Health screenings. For substance use, the call-taker administers a Brief Questionnaire for Initial Placement (BQuiP) screening to determine the level of care.

Step 8: The call-taker determines the client's score based on the screenings undertaken.

- **Step 8a:** If the client scored between 0 and 5 based on the screening conducted, the call-taker transfers the client to Cencal to provide services.
    i. The call-taker subsequently completes and documents the phone call in Smartcare (including e-mails and referrals). The workflow based on this call outcome is subsequently complete.
- **Step 8b:** If the client scored above 5 on the screening, the call-taker determines if the telephone call is urgent or routine based on protocol. (e.g., A call is deemed urgent if the client is experiencing mental health impairments such that they cannot wait for a regular appointment and need to be seen within 48 hours.)

Step 9 : The following steps are dependent on whether the call is considered routine or urgent.

- **Step 9a:** If the call-taker determines that the call is routine, the call-taker schedules an appointment for the client at the BWell Outpatient Clinic via a shared calendar based on availability.
    i. The call-taker provides the client with the appointment date, time, and location verbally during the telephone call.
    ii. The call-taker provides referral information to the clinic/provider via secured e-mail.
    iii. The call-taker completes documentation and inputs the information in Smartcare.

Workflow – Access Line Routine and Urgent Calls

iv. Prior to the client's appointment, the clinic/provider conducts a reminder call with the client directly.

v. In the event that the client needs to reschedule or cancel their appointment, the Access Line encourages the client to contact the clinic directly. However, the Access Line can reschedule the appointment on behalf of the client by calling the clinic and updating the shared calendar. The workflow based on this call outcome is subsequently complete.

- **Step 9b:** If the call-taker determines that the call is urgent, the call-taker calls the BWell Crisis Clinic to arrange a walk-in appointment or schedule an appointment with Clinic's Administrative Office Professional (AOP). The appointment is typically scheduled within 48 hours for urgent calls.

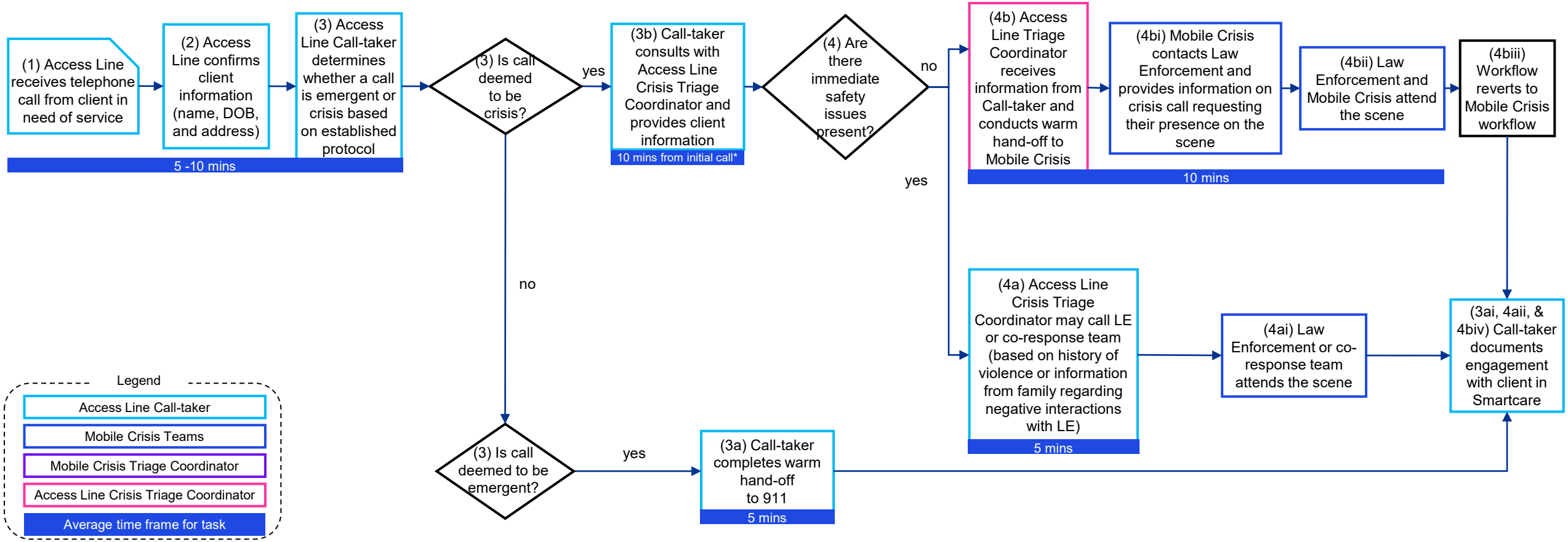
  i. The call-taker calls the client back and provides the client with the appointment date, time or walk-in hours, and location of services.

  ii. The call-taker completes the screening documentation and crisis clinic access information via Smartcare.

  iii. The clinic engages directly with the client at the appointment and determines the appropriate level of care and services for the client. The workflow based on this call outcome is subsequently complete.

Workflow – Access Line Emergent and Crisis Calls

The following workflow relates to the flow of emergent, urgent, and crisis calls from the Access Line to 911 and Crisis Services and includes a step-by-step guide explaining the workflow.



*Usage of language line can double all timeframes listed.

Workflow – Access Line Emergent and Crisis Calls

Step 1: The Access Line receives a telephone call from a community member in need of service or a family member or case manager requesting service on behalf of client.

Step 2: The Access Line call-taker confirms the client's name, date of birth, and address.

Step 3: The Call-taker determines whether the call is considered emergent or crisis based on documented protocols. *(i.e. Calls are deemed to be emergent if the information gathered from the call indicates immediate, clear potential safety risks that need immediate attention. Calls are deemed to be crisis if the client is having an active current mental health crisis but doesn't have any immediate safety risks. However, the client has potential to be hospitalized if they do not get assessed immediately.)*

- **Step 3a:** If the call-taker determines the call to be an emergent call, the call-taker conducts a warm hand-off to 911.
    i. The call-taker documents the engagement with client in SmartConnect. The workflow based on this call outcome is subsequently complete.
- **Step 3b:** If the call-taker determines the call to be a crisis call, they provide a warm hand-off to the Access Line Crisis Triage Coordinator. **The workflow proceeds to step 4.**

Step 4: The Access Line Triage Coordinator engages the call-taker and asks a series of questions to determine if immediate safety issues are present.

- **Step 4a:** If the Access Line Triage Coordinator determines that immediate safety issues are present (e.g., access to fire-arms etc.) or based on information provided by the client's family, the client has a history of violence, the Access Line Triage Coordinator contacts Law Enforcement or co-response teams to attend the scene.
    i. Law Enforcement or co-response teams attend the scene and workflows follow Mobile Crisis or Crisis Intervention Team (CRT) workflow.
    ii. The call-taker documents the interaction with the client in Smartcare. The workflow based on this call outcome is subsequently complete.

Workflow – Access Line Emergent and Crisis Calls

- **Step 4b:** If the Access Line Triage Coordinator determines that there are no immediate safety issues present, the Triage Coordinator conducts a warm hand-off to Mobile Crisis.
    i. Mobile Crisis contacts Law Enforcement, provides them with information on the crisis call, and requests that Law Enforcement attends the scene.
    ii. Law Enforcement and Mobile Crisis attend the scene together.
    iii. The workflow reverts to Mobile Crisis workflow.
    iv. The call-taker documents the interaction with the client in Smartcare. The workflow based on this call outcome is subsequently complete.

Santa Barbara Crisis Services Review

Workflow: Law Enforcement to Mobile Crisis

Legend: AMR; Law Enforcement (LE); Cottage Hospital; Mobile Crisis; Full Service Partnership (FSP); South County avg. times; North/West County avg. times

one COUNTY one FUTURE

This following workflow relates to the flow of crisis clients from Law Enforcement engagement to Mobile Crisis Services.

In West County, if client is connected to FSP, FSP will attend scene with Mobile Crisis and complete safety plan, if necessary and coordinate follow up.

(1) Mobile Crisis receives telephone call from Law Enforcement regarding mental health crisis

(2) Mobile Crisis requests client information (name, DOB, address, and situation)
10-20 mins
10-25 mins

(3) Mobile Crisis searches client in SmartCare to determine pre-existing conditions and if client is connected to FSP

(4) Through collab with Law Enforcement, is an in-person evaluation required?

yes

(4c) Mobile Crisis travels to scene
15-60 mins
10-55 mins

(5) Law Enforcement remains on scene and confirms that the scene is safe for Mobile Crisis/to engage client

(6) Mobile Crisis conducts crisis evaluation, attempts to de-escalate the situation while determining if client meets 5150 criteria
45-180 mins
45-120 mins

(7) Mobile Crisis, where appropriate, provides education to family and caregiver

no

(4a) If client is willing to go to ED voluntarily, Mobile Crisis contacts hospital and provides information via telephone call. On rare occasions, Mobile Crisis will do an in-person hand-off at hospital.

(4ai) Mobile Crisis documents interaction with client

(4b) Based on information provided and collaboration with Law Enforcement, a 5150 is not required and Mobile Crisis does not attend scene

(8) Is client gravely disabled or danger to self or others?

yes

(8b) Mobile Crisis may consult with supervisor (sometimes colleague, psychiatry or PHF) based on case complexity (e.g. dementia, development disorders) at staff discretion, writes 5150 hold and informs client

(9) LE requests AMR

(10) Is AMR available?

Arrives within 15-45 mins
Arrives within 15-120 mins

yes

(10a) Mobile Crisis calls ER to provide verbal hand over

(10ai) Mobile Crisis gives hold documents to AMR

(10aii) AMR transports client to ER
10-25 mins

(10aiii) Mobile Crisis may follow AMR & report on client condition in-person
10-15 mins

(11) Mobile Crisis returns to office and documents interaction in Smartcare & SmartSheet
15-180 mins
30-65 mins

(12) Is client admitted to the ER in Cottage hospital?

yes

(12ai) ED provides medical clearance
30-60 mins
60-180 mins

(12aii) Cottage Hospital reassess client every 24 hours to determine hold applicability

(12biii) Workflow reverts to Hospital Bed Placement workflow

no

(12b) Mobile Crisis reassesses client every 24 hours to determine hold applicability

(12b) Hold remains?

yes

(12bii) While on hold, Mobile Crisis may request that the hospital schedules a telepsych visit to determine the medication

no

no

(10b) On rare occasions and if client is cooperative, LE transports client to ER

(10bi) Mobile Crisis travels to ED and gives hold documents to ED Staff and remains in ER until transfer of client care occurs
15-150 mins
15-60 mins

(10bii) Mobile Crisis leaves ED

(10c) On rare occasions, 2 Mobile Crisis Clinicians transport client if they know the client and the client is cooperative

(8ai) Mobile Crisis continues to de-escalate situation

(8aii) Mobile Crisis develops safety plan with client and where appropriate, family/ caregiver
30-60 mins
10-55 mins

(8aiii) Mobile Crisis leaves scene and returns to office to document interaction in Smartsheet and Smartcare
45-90 mins
45-90 mins

(8aiv) Mobile Crisis advises Triage team and follows up for 72 hours

If client is not linked to FSP and may benefit from ongoing services

MH

(8av) If client is willing, Mobile Crisis provides client with Access Line number in order for them to call and connect to mental health services

Detox

(8avi) Mobile Crisis refers client to the ER

(8avi) Detox occurs within the ER

(8avi) ER contacts Access Line or crisis clinics to coordinate services

Workflow – Law Enforcement to Mobile Crisis

Step 1: Mobile Crisis receives telephone call from Law Enforcement with regard to an adult or youth in a behavioral health crisis.

Step 2: The Mobile Crisis case worker/clinician requests client's name, date of birth, address, and information on the current crisis situation and location.

Step 3: The Mobile Crisis case worker/clinician reviews the County's Electronic Health Record (EHR), Smartcare to determine if the client has any pre-existing conditions or prior engagement with the CRT or Mobile Crisis. The case worker/clinician also identifies if client is connected to FSPs.

Step 4: The Mobile Crisis case worker/clinician collaborates with Law Enforcement to determine if an in-person evaluation is required based on presenting issues.

- **Step 4a:** If the client indicates that they are willing to go to the Emergency Department voluntarily, Mobile Crisis does not attend the scene. However, the Mobile Crisis case worker/clinician contacts the Emergency Department via telephone to advise the Emergency Department that a client is on route and provides client information and details of the crisis situation. On rare occasions, the Mobile Crisis case worker/clinician may meet the client at the Emergency Department, and conducts a warm hand-off to the Emergency Department staff.
    i. Mobile Crisis documents their interaction with the client in Smartsheet and Smartcare. The workflow based on this call outcome is subsequently complete.
- **Step 4b:** If based on collaboration and engagement with Law Enforcement, it is determined that an in-person evaluation for a 5150/5585 hold is not required, Mobile Crisis does not attend the scene and Law Enforcement resolves the case by transporting the client to Emergency Department or jail (dependent on the client situation). The workflow based on this call outcome is subsequently complete.
- **Step 4c:** If through collaboration and engagement with Law Enforcement, it is determined that an in-person evaluation is required, Mobile Crisis attends the scene. **The workflow proceeds to Step 5.**

Step 5: Upon arrival, the Mobile Crisis case worker/clinician engages with Law Enforcement to confirm that the scene is safe for Mobile Crisis to engage the client.

Step 6: Once the scene is cleared as safe by Law Enforcement, the Mobile Crisis case worker/clinician introduces him/herself to the client, attempts to de-escalate the situation, and conducts a crisis evaluation to assess the client's mental state and determine if the client meets criteria for a 5150 hold.

Workflow – Law Enforcement to Mobile Crisis

Step 7: If it is appropriate, the Mobile Crisis case worker/clinician may provide psychoeducation to the client's family and/or caregiver.

Step 8: Based on the mental state evaluation conducted in Step 6, the Mobile Crisis case worker/clinician evaluates if the client meets one of the following three conditions (1) Gravely disabled, (2) Danger to self, or (3) Danger to others.

- **Step 8a:** If the client does not present any of the conditions listed in Step 8, the following next steps are undertaken:
  i. The Mobile Crisis case worker/clinician continues to de-escalate the situation.
  ii. Following de-escalation, the case worker/clinician develops a safety plan with the client, and when appropriate, with the family or caregivers. The case worker/clinician leaves the scene once the safety plan has been developed.
  iii. The Mobile Crisis case worker/clinician returns to the office to document the client interaction in Smartsheet and Smartcare.
  iv. For the next 72 hours, the Mobile Crisis case worker/clinician follows up with the client and/or family and caregivers to determine the client's progress on the safety plan.
  v. If the client is not already connected to services and is willing to, the Mobile Crisis case worker/clinician provides the client with the number for the Access Line to be connected to services.
  vi. If the client needs detox services, Mobile Crisis refers the client to the Emergency Department.
    - The Emergency Department conducts detox services in-house.
    - The Emergency Department contacts the Access Line or Crisis Clinics to coordinate further services post-discharge. The workflow based on this call outcome is subsequently complete.
- **Step 8b:** If the client presents one or more of the conditions listed in Step 8, Mobile Crisis may consult with their supervisor [colleague, psychiatry, or PHF based on the complexity of the client's case (e.g., if the client has dementia, development disorders, etc.) at the case worker's/clinician's discretion.]
  i. The Mobile Crisis case worker/clinician subsequently writes a 5150 hold, advises the client that they have been placed on hold and will be taken to the Emergency Department for medical clearance. **The workflow proceeds to Step 9.**

Step 9: Law Enforcement requests an American Medi-cal Response (AMR) to transport the client to the nearest Emergency Department.

Workflow – Law Enforcement to Mobile Crisis

Step 10: The next step is dependent on whether the AMR is available for transportation in a timely manner.

- **Step 10a:** If the AMR is available to respond timely, the Mobile Crisis case worker/clinician calls the Emergency Department to verbally advise that a client will be transported, confirm client information, and provide detail of the crisis situation experienced.
  i. Once the AMR arrives at the scene, the Mobile Crisis case worker/clinician provides hold documentation to the AMR.
  ii. The AMR transports the client to the nearest Emergency Department.
  iii. In some cases, the Mobile Crisis case worker/clinician may follow the AMR to the Emergency Department and report on the client's condition to Emergency Department staff. **The workflow proceeds to Step 11.**
- **Step 10b:** On rare occasions, if the AMR is unavailable and if the client is cooperative, Law Enforcement may transport the client directly to the Emergency Department.
  i. In these situations, the Mobile Crisis case worker/clinician may follow Law Enforcement and provide hold documentation directly to the Emergency Department staff.
  ii. The case worker/clinician remains in the Emergency Department until the client is transferred to the appropriate care, and leaves the Emergency Department thereafter. **The workflow proceeds to Step 11.**
- **Step 10c:** Finally, on rare occasions, if the AMR is unavailable and if the client is cooperative, two Mobile Crisis clinicians may transport the client to the Emergency Department in a caged car if they are familiar with the client.

Step 11: The Mobile Crisis case worker/clinician returns to the office to document their interaction with the client in Smartcare and SmartSheet.

Step 12: This step is dependent on the Emergency Department to which a client in crisis is admitted.

- **Step 12a:** If the client is admitted to Cottage Hospital's Emergency Department:
  i. Cottage Hospital medically clears the client and
  ii. Reassesses the client every 24 hours to determine whether the hold continues to remain. The call is subsequently completed and the workflow reverts to the Hospital Bed Placement workflow.

Workflow – Law Enforcement to Mobile Crisis

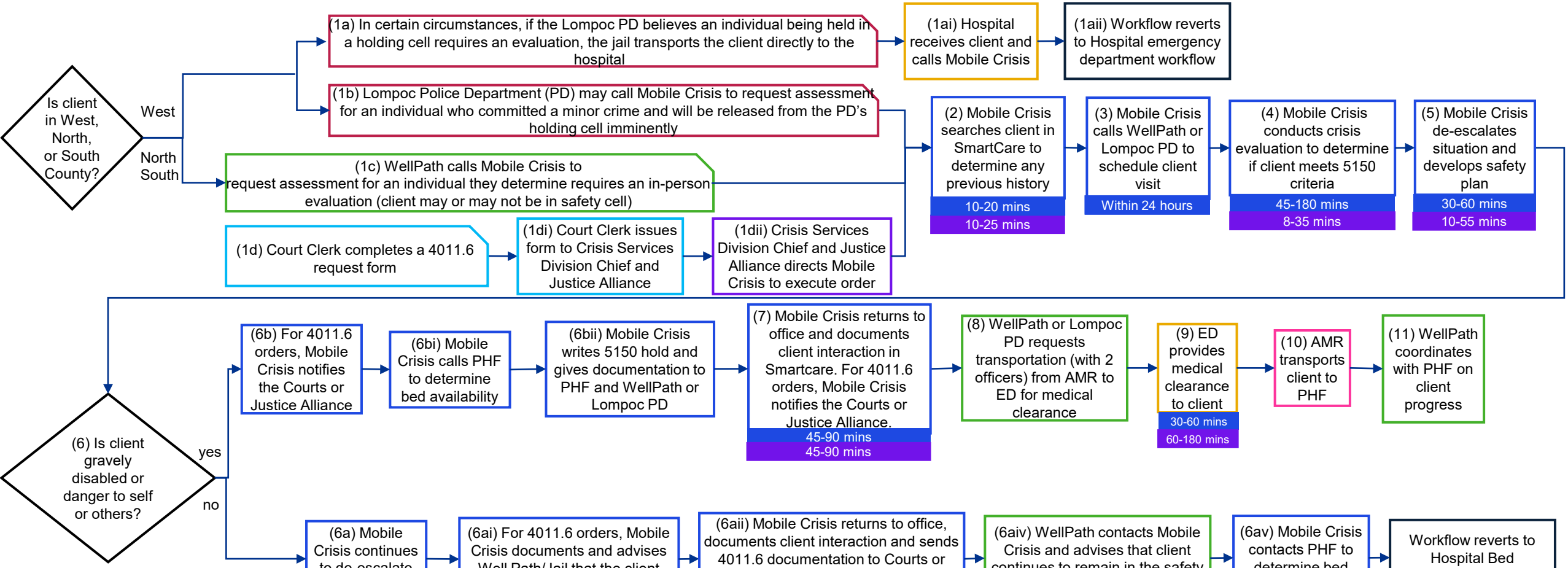
- **Step 12b:** If the client is admitted to an emergency department other than Cottage Hospital, the Mobile Crisis team reassesses the client every 24 hours to determine whether hold continues to apply.
    i. If the Mobile Crisis case worker/clinician determines that the hold is rescinded, a safety plan is developed with client and where appropriate, with the client's family and/or caregivers. The workflow follows the steps outlined in 8a(iii) to 8a(vi).
    ii. In West County, if the hold continues to apply, Mobile Crisis may request that the hospital schedules a telepsych visit to determine the appropriate medication that the client requires. The workflow reverts to the Hospital Bed Placement workflow.
    iii. In North and South County, if the hold continues to apply, the workflow reverts to the Hospital Bed Placement workflow.

Workflow: Jails/Courts to Mobile Crisis

Legend

- WellPath
- Courts
- Crisis Services Division Chief
- Lompoc PD Holding Cell
- Mobile Crisis
- AMR
- Emergency Department
- South County avg. times
- North/West County avg. times

This following workflow relates to the flow of crisis clients from the County's Jails or Courts to Mobile Crisis Services.



Workflow – Jails/Courts to Mobile Crisis

The commencement of this workflow is contingent on the County where the client resides, or is located in, as well as the originator of the request for an in-person evaluation (i.e. County jails or the Courts).

Step 1a: In West County, in certain circumstances, an individual may be held in a Lompoc PD holding cell. If Lompoc PD believes that an incarcerated individual requires an evaluation, they transport the client directly to the hospital.

i. The receiving hospital calls Mobile Crisis once the client arrives at the hospital.

ii. The Mobile Crisis case worker/clinician attends the hospital to complete the in-person evaluation and the workflow reverts to the Hospital Emergency Department workflow on page 11.

Step 1b: In other cases, in West County, Lompoc PD may call Mobile Crisis to request an assessment for an incarcerated individual held in a holding cell who has committed a minor crime and will be released from custody imminently. In this circumstance, the workflow proceeds to Step 2.

Step 1c: In both North or South County, WellPath may call Mobile Crisis to request an assessment for an incarcerated individual they determine requires an in-person evaluation. The client may or may not be in a safety cell. In this circumstance, the workflow proceeds to Step 2.

Step 1d: Finally, the Courts via a Court Clerk may complete a 4011.6 request form to request an in-person evaluation for an individual in custody.

i. The Court Clerk issues the 4011.6 request form to the Crisis Services Division Chief and Justice Alliance to request completion of an in-person evaluation.

ii. The Crisis Services Division Chief and Justice Alliance directs Mobile Crisis to execute the order. The workflow proceeds to Step 2.

Step 2: The Mobile Crisis case worker/clinician reviews Smartcare to determine if the client has any pre-existing conditions or prior engagement with Mobile Crisis.

Step 3: Mobile Crisis calls WellPath to schedule a time to visit the client within 24 hours of request.

Step 4: The Mobile Crisis case worker/clinician introduces him/herself to the client and conducts a crisis evaluation to assess the client's current mental state and determine if the client meets criteria to be placed on a 5150 hold.

Step 5: Initially, the Mobile Crisis case worker/clinician engages with the client to de-escalate the situation

Workflow – Jails/Courts to Mobile Crisis

Step 6: Based on the mental state evaluation conducted in Step 4, the Mobile Crisis case worker/clinician determines if the client is considered to meet one of the following three conditions (1) Gravely disabled, (2) Danger to self, or (3) Danger to others.

- **Step 6a:** If the client does not present any of the conditions listed in Step 6, the Mobile Crisis case worker/clinician continues to de-escalate the situation.
  - i. Once the situation is successfully de-escalated, if a 4011.6 order was issued, Mobile Crisis documents and advises WellPath or Lompoc PD that the client does not meet the criteria for a 5150 hold.
  - ii. The Mobile Crisis case worker/clinician leaves the scene, returns to the office, and documents the interaction with the client in Smartcare. However, documentation may occur at the end of the day, if a Mobile Crisis case worker/clinician is required to attend to another call thereafter.
  - iii. If a 4011.6 order was issued, the case worker/clinician sends that documentation to the Courts or Justice Alliance and advises them that the client does not meet the criteria for a 5150.
  - iv. If the client is in North or South County, WellPath contacts Mobile Crisis to advise that the client continues to remain in the safety cell due to presenting concerns.
  - v. The next step requires that Mobile Crisis contact the PHF to determine the bed availability and the workflow reverts to the Hospital Bed Placement workflow on page 15.
- **Step 6b:** If the client presents one or more of the conditions listed in Step 6, if a 4011.6 order was issued, the Mobile Crisis case worker/clinician notifies the Courts or Justice Alliance of client presentation and the following next steps are undertaken:
  - i. The Mobile Crisis case worker/clinician calls the PHF to determine bed availability.
  - ii. The Mobile Crisis case worker/clinician writes the 5150 hold and provides the hold documentation to the PHF and WellPath or the Lompoc PD as appropriate. The workflow proceeds to Step 7.

Workflow – Jails/Courts to Mobile Crisis

Step 7: Mobile Crisis leaves the scene and returns to their office to document the interaction with the client in Smartcare. For 4011.6 orders, Mobile Crisis notifies the Courts or Justice Alliance. However, it is important to note that documentation may occur at the end of the day, where a Mobile Crisis case worker/clinician is required to attend another call thereafter.

Step 8: WellPath or Lompoc PD requests the AMR to transport the client with two officers to the Emergency Department for medical clearance.

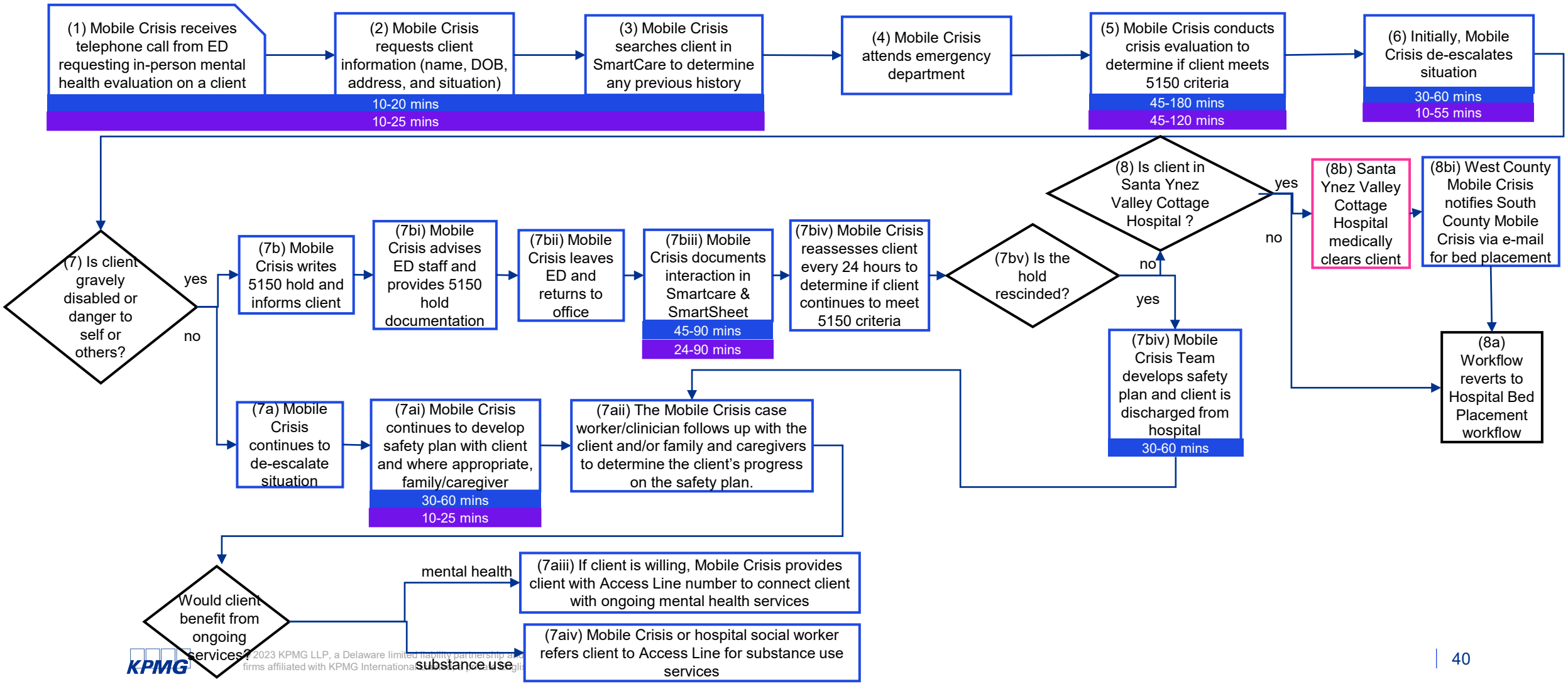
Step 9: The Emergency Department medically clears the client.

Step 10: Once medical clearance is provided, the AMR transports the client to the PHF to receive the appropriate services and level of care.

Step 11: WellPath or Lompoc PD coordinates with the PHF on the client's progress.

Workflow: Hospital ED to Mobile Crisis

The following workflow relates to the flow of crisis clients within Hospital emergency departments at Lompoc and Marion Hospital to Mobile Crisis Services.



Workflow – Hospital ED to Mobile Crisis

Step 1: The Mobile Crisis receives a telephone call from the Emergency Department at Lompoc, Marion, or Santa Ynez Valley Cottage Hospital requesting completion of an in-person evaluation for an individual in crisis.

Step 2: The Mobile Crisis case worker/clinician requests the client's name, date of birth, address and information on the current crisis situation.

Step 3: The Mobile Crisis case worker/clinician reviews Smartcare to determine if the client has any pre-existing conditions or prior engagement with Mobile Crisis.

Step 4: Mobile Crisis attends the appropriate Emergency Department to conduct the in-person evaluation.

Step 5: The Mobile Crisis case worker/clinician introduces him/herself to client and conducts a crisis evaluation to assess the client's current mental state and determine if the client meets criteria for a 5150 hold.

Step 6: Initially, the Mobile Crisis case worker/clinician engages with the client to de-escalate the situation.

Step 7: Based on the assessment conducted in Step 5, the Mobile Crisis case worker/clinician determines if the client is considered to meet one of the following three conditions (1) Gravely disabled, (2) Danger to self, or (3) Danger to others.

- **Step 7a:** If the client does not present any of the conditions listed in Step 6, the Mobile Crisis case worker/clinician continues to de-escalate the situation.
    i. Following de-escalation, the Mobile Crisis case worker/clinician develops a safety plan with the client, and where appropriate, the client's family and/or caregivers.
    ii. For the next 72 hours, the Mobile Crisis case worker/clinician follows up with the client and/or family and caregivers to determine the client's progress on the safety plan.
    iii. If the client is not connected to services, requires mental health and is willing to be connected, the Mobile Crisis case worker/clinician provides the client with the number for the Access Line to be connected to services.
    iv. If the client requires substance use support and is willing to be connected, the Mobile Crisis or hospital social worker provides the client with the number for the Access Line.

Workflow – Hospital ED to Mobile Crisis

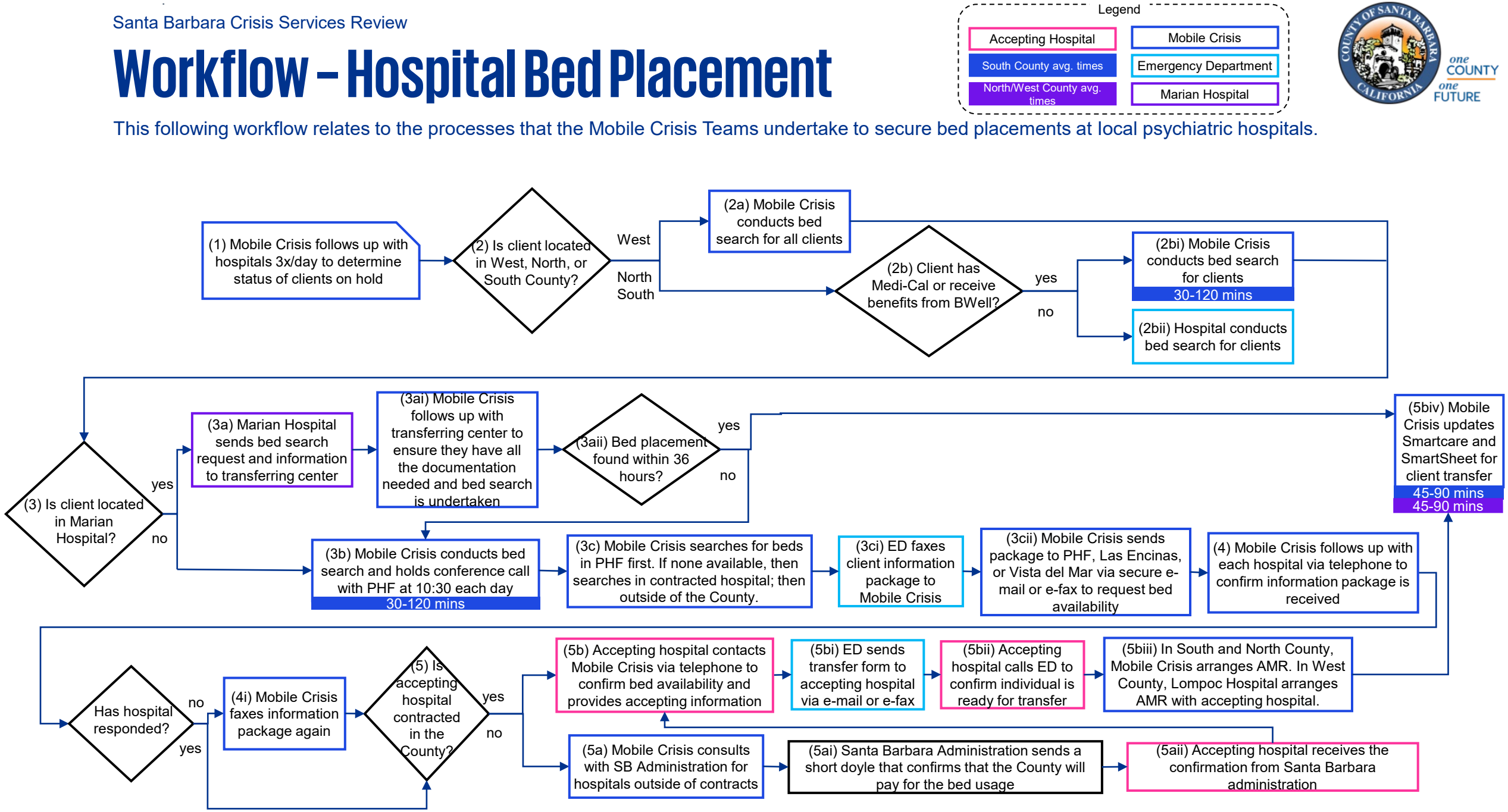
- **Step 7b:** If the client presents one or more of the conditions listed in Step 7, the Mobile Crisis case worker/clinician subsequently writes a 5150 hold.
  i. The Mobile Crisis case worker/clinician advises the staff in the Emergency Department that the client meets the 5150 hold criteria and provides them with the hold documentation.
  ii. The Mobile Crisis case worker/clinician leaves the Emergency Department and returns to the office.
  iii. The Mobile Crisis case worker/clinician documents their interaction with the client in Smartcare and SmartSheet. However, it is important to note that documentation may occur at the end of the day, where a Mobile Crisis case worker/clinician is required to attend another call thereafter.
  iv. The Mobile Crisis case worker/clinician reassesses the client every 24 hours to determine if the client should remain on hold. If the client remains on hold, **the workflow proceeds to Step 8.**
  v. If the case worker/clinician determines that the client no longer meets the criteria to be on hold, the case worker/clinician rescinds the hold and develops a safety plan. The client is then discharged from the Emergency Department.
    - For the next 72 hours, the Mobile Crisis case worker/clinician follows up with the client and/or family and caregivers to determine the client's progress on the safety plan.
    - If the client is not connected to services and is willing, the Mobile Crisis case worker/clinician provides the client with the number for the Access Line to be connected to services.

Step 8: This step is dependent on the Emergency Department to which the client has been admitted.

- **Step 8a:** If the client is in Marion Hospital, the workflow reverts to the Hospital Bed Placement workflow.
- **Step 8b:** If the client is in Santa Ynez Valley Cottage Hospital, Santa Ynez Valley Cottage Hospital staff medically clears the client.
  i. West County Mobile Crisis case worker/clinician notifies the South County Mobile Crisis team via e-mail that the client is medically cleared and awaiting bed placement. South County Mobile Crisis then undertake the bed placement process outlined in the Hospital Bed Placement workflow. This workflow is subsequently complete.

Workflow – Hospital Bed Placement

This following workflow relates to the processes that the Mobile Crisis Teams undertake to secure bed placements at local psychiatric hospitals.



Workflow – Hospital Bed Placement

Step 1: Mobile Crisis teams follows up with each hospital three times a day to determine the status of a client placed on hold.

Step 2: This step is dependent on the location of the client:

- **Step 2a:** If the client is located in West County, Mobile Crisis conducts the bed search for all clients, regardless of client's insurance or benefits.
- **Step 2b:** If the client is located in North or South County, the client's insurance status must be determined.
    i. If the client has Medi-Cal or is a client of BWell, Mobile Crisis conducts the bed search for the client. **The workflow proceeds to Step 3.**
    ii. If the client does not have Medi-Cal or is not a client of BWell, the hospital conducts the bed search for the client. The workflow based on this outcome is subsequently complete.

Step 3: This step is dependent on the Emergency Department where the client is located:

- **Step 3a:** If the client is in Marian Hospital, Marian Hospital conducts a bed search request via its transferring center. The Emergency Department sends the bed search request with the client's information to the transferring center.
    i. Mobile Crisis follows up with transferring center to confirm the request for the client's bed search has been undertaken and the client's information has been received.
    ii. If a bed has been located within 36 hours, **the workflow proceeds to step 5b(iv).**
    iii. If a bed has not been located within 36 hours, the bed search reverts to Mobile Crisis and the **workflow proceeds to Steps 3b and 3c.**
- **Step 3b:** If the client is not located in Marian Hospital, Mobile Crisis undertakes the bed search beginning with the PHF and holds a call with the PHF at 10.30am each day to support this process.
- **Step 3c:** If Mobile Crisis cannot locate a bed in the PHF, Mobile Crisis subsequently searches for a bed in Santa Barbara contracted hospitals. If both options are exhausted without successfully locating a bed, Mobile Crisis searches for a bed outside of the county.
    i. The Emergency Department faxes an information package containing the client's information to Mobile Crisis.

Workflow – Hospital Bed Placement

i. Once received, Mobile Crisis requests bed availability via e-mail or e-fax by sending the information package to the PHF, Las Encinas, or Vista del Mar. Mobile Crisis also holds a daily conference call with the PHF at 10:30 a.m. to discuss bed placements. **The workflow proceeds to Step 4.**

Step 4: Mobile Crisis calls each psychiatric hospital to confirm their receipt of the information package.

i. If the hospital does not respond, Mobile Crisis faxes the information package again. The bed search continues until a bed placement is identified.

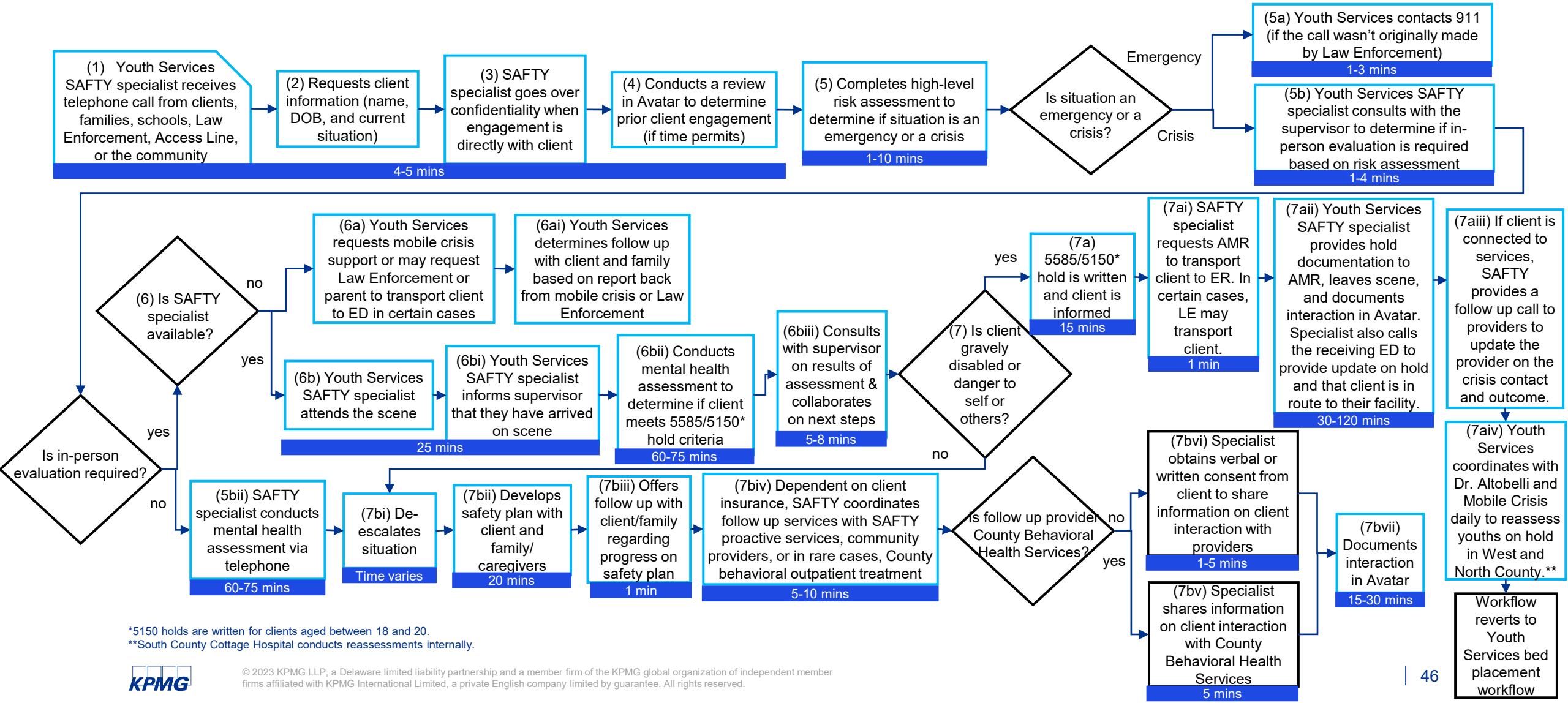
Step 5: This step is dependent on the contract status of the accepting hospital.

- **Step 5a:** If the accepting hospital is not contracted with the County, Mobile Crisis consults with Santa Barbara Administration and requests that a short doyle be sent to the accepting hospital.
  i. Santa Barbara Administration sends the accepting hospital a short doyle to confirm payment for the client's bed placement and usage.
  ii. The accepting hospital confirms bed placement and the **workflow proceeds to Step 5b.**
- **Step 5b:** If the accepting hospital is contracted with the County or if the client has insurance, the hospital contacts Mobile Crisis and confirms the bed availability and provides the necessary accepting information over the telephone.
  i. The Emergency Department sends a transfer form to the accepting hospital via e-mail or fax.
  ii. The accepting hospital then calls the Emergency Department where the client is located to confirm that the client is ready for transfer.
  iii. In North and South County, Mobile Crisis arranges transportation for the client via AMR. In West County, Lompoc Hospital arranges transportation for the client.
  iv. Mobile Crisis updates Smartcare and Smartsheet for the client transfer.

Workflow – Youth Services

Legend: Law Enforcement | Youth Services SAFTY specialist | Average time frame for task

This following related to the workflow for Law Enforcement, Access Line, Schools, Families or the Community to contact SAFTY when an youth is experiencing crisis as well as a step-by-step guide explaining the workflow.



*5150 holds are written for clients aged between 18 and 20.
**South County Cottage Hospital conducts reassessments internally.

Workflow – Youth Services

Step 1: The Youth Services SAFTY specialist receives a telephone call from a youth in need of service or families, schools, Law Enforcement, the Access Line, or the community requesting service on behalf of a youth.

Step 2: The Youth Services SAFTY specialist confirms the client's name, date of birth, and details of the current situation or challenges being experienced by the youth.

Step 3: In instances where the SAFTY specialist directly engages with the youth requiring service, the SAFTY specialist outlines and confirms confidentiality and release of information.

Step 4: Time permitting, the SAFTY specialist conducts a review of its Electronic Health Record (Avatar) to determine any pre-existing client condition and prior engagement history.

Step 5: The SAFTY specialist conducts a high-level risk assessment to consider whether the situation is an emergency or a crisis. The call is considered an emergency if a client requires urgent medical assistance or safety concerns exist.

- **Step 5a:** If the situation is considered an emergency based on the risk assessment, the SAFTY specialist contacts 911 to request medical/Law Enforcement response. The workflow based on this call outcome is subsequently complete.
- **Step 5b:** If the situation is considered a crisis, the SAFTY specialist consults with the on call supervisor to determine whether an in-person evaluation is required based on the risk assessment conducted in step 5.
    i. If the supervisor and specialist determine that an in-person evaluation is required, the **workflow proceeds to Step 6.**
    ii. If the supervisor and specialist determine that an in-person evaluation is not required, the SAFTY specialist subsequently conducts a mental health assessment via telephone. **Workflow proceeds to Step 7b** regarding safety planning**.**

Step 6: The SAFTY specialist determines availability to attend the scene where the youth is experiencing crisis.

- **Step 6a:** If the SAFTY specialist is unavailable due to attending another call, the SAFTY specialist requests support from Mobile Crisis to respond. Alternatively, in certain circumstances, if the youth is willing, the specialist may request Law Enforcement or the youth's parents to transport the youth directly to the Emergency Department.
    i. Based on the report provided to SAFTY by Mobile Crisis or Law Enforcement after the youth's crisis is addressed, the SAFTY specialist.

Workflow – Youth Services

may determine if the youth requires follow up services and can conduct the necessary referral. The workflow based on this call outcome is subsequently complete.

- **Step 6b**: If the SAFTY specialist is available, he/she travels to the scene and undertakes the following:
  i. Contacts the supervisor to inform them that they have arrived at the scene.
  ii. Introduces themselves to the youth and conducts a mental health assessment to determine if the youth meets 5585 or 5150 hold criteria. (5150 holds are written for youths aged between 18 and 20).
  iii. Provides the results of the mental health assessment to the supervisor and consults with them on the appropriate next steps.

Step 7: Based on the mental health assessment and consultation with the on call supervisor, the SAFTY specialist evaluates whether the youth meets one of the following conditions (1) Gravely disabled, (2) Danger to self, or (3) Danger to others.

- **Step 7a:** If the client meets one or more of the conditions outlined in Step 7, the SAFTY specialist writes the appropriate hold (5585 or 5150). He/she also advises the client that they have been placed on hold and will be taken to the nearest hospital for medical clearance (i.e. Marian Medi-cal Center, Lompoc, Santa Barbara) and the following next steps are undertaken:
  i. The SAFTY specialist requests AMR to transport the youth to the Emergency Room. In certain cases, Law Enforcement may transport the youth, depending on client willingness.
  ii. The SAFTY specialist subsequently provides the hold documentation to AMR upon arrival, calls the receiving Emergency Department to inform them that a youth is on route to their facility, and verbally advises the Emergency Department of the client's situation and condition. The SAFTY specialist returns to the office, where they document their interaction in Avatar.
  iii. If the youth is already connected to services, the SAFTY specialist conducts a follow up call to the client's provider and provides an update on engagement with the youth and related outcome. (i.e. hold/safety plan etc.)
  iv. In West and North County, the SAFTY specialist coordinates with Dr. Altobelli and Mobile Crisis daily to reassess youths on hold every 24 hours. In South County, reassessments are conducted internally by Cottage Hospital. The workflow subsequently reverts to Youth Services Bed Placement workflow on page 9.

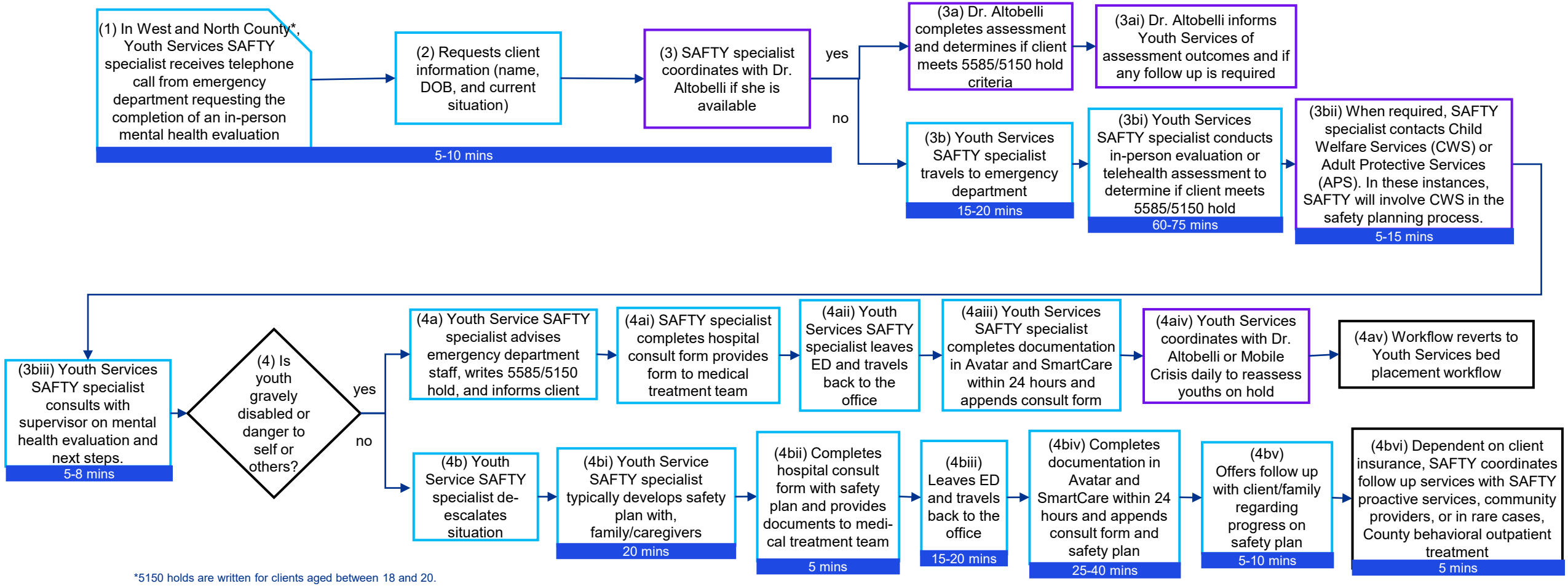
Workflow – Youth Services

- **Step 7b:** If the client does not meet any of the three conditions outlined in Step 7, the following next steps are undertaken:
  i. The SAFTY specialist engages with the client to seek to de-escalate the situation.
  ii. Following de-escalation, the SAFTY specialist develops a safety plan with the youth, and when appropriate, with the family or caregivers. The specialist leaves the scene once the safety plan has been developed.
  iii. The SAFTY specialist offers a follow up with the youth and/or family regarding progress on the safety plan, where the client is willing.
  iv. Dependent on the youth's insurance, SAFTY may coordinate follow up services with SAFTY proactive services, community providers, or in rare cases, County behavioral outpatient treatment.
  v. If the SAFTY specialist coordinates services with County Behavioral Health Services, they share information on client interaction with County Behavioral Health Services staff.
  vi. If the SAFTY specialist coordinates with, community providers, or other services excluding County Behavioral Health Services, the specialist obtains verbal or written consent from the youth to share information on the interaction.
  vii. The SAFTY specialist subsequently documents the interaction with the client in Avatar. The workflow based on this call outcome is subsequently complete.

Workflow – Hospital EDs to Youth Services

Legend: Youth Services SAFTY specialist; Dr. Altobelli; Average time frame for task

This following describes the workflow for youth who require in-person evaluations at Emergency Hospitals and includes a step-by-step guide explaining the workflow in North and West County. In South County, Cottage Hospital write their own 5150/5558 holds.



*5150 holds are written for clients aged between 18 and 20.
**South County Cottage Hospital conducts reassessments internally.

Workflow – Hospital EDs to Youth Services

Step 1: In West and North County, the SAFTY specialist receives a telephone call from the Emergency Department requesting the completion of an in-person mental health evaluation for a youth. In South County, in-person evaluations are undertaken directly by Cottage Hospital.

Step 2: The SAFTY specialist confirms the client's name, date of birth, and details on the current situation or challenges being experienced by the youth.

Step 3: The SAFTY specialist coordinates with Dr. Altobelli to confirm her availability to complete the in-person evaluation.

- **Step 3a:** If Dr. Altobelli is available, she completes the evaluation and determines if the youth meets 5585/5150 hold criteria.
  i. Dr. Altobelli informs the SAFTY specialist if the client meets criteria for a hold based on evaluation and also confirms whether a follow up is required. The workflow based on this call outcome is subsequently complete.
- **Step 3b:** If Dr. Altobelli is not available to complete the in-person evaluation, the SAFTY specialist travels to the Emergency Department or utilizes telehealth to undertake the following key steps:
  ii. Conduct a mental health evaluation to determine if the youth meets the criteria for a 5585/5150 hold.
  iii. If necessary and required, the SAFTY specialist contacts Child Welfare Services (CWS) or Adult Protective Services (APS). In these instances, the SAFTY specialist will inform CWS and APS of the client situation and where appropriate, coordinate with them on any safety planning processes.
  iv. The SAFTY specialist provides the results of the mental health assessment to their supervisor and consults with them on the appropriate next steps.

Step 4: Based on the mental health assessment and consultation with the on call supervisor, the SAFTY specialist evaluates whether the youth meets one of the following conditions (1) Gravely disabled, (2) Danger to self, or (3) Danger to others.

- **Step 4a:** If the client meets one or more of the conditions outlined in Step 4, the SAFTY specialist advises the staff in the Emergency Department, writes the appropriate hold (5585/5150), and informs the client on their status:
  i. The SAFTY specialist completes the hospital consult form and provides that form to the medical treatment team in the Emergency Department.

Workflow – Hospital EDs to Youth Services

ii. The SAFTY specialist leaves the Emergency Department and returns to the office.

iii. Within 24 hours of the client interaction, the SAFTY specialist completes the necessary documentation in Avatar and SmartCare, and appends the hospital consult form.

iv. The SAFTY specialist coordinates with Dr. Altobelli and Mobile Crisis daily to reassess youths on hold.

v. The workflow reverts to Youth Services Bed Placement workflow on page 8.

- **Step 4b:** If the client does not meet any of the conditions in Step 4, the SAFTY specialist engages with the client to seek to de-escalate the situation.

  i. Following de-escalation, the SAFTY specialist develops a safety plan with the youth's family or caregivers.

  ii. The SAFTY specialist completes a hospital consult form with the safety plan and provides the documents to medical treatment team in the Emergency Department.

  iii. The SAFTY specialist leaves the Emergency Department and returns to the office.

  iv. Within 24 hours of the client interaction, the SAFTY specialist completes the necessary documentation in Avatar and SmartCare, and appends the hospital consult form and safety plan documentation to the documentation.

  v. The SAFTY specialist offers a follow up with the youth and/or family regarding progress on the safety plan.

  vi. Depending on the youth's insurance, SAFTY coordinates follow up services with SAFTY proactive services, community providers, or in rare cases, County behavioral outpatient treatment.

Workflow – Youth Services Hospital Bed Placement

Legend
- Youth Services SAFTY specialist
- AMR
- Average time frame for task

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This following workflow relates to the processes that the Youth Services undertake to secure bed placements at local psychiatric hospitals and includes a step-by-step guide explaining the workflow.

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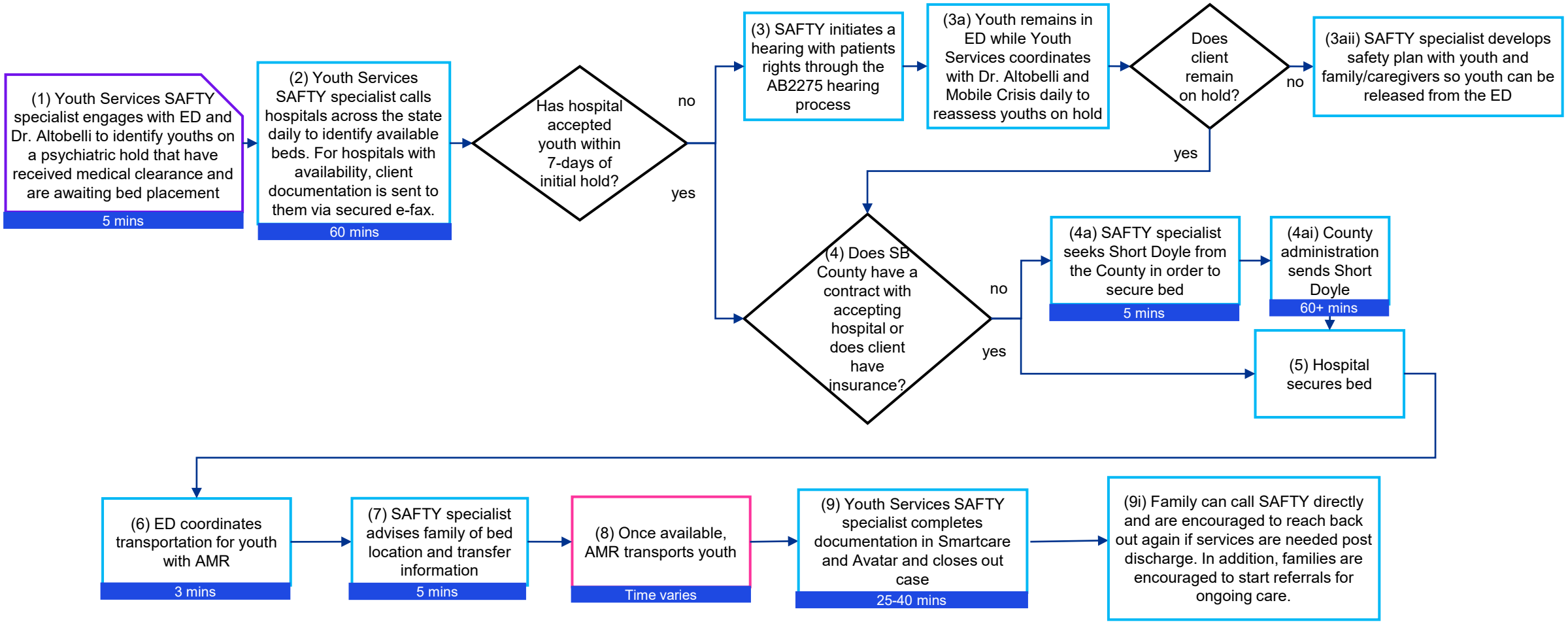


Workflow – Youth Services Hospital Bed Placements

Step 1: The SAFTY specialist engages with Emergency Department and Dr. Altobelli to identify youths on a psychiatric hold that have received medical clearance and are awaiting bed placement.

Step 2: The SAFTY specialist calls hospitals across the state daily to identify available beds. For hospitals with availability, documentation on the youth is sent to the hospitals via secured e-fax.

Step 3: If a youth continues to remain in the Emergency Department for 7 or more days post being place on hold, the SAFTY specialist initiates a hearing with patients rights through the AB2275 hearing process.

- **Step 3a:** During the hearing process, the youth remains in the Emergency Department. On a daily basis, the SAFTY specialist coordinates with Dr. Altobelli and Mobile Crisis to reassess the youth on hold.
    i. If the hold continues to remain, the youth remains in the Emergency Department until a bed becomes available and the **workflow proceeds to Step 4.**
    ii. If the hold is rescinded, the SAFTY specialist develops a safety plan with the youth and family/caregivers so that the youth can be discharged from the Emergency Department. The workflow is subsequently completed based on this outcome.

Step 4: If a youth is accepted into a hospital, the client's insurance and Santa Barbara's contract status are considered prior to hospital acceptance.

- **Step 4a:** If Santa Barbara County does not have a contract with the accepting hospital or the youth does not have insurance, the accepting hospital requests a Short Doyle from the County in order to secure payment for the youth's bed placement:
    i. Santa Barbara's County administration acknowledges the request and sends the Short Doyle to the hospital. The **workflow proceeds to step 5.**
- **Step 4b:** If Santa Barbara County has a contract with the accepting hospital, or the client has insurance, the **workflow proceeds to Step 5.**

Step 5: The accepting hospital confirms client acceptance and secures bed placement. The bed placement is secured following receipt of the Short Doyle requested in step 4, where required.

Step 6: The Emergency Department where the youth is located engages with AMR to coordinate transportation of the youth from the Emergency Department to the accepting hospital

Workflow – Youth Services Hospital Bed Placements

Step 7: The SAFTY specialist contacts the youth's family or caregivers and provides them with the name and location of the accepting hospital and all other pertinent transfer information. The SAFTY specialist will also answer any questions the family may have.

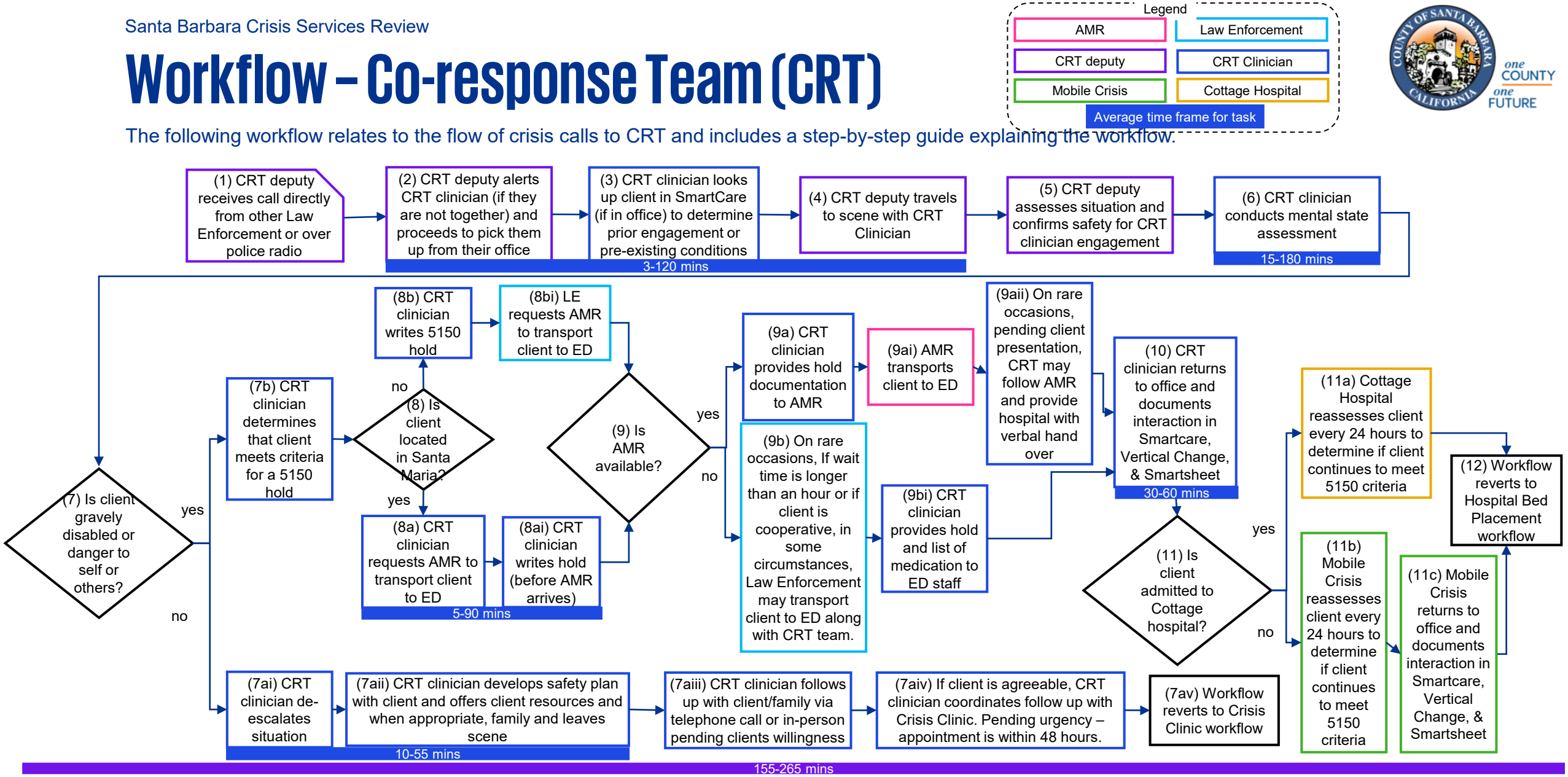
Step 8: Once an AMR becomes available, the AMR transports the youth to the accepting hospital. The estimated arrival time is not provided by the AMR and often times, a secured bed may be lost due to the significant lapse in time between securing bed placement and transportation.

Step 9: Once the youth is successfully transferred, the SAFTY specialist completes documentation regarding the youth in Smartcare and Avatar.

i. If desired, once the youth is discharged from the facility, the family is encouraged to call SAFTY if they believe that the youth can benefit from additional services. Families are also encouraged to start referrals for ongoing care.

Workflow – Co-response Team (CRT)

The following workflow relates to the flow of crisis calls to CRT and includes a step-by-step guide explaining the workflow.



* The purpose of a workflow time log is to provide the reader with information on the length of time each step takes as well any variances across teams. However, the timelines provided to the consulting team were clustered across steps. This creates challenges in accurately identifying opportunities for process efficiency across teams.

Workflow – CRT

Step 1: The CRT deputy receives a mental health crisis call from other Law Enforcement or over the police radio.

Step 2: The CRT deputy alerts the CRT clinician of the mental health crisis call, where they are not together and the CRT deputy collects the CRT clinician from their office.

Step 3: If the CRT clinician is in the office at the time of call receipt, the CRT clinician reviews the County's EHR, Smartcare to determine if the client has any pre-existing conditions or prior engagement with CRT or Mobile Crisis.

Step 4: The CRT deputy, accompanied by the CRT clinician, travels to the scene.

Step 5: Upon arrival, the CRT deputy assesses the situation and determines if it is safe for the CRT clinician to engage with the client.

Step 6: Where the CRT deputy, confirms the safety of the scene, the CRT clinician introduces him/herself to the client and conducts a mental state assessment.

Step 7: Based on the mental state assessment, the CRT clinician evaluates if client meets one of the following three conditions (1) Gravely disabled, (2) Danger to self, or (3) Danger to others.

- **Step 7a:** If the client does not present any of the conditions listed in Step 7, the following next steps are undertaken:
  i. The CRT clinician engages with the client to de-escalate the situation.
  ii. Following de-escalation, the CRT clinician develops a safety plan with the client, and when appropriate, with the family or caregivers. The clinician leaves the scene once the safety plan has been developed.
  iii. The CRT clinician follows up with the client and/or family via telephone or in-person, pending client willingness.
  iv. If the client is in agreement to ongoing services post follow up, the CRT clinician coordinates a follow up appointment with the Crisis Clinic. If the situation is urgent, the appointment is normally scheduled to occur within the next 48 hours.
  v. The CRT clinician workflow based on this call outcome is subsequently complete and the workflow reverts to the Crisis Clinics workflow.
- **Step 7b:** If the client presents one or more of the conditions listed in Step 7, the CRT clinician determines that the client meets the criteria for a 5150 hold**. The workflow proceeds to Step 8.**

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Workflow – CRT

Step 8: If it is determined that the client meets the criteria for a 5150 hold, the workflow varies slightly depending on the client's location.

- **Step 8a:** If the client is located in Santa Maria, the CRT clinician requests the AMR to transport the client to the nearest Emergency Department.
  i. While the CRT clinician awaits the AMR's arrival, the CRT clinician writes the 5150 hold for the client. The workflow proceeds to Step 9.
- **Step 8b:** If the client is in a city other than Santa Maria, the CRT clinician commences the writing of the 5150 hold.
  ii. Law Enforcement concurrently requests the AMR to transport the client to the nearest Emergency Department.

Step 9: AMR travels to the scene in instances where they are available.

- **Step 9a:** If the AMR is available to transport the client within a timely manner, the CRT clinician provides the hold documentation directly to the AMR.
  i. AMR transports the client to the Emergency Department.
  ii. Pending client presentation, CRT may follow AMR to the Emergency Department and provide a verbal handover.
- **Step 9b:** If AMR is not available within a timely manner (i.e. within an hour) and pending client cooperation, Law Enforcement may transport clients to the Emergency Department. This occurs on rare occasions.
  i. If Law Enforcement transports a client to the Emergency Department, the CRT Team will follow Law Enforcement to the Emergency Department and provide hold documentation as well as a list of medication to Emergency Department staff, where available. It is important to note, this occurs on very rare occasions.

Step 10: The CRT Team leaves the Emergency Department or scene and returns to the office and documents the interaction with the client in Smartcare, Vertical Change, and Smartsheet.

Step 11: This step is dependent on the Emergency Department to which a client in crisis is admitted.

- **Step 11a:** If the client is admitted to Cottage Hospital's Emergency Department, Cottage Hospital reassesses the client every 24 hours to determine whether the hold continues to remain. The workflow proceeds to Step 12.

Workflow – CRT

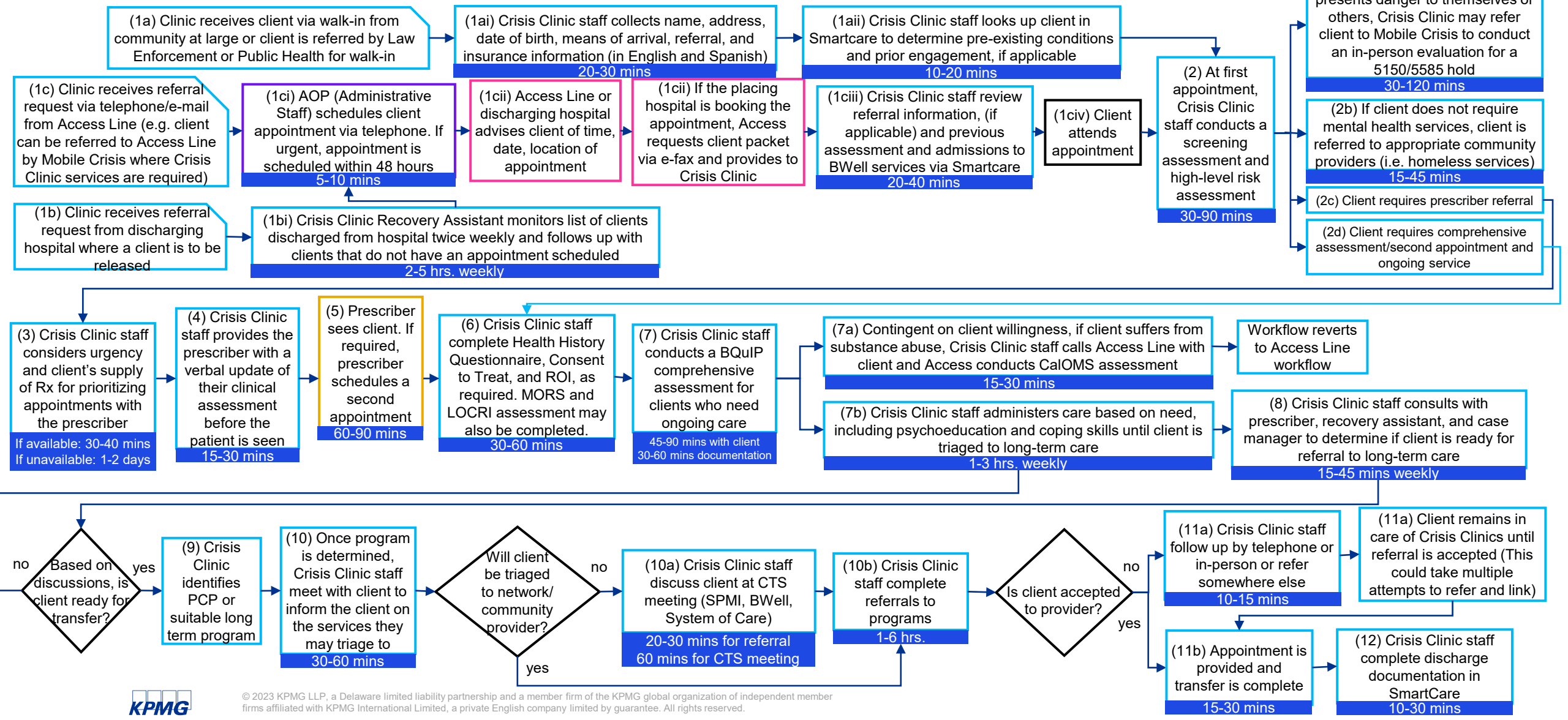
- **Step 11b:** If the client is admitted to an Emergency Department other than Cottage Hospital, the *Mobile Crisis* team reassesses the client every 24 hours to determine whether hold continues to remain
- **Step 11c:** Mobile Crisis returns to office and documents interaction in Smartcare, Vertical Change, & Smartsheet

Step 12: The workflow reverts to the Hospital Bed Placement workflow.

Santa Barbara Crisis Services Review

Workflow – Crisis Clinics

This following workflow relates to Crisis Clinics processes.



Workflow – Crisis Services Clinics

The commencement of this workflow is contingent on the form in which the Crisis Clinic receives a client.

Step 1a: The Crisis Clinic receives a client via walk-in from the community at large or the client is referred to the clinic by either Law Enforcement or Public Health for a walk-in.

i. The Crisis Clinic staff collects and documents the client's name, address, date of birth, means of the client's arrival, the client's referral source, and the client's insurance information in both English and Spanish.

ii. The Crisis Clinic staff looks up the client in Smartcare to determine a client's pre-existing condition and prior engagement history (if any). **The workflow proceeds to step 2.**

Step 1b: The Crisis Clinic receives a referral request from a hospital where a client is to be discharged.

i. The Crisis Clinic Recovery Assistant monitors a list of clients that are discharged from hospitals two times a week and then follows up with the clients that do not have an appointment scheduled with the Crisis Clinic. **The workflow proceeds to step 1c(i).**

Step 1c: The Crisis Clinic receives a referral request for a client via either telephone or e-mail from the Access Line (e.g. a client can be referred to the Access Line by Mobile Crisis where Crisis Clinic services are required.)

i. The Crisis Clinic administrative staff subsequently schedules an appointment for the client via telephone. If the matter is considered urgent, the appointment is normally scheduled within the next 48 hours.

ii. The Access Line or the discharging hospital provide the client with the time, date, and location of the scheduled appointment. If the hospital is scheduling the appointment, the Access Line staff requests a client packet via e-fax and provides the packet to the Crisis Clinic.

iii. Prior to the appointment, the Crisis Clinic staff utilizes Smartcare to review the client's referral information (if applicable) and any available information on the client's previous assessments and admissions to BWell services.

iv. After the Crisis Clinic staff conducts the review in Smartcare, the client attends the appointment. **The workflow proceeds to step 2.**

Step 2: At the client's initial appointment, the Crisis Clinic staff conducts a screening assessment and high-level risk assessment to assess the client's mental state and determine the appropriate level of care and services. There is not a standardized form for this assessment.

Workflow – Crisis Services Clinics

- **Step 2a:** If the client is considered to be gravely disabled, or presents danger to themselves or others, the Crisis Clinic may refer the client to Mobile Crisis to conduct an in-person evaluation for a 5150/5585 hold. The workflow subsequently reverts to the Mobile Crisis Team Workflow.
- **Step 2b:** In certain instances, the client may not require mental health services and the Crisis Clinics may not provide the appropriate services, e.g., housing support. In these instances, the client is referred to the appropriate community providers (e.g., homeless services).
- **Step 2c:** In other circumstances, the client may require medication support. In these instances, the client is referred to the Crisis Clinic prescriber and the **workflow proceeds to step 3**.
- **Step 2d:** Lastly, the client may require a comprehensive assessment or second appointment and ongoing services. In these instances, **the workflow proceeds to step 6.**

Step 3: For the purposes of prioritizing scheduling with prescriber, Crisis Clinic staff considers the urgency and the client's supply of medication. Prescriber appointments can occur within 30 to 40 minutes or within 1 to 2 days based on prescriber availability.

Step 4: Prior to the appointment, the Crisis Clinic staff provides the prescriber with a verbal update of their clinical assessment of the client.

Step 5: Once the initial appointment is held, if required, the prescriber schedules a second appointment with the client.

Step 6: The Crisis Clinic staff completes several forms and documentation including a Health History Questionnaire, Consent to Treat, and Release of Information (ROI), as required. Milestones of Recovery Scale (MORS) and Level of Care and Recovery Inventory (LOCRI) assessments may also be completed.

Step 7: After the documentation is completed, the Crisis Clinic staff conducts a Brief Questionnaire for Initial Placement (BQuIP) comprehensive assessment if the client requires ongoing care and services.

- **Step 7a:** If the client suffers from substance abuse, contingent on client willingness, the Crisis Clinic staff calls the Access Line with the client present and the Access Line staff conducts a California Outcomes Measurement System (CalOMS) assessment. **The workflow subsequently reverts to the Access Line workflow.**
- **Step 7b:** The Crisis Clinic staff administers care to the client based on the client's need, including psychoeducation and coping skills, until the client is triaged to long-term care. **The workflow based on this outcome proceeds to step 8.**

Workflow – Crisis Services Clinics

Step 8: After administering care, the Crisis Clinic staff consults with the client's prescriber, recovery assistant, and case manager to determine if the client is ready for referral to long-term care.

Step 9: Based on discussions held under step 8, if the client is deemed ready for referral and transfer to long-term care, the Crisis Clinic staff refers the client to a primary care provider or a suitable long-term program. If the client is not ready for referral to long-term care, they continue to receive services from the Crisis Clinic.

Step 10: Once the appropriate program for the client is determined, the Crisis Clinic staff meets with the client to provide information on the services the client may triage to.

- **Step 10a:** If the client is to be triaged to other Serious Persistent Mental Illness (SPMI), BWell, or System of Care providers, the Crisis Clinic staff discusses the client at a Comprehensive Therapeutic Services (CTS) meeting to consider appropriate program. If a suitable program is determined, the Crisis Clinic staff completes the referral after the CTS meeting is held.
- **Step 10b:** If the client is to be triaged to a network or community provider, Crisis Clinic staff completes the referral.

Step 11: The client must subsequently be accepted to the referred services for transfer to occur.

- **Step 11a:** If the suggested provider does not accept the client, the Crisis Clinic staff follows up with the provider by telephone or in-person. If acceptance is still not granted, the staff refers the client to another provider. The client remains in the care of the Crisis Clinics until the referral is accepted. **The workflow proceeds to step 12.**
- **Step 11b:** If the client is accepted, the client's appointment is scheduled and provided. The transfer is thereby complete.

Step 12: After the transfer, the Crisis Clinic staff completes discharge documentation in SmartCare.

Performance Analysis

Data Sources

In conducting this review, KPMG reviewed over 10 datasets related to staffing, productivity, call volumes, average length of service, response times, and financials. The following table outlines and describes the key data sources received by KPMG in conducting this review. There were a number of challenges identified with several of the datasets provided and these challenges have been outlined in detail on the following page.

Data Source	Data Description
Productivity data	KPMG was provided with aggregate productivity data from January 2021 (Q3 FY20-21) to March 2023 (Q3 FY22-23). The Department developed this productivity data by exporting data from the Department's EHR and combining it with employee timecard data to develop a complete understanding of staff time and activity.
Clinician's Gateway data and Smartcare data	EHR data which provides data on number of clients served, presenting issues, length of intervention, average length of service, and cancellation/no shows across all crisis services programs (i.e., Mobile Crisis, Co-response, and Crisis Clinics). Clinician's Gateway data was provided over a three-year period from FY20-22. In July 2023, the Department transitioned its EHR from Clinician's Gateway to SmartCare. KPMG received Smartcare data for a one month period i.e., August 2023.
Vertical Change data	Includes data on call volumes, response times, call source, and outcomes, specifically for co-response teams over a three-year period from FY 20-22. This dataset was initially created specifically to track grant metrics related to Co-response.
Smartsheet data	Provides data related to call volumes, referral source, response times, location of evaluation, method of evaluation, and outcome for both Mobile Crisis and Co-response from December 2021 to July 2023. This data is collected by the Department to support leadership in understanding Mobile Crisis and Co-response call volumes and response times, given this information is not available within the Department's EHR and thus requires manual collection via Smartsheet.
KPMG data collection template	Due to a number of data limitations outlined on the following page, KPMG requested that the **Mobile Crisis and Co-response** teams, collect 21 key data points identified by KPMG over a four-week period. These data points included call volumes, response times, call source, evaluation location, outcome, Law Enforcement involvement, and referral facility.
Youth Services data	Data provided by Casa Pacifica which identifies call volumes, referral source, reason for call, call outcome, and length of time to dispatch, and travel time for youth crisis services teams over a three-year period from FY20-22.
Access Line data	Includes call volumes and call types for all calls received by the Access Line over a three-year period from FY20-22.
Protocall data	PDF documents which identify call volumes as well as cost data for all Protocall calls from June 2022 to June 2023.
Financial Budget data	Provides revenue and expenditure data for the Crisis Services Program over a three-year period (FY20-22).

Data Limitations

During analysis, a number of data limitations and challenges were identified with several key datasets provided by the Department, as outlined in the table below. Furthermore, an initial analysis of Crisis Program data suggested significantly low volumes across crisis teams which did not appear to align with staff reports during interviews. As a result, KPMG requested and facilitated the collection of 21 key data points across Mobile crisis and Co-response teams over a four-week period (August 7 – September 3, 2023). A detailed overview of the steps undertaken to support crisis services staff in the collection of these data points has been included in the Appendix to this report. However, the results of this four-week analysis did not significantly differ from the original analysis undertaken and the Crisis Services Program experienced low volumes across teams.

Data Source	Data Limitation and Impact to Analysis
Productivity data	As part of analysis, KPMG compared the employee names within the productivity data provided with the employee names per current team staffing schedules. Based on this comparative analysis, **six employees were missing from the productivity report provided**. All six employees are currently assigned to crisis clinics with one employee working in South County, two working in North County, and three working in West County. KPMG requested an update report from the Department that included the six employees; however, were advised that an update report could not be provided. The exclusion of these six employees may skew the productivity analysis for each crisis clinic. Furthermore, crisis staff members often work across multiple teams to meet peak demand volumes; therefore, supporting the Access Line incoming telephone calls, or conducting activity for mobile crisis service. All activity conducted by front line staff has been included as part of the Department's productivity calculation which is outlined beginning on page 71 of this report with further regional level analysis included within the Appendix of this report.
Clinician's Gateway data	Clinician's Gateway data does not separately identify whether client contact was with Mobile Crisis, Co-response, or Crisis Clinics. While KPMG explored options to bifurcate the data across teams within Clinician's Gateway, these options were unsuccessful. As a result, it is was not possible to utilize this dataset to complete a more granular team level analysis that is linked to the varying role and responsibility of each service over a thee-year period.
Vertical Change data	Vertical Change data identifies the number of calls responded to by Co-response teams. While the data integrity of this dataset was significantly better than the Smartsheet data provided, a significant number of blank cells were identified related to response times, time spent on scene, and call outcomes. Resultantly, this limited analysis on Co-response workload and response time as well as acuity of individuals requiring service.

Data Limitations

Data Source	Data Limitation and Impact to Analysis
Smartsheet data	Mobile Crisis and Co-response collect all data related to call volume, response times, and call outcome manually utilizing Smartsheet, given the EHR system does not have functionality to collect these data points. However, as a result of the manual nature of data collection, a significant number of blank cells (between 14 percent and 75 percent) were identified within the dataset which reduced the reliability of the data in developing critical insights. Furthermore, the dataset does not separately identify whether a call was responded to by Mobile crisis or Co-response, limiting the opportunity to conduct a team level analysis utilizing this dataset.
Protocall data	Protocall data encompassed billing reports which were provided in PDF format. These PDF documents identified call volumes as well as cost data. Given PDF does not allow for ease of analysis, KPMG conducted an analysis of call volumes by time of day for a sample period (April 2023 – June 2023).
FTE and staffing data	FTEs were identified based on staffing charts provided by the Department. However, Division leadership notes that in many cases, staff work across a variety of programs including Crisis Services (i.e. Mobile Crisis, Co-response, Crisis Clinics). Therefore, FTE numbers may vary based on demand at any specific time.
Financial Budget data	Department budgets do not track cost data by team, but rather track costs by region. Therefore, cost of interaction per team could not be calculated. Instead, KPMG developed cost of interaction per region across all teams. However, this does not provide insight into team level costs to allow for comparison across regions, service, and identify targeted opportunities for enhanced financial efficiency.

Key Data Insights

The following slides contain a summary of performance data for each team including Mobile Crisis, Co-response, Crisis Clinics, Access Line, and Protocall. A more detailed analysis is included in the Appendix to this report. The following are the key takeaways based on the analysis undertaken:

- **Productivity:** KPMG understands that the Department's productivity target for client services is 50 percent, which aligns to industry knowledge for Mobile Crisis and Co-response services, i.e., *direct therapeutic interaction*. However, typically higher targets are in place for office-based crisis services (i.e. Crisis Clinics), as they align with outpatient office-based services. Based on data analysis, undertaken between Q3 FY20-21 – Q3 FY22-23, Mobile Crisis , Co-response, and Crisis Clinics, **rarely met the Department's performance target of 50 percent, as outlined in the following section, with productivity averaging 23 percent across teams**. The Department includes additional activities under productivity that are not deemed *direct therapeutic interactions*. KPMG outlines a number of opportunities to enhance team productivity for future considerations.
- **Mobile Crisis Service:** Based on data collected by KPMG over the four-week period (August 7 – September 3, 2023), Mobile Crisis experience low volumes with an **average of 49 interactions per week across three teams**. This equates to **16 service interactions per week per team, two service interactions per day per team, or less than three service interactions per FTE**, based on the 17 FTEs employed. Across weeks, Mobile Crisis spent an average of 98 minutes on crisis services calls. These low volumes align with the two-year productivity analysis outlined above. Finally, 66 percent of the calls responded to between August 7 – September 3, 2023 occurred in settings that will not be reimbursable post Medi-Cal Crisis Benefit Implementation. Please refer to opportunity 2.1 for further information on potential opportunities to redesign Mobile Crisis to align with the Medi-Cal Crisis Benefit requirements.
- **Co-response Services:** Similar to Mobile Crisis , Co-response teams also experienced low volumes over the four-week period analyzed with a total of 62 calls received across its three teams. This equates to an average of **16 service interactions per week, five service interactions per team per week, or one service interaction per day** across each team. Across weeks, Co-response spent an average of 77 minutes on crisis services calls, lower than that of Mobile Crisis. Again, these low volumes align with the two-year productivity analysis outlined above.
- **Crisis Clinics:** In addition to Mobile Crisis and Co-response, Crisis Clinics also experienced relatively low volumes over the period analyzed which would suggest significant capacity. Between August 7 and September 3, 2023, Crisis Clinics experienced an average of 55 service interactions per week**, 18 interactions per clinic per week, or less than four interactions per day across each clinic**. On average each service interaction took an average of 27 minutes. Based on the average number of weekly service interactions, this equates to 25 hours or 0.6 FTEs, based on a 40-hour week against the 17.25 FTEs employed including 1.25 FTE prescribers.

Key Data Insights

- **Youth Crisis Services:** Similar to both Mobile Crisis and Co-response, Youth Crisis Services experiences low call volumes. Over a three-year period, FY20-FY22, an average of 2,118 calls were received annually. This equates to **six calls per 12-hour shift**. However, 11 percent of these calls (one call) are related to locating a bed placement for a client and upon exclusion of these calls, **an average of five calls are received per 12-hour shift.** However, it is also important to note that an average of **70 percent of calls received** do not require an in-person response. Please refer to opportunity 4.1 for further information on potential opportunities to redesign Mobile Crisis and Youth Crisis Services to account for the new Medi-Cal Crisis Benefits.
- **Access Line:** Based on analysis undertaken from the Access Line call answering system, an average of **66 calls per day/7 calls per hour between 8 a.m. and 5 p.m. are answered daily**. On average, 47 of these calls are incoming calls while an average of 19 are outgoing. The mean call handling time is 28 minutes for incoming calls (call handling time is not available for outgoing calls), the **Access Line staff are 75 percent utilized on a daily basis based on the budgeted 5.5 FTE over a three-year period**. An average of 59 percent of all calls handled were classified as Mental Health; however, based on the data provided, it was not possible to identify those calls that resulted in engagement with Mobile Crisis, Co-response, or Crisis Clinics.
- **Protocall:** Protocall answers Access Line calls between 5 p.m. and 8 a.m. during week days, from 5 p.m. on Friday until Monday at 8 a.m. They receive an **average of 19 calls per day or 1.4 calls per hour, during hours of operation.** Volumes are low between 10 p.m. and 7 a.m. daily with less than one call typically received during this period. While it is understood the Department is considering transitioning from Protocall to a local provider to answer calls in the future, the Department may consider transitioning Access Line calls to Mobile Crisis particularly during 10 p.m. and 7 a.m. given the low volumes experienced during these times. Please refer to opportunity 5.1 for further detail on this potential transition,

Cost of Service Interaction per Region

Based on a review of financial data provided and engagement with the Department's Finance Division, **it is not possible to bifurcate cost by crisis services program** (i.e., Mobile Crisis, Co-response, and Crisis Clinics). As such, **a cost estimate per service interaction has been developed *by region*.** This was undertaken utilizing the following steps:

- Financial Information System (FIN) data was analyzed to determine average regional cost for crisis services over a three-year period (FY20-22).
- Total average volume per region across Mobile Crisis, Crisis Clinics, and Co-response was identified utilizing data from Clinician's Gateway, the Department's EHR between FY20 and FY22.
- Average cost per service interaction per region was calculated by dividing average annual cost between FY 20 and FY22 by average annual volume based on Clinician's Gateway data over the same period.
- **It is important to note that these costs are estimates only and are based on the financial data received. As such, we would encourage the Department to only use these findings as estimates and not to draw final conclusions based on this analysis. In order to draw firm conclusions, a more detailed financial analysis should be undertaken by the Department.**

Region	Average Actual Cost FY20-22	Total Average Volume FY20-22	Average Cost per Service Interaction per Region
North	$ 2,001,743	2,838	$705
South	$ 2,601,836	2,237	$1,163
West	$ 1,460,822	1,624	$899
Total	**$ 6,064,401**	**6,699**	**$905**

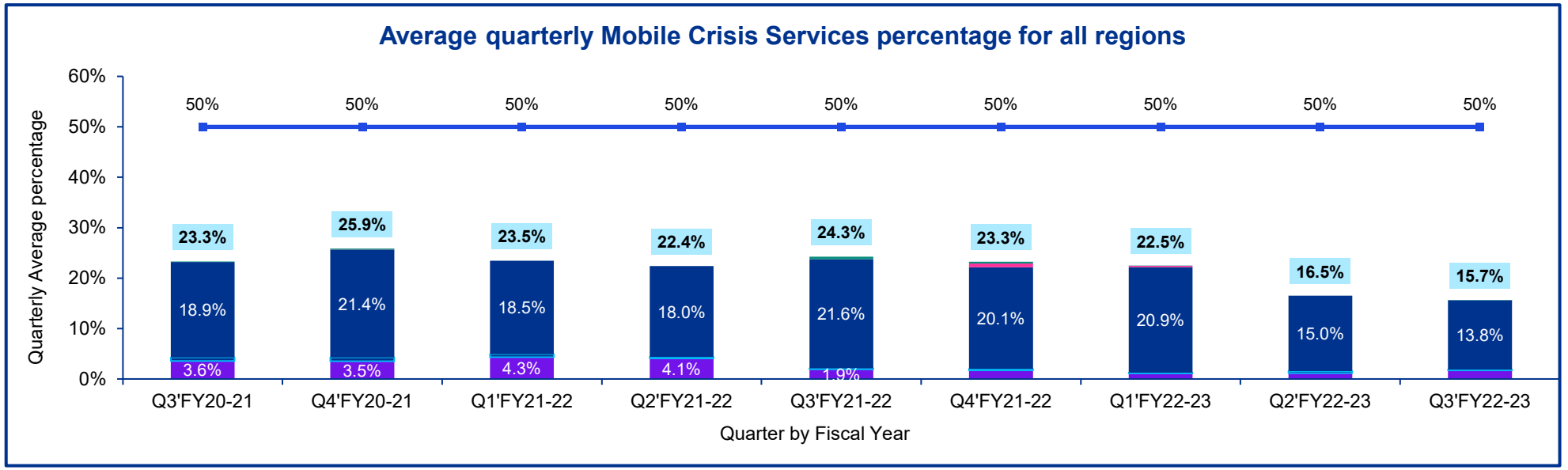
- Given the Co-response has one team that operates between North and West County, 50 percent of the North County cost per visit and 50 percent of the West County cost per visit were added together to estimate average cost per service for Co-response Services offered in North and West County. i.e. (705/2 + $899/2 = $802)

Crisis Services Productivity Analysis

Mobile Crisis Teams – All Regions

Key

- Target
- Mobile Crisis Percentage
- Direct Services Percentage
- Client Support Services Percentage
- MCO Percentage
- Quality Control Management (QCM) Percentage
- *Access Line Percentage



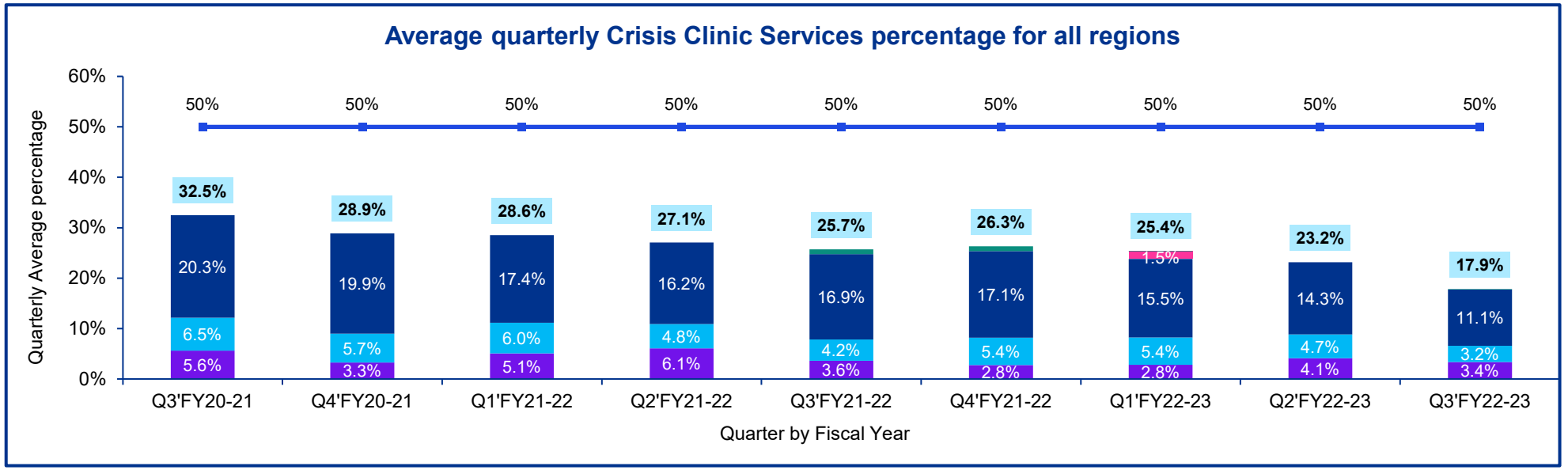
	Q3'FY20-21	Q4'FY20-21	Q1'FY21-22	Q2'FY21-22	Q3'FY21-22	Q4'FY21-22	Q1'FY22-23	Q2'FY22-23	Q3'FY22-23
Target	50%	50%	50%	50%	50%	50%	50%	50%	50%
Average Mobile Crisis Percentage	23.3%	25.9%	23.5%	22.4%	24.3%	23.3%	22.5%	16.5%	15.7%
Average Direct Services Percentage	18.9%	21.4%	18.5%	18.0%	21.6%	20.1%	20.9%	15.0%	13.8%
Average Client Support Services Percentage	0.7%	0.7%	0.6%	0.3%	0.2%	0.3%	0.2%	0.4%	0.1%
Average MCO Percentage	0.0%	0.0%	0.0%	0.0%	0.0%	0.8%	0.3%	0.0%	0.0%
Average QCM Percentage	0.1%	0.2%	0.0%	0.0%	0.5%	0.4%	0.1%	0.0%	0.0%
*Average Access Percentage	3.6%	3.5%	4.3%	4.1%	1.9%	1.7%	1.1%	1.2%	1.7%

	Q3'FY20-21	Q4'FY20-21	Q1'FY21-22	Q2'FY21-22	Q3'FY21-22	Q4'FY21-22	Q1'FY22-23	Q2'FY22-23	Q3'FY22-23
Training Percentage	1.1%	1.7%	0.4%	3.6%	2.5%	1.8%	2.4%	1.0%	2.0%
Meeting Percentage	0.0%	0.4%	0.8%	0.7%	0.9%	1.4%	0.8%	0.9%	0.5%

Crisis Clinic Teams – All Regions

Key

- Target
- Crisis Clinics Percentage
- Direct Services Percentage
- Client Support Services Percentage
- MCO Percentage
- Quality Control Management (QCM) Percentage
- *Access Line Percentage



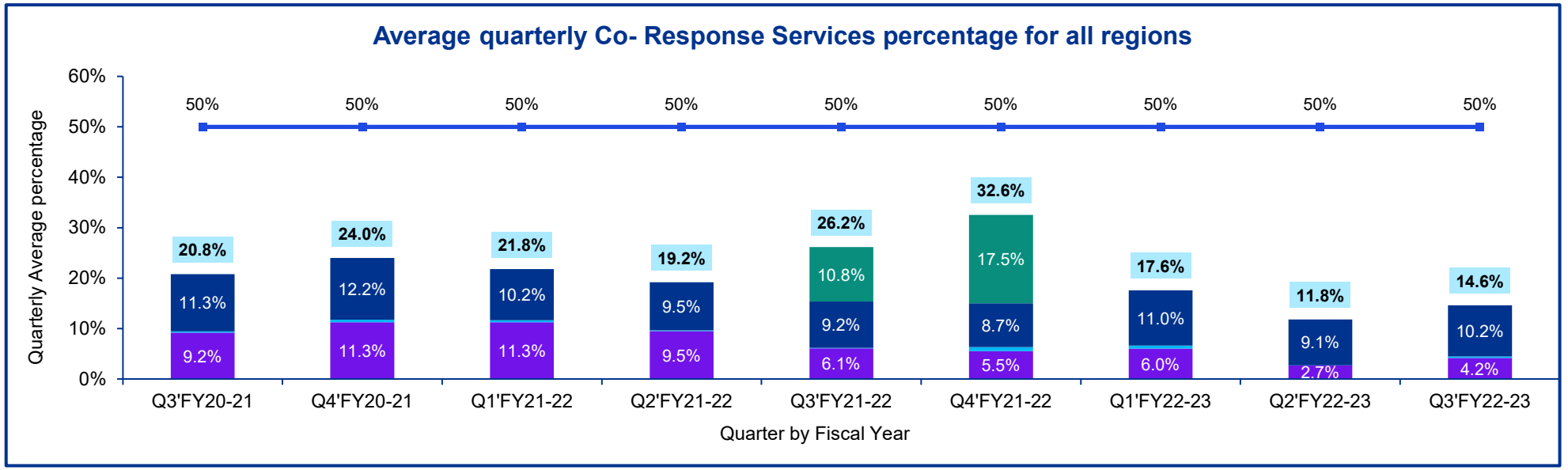
	Q3'FY20-21	Q4'FY20-21	Q1'FY21-22	Q2'FY21-22	Q3'FY21-22	Q4'FY21-22	Q1'FY22-23	Q2'FY22-23	Q3'FY22-23
Target	50%	50%	50%	50%	50%	50%	50%	50%	50%
Average Mobile Crisis Percentage	32.5%	28.9%	28.6%	27.1%	25.7%	26.3%	25.4%	23.2%	17.9%
Average Direct Services Percentage	20.3%	19.9%	17.4%	16.2%	16.9%	17.1%	15.5%	14.3%	11.1%
Average Client Support Services Percentage	6.5%	5.7%	6.0%	4.8%	4.2%	5.4%	5.4%	4.7%	3.2%
Average MCO Percentage	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.5%	0.0%	0.0%
Average QCM Percentage	0.0%	0.0%	0.0%	0.0%	0.9%	0.9%	0.1%	0.0%	0.1%
*Average Access Percentage	5.6%	3.3%	5.1%	6.1%	3.6%	2.8%	2.8%	4.1%	3.4%

	Q3'FY20-21	Q4'FY20-21	Q1'FY21-22	Q2'FY21-22	Q3'FY21-22	Q4'FY21-22	Q1'FY22-23	Q2'FY22-23	Q3'FY22-23
Training Percentage	7.3%	8.5%	4.6%	6.3%	3.8%	3.7%	1.7%	4.5%	9.4%
Meeting Percentage	10.9%	11.1%	9.8%	10.2%	8.2%	7.7%	6.8%	8.3%	10.7%

Co-Response Teams – All Regions

Key

- Target
- Co-Response Percentage
- Direct Services Percentage
- Client Support Services Percentage
- MCO Percentage
- Quality Control Management (QCM) Percentage
- *Access Line Percentage



	Q3'FY20-21	Q4'FY20-21	Q1'FY21-22	Q2'FY21-22	Q3'FY21-22	Q4'FY21-22	Q1'FY22-23	Q2'FY22-23	Q3'FY22-23
Target	50%	50%	50%	50%	50%	50%	50%	50%	50%
Average Mobile Crisis Percentage	20.8%	24.0%	21.8%	19.2%	26.2%	32.6%	17.6%	11.8%	14.6%
Average Direct Services Percentage	11.3%	12.2%	10.2%	9.5%	9.2%	8.7%	11.0%	9.1%	10.2%
Average Client Support Services Percentage	0.3%	0.5%	0.4%	0.1%	0.1%	0.8%	0.6%	0.0%	0.3%
Average MCO Percentage	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Average QCM Percentage	0.0%	0.0%	0.0%	0.0%	10.8%	17.5%	0.0%	0.0%	0.0%
*Average Access Percentage	9.2%	11.3%	11.3%	9.5%	6.1%	5.5%	6.0%	2.7%	4.2%

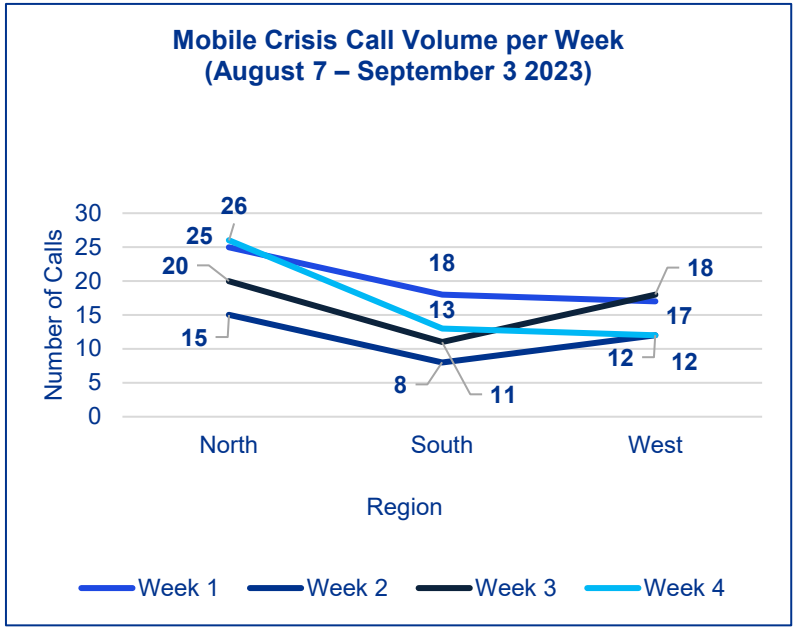
	Q3'FY20-21	Q4'FY20-21	Q1'FY21-22	Q2'FY21-22	Q3'FY21-22	Q4'FY21-22	Q1'FY22-23	Q2'FY22-23	Q3'FY22-23
Training Percentage	2.1%	0.7%	2.2%	1.0%	1.3%	0.6%	1.4%	1.5%	4.2%
Meeting Percentage	0.6%	0.5%	0.8%	0.6%	0.5%	0.2%	0.5%	0.1%	0.2%

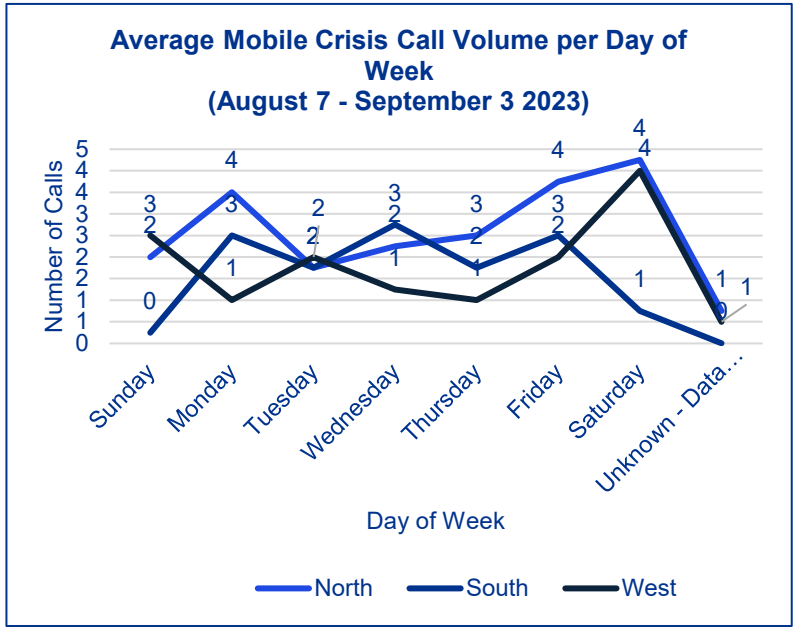
KPMG four-week analysis – Mobile Crisis and Co-response Teams

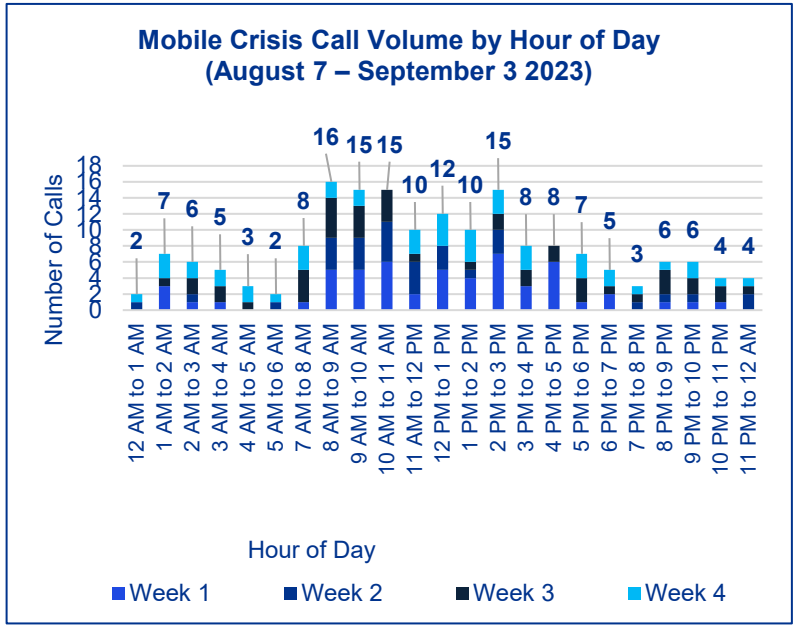
Mobile Crisis Data Analysis (Aug 7 – Sept 3, 2023)

In total, Mobile Crisis received a total of 195 calls over the four-week period analyzed, this equates to an average of 49 service interactions per week, 16 service interactions per week per team, or 2 service interactions per day per team. On average, Saturday was the busiest day of the week across teams with Sunday representing the day with the lowest call volumes. 47 percent of all calls resulted in a 5150/5585 hold and 67 percent of the calls occurred in settings that will not be reimbursable post Medi-Cal Crisis Benefit Implementation.*

Total Mobile Crisis FTES**	Average Weekly Call Volume per Team	Average Weekly Daily Volume per Team	Busiest Day of the Week	Busiest Hour of Day	% Law Enforcement Involvement	% Face- to-Face Contact	Most common Service Location***	Most common Service Outcome	Average Response Time	Average Time Spent of Call	Average AMR Response Time
17	16	2	Saturday	8AM – 9AM	43%	87%	ER(50%)	Hold (47%)	21 mins	98 mins	28 mins







*Please refer to Appendix for a detailed analysis of Mobile Crisis Services by Region

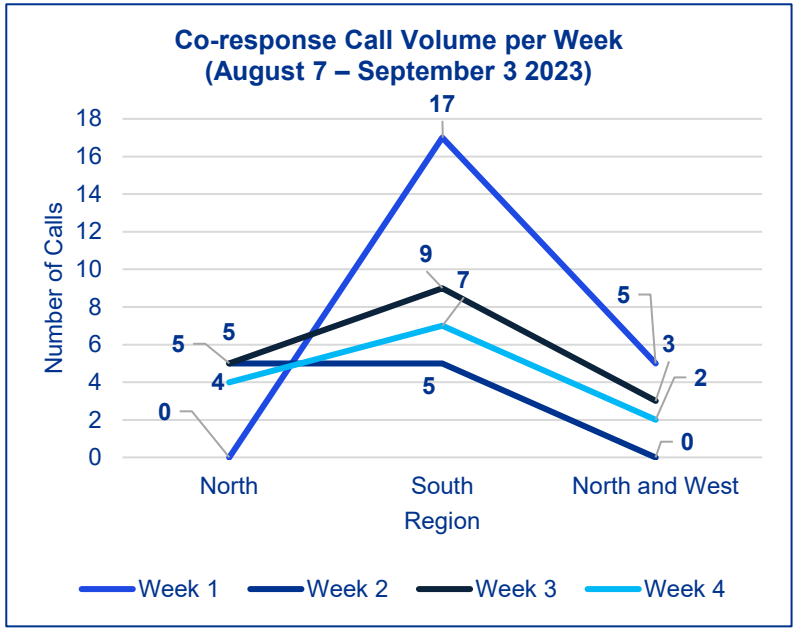
**FTEs exclude management, supervisory, and administrative staff given they do not typically provide frontline services

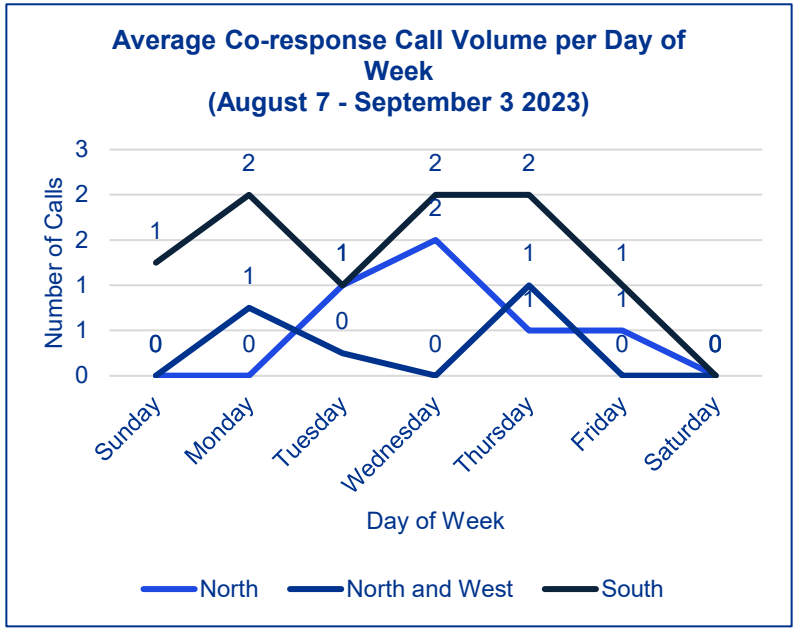
***Please refer to Appendix for a breakdown of location for all calls received across each region

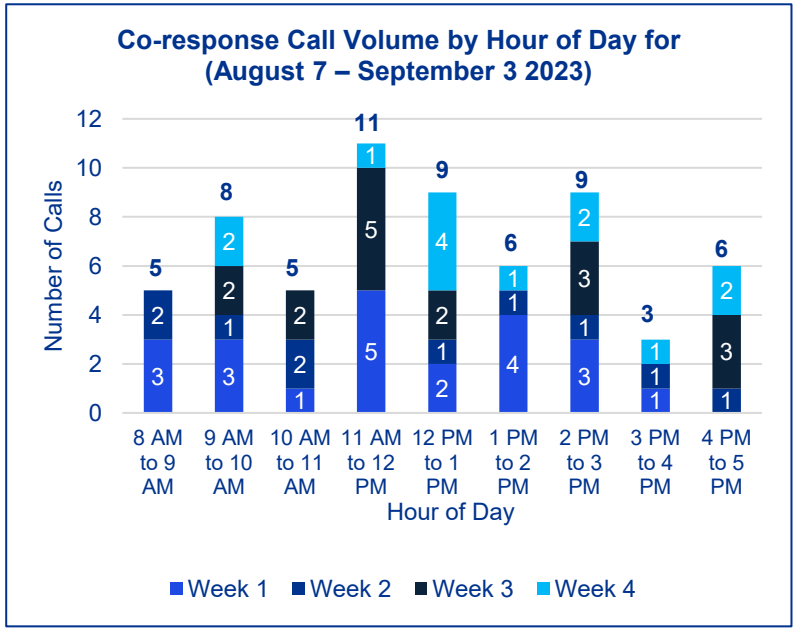
Co-Response Crisis Data Analysis (Aug 7 – Sept 3, 2023)

In total, Co-response received a total of 62 calls over the four-week period analyzed, this equates to an average of 16 service interactions per week, 5 service interactions per team per week or 1 service interaction per day across each team. Overall, the highest number of calls were received on Wednesdays and Thursdays with the no calls received on Saturdays and no calls received between 5 p.m. and 6 p.m. across teams over the four-week period. 86 percent of all interactions (51 calls) were In-Person (Face to Face) interactions.*

Total Mobile Crisis FTES**	Average Weekly Call Volume per Team	Average Weekly Daily Volume per Team	Busiest Day of the Week	Busiest Hour of Day	Average % Face- to Face Contact	Most common Service Location	Most common Service Outcome	Average Response Time	Average Time Spent of Call	Average AMR Response Time
5	5	1	Wednesday & Thursday	11AM – 12PM	86%	Community (53%)	Other (39%)	15 mins	77 mins	25 mins







*Please refer to Appendix for a detailed analysis of Mobile Crisis Services by Region

**FTEs exclude management, supervisory, and administrative staff given they do not typically provide frontline service

Partnership with Santa Maria Police Department: Team operates Tuesday to Friday 8 AM - 6.PM
Partnership with South County Sherriff's Office: Team operates seven days a week, from 8 AM – 6 PM
Partnership with North County Sherriff's Office: Team operates Monday to Thursday from 8 AM – 6 PM

KPMG four-week analysis – Crisis Clinics Data

Crisis Clinic Service Interaction Volumes

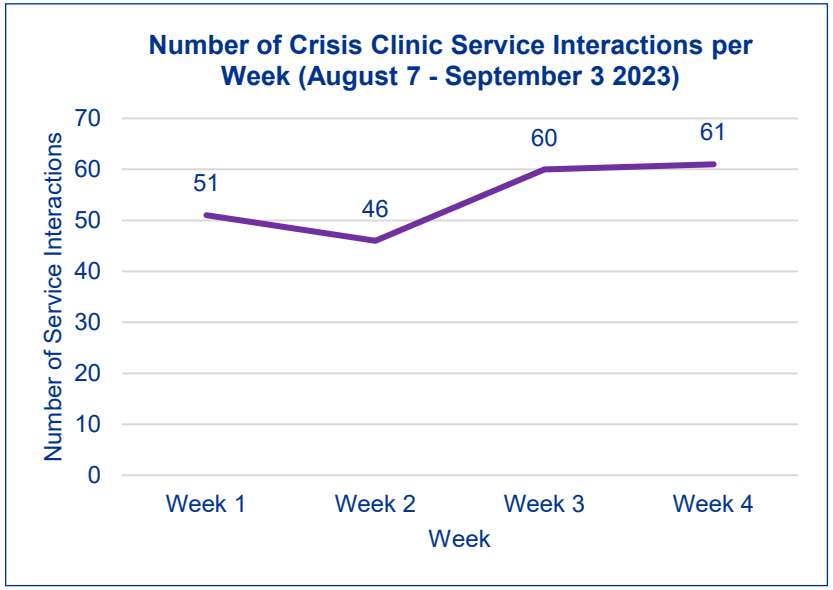
- As outlined, KPMG engaged with the Department to implement a four-week data collection process (August 7, 2023 – September 3, 2023) which incorporated Mobile Crisis and Co-response and required the collection of 21 key data points. In an effort to prevent additional clinician workload, a similar data collection process was not implemented across Crisis Clinics as KPMG considered that the Mobile Crisis and Co-response data collected could be extrapolated from total volumes within the Department's EHR to identify Crisis Clinic volumes.
- Considering the above, KPMG estimated Crisis Clinic service interaction volumes between August 7, 2023 – September 3, 2023 utilizing the following key steps:
  - **Step 1:** KPMG obtained total service interaction data across Crisis Clinics, Co-response, and Crisis Clinics from the Department's newly implemented EHR, Smartcare between August 7, 2023 – September 3, 2023.
  - **Step 2:** KPMG subtracted the Crisis Clinic and Co-response service interaction volumes collected during the four-week data collection period outlined above from the total service interaction volumes identified under step 1 above to identify Crisis Clinic volumes.
  - **Step 2:** As a result, the following Crisis Clinic volumes were identified across regions. A more in-depth analysis of Crisis Clinic volumes across regions is outlined on the following page.

Crisis Clinic Volumes (August 7, 2023 – September 3, 2023)					
	Week 1	**Week 2**	**Week 3**	**Week 4**	**Total**
North County Crisis Clinic	28	12	32	14	86
South County Crisis Clinic	3	19	24	31	77
West County Crisis Clinic	20	15	4	16	55
Total	**51**	**46**	**60**	**61**	**218**

Crisis Clinics Data Analysis Overview (Aug 7 – Sept 3, 2023)

In total, Crisis Clinics experienced a total of 218 service interactions over the four-week period analyzed, this equates to an average of 55 service interactions per week, or 11 service interaction per day across all three clinics. Across the same period, Clinic prescribers averaged 10.5 service interactions per week or 2 per day across clinics. Crisis Clinics provided an average of 14 medication support procedures across clinics on a weekly basis or 4.5 per clinic. During staff engagement, it was indicated that approximately 80 percent of referrals from EDs are 'no shows' for initial appointment. On average each service interaction took an average of 27 minutes. Based on the average number of weekly service interactions, this equates to 25 hours or 0.6 FTEs, based on a 40-hour week against the 17.25 FTEs including 1.25 FTE prescribers.

Total Crisis Clinic FTES*	Total Service Interaction Volume	Average Weekly Service Interaction Volume	Average Daily Service Interaction Volume**	Average Daily Service Interaction Volume per FTE	Average Prescriber Service Interactions per week	Average Prescriber Service Interactions per day**	Average No Show Rate***	Average Cancellation Rate***	Average Service Minutes****
17.25	218	55	11	0.5	10.5	2	6%	1%	27 minutes



Total Estimate Crisis Clinic Volumes					
	Week 1	**Week 2**	**Week 3**	**Week 4**	**Total**
Total Service Interaction Volume – (Smart Care Data)	133	91	126	125	475
Mobile Crisis and Co-response Service Interaction Volume – (KPMG Data Collection Template)	82	45	66	64	257
Variance - (represents Crisis Clinic Volumes)	**51**	**46**	**60**	**61**	**218**

Medication Support Procedures					
Procedure	**Week 1**	**Week 2**	**Week 3**	**Week 4**	**Total**
Medication Support Existing Client	5	7	12	7	31
Medication Training and Support	3	4	7	3	17
Medication Support New Client	2	1	1	3	7
Prolonged Office or Other Outpatient EM Service(s)	2	1	0	1	4
Oral Medication Administration	1	1	0	2	4
Interactive Complexity	0	0	0	1	1
Total	**13**	**14**	**20**	**17**	**64**

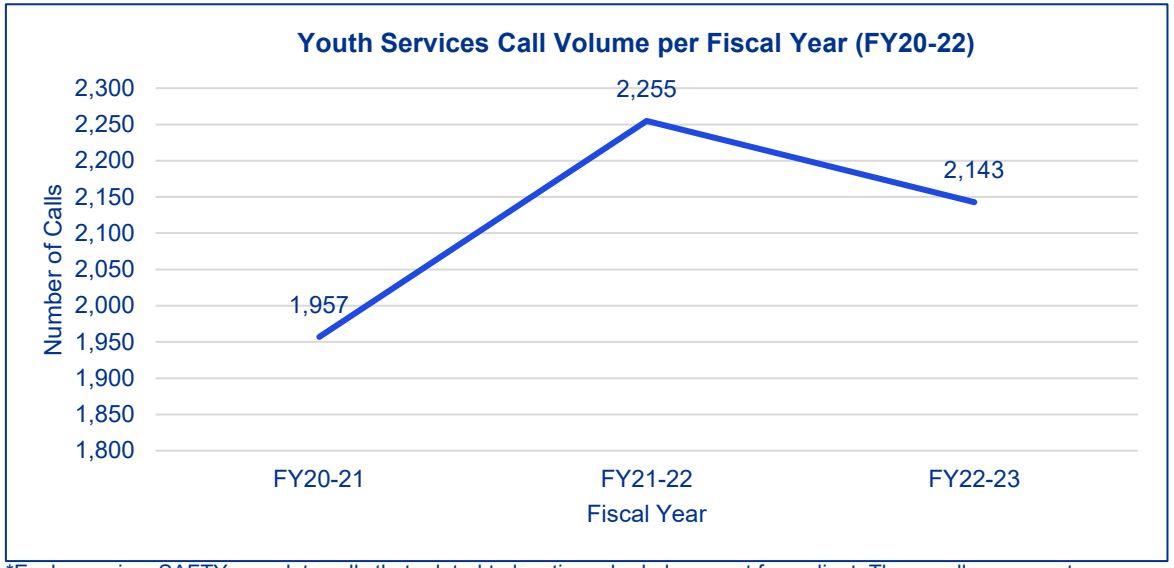
*FTEs exclude all Administrative Office Professionals (AOPs) and supervisory./management staff given they would not provide front line clinic services. However, it includes 1.25 Prescriber FTEs. Extra Help staff have been included as 0.5 FTE.
**Crisis Clinics operate from Monday to Friday between 8a.m. and 6p.m. Average daily service interactions are calculated based on a five day week.
*** Across Interviews, staff reported that cancellation and no shows rates are not always correctly documented within the Department's EHR; therefore, they may not accurately reflect actual cancellation/no show rates.
****Average Service Minutes are based on the service minutes experienced across all procedures as outlined on page 3.

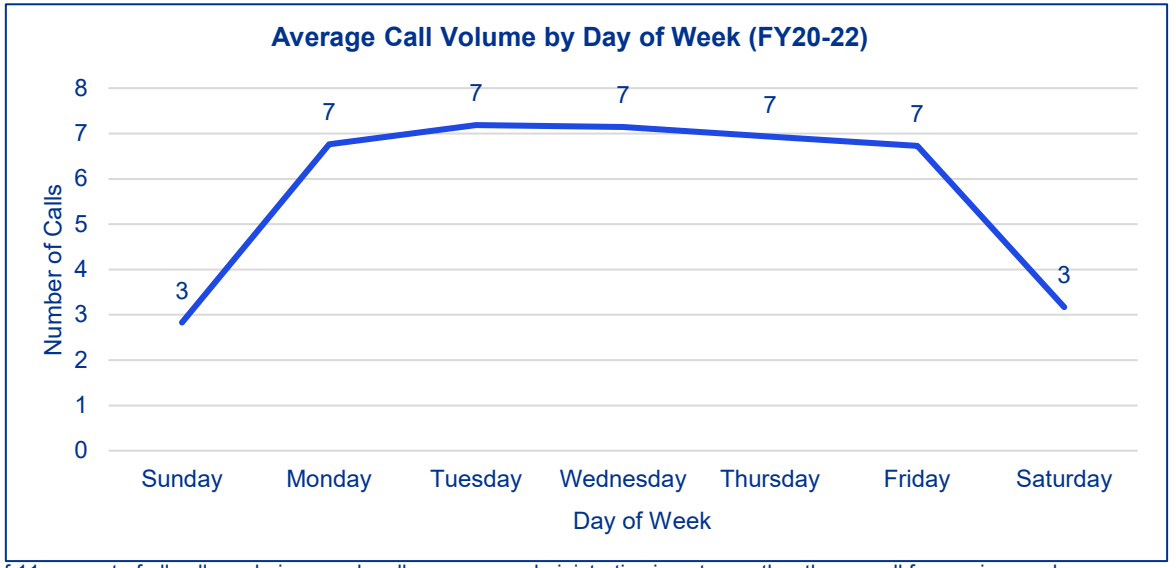
Youth Crisis Services

Youth Services – Mobile Crisis Data

Youth Services call volume average 2,118 calls annually; however, call volumes increased by 15 percent between FY20 and FY21 due to pressures resulting from COVID-19, before declining by 5 percent between FY21 and FY22. Based on an analysis of calls by day of week and hour of day, call volume typically remains relatively flat between Monday and Friday resulting in no peak call times. However, call volumes decrease significantly during weekends.

Number of FTEs funded	Annual Average Call Volume (FY20-22)	Average Call volume per month (FY20-22)	Average Call Volume per 12-hr. shift ex. Bed Search* (FY20-22)	Average Bed Search Call 12-hr. shift (FY20-22)	Min-Max Time to Dispatch (FY21-22)	Mean Time to Dispatch (FY21-22)	Median Time to Dispatch (FY21-22)	Min-Max Time to Arrival (FY21-22)	Mean Time to Arrival (FY21-22)	Median Time to Arrival (FY21-22)	Estimate Time on Scene (FY21-22)	Percentage Calls considered Crisis (FY20-22)	Percentage Face-to-Face Contacts (FY20-22)	Cost per Call
8.5	2,118	177	5	1	1 – 265 mins	13 mins	9 mins	1 – 138 mins	25 mins	19 mins	96 – 189 mins	26%	27%	$585





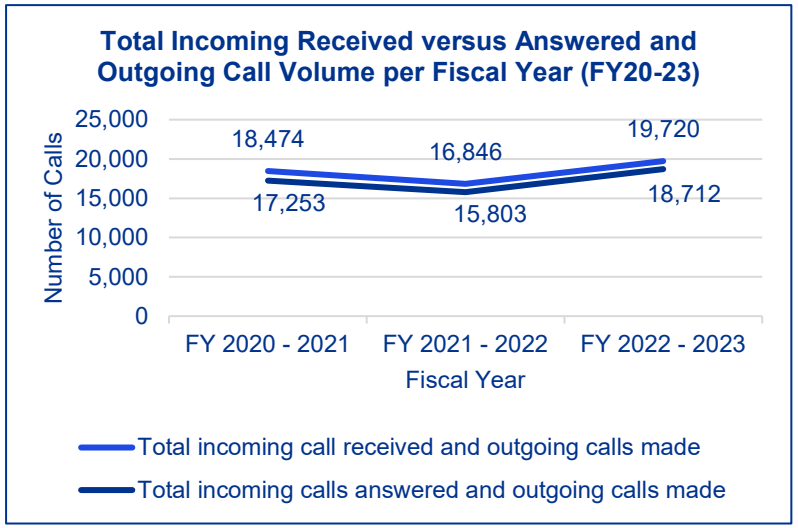
*Each morning, SAFTY complete calls that related to locating a bed placement for a client. These calls represent an average of 11 percent of all calls and given such calls are more administrative in nature rather than a call for service, we have presented these calls separately above to provide a more accurate picture of call volume as a result of calls for service.

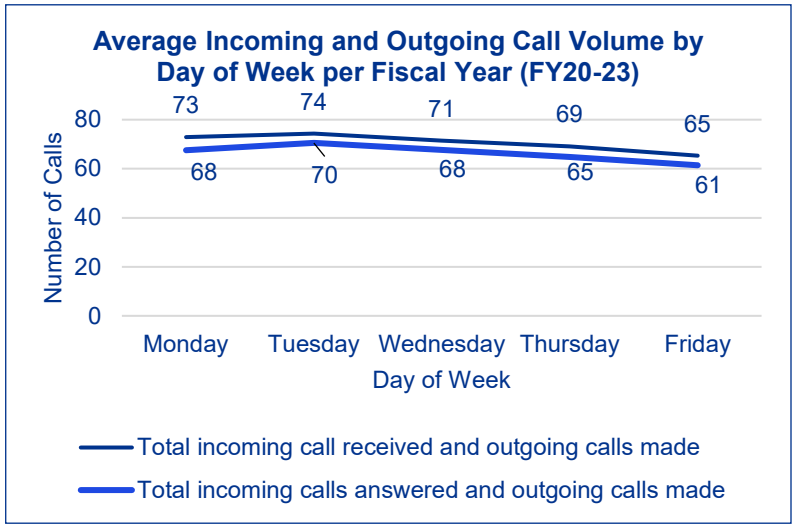
Access Line and Protocall Data Analysis

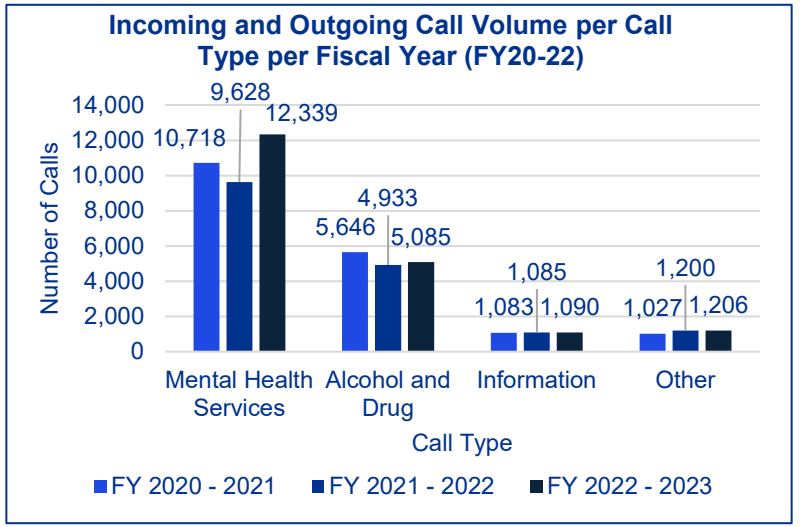
Access Line – Incoming & Outgoing Call Volumes (FY20-22)

The Access Line answers calls from Monday to Friday from 8 a.m. to 5 p.m. Between FY20-23, an average of 18,346 calls were received including incoming and outgoing calls. However, 17,256 of these calls were answered, averaging 66 calls per day and 7 calls per hour. The number of calls received increased by 17 percent between FY21 and FY22. An average of 59 percent of all calls handled were classified as Mental Health. The data does not provide a breakdown of the percentage of these calls that were considered crisis calls.

Number of FTEs funded	Annual Average Incoming and Outgoing Calls	Annual Average Incoming Calls Answered and Outgoing Calls	Average Call Received/Answered per day*	Average Call Received/Answered per hour	% Spanish Speaking Call Volume	% Incoming/ Outgoing Calls	Min-Max Talk Time (FY20-22)	Mean Talk Time (FY20-22)	Median Talk Time (FY20-22)	Min-Max Call Handling Tim* (FY20-22)	Mean Call Handling Time (FY20-22)*	Median Call Handling Time (FY20-22)*
5.5	18,346	17,256	71/66	8/7	6%	72%/28%	4 secs – 1 hr. 22 mins.	5 mins	3 mins	30 secs – 4.5 hrs.	28 mins	25 mins





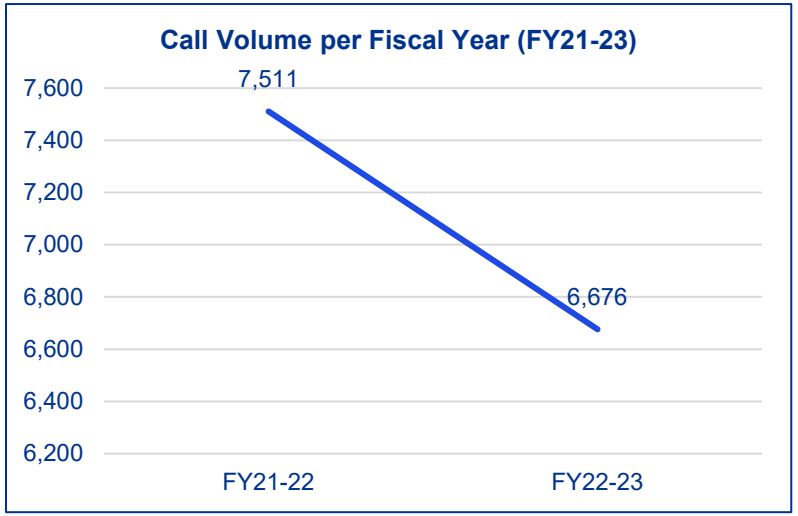


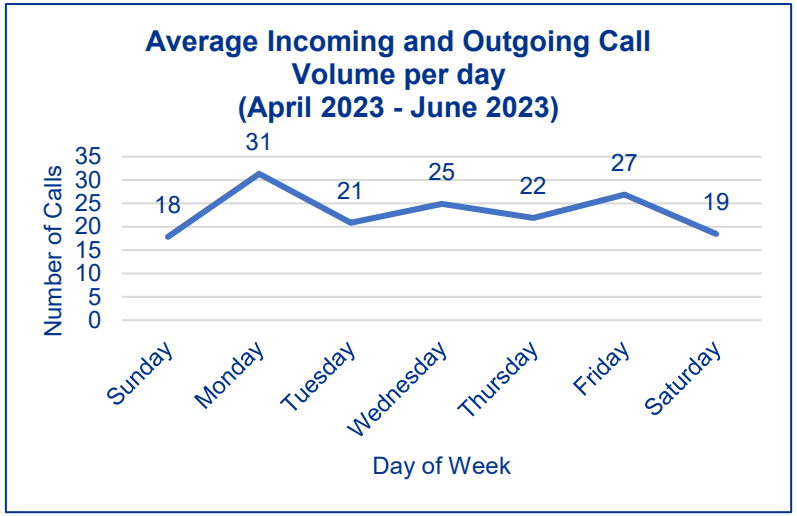
*Call handling Time relates only to incoming calls as this information was not available for outgoing calls
**It is important to note the Department does not utilize separate cost coding to separately track the costs of the Access Line. Therefore, cost per call could not be calculated.

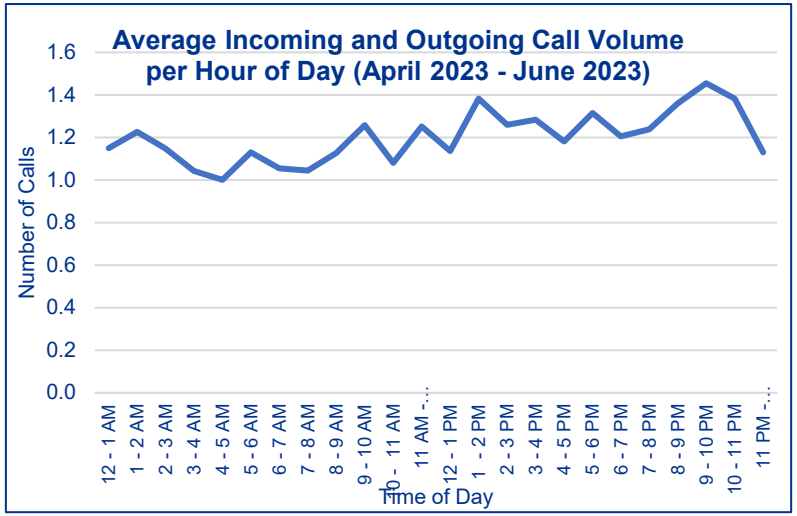
Protocall Data Analysis

Protocall answers Access Line calls between 5 p.m. and 8 a.m. during week days, and from 5 p.m. on Friday until Monday at 8 a.m., and during staff meetings. Calls also roll over to Protocall from the Access Line after a period of time in queue. They receive an average of 7,095 calls annually which equates to an average of 19 calls per day during hours of operation. Of note, call volumes between FY22 and FY23 declined by approximately 11 percent. **Based on call volumes, Protocall answers between 1.2 and 1.4 calls per hour.

Annual Average Call Volume (FY21-23)	Average Call volume per month (FY21-23)	Average Call Volume per day (FY21-23)	*Average Call Volume per hour (Apr – Jun 2023)/ (FY21-23)	Busiest Month of Day of Week (Apr – Jun 2023)	Time Period with Lowest Volume Apr – Jun 2023)	Average Percent of Calls Answered (FY21-23)	***Cost per Call
7,095	592	19	1.2 – 1.4**	Monday	10 pm– 7am	86%	$35







*Protocall data was provided to KPMG in pdf format which does not allow for ease of analysis. However, KPMG manually converted pdf data to Excel for a three-month period (April – June 2023) to assess call volume by hour.
** A range for average call volume per hour was calculated utilizing two distinct methodologies. One methodology identified the total hours per week that Protocall typically answers calls (123 hours) which based on annual call volumes provides an average call volume of 1.4 calls per hour. The second methodology is based on the analysis of the three months of data (April – June 2023) and specifically identifies the number of calls answered by hour of day to calculate a daily average call volume per hour based on actual calls within that period. This provides an average of 1.2 calls per hour.
*** Cost per call is based on billing information received from the Department. The Department has negotiated a rate of $30 per hour for the first 300 calls answered per month, with any calls received above this amount being charged at a premium rate. Based on calls between April and May 2023, this averaged $35 per hour.

Opportunities for Consideration

Co-response – Opportunities for Consideration

Co-Response Team: Opportunities for Consideration

1.1 **Establish joint metrics and targets with clear definitions, calculations, inclusionary and exclusionary criteria and sources to extrapolate data from. Display outcomes on a joint dashboard that is reviewed on a weekly and monthly basis.**

Background: Co-Response teams were developed in the late 1980s following an adverse event in Memphis between Law Enforcement and a citizen with mental health issues*. Based on the positive impact and outcomes evident as a result of the partnership between Law Enforcement and mental health clinicians, the model expanded across counties, states, and countries. Today, the model is deemed to be a best practice model with advocate groups calling for further expansion, particularly in light of recent adverse incidents in the US as it relates to individuals with behavioral health issues and Law Enforcement.

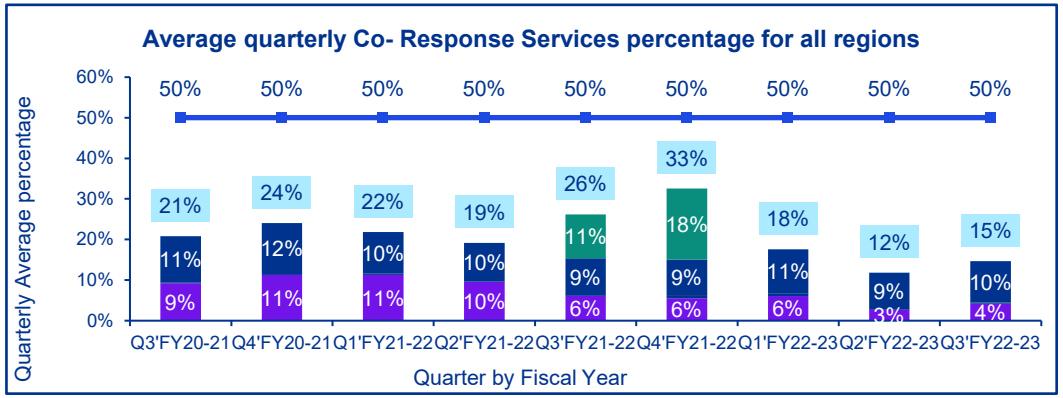
Current State: In 2020, Santa Barbara County commenced the implementation of Co-response in collaboration with Law Enforcement. There are currently four teams in operation as follows:.

- Two teams in partnership with the Sherriff's Office, which operate seven days a week from 8 a.m. to 6 p.m.;
- One team, in partnership with Santa Barbara Police Department (SBPD), which operates Monday to Thursday from 8 a.m. to 6 p.m.;
- One team, in partnership with Santa Maria Police Department (SMPD) which operates Tuesday to Friday from 8 a.m. to 6 p.m.

Across several stakeholder engagement sessions with Law Enforcement, co-response deputies, BWell clinicians and management, several key challenges were raised with regard to the overall function of the team. These included lack of co-location between co-response deputies and BWell clinicians, high vacancy rates across BWell clinicians which are not always backfilled as well as high rates of vacation and training among co-response deputies. These challenges have impacted the effectiveness of the model. This report identifies a number opportunities for consideration to address these challenges.

*http://www.CRT.memphis.edu/overview.php?page=1

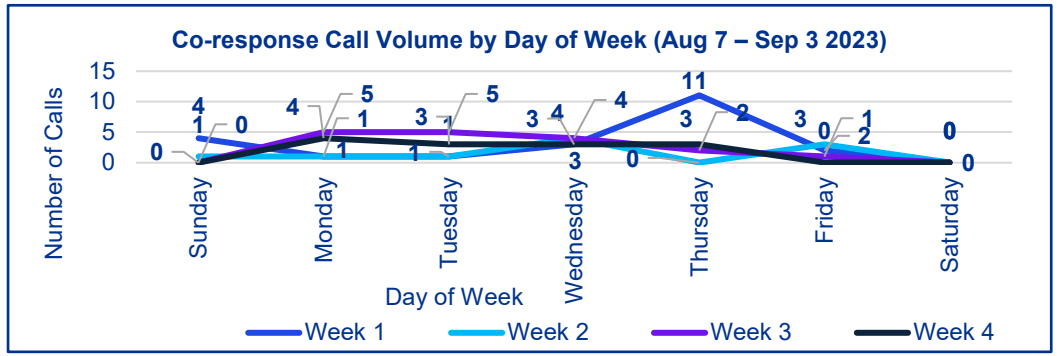
Data Analysis: Based on the analysis of key data, which includes productivity data and data collected by KPMG over a four-week period to understand Co-response team performance, it became clear that the Co-response mission is highly impacted by low rates of activity. For example, based on productivity data analyzed between Q3 FY21-22 and Q3 FY22-23, co-response teams across regions **demonstrated low productivity by quarter, ranging from 12 percent to 33 percent** with an average of 21 percent over the time period analyzed. This is well below the Department's target of 50 percent. Further, when examining all co-response **teams direct billable service utilization, the teams range between 8.7 percent and 12.2 percent**



Co-Response Team: Opportunities for Consideration

1.1 **Establish joint metrics and targets with clear definitions, calculations, inclusionary and exclusionary criteria and sources to extrapolate data from. Display outcomes on a joint dashboard that is reviewed on a weekly and monthly basis.**

KPMG conducted a four-week data analysis between August 7 and September 3, 2023 in response to data integrity issues identified with initial data and outlined in more detail in the data analysis section of this report. This analysis produced similar results, aligning with the productivity data initially provided by the Department. For example, on average, co-response teams received an average of 16 calls per week. This equates to an average of five calls per team per week or one call per day. Teams spent an average of 77 minutes per call, which includes travel time. There were **seven days** over the four-week period **with no activity (0 calls) among co-response teams**, this excludes two weeks were one of the teams was not operating due to one of the personal being off.



When engaging management in order to better understand the low utilization for these teams, they indicated that volumes are low due to Co-response deputy or BWell clinician sick leave or vacation time.

However, in general BWell clinicians have acknowledged low call volumes from Law Enforcement.

Finally, across stakeholder engagements with both Law Enforcement and BWell leadership and staff, it became clear that discrepancies exist between what is considered to be a co-response call by Law Enforcement and by BWell. However, it is important to note that based on calls documented by BWell in its EHR system, significant capacity exists across BWell clinicians. Several of the opportunities for consideration below will support both departments in evaluating the partnerships/model of care in a consistent manner. This will allow for increased collaboration and enhanced data-driven decision making on service enhancement.

Opportunities for Consideration

As co-response teams are deemed to be a leading practice model with expansion consistently being encouraged across the Country, the County should consider the following opportunities in order to better understand the gap between behavioral health calls and co-response team activity.

- **Develop a Minimum dataset (MDS):** Develop joint metrics between Law Enforcement and BWell. Metrics for consideration may include the 21 metrics collected by KPMG during the four-week rapid analysis period. This will support management across departments to better understand, number of calls, time of calls, client outcomes, etc.

[1] http://www.CRT.memphis.edu/overview.php?page=1

Co-Response Team: Opportunities for Consideration

1.1 **Establish joint metrics and targets with clear definitions, calculations, inclusionary and exclusionary criteria and sources to extrapolate data from. Display outcomes on a joint dashboard that is reviewed on a weekly and monthly basis.**

As part of the development of these metrics, it is critical that leadership across Law Enforcement and BWell develop agreed upon data definitions, calculation, and exclusionary criteria across the metrics selected for collection. As noted, the metrics and data definitions developed by KPMG for the four-week data collection process can be utilized as a starting point for this exercise.

Metrics Evaluated		
Region	Time Call Cleared	Staff Responder
Team	Travelled to ED	Time Hold Written
Source of Call	Time left ED	AMR Response Time
Time Arrived on Scene	Evaluation Method	Law Enforcement Involvement
Date of Call	Location of Evaluation	Outcome
Time of Call	Facility Name	Hold Type

- **Develop a shared dashboard of agreed upon performance metrics across departments:** As a next step, BWell and Law Enforcement may consider the development of a shared dashboard of the agreed upon joint metrics for Co-response. The dashboard should be accessible to Law Enforcement leadership, BWell leadership, Crisis Services mangers and supervisors, and co-response deputies and staff members allowing them to see program outcome performance and utilization measures.
- **Establish joint weekly meetings:** Thirdly, weekly analysis should be produced and discussed during weekly meetings between middle management from BWell and Law Enforcement. These meetings can be utilized to examine data and collaboratively consider how co-response team utilization can be improved, whether the model requires tweaking or whether targeted intervention by team is necessary. For example, areas for consideration may relate to the following:
  - Do uniform officers know when to engage Co-Response?
  - If there is a discrepancy between the number of behavioral health calls versus those that co-response teams engage with, why is this occurring and can these issues be actively addressed by both Law Enforcement and BWell management?
- **Establish monthly meetings (or add to already established agendas):** At a senior management level, across both Law Enforcement and BWell, data should be reviewed on a monthly basis during established monthly meetings to determine if there are opportunities to improve utilization across teams. This process should be established for a six-month period at a minimum with targeted intervention to improve optimization of teams, where necessary. It is important to note that during both weekly joint meetings with middle management and monthly meetings with senior leadership , ***data quality personnel*** from both departments should be present to address any data cleansing issues and improve on the data analysis, where necessary.

http://www.CRT.memphis.edu/overview.php?page=1

Co-Response Team: Opportunities for Consideration

1.1 **Establish joint metrics and targets with clear definitions, calculations, inclusionary and exclusionary criteria and sources to extrapolate data from. Display outcomes on a joint dashboard that is reviewed on a weekly and monthly basis.**

Finally, it is important to note **that based on data analysis, an expansion of the co-response teams is cautioned against until there is a greater utilization across current clinicians and clear tracking of outcomes that benefit the community.**

- **Develop clear expectations for co-response teams:** Finally, in the future, there is an opportunity for the departments to develop clear expectations for co-response teams across the following areas:
  - **Physical Location of Teams:** It is our understanding that the Co-response deputy is located within the Sheriff's Office or Police Department while the Co-response clinician is located in a BWell office until a call is received from a uniform officer. Following receipt of a call, the Co-response deputy contacts the BWell clinician and collects them from their office prior to responding to the call. In the future state, BWell may consider having clinicians commence their shift in the Law Enforcement cruiser and remain in the field for the duration of the shift
  - **Align on hours of operations:** Based on the four-week data collection, it would appear that there are no calls responded to between 5 and 6 p.m. daily. When drilling down on cause, it is our understanding that the clinicians are not available from 5-6 p.m., however, Law Enforcement may respond to calls during this time. If the clinician is required to work 10 hour shifts/40 hours a week and their hours of operation are from 8 a.m. to 6 p.m., the clinician should be available to respond to behavioral health calls from 8 a.m. to 6 p.m.
  - **Community engagement during low call volumes:** The co-response teams may consider engaging with community partners to make their presence known. Engaging schools, colleges, peer support organizations or areas where consumers may present etc. will build community awareness of their capability. This may improve call volumes and client engagement.
  - **Technology advancement**: Searching client history in advance of calls can be conducted virtually through technology advancement. This can be achieved by providing each clinician with a tablet and ensuring that they have access to WIFI while they are in the field. This will prevent the need for clinicians to be in the office to complete this task.
  - **Documentation:** In the future, post client engagement documentation can be conducted in the field based on availability of laptops and WIFI connection. If BWell's technology capacity cannot meet the capability to document in the field, there should be a specific time allotment for case documentation. It is our understanding based on engagement with BWell clinicians that documenting client interaction may take up to 3 hours. This is not realistic and not typically aligned with industry standards. It is important for clinicians to also be aware that the reader only wants to be made aware of the main clinical issues and not every detail of the interaction. A more detailed opportunity with regards to documentation can be found in opportunity 7.1 as this issue crosses all crisis services.

http://www.CRT.memphis.edu/overview.php?page=1

Co-Response Team: Opportunities for Consideration

1.1 **Establish joint metrics and targets with clear definitions, calculations, inclusionary and exclusionary criteria and sources to extrapolate data from. Display outcomes on a joint dashboard that is reviewed on a weekly and monthly basis.**

- **Develop a roster of staff to provide coverage for co-response team members:** Based on the number of weeks that the full co-response teams are 'down' due to either the officer or clinician being off due to vacation, training or sick time, there is an opportunity to cross train other members from both departments to step in and support the overall function of the team. For Law Enforcement, this would allow for additional officers to be exposed to the model, and develop a skill set that will ultimately enhance their ability to address individuals who present with behavioral health issues. For BWell, this will enhance the teams knowledge of what the co-response teams do within the field and support quick replacement in the event positions become vacant. This may be critical as we understand that there was long periods of vacancy for these roles due to difficulties experienced by BWell in recruiting for the role.

[1] http://www.CRT.memphis.edu/overview.php?page=1

Co-Response Team: Opportunities for Consideration

1.1 **Establish joint metrics and targets with clear definitions, calculations, inclusionary and exclusionary criteria and sources to extrapolate data from. Display outcomes on a joint dashboard that is reviewed on a weekly and monthly basis.**

The below graphics provides a visualization of the key considerations for both developing and aiding the implementation of an MDS, as well as the development of accurate reports into the future. This includes guidance on generating KPI reporting; key definitions of inputs and outputs; and, the purpose of including each measure.

1. Indicator Description
A description of the information that the data element is requiring the user to capture.

2. Indicator Purpose
The reason for which this KPI was selected to be observed by the ACR Office.

3. Indicator Calculation
A description of how the calculation for the KPI is to be conducted.

4. Inclusions/Exclusions
A list of factors that must be included and/or excluded to conduct the KPI calculation.

5. Considerations and Limitations
A list of factors that may affect the way the KPI is calculated.

Indicator: Funding and projected new funding allocated to the ACR Services.	
Indicator Description	– The total amount of current and projected funding that is allocated for use towards Alternative Crisis Response Services (ACR) within LA County.
Indicator Purpose	– To examine total funding and growth of funding across ACR Services. Desired outcome is to demonstrate increase in funding for ACR services to support consumers being cared for in least intrusive setting.
Indicator Calculation	– The sum of current total funding for ACR Services. – The sum of projected new funding allocated for ACR Services.
Inclusions/Exclusions	– Includes all funding currently allotted to ACR Services. – Includes all funding currently allotted to ACR Services but underutilized. – Includes all projected funding allotted to ACR Services. – Includes all projected partial funding allotted to ACR Services. – Includes current and projected funding regardless of funder. – Excludes projected funds that have not received final approval, by funder or LA County for ACR Service usage.
Considerations and Limitations	– The County is to take into consideration all aspects of current and projected funding regardless of the source as long as it is allocated and approved for ACR Services.
Types of Analysis	– Total amount of funding (present and projected) allocated to ACR services.
Reporting Frequency	– Monthly and annually.
Data Source(s)	– To be added by primary and secondary lead for this KPI.
Reported by:	– Primary: Finance Lead is responsible for reporting current and projected funding.
Data elements required for indicator calculation:	– Sum of funds currently allotted to ACR Services. – Sum of projected funds approved for ACR Services.

6. Types of Analysis
The category of analysis that is to be conducted when calculating the KPI.

7. Reporting Frequency
Description of how often the KPI should be reported (i.e.: monthly, quarterly, annually).

8. Data Source(s)
The data that is to be utilized when conducting the KPI calculation.

9. Reported By
The department or partnership responsible for recording and providing the data required.

10. Data elements required for calculation
A list of the data information needed in order to conduct the KPI calculation.

Mobile Crisis – Opportunities for Consideration

Mobile Crisis: Opportunities for Consideration

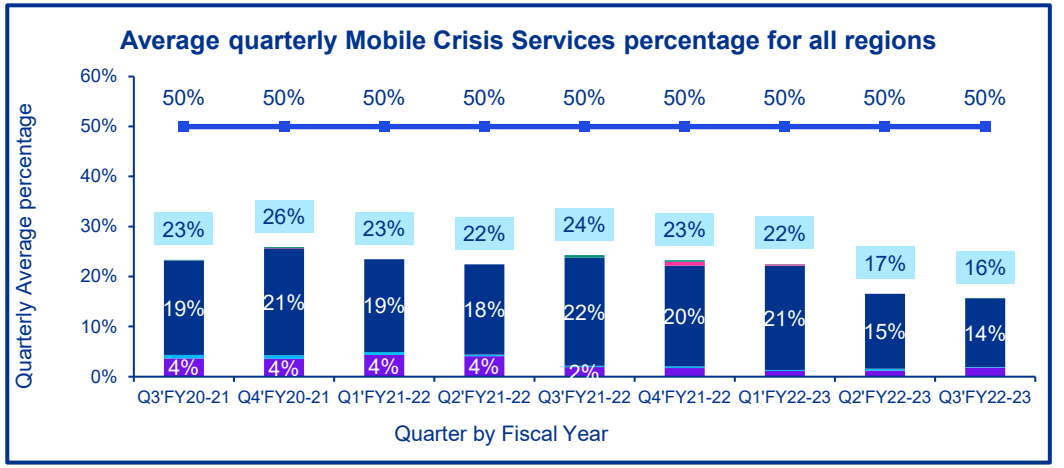
2.1 **Revamp Mobile Crisis Services to align with the new Medi-Cal Crisis Benefits requirement, while establishing crisis worker roles in high referral volume areas, such as emergency departments and jails.**

Current State: Mobile Crisis provides a 24/7/365 non-Law Enforcement response to individuals experiencing a crisis within the community. This includes crisis evaluation, de-escalation and safety planning, and Lanterman-Petris-Short Act (LPS) placement, if deemed required.

The Crisis Services program has dedicated three mobile crisis teams across the County's three regions, North County, South County, and West County with a total of 17 FTEs excluding management, supervisory, and administrative staff. Teams are largely staffed by case managers with licensed supervisory staff that are on call outside of regular hours.

Data Analysis: Based on the analysis of data, which includes productivity data and data collected by KPMG over a four-week period to understand Mobile Crisis performance, Mobile Crisis call volumes are low. For example, based on productivity data analyzed between Q3 FY21-22 and Q3 FY22-23, mobile crisis teams across regions **demonstrated low productivity by quarter, ranging from 16 percent to 26 percent with an average of 22 percent over the time period analyzed.** This is well below the Department's target of 50 percent. Further, when examining **direct billable service utilization, mobile crisis teams range between 14 percent and 22 percent**.

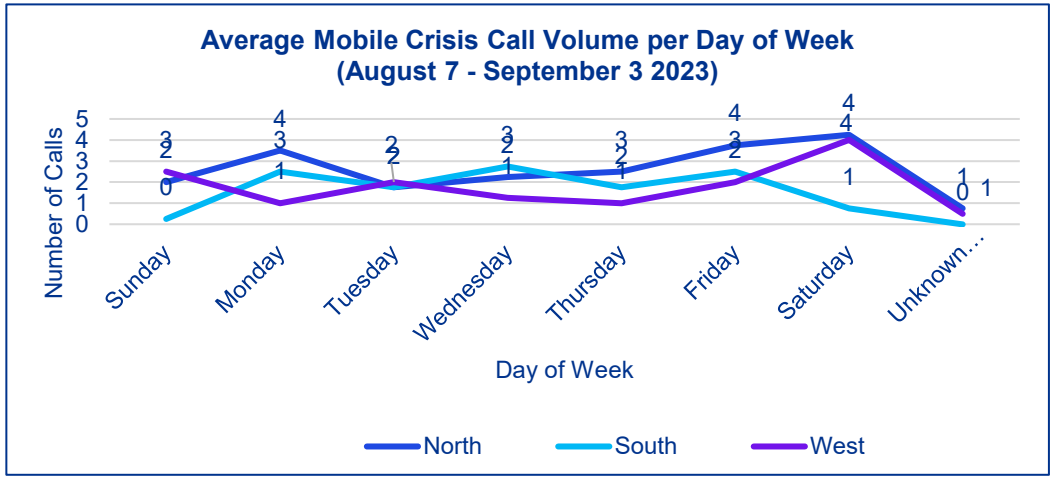
At a regional level, South County experienced the lowest productivity averaging 12 percent, while North county demonstrated the highest average productivity at 27 percent over the time period analyzed. However, both continue to be lower than the Department's target.

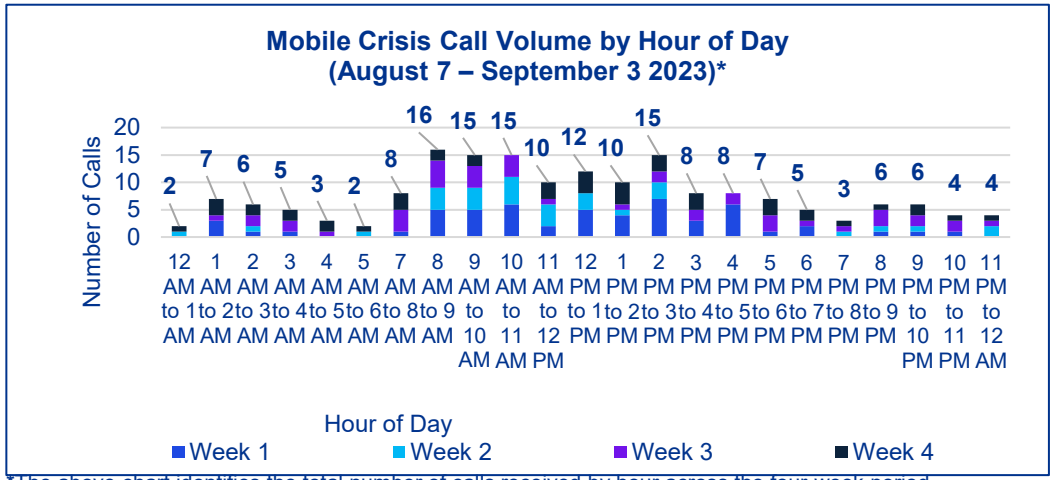


In addition, the four-week data analysis conducted by KPMG produced similar results regarding low utilization, aligning with the productivity data initially provided by the Department. For example, on average, mobile crisis teams received an average of 16 calls per week per team. This equates to an average of two calls per team per day with each call averaging 98 minutes in total including travel time. Finally, across weeks call volumes peak between 7 a.m. and 5 p.m. with significantly lower volumes between 7 p.m. and 1 a.m. and 4 a.m. and 5 a.m.

Mobile Crisis: Opportunities for Consideration

2.1 **Revamp Mobile Crisis Services to align with the new Medi-Cal Crisis Benefits requirement, while establishing crisis worker roles in high referral volume areas, such as emergency departments and jails.**





*The above chart identifies the total number of calls received by hour across the four-week period

Medi-Cal Crisis Benefit Impact: Furthermore, in the future state, Mobile Crisis will be significantly impacted by the new Medi-Cal Crisis Benefit that will be rolling out in January 2024. This will result in a number of critical changes to Mobile Crisis across a variety of areas including, team staffing requirements, service access, dispatch and triage, response times, safety planning, care coordination, data and reporting. However, perhaps the most significant requirement is to restrict reimbursement for provision of mobile crisis services in certain "restricted" settings. These settings include inpatient hospital, inpatient psychiatric hospital, emergency department, residential SUD treatment and withdrawal management facility, mental health rehabilitation, PHF, special treatment program, skilled nursing facility, intermediate care facility, settings subject to the inmate exclusion such as jail, prison, and juvenile detention facility, and other crisis stabilization and receiving facilities.

Based on the four-week analysis completed by KPMG, approximately 66 percent of all mobile crisis calls are being conducted in restricted settings, i.e., emergency departments, jails and 24-hour facilities. Once these volumes are removed from current volumes, the overall number of calls will decrease by approximately 66 percentage, leaving an average of approximately six calls per week per team. With a team of 17 FTEs, the teams overall volumes will average less than one visit per 24 hour day.

While KPMG conducted a three-year analysis of EHR data including service location, it could not be bifurcated to identify Mobile Crisis from Co-response or Crisis Clinics. However, despite the inability to bifurcate the data by team, the data suggested that a large percentage of all crisis

Mobile Crisis: Opportunities for Consideration

2.1 **Revamp Mobile Crisis Services to align with the new Medi-Cal Crisis Benefits requirement, while establishing crisis worker roles in high referral volume areas, such as emergency departments and jails.**

services (Mobile Crisis, Co-response, and Crisis Clinics) are provided in restricted settings. This aligns with the four-week analysis conducted for this review, confirming that a large percentage of calls will not be reimbursed under the new crisis benefit. With already low volumes and the removal of these additional non-reimbursable volumes, this may leave the current mobile team structure financially unsustainable.

Opportunities for Consideration

- **Consider the feasibility of developing one mobile crisis team.** In response to the implementation of the Medi-Cal Crisis Benefit, the Department may wish to consider developing one (1) mobile crisis team, located mid-way through the County in order to meet the response targets established by the Medi-Cal Benefit of 60 minutes for urban areas and 120 minutes for rural areas, which according to the four-week analysis, the mobile teams exceed the targets. In order for the team to be financially viable, they will need to respond to both child and adolescent, adults, and older adults.*.
- **Establish Crisis Team structure**: The Department will need to revise the current crisis team structure to accommodate the requirements of the new Medi-Cal Crisis Benefit. This change will require two staff to be on at all times and a change in the staffing structure to include certified peer support worker, which will require highlighting roles and responsibilities of each personal. One staff can be virtual if determined by both team members.
- **Establish training and safety protocols:** This team is required to be 24/7/365 and respond to calls without Law Enforcement, unless warranted due to safety reasons, which will be the largest shift in thinking from current practice. To support this shift, the Department will need to consider enhancing their training and established safety protocols, i.e., check in at the start of each call, with clear check in points to help ensure workers safety while on the scene and potentially panic buttons that send a signal to an established platform.
- **Establish and station a crisis worker role in the emergency departments**: To accommodate the high referral volumes currently seen from hospitals, a crisis worker, under the Mental Health Services Act (MHSA) funding can be located in the North County Emergency Department and the West County Emergency Department. The crisis worker stationed in emergency departments can support client care, improve working relationships among hospital partners and develop a collaborative and standardized approach to handover and workflow among the mobile crisis, co-response and crisis clinic teams. This would align with what is seen in other s and would address stakeholder feedback.
- **Establish a crisis worker role in the jails:** While the volumes do not support a position to be stationed in the jails, stakeholder feedback indicates limited support from the mobile crisis teams across each jail. To facilitate consumers receiving the care they need while in jail, and improve relations between the teams, having a shared role between emergency departments and jails will provide sufficient volumes for

* Please refer to SAFTY analysis to fully understand why the opportunity includes child and adolescent volumes.

Mobile Crisis: Opportunities for Consideration

2.1 **Revamp Mobile Crisis Services to align with the new Medi-Cal Crisis Benefits requirement, while establishing crisis worker roles in high referral volume areas, such as emergency departments and jails.**

that role and provide much needed support for consumers across both settings. Regardless of where the crisis worker begins their shift, i.e., emergency department or jail, the team will no longer be stationed in the crisis offices.

  - **Projected volumes:** Based on the four-week analysis, the crisis worker stationed in the emergency departments and supporting the jails will average 30 weekly interventions or approximately four per day across regions. Based on this analysis, 1 FTE would support such volumes; however, it is important to note that once the crisis worker is stationed in the emergency departments, it is likely that volumes will increase as hospitals will see the benefit of engaging the crisis workers in client care.

- **Engage with clients while in the Emergency Department:** The Department should set clear expectations for mobile crisis staff to collaborate with Crisis Clinics for urgent appointments and follow up care for all clients (unless they are refusing follow up care). Mobile crisis staff sharing their involvement with the client, specifically peer support workers and case managers is important to facilitate understanding of the client crisis. These two roles will be encouraged to engage with the clients while they are in the Emergency Department in order to facilitate contact and to begin building a therapeutic relationship in order to improve attendance at the initial Crisis Clinic visit.

Other opportunities for consideration that align with the new Medi-Cal Benefits:

- **Expand Access Line to include a new Mobile Crisis Line**: As part of the new Medi-Cal Crisis Benefit requirement, Mobile Crisis is required to have a stand alone telephone line. At this time, the current practice varies in terms of contacting mobile crisis teams as Law Enforcement, hospitals and the community may contact the Access Line or a clinician's telephone directly. Therefore, there is no formal tracking of when calls are received, if they are responded to, when the team attends the scene, when they return, etc. Additionally, during stakeholder engagements, community partners noted that in certain instances, there can be resistance by specific team members to attend a call as they do not deem the client's presentation to be within scope of the team's requirements. This feedback was received from hospital personnel, Law Enforcement, NAMI, Public Defender and jails, which account for all groups engaged in stakeholder engagement. By implementing a standalone telephone line for Mobile Crisis and having individual(s) that is not part of the Mobile Crisis team, determine if a call meets Mobile Crisis requirements, this will allow the Department to meet the new Medi-Cal Crisis Benefit requirement and address the feedback received from the various stakeholders. This can be achieved through the current Access Line number with a split line, i.e., if you are seeking Mobile Crisis, please press 1, if you are seeking to coordinate mental health and/or addiction services, please press 2 etc.

Mobile Crisis: Opportunities for Consideration

2.1 **Revamp Mobile Crisis Services to align with the new Medi-Cal Crisis Benefits requirement, while establishing crisis worker roles in high referral volume areas, such as emergency departments and jails.**

- **Establish roles and responsibilities for the new Mobile Crisis Team:** In addition to establishing a standalone telephone line, the Department will need to consider establishing clear roles and responsibilities that detail response criteria by the Mobile Crisis Team. Education and training will also need to be established by the Department with regards to this expectation, in addition to documentation requirement for all calls received regardless of whether the team is physically responding to the call or not. Data extrapolated from the documentation should be used by the Department to assist in understanding the types of calls received, response rate by each specific team and client outcomes.

Mobile Crisis: Opportunities for Consideration

2.1 Revamp Mobile Crisis Services to align with the new Medi-Cal Crisis Benefits requirement, while establishing crisis worker roles in high referral volume areas, such as emergency departments and jails.

North County Mobile Crisis Services: *81 percent of the total services (70 calls).*

North County Mobile Crisis - # of Calls per Service Location					
Service Location	# Calls				% Calls
	Wk. 1	Wk. 2	Wk. 3	Wk. 4	Wk.1-4
Hospital ER	18	10	11	17	65%
Inpatient Hospital	1	0	4	0	6%
Telephone	1	0	0	0	1%
Asstd. Living	1	0	0	0	1%
Prison	1	1	1	4	8%
Community	1	2	1	3	8%
24H Program	1	1	0	0	3%
Home	1	0	1	1	3%
Office	0	1	1	0	3%
Other (incl Undefined)	0	0	1	1	2%
Total	**25**	**15**	**20**	**26**	**100%**

North County - Estimate Future Reimbursable Visits by service Location	
Service Location	**# of Calls**
Total Service Interactions (4 week period)	86
Number of non-reimbursable services post Medi-Cal Crisis Benefit (4 week period)	70
Future potential <u>weekly</u> Medi-Cal reimbursable services	**4**

South County Mobile Crisis Services: *34 percent of the total services (17 calls).*

South County Mobile Crisis - # of Calls per Service Location					
Service Location	# Calls				% Calls
	Wk. 1	Wk. 2	Wk. 3	Wk. 4	Wk.1-4
Community	7	1	2	7	34%
Hospital ER	2	0	0	0	4%
Prison	2	4	6	2	28%
Office	2	0	1	0	6%
Home	2	1	0	2	10%
Community Mental Health	1	0	0	0	2%
Telephone	1	1	2	0	8%
Homeless Shelter	1	0	0	0	2%
Other	0	1	0	2	6%
Total	**18**	**8**	**11**	**13**	**100%**

South County - Estimate Future Reimbursable Visits by service Location	
Service Location	**# of Calls**
Total Service Interactions (4 week period)	50
Number of non-reimbursable services post Medi-Cal Crisis Benefit (4 week period)	17
Future potential <u>weekly</u> Medi-Cal reimbursable services	**8**

West County Mobile Crisis Services: *69 percent of the total services (41 calls).*

West County Mobile Crisis - # of Calls per Service Location					
Service Location	# Calls				% Calls
	Wk. 1	Wk. 2	Wk. 3	Wk. 4	Wk.1-4
Hospital ER	11	8	10	9	64%
Office	2	0	0	0	3%
Telephone	1	0	3	0	7%
Prison	1	0	0	0	2%
Community	1	2	1	0	7%
Home	1	1	1	1	7%
Inpatient Hospital	0	1	0	0	2%
24H Program	0	0	1	0	2%
Other (incl Undefined)	0	0	2	2	7%
Total	**17**	**12**	**18**	**12**	**100%**

West County - Estimate Future Reimbursable Visits by service Location	
Service Location	**# of Calls**
Total Service Interactions (4 week period)	59
Number of non-reimbursable services post Medi-Cal Crisis Benefit (4 week period)	41
Future potential <u>weekly</u> Medi-Cal reimbursable services	**5**

Crisis Clinic– Opportunities for Consideration

Crisis Clinic: Opportunities for Consideration

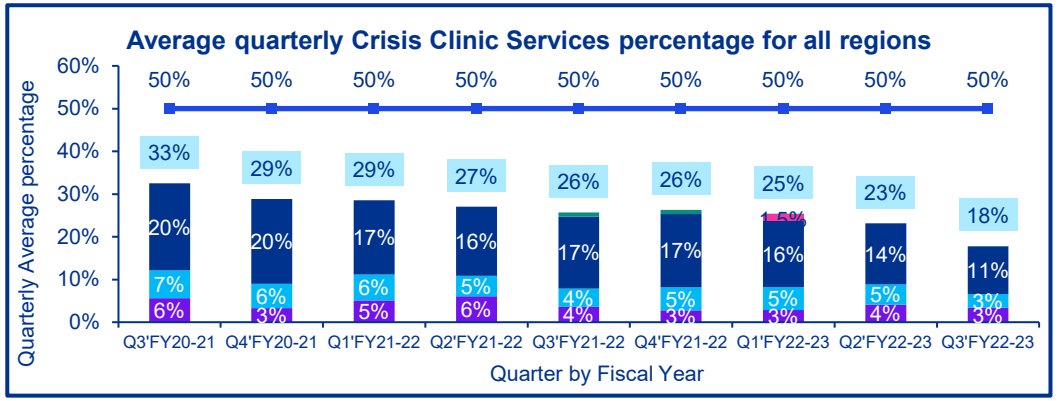
3.1 **Optimize Crisis Clinic capacity and capabilities through an effective marketing and communication plan developed by BWell and issued among key stakeholders. Shifting the model of care to be more fluid based on client need and engagement.**

Current State: Crisis clinics operate Monday through Friday from 8 a.m. to 6 p.m., with a multidisciplinary team of licensed clinicians, case managers, peer support workers, and prescribers. They serve those who are experiencing a crisis. Referrals can come from a variety of stakeholders, which can include Law Enforcement, emergency departments/hospitals, jails, public defender, families/caregivers or self.

There are three dedicated crisis clinic teams across North County, South County, and West County with a total of 17.25 FTEs including 1.25 FTE prescribers and excluding management, supervisory, and administrative staff.

It should be noted that the crisis clinic model, or urgent clinic as also referred to, which facilitates rapid access to a multidisciplinary team, including a prescriber, is deemed to be a best practice. In studies, the model has demonstrated a decrease of emergency department visits, psychiatric in patient admissions, rapid housing, and decrease in justice involvement. It also elevates pressure from other behavioral health systems as some clients stabilize once rapid crisis services are received.

Data Analysis: KPMG examined two types of data. The first data set reviewed analyzed aggregate productivity data from January 2021 (Q3 FY20-21) to March 2023 (Q3 FY22-23). This data demonstrates that the crisis clinics across all three regions were not meeting the Department's target of 50 percent. Overall productivity ranged from 18 to 33 percent, with an average of 26 percent. When examining direct service interaction, crisis clinics ranged from 11 percent to 20 percent with an average of 16.5 percent.



KPMG conducted a four-week rapid data analysis to better understand current performance and to determine whether it aligns with the productivity analysis undertaken. During this period, crisis clinics experienced a total of 218 service interactions, equating to an average of 55 service interactions per week, or 11 service interactions per day across all three clinics. Across the same period, clinic prescribers averaged 10.5 service interactions per week or 2 per day across clinics.

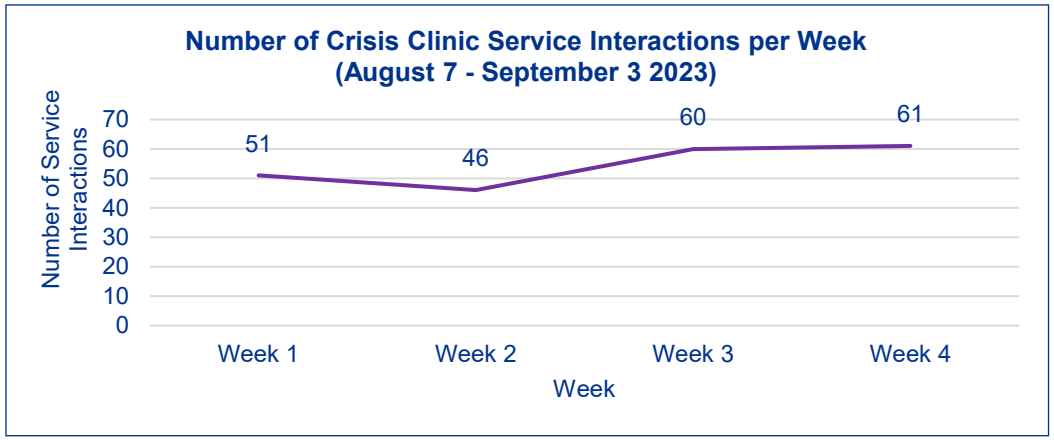
During staff engagement, it was indicated that approximately 80 percent of referrals from emergency departments are typically 'no shows' for initial appointment. Based on the data analyzed, it appears that this is not accurately reflected within the Department's EHR.

Overall, there is relatively low volumes that would suggest there is significant capacity across crisis clinics. On average, each service interaction took an average of 27 minutes. Based on the average number

Crisis Clinic: Opportunities for Consideration

3.1 **Optimize Crisis Clinic capacity and capabilities through an effective marketing and communication plan developed by BWell and issued among key stakeholders. Shifting the model of care to be more fluid based on client need and engagement.**

of weekly service interactions, this equates to 25 hours or 0.6 FTEs, based on a 40-hour week against the 17.25 FTEs employed. Based on the multidisciplinary approach of the program, the 0.6 FTE is across all personnel affiliated with the clinics.



Opportunities for Consideration:

Based on stakeholder engagement, there appears to be a lack of awareness of crisis clinic capacity and capabilities among key stakeholders. For example, hospital personnel indicated that consumers often returned to the emergency departments as they could not access a prescriber within BWell Services. Other stakeholders indicated that the structure of the Clinic does not align with the target population it is meant to service, i.e., office based versus field based. In order to address the low volumes and stakeholder engagement feedback, BWell may wish to consider the following opportunities:

- **Develop a marketing strategy and communicate crisis clinic capabilities.** As a first step, the Department may consider developing a marketing strategy and communicating it to key stakeholders and the community at large. Developing a working collaborative relationship between the crisis staff that will be stationed in the emergency department and jails and crisis clinics will help mitigate clients being discharged without formally connecting with crisis clinic staff.
- **Shift crisis clinic staffing structure from office based to field based:** One way to positively engage consumers is to interact with them while they are in the emergency departments or jail prior to their release. This is particularly important for case managers and peer support workers so that they can follow up with consumers between time of discharge and their first appointment. Determining best methods of client engagement will be key for this team, as clients in crisis typically have a high rate of no shows for their first office appointment. While crisis staff indicated that over 80 percent of clients referred from the emergency department do not attend, this statistic is higher than is typically experienced within the industry based on KPMG experience which is closer to 50 percent. Regardless, early engagement and determining the most suitable place for engagement will facilitate better client engagement and ultimately client outcomes.
- **Provide Availability for same day or next day appointments for all referrals:** Based on the low volume of activity across all three crisis clinics and in particular among prescribers, same day or next day appointments should be made available to all referrals. By rapidly engaging and providing treatment, this will aim to mitigate further

Crisis Clinic: Opportunities for Consideration

3.1 **Optimize Crisis Clinic capacity and capabilities through an effective marketing and communication plan developed by BWell and issued among key stakeholders. Shifting the model of care to be more fluid based on client need and engagement.**

involvement with other sectors such as hospitals and justice crisis clinic teams should aim to aggressively case manage clients with the ultimate goal of minimizing other sector involvement, when deemed appropriate. Prescriber availability is a very valuable resource that should not continue with such low utilization based on the need noted during stakeholder engagement. With the combination of the shift in crisis clinic staff mandate and the embedding a crisis worker in emergency departments and jails, it is anticipated that higher referral volumes and better engagement can be achieved.

- **Establish a Round Table among Key Stakeholders** to formally review clients who are cycling through emergency departments, crisis clinics, and other systems, such as justice. It is typical for different sectors to point fingers with regard to specific clients that continue to cycle through the system; however, solutions can truly only be achieved through a collaborative approach across key stakeholders. Through data collected at the various sectors, individuals should be identified and brought forward for formal discussion and case planning among key stakeholders. These clients can be identified through the crisis clinic but care planning and outreach can be shared among Mobile Crisis, Co-response, and the Access Line. The involvement of peer support workers is key for these individuals
- **Establish Targets in line with Ambulatory Services:** While the crisis clinics are not achieving the targets set by the Department, leadership may wish to increase the targets to align with what is typically seen for ambulatory services, for those that are office based and not mobile, which is between 65-70 percent.
- **Establish average length of service for crisis clinic and transition planning for ongoing treatment:** Based on analysis conducted, service can range from 1 day to 1,764 days, which is well beyond the mandate of a typical crisis program. When engaging front line staff to better understand why there is such a wide range in length of service, they indicated that while clients are referred to ongoing care, they are not necessarily accepted to service in a timely manner. In fact, there are times when referrals are sent and they are not acknowledged, requiring crisis clinic staff to repeatedly send referrals and follow up via e-mail. While there is an escalation process, it does not appear to be effective. Leadership should consider setting a range for length of service for crisis clinics and an effective transition plan for ongoing care with an escalation process. Any referral sent should be acknowledged and a documented timeframe for transition provided.
- **Establish metrics and develop dashboards to be shared with front line staff and management:** To effectively set and manage expectations around utilization, the Department should shift its current approach and establish targets, with clear definitions, calculations, and display analysis on a weekly basis for staff, supervisors, and management. This approach typically results in better outcomes that are sustainable as it allows for management to identify low performers, brainstorm and trial new ideas, targeting personnel issues with quantifiable data. It also allows front line staff to view their performance in comparison to their peers.

Crisis Clinic: Opportunities for Consideration

3.1 **Optimize Crisis Clinic capacity and capabilities through an effective marketing and communication plan developed by BWell and issued among key stakeholders. Shifting the model of care to be more fluid based on client need and engagement.**

The following are examples of dashboards that could be implemented for the various levels of crisis services teams to allow for greater ease in data analysis and tracking.

Supervisor Dashboard

Administrator Dashboard

Executive Dashboard

Youth Crisis Services (SAFTY) – Opportunities for Consideration

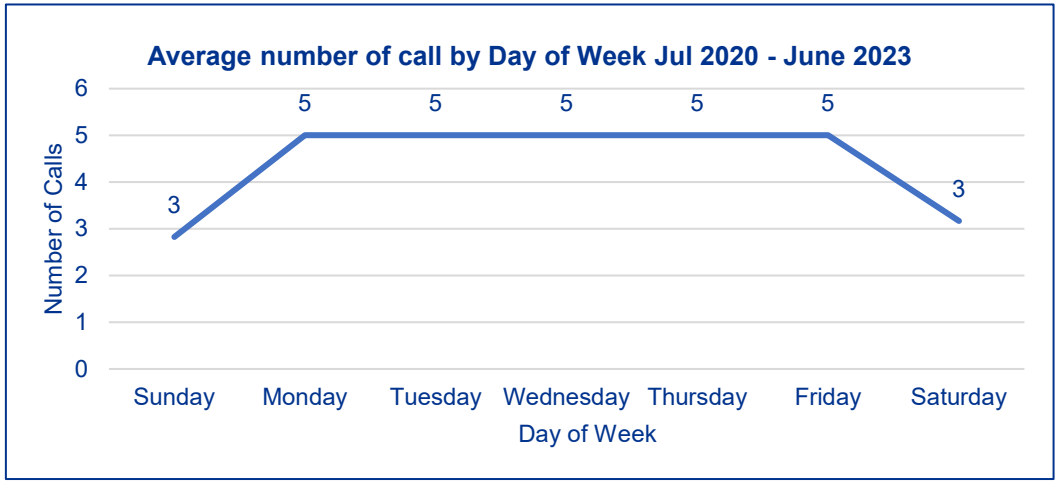
Youth Services: SAFTY Opportunities for Consideration

4.1 **Recognizing the requirements for the new Medi-Cal Crisis benefits, in order to have the team financially sustainable, consider merging youth crisis services with adult crisis services to create a central team that services the County.**

Current State: The Department contracts with Casa Pacifica through the Safe Alternatives for Treating Youth (SAFTY) Mobile Crisis Response Program to provide crisis services to individuals under the age of 20. Casa Pacifica, through its SAFTY program offers a mobile crisis response and hotline service which is available between 8 a.m.- 8 p.m. daily. Outside of these hours, BWell Crisis Services responds to youth crisis services calls. Throughout the course of this review, Casa Pacifica provided high quality data from its EHR system (Avatar) that was easily analyzed over a three-year period (FY20-21 to FY22-23). This allowed for ease of understanding in terms of team activity and performance.

Data Analysis: Based on the analysis of Youth Services EHR data over a three-year period, between FY20-21 and FY22-23, the Youth Services Crisis Team experience relatively low call volumes. For example,

- During the week, the Team averaged five calls over a 12-hour shift. It is important to note that 11 percent of all calls or approximately one calls per 12-hour shift were directed to bed searching for youth on hold in emergency departments. These calls were removed from our analysis as they are administrative in nature and in other settings, are conducted by non-clinical personal, i.e., clerical staff.
- During the weekend (Saturday and Sunday), call volumes dropped to three calls over a 12-hour shift.
- **Cost per call is approximately $585**, which is significantly high for an ambulatory service.



- Between FY2020-21 and FY 2022-23, 73 percent of all interactions were resolved via telephone and did not require a face to face intervention. Of the **73 percent resolved via telephone, 93 percent of these calls were requesting information only.**

Percentage Contacts by Contact Type			
Contact Type	**FY20-21**	**FY21-22**	**FY22-23**
Telephone	73%	76%	70%
Face to Face	27%	24%	30%
Total	**100%**	**100%**	**100%**

Youth Services: SAFTY Opportunities for Consideration

4.1 **Recognizing the requirements for the new Medi-Cal Crisis benefits, in order to have the team financially sustainable, consider merging youth crisis services with adult crisis services to create a central team that services the County.**

Medi-Cal Crisis Benefit Impact: As noted and outlined in detail in the *Medi-Cal Crisis Benefit Assessment of Requirements* section of this report, there will be a number of significant changes to mobile crisis services in the future. However, based on analysis, perhaps the most significant impact for SAFTY will relate to the provision of services in settings which will become non-reimbursable in the future, as well as the requirement under Medi-Cal Crisis Benefit to provide face to face services and the need for two staff to respond to calls.

- **Service Location:** Youth Services conduct a high percentage of their visits in settings that will be non-reimbursable in future state. Based on analysis of service location over a three-year period, approximately 680 visits were conducted in settings which will become non-reimbursable in the future. Subtracting these visits from total calls received over the three-year period leaves Youth Services with an average of 1,438 visits per year, which equates to ***3.9 visits per day***.
- **Face to face requirement:** Over the past three-years, Youth Services have conducted the majority of their interactions via telephone. Face to face interactions, primarily conducted by a single clinician, ranged between 24 and 30 percent over the three-year period analyzed. Once visit volumes related to restricted settings are removed based on the above service location analysis (680 visits) and the requirement for face to face interactions is implemented, Youth Services will service approximately ***one visit per day.***

Call Volumes by Caller

Caller	FY20-21	FY21-22	FY22-23	Average	Percentage
Emergency Room/ICU	414	560	540	505	24%
Family or Guardian	457	362	386	402	19%
School	172	503	448	374	18%
Law Enforcement	181	160	158	166	8%
CARES	134	123	52	103	5%
Client	108	91	63	87	4%
SB BWell	79	65	72	72	3%
Medi-cal Office	46	80	56	61	3%
CIM	15	43	50	36	2%
Access Line	35	15	35	28	1%
Child Welfare	9	6	10	8	0%
Other	278	205	185	223	11%
Unknown	29	42	88	53	3%
Total	**1,957**	**2,255**	**2,143**	**2,118**	**100%**

Estimate Future Reimbursable Visits by Caller	
Average service interactions FY20-22	2,118
Average number of non-reimbursable services post Medi-Cal Crisis Benefit	680
Estimate Future Medi-Cal reimbursable services	**1,438**

Youth Services: SAFTY Opportunities for Consideration

4.1 **Recognizing the requirements for the new Medi-Cal Crisis benefits, in order to have the team financially sustainable, consider merging youth crisis services with adult crisis services to create a central team that services the County.**

Opportunity for Consideration:

- **Consider creating a single mobile crisis team that services all age groups across the County:** While we are not able to confirm if the 30 percent face to face interactions are in non-reimbursable settings under the new Medi-Cal Crisis Benefit, they most likely account for a high percentage based of the team's requirement to conduct 5150 and 5585 Holds. Regardless, the impact of the new Medi-Cal Crisis Benefit will make this team non-financially sustainable moving forward. The Department may wish to consider creating a single mobile crisis service (collapsing the SAFTY team and the adult Mobile Crisis team) that can service both populations. This will require education and training by those selected to operate this new mobile crisis team to help ensure they understand various presentations by those from child and adolescent, to adults to older adults.

Access Line Opportunities for Consideration

Access Line: Opportunities for Consideration

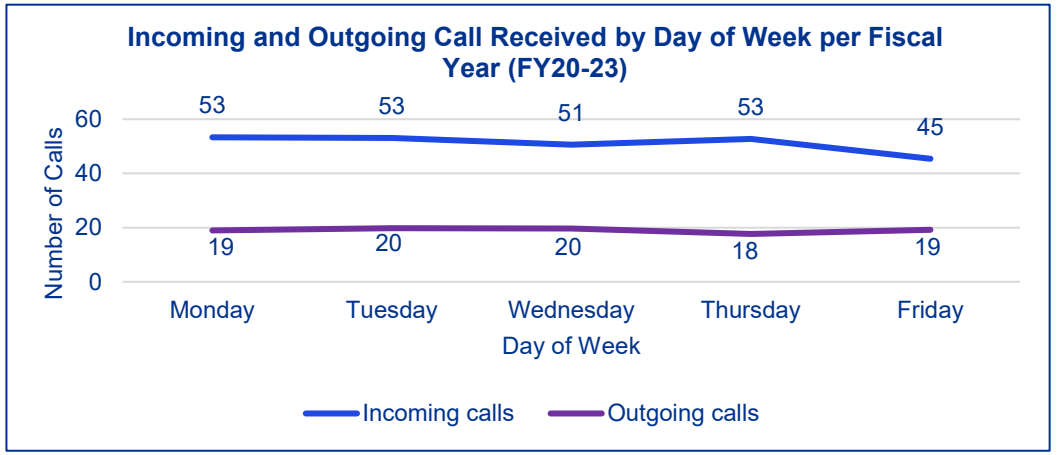
5.1 Enhance Access Line features to include a designated Crisis Line that operate 24/7/365 for Child, Adolescents, Adults and Older Adults.

Current State: The Access Line operate as a centralized call center for Medi-Cal clients seeking mental health and/or addiction services across the County. The Access Line Team is budgeted for 5.5 FTE licensed clinicians and is currently operating with 4.5 FTE. These clinicians conduct standardized screening, determine level of care requirement and coordinate appointments with BWell Services. They also provide the caller with provider information for services not affiliated with the County. However, it is important to note that based on recent changes by the State in implementing standardized screening tools for both mental health and substance use, the Department will be changing the qualifications for Access Line clinician from graduate degree to associate degree.

Currently, the Access Line answer calls between 8 a.m. and 5 p.m., Monday through Friday. Outside of these hours, the County contracts with an outside provider, Protocall, who answer calls between 5 p.m. and 8 a.m. daily and over a 24-hour period during weekends and holidays.

Access Line Data Analysis: Based on data analysis over a three-year period (FY20-22), the Access Line receives an **average of 51 calls per day which equates to almost six calls per hour**. Approximately, 92 percent of all calls received are answered. Unanswered calls within a certain period of time due to the Access Line Team servicing other calls, automatically transfer to Protocall. The Access Line team also return calls to consumers under certain circumstances **and as a result make approximately, 19 outgoing calls per day or 2 per hour**.

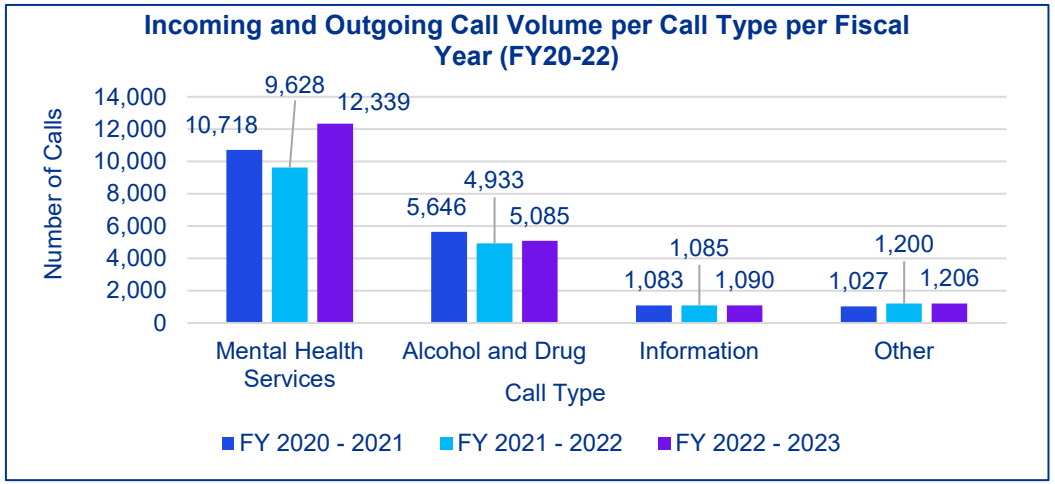
Analysis suggests that mean call handling time is approximately 28 minutes across both incoming and outgoing calls. Based on budgeted staffing levels (5.5 FTEs) over the three-year period, **the Access Line is 75 percent utilized.**



It is important to note that based on the data provided, it is not possible to identify the percentage of calls received that relate to crisis only calls and it is understood that this data is not currently tracked. However, 59 percent of calls received require Mental Health Services. In the future state, the Department should consider tracking crisis call volume as well as other calls volumes (routine services, information only etc.) to provide a greater understanding of the demand for services across the County.

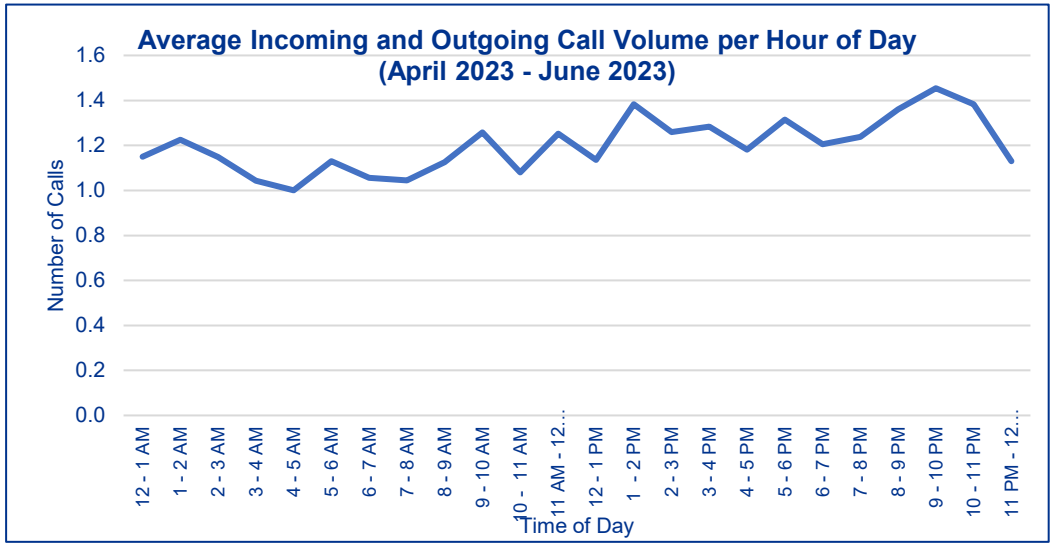
Access Line: Opportunities for Consideration

5.1 Enhance Access Line features to include a designated Crisis Line that operate 24/7/365 for Child, Adolescents, Adults and Older Adults.



Finally, based on financial budgetary data provided, the Department does not track costs by individual team and therefore, it was not possible to calculate the overall cost of operating the Access Line as well as cost per call.

Protocall Data Analysis: Based on analysis of Protocall billing data provided by the Department in PDF format between FY21 and FY22, Protocall answers an average of 19 calls per day. This equates to approximately 1.4 calls per hour with each call costing approximately $35. In order to understand, call volume by hour of day, a sample three-month period of data was analyzed given the provision of data via PDF did not allow for ease of analysis over a two-year period. Based on this analysis, highest call volumes were experienced between 5 p.m. and 10 p.m. and lowest call volumes between 10 p.m. and 7 a.m. with no more than one call per hour being received over this period. In the future state, the Department indicated that they are seeking a new local provider to respond to after hours calls. However, as outlined in the opportunities for consideration section, given the low volumes experienced during these times, the Department may consider directing all Access Line calls to Mobile Crisis after hours.



Medi-Cal Crisis Benefit Impact: Under the new Medi-Cal Crisis Benefit, the Mobile Crisis Team must identify a single telephone number to serve as a crisis services hotline connected to the dispatch of mobile crisis teams to receive and triage beneficiary calls. However, while the Access Line is the designated hotline to connect the community's Medi-Cal clients to mental health and addiction services, including crisis services,

Access Line: Opportunities for Consideration

5.1 Enhance Access Line features to include a designated Crisis Line that operate 24/7/365 for Child, Adolescents, Adults and Older Adults.

all crisis calls do not come through this line. Rather, based on interviews with stakeholders and Department staff, the vast majority of calls are received directly by Mobile Crisis through clinician's cell phones. Furthermore, Casa Pacifica answers all crisis calls related to Youth Services between 8 a.m. and 8 p.m. daily with all calls outside of these hours directed to Mobile Crisis. This results in inability to accurately determine the total crisis services call volumes, given there is no single access point and resultantly no single source of truth with regards data.

Opportunity for consideration

- **Consider designating a specific line within the Access Line to Crisis Services:** In the future state, in order to meet the requirements of the Medi-Cal Crisis Benefit, the Department may consider designating a specific line within the Access Line as the crisis services hotline for both children, youth, adults and older adults. Given the requirement for a 24-hour service and the potential increase in Access Line call volumes as a result of the transition, the Department will need to consider hours of operation and staffing levels. We understand that the Department is in discussions with a local provider to take over the afterhours call center activity. However, based on current call volume activity, the Department may wish to consider keeping this activity within its current services as opposed to outsourcing. As noted in the data analysis section of this opportunity, Protocall answers approximately 1.4 calls per hour, with lower volumes experienced between 10 p.m. and 7 a.m. In the future, the Department may consider redirecting the requirement to answer calls from 10 p.m. to Mobile Crisis given the low call volumes experienced by Protocall coupled with the low service interactions experienced by Mobile Crisis during the night shift.
  - **Future State Model:** In considering the implementation of this opportunity, the future state model may be envisioned as follows:
    - Mobile Crisis Hotline operates 24/7/365 through a designated Access Line number, i.e., press 1 if you are seeking crisis services. This will account for all ages, i.e., child, adolescents, adults, and older adults.
    - The 5.5 FTE Access Line staff operate at 75 percent utilization; therefore, additional staff will need to be designated to address the new created crisis line.
    - The new designed Crisis Line would be responded to by a designated personal from 7 a.m. to 10 p.m., 7-days a week to accommodate volumes seen across the four services, SAFTY, Mobile Crisis, Access Line, and Protocall. Volumes on weekends are lower across all services so the Department may wish to decreased the personnel dedicated to the Crisis Line on weekends and have the Mobile Crisis Team respond to the Crisis Line; however, for this opportunity we intentionally left the hours and personnel the same to accommodate an increase in volumes. Based on current data outlined in the table on the following page, 2.8 FTE (excluding backfill) is sufficient. During these hours, the line can be queued to push calls to the Access Line staff as back up to respond to calls or as an additional backup, the Mobile Crisis Team.

Access Line: Opportunities for Consideration

5.1 Enhance Access Line features to include a designated Crisis Line that operate 24/7/365 for Child, Adolescents, Adults and Older Adults.

	SAFTY Annual Average Volumes/daily	Monthly Mobile Crisis Volumes* (Aug 7 – Sep 3 2023)/daily	Average Annual Protocall Volumes / daily
Total call volumes	2,118/5.8	195/6.3	7,095/19.4
Call Volumes excluded: Jail/ED	1,613/4.5	77/2.5	N/A**

Based on historical volumes, it is anticipated that 31.5 calls are received on a daily basis; however, it is important to note that volumes from emergency departments, jails and other restricted settings will be removed once the implementation of the Medi-Cal Crisis Benefits takes place; therefore, leaving the overall daily volumes for Mobile Crisis at approximately 2.5 calls per day and for youth services at 4.5 calls per day, on average, with approximately 26 calls per day.

Once the crisis workers are embedded in the emergency departments, those clients will be cared for by those dedicated clinicians.

From 10 p.m. to 7 a.m., we recommend that the overnight Mobile Crisis Team answer the Crisis Hotline. Based on historical low volumes for Mobile Crisis after 10 p.m., the two person Mobile Crisis Team will likely have a limited role until volumes increase based on the Department's marketing of available services. As it currently stands, the two person team can answer crisis calls and respond to calls that require in-person interventions. If additional calls come into the Crisis Line while the team is in the field, one member of the team can step away and respond to the call, which is the current practice; however, based on the low volumes, additional personnel is not currently warranted. If the team is to attend calls in-person, the on call supervisor (already in place) would need to be the designated individual that the team checks in with if the Department implements the safety protocol recommendation.

Based on the data, 2.8 FTE should be reassigned from the current Mobile Crisis/SAFTY Team to the new designated Crisis Hotline; however, leadership will need to closely review the data to determine if additional personnel is needed to support the potential increase in volumes, in which time additional personnel can be added as warranted.

These decisions can be conducted once the transition in model has been fully achieved as it is anticipated that there will be a ramp up period. However, as outlined throughout this report, call volumes are very low across teams and the 24/7/365 mobile crisis staffing coverage is to accommodate the Medi-Cal Crisis Benefit requirement.

***Of importance, Santa Barbara has not yet implemented the national 988 Suicide Prevention hotline, which went live in other jurisdictions as of July 2022. Based on other jurisdictions, there is a significant increase in crisis volumes once 988 is implemented. It is our understanding that there is no current plan for the implementation of 988 Crisis Line and therefore, the analysis conducted is based on historical volumes.

*Given the Department's EHR cannot separately bifurcate mobile crisis volumes from crisis clinic volumes and given the data limitations of the Smartsheet data provided, the data as a result of the four-week collection period has been included to consider monthly volumes

**Based on the Protocall data provided, it is not possible to determine the source of each call (i.e. Jail, Emergency Department etc.)

Opportunities for Consideration Across all Crisis Services

Opportunities for Consideration Across All Crisis Services

6.1 **Collaborate with Law Enforcement and establish a triage protocol that outlines which crisis team is most suited to attend crisis call within the community. Develop triage protocol documentation and conduct County wide education with key stakeholders.**

Current State: Currently, there does not appear to be a clear triage process for when mobile crisis teams versus co-response teams are dispatched to respond to calls within the community. Based on stakeholder engagement, the typical deciding factor is based on a decision point made by Law Enforcement i.e. who Law Enforcement direct the call to (Mobile Crisis or Co-response).

Further, outside of Co-response hours of operation, Mobile Crisis respond to all calls across the County. Mobile Crisis typically request Law Enforcement presence as they respond to a call. While not referred to as Co-response, calls are typically being attended by a uniform officer and a BWell clinician. Currently, the main difference between Co-response and Mobile Crisis is that the uniform officer attending mobile crisis calls does not have the in-depth training that non-uniformed officers associated with Co-response receive. Furthermore, the uniformed officer and mobile crisis case worker may not have developed the same collaborative relationship that co-response teams have developed as a result of working side-by-side on a daily basis. However, importantly, consumers and the general public may not necessarily know or understand the difference between the teams.

Medi-Cal Crisis Benefit Impact: Additionally, the implementation of the new Medi-Cal Crisis Benefit provides direction for future state mobile crisis services surrounding assessment, triage, and safety protocols.

As outlined in detail in the *Medi-Cal Crisis Benefit Assessment of Requirements* section of this report, Mobile Crisis currently meets several of the new requirements. However, the Department will need to consider a procedural shift with regards to the following key areas which are key requirements of the Medi-Cal Crisis Benefit:

- Co-response teams which include specially trained Law Enforcement officers may not provide or be reimbursed for mobile crisis services, under Medi-Cal Crisis Benefit, unless they meet specific mobile crisis team requirements outlined in detail in the Medi-Cal Crisis Benefit implementation plan and summarized in the *Medi-Cal Crisis Benefit Assessment of Requirements* section of this report.
- BWell will be required to collaborate with Law Enforcement to determine how mobile crisis teams and Law Enforcement can best work together to safely resolve and de-escalate behavioral health crises, minimizing the role of Law Enforcement.
- As part of its implementation plan, the Department will be required to describe its go-forward strategies to avoid unnecessary Law Enforcement involvement in mobile crisis services. This will be of particular importance given that stakeholder engagements suggest high Law Enforcement engagement across calls, which was verified by the data analyzed, for example,
  - Based on the four-week rapid assessment conducted by KPMG,48 calls (25 percent) of all calls received were from Law Enforcement.

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Opportunities for Consideration Across All Crisis Services

6.1 **Collaborate with Law Enforcement and establish a triage protocol that outlines which crisis team is most suited to attend crisis call within the community. Develop triage protocol documentation and conduct County wide education with key stakeholders.**

- In addition, 81 (42 percent) mobile crisis calls had Law Enforcement involvement. 83 (80 percent) of the calls which did not involve Law Enforcement occurred in the emergency department or jail and by nature would not have required Law Enforcement involvement.
- Based on stakeholder engagement with Law Enforcement, they also indicated that based on the 'potential for violence', across crisis calls, Law Enforcement is required to be present.

Opportunities for consideration

- **Triage of crisis calls to determine mobile crisis versus co-response teams:** In the future state, Law Enforcement and BWell should come to an agreement as to which calls should be responded by which teams. A sample of factors listed below can be considered for triaging to co-response teams. The individual has
  - A noted history of aggression/access to weapons
  - Physical threat towards self or others, or
  - Active command hallucination

  All other calls could be directed to mobile crisis teams.

Opportunities for Consideration Across All Crisis Services

6.1a Establish a Safety Protocol for the Mobile Crisis Team that aligns with the new Medi-Cal Crisis Benefits requirements.

Implementation of Safety Protocol to support the mobile crisis team while in the field: Based on stakeholder engagement with front line staff and a result of the future Medi-Cal Crisis Benefit, BWell should consider developing safety protocols for mobile crisis teams that consist of the following to support them while in the field:

- In the future, given calls will be required to go through a 24/7/365 hotline/call center, all calls should be documented regardless of outcome, (i.e., if they are being responded to or not). This will help to ensure the Department has a history of all calls and actions taken, especially with regards to client presentation and behavior.
- Prior to attending a call in the community, mobile crisis teams should document/confirm the address and/or community location they will be attending.
- Protocol should also require mobile crisis teams to check in with the call center or supervisor to confirm arrival at scene and advise that they are about to enter the premise.
- A timeline should be established for the onsite mobile crisis team to touch base with the call center or supervisor via text. This can be established within the first 15 minutes of the onsite engagement and can subsequently occur periodically.
- The Department may also consider implementing safe words or codes, such as “all good” if engagement is going according to plan or “checking in” for please call 911 as assistance is required. If the mobile team does not check in at stated time, the call center or supervisor should contact the team. If no response is received from the team, a protocol should be established where Law Enforcement is engaged to assist at the address that is documented on file.
- At the conclusion of the call, the mobile crisis team may be required to check in again via text. This will support monitoring of staff safety and their commute to another call or return to the office.

The purpose of the multiple check-ins is to help ensure the team feels supported in the event a safety issue arises while in the field. This process may decrease the need for extensive Law Enforcement involvement on the majority of the calls.

It is important to note that there are technology solutions that can be used for dispatching of mobile crisis teams that monitors their whereabouts, and calculates response time, time on scene and can also be used for safety measures that the Department may wish to consider.

Opportunities for Consideration Across All Crisis Services

7.1 **Implement standardized documentation for mobile crisis teams as issued by DHCS. Develop standardized documentation and training for all other crisis staff. Conduct routine evaluation of clinicians documentation. Develop improvement plans as required.**

Current State: During stakeholder engagement, staff across mobile crisis and co-response teams advised that often times it may take up to three hours to complete documentation related to a call. When engaging mobile crisis clinicians, there did not appear to be a standardized documentation among the teams. Separately, during stakeholder engagement, emergency departments advised that hold documentation often lacks detail surrounding criteria for detainment, however, includes information not necessarily relevant for why the individual met the 5150/5585 Hold.

Medi-Cal Crisis Benefit Impact: The mobile crisis team will need to implement the following to be compliant with the new Medi-Cal Crisis Benefit:

- When delivering a crisis assessment, mobile crisis teams shall use a standardized crisis assessment tool. DHCS will develop a template that Medi-Cal behavioral health delivery systems may use as the standardized crisis assessment tool.
- When appropriate, crisis planning may include the development of a written crisis safety plan. As part of the training and technical assistance process, DHCS will develop a template that Medi-Cal behavioral health delivery systems may use as a standardized tool for writing a crisis safety plan.

Opportunity for Consideration:

Regularly evaluate the content and value of current documentation and provide training, where necessary: While it is important that clinicians conduct detailed documentation, up to a three-hour period to document one interaction would appear excessive. Additionally, to not identify how the individual meets criteria for the 5150/5585 Hold requires attention. While it is not uncommon for clinicians to over document, it is important for them to understand the level of documentation that is considered helpful and required by hospital personnel. It is also important that crisis teams are aware that hospital personnel consider the documentation received to be excessive and not informative as to why the individual met the 5150 hold criteria. Resultantly, in the future state, the Department may consider undertaking the following:

- Developing **standardized documentation for assessments, follow up and safety planning across all crisis services.**
- Developing training on documentation requirements as part of the on-boarding of all crisis services staff.
- Implementing routine procedures for the Crisis manager or Department educators to conduct regular evaluation of clinicians' documentation. Based on documentations review, Department management or educators should subsequently support the implementation of improvement plans, where necessary.

In addition to the above opportunities, implementing a handover framework between teams align with best practice. Building on this opportunity, the following opportunity (7.1a) details leading practice solutions for handover between clinical teams and across different departments/organizations.

Opportunities for Consideration Across All Crisis Services

7.1a Standardization documentation and Handover Framework between Mobile Crisis/Co-Response Team and others, such as Emergency Departments.

Current State: During stakeholder engagement, emergency department personnel reported a lack of standardization in information sharing on clients being brought to the emergency department on a 5150 or 5585 Hold. Furthermore, based on interviews with staff across crisis teams, there does not appear to be a standardized process or established documentation for teams to follow with regards to information sharing and warm hand-off. As a result, there are inconsistent information sharing processes in place across teams and clinicians. For example, certain mobile crisis and co-response staff reported attending the emergency department in certain instances depending on client presentation, while others reported calling the emergency department to share information on client presentation. However, the vast majority do not typically conduct a warm hand-off. As a result, emergency department staff reported often requiring additional information from crisis teams; however, experience challenges in both identifying and communicating with the staff member who initially wrote the hold and engaged with the client.

Opportunity for consideration

Develop and implement a standardized documentation and handover framework between teams: Based on stakeholder engagement, the Department should consider developing/implementing a standardized documentation and framework for handover between teams, including external partners such as the emergency departments. The exchange of client information between professionals is critical to help ensure key details are shared before client care is transferred.

Leading practice identifies standardized process and information exchange to facilitate knowledge sharing of consumers presentation and any risk issues, such as medical, aggression or otherwise for those accepting the client into their care. An example of a framework that is widely used in healthcare is the ISBAR (Introduction, Situation, Background Assessment and Recommendation) framework*, which is endorsed by the World Health Organization. It provides a standardized approach to communication which can be used in many settings. This framework, if considered, would require training by those issuing it and those that are accepting it. Therefore, the Department would need to engage external partners to successfully implement this framework. Once agreement is reached on the ISBAR or another handover tool, training and education will be required for completion by the Department.

ISBAR Framework

The ISBAR framework consists of five elements focused on communication, which include:

Introduction	Who you are, your role, where you are and why you are communicating?
Situation	What is happening at the moment?
Background	What are the issues that led up to the situation?
Assessment	What do you believe the problem is?
Recommendation	What should be done to correct the situation?

Reference: ISBAR Trip Tick | IHI - Institute for Healthcare Improvement

Opportunities for Consideration Across All Crisis Services

8.1 **Streamline data input and collection to one source of truth that will allow for effective analysis and decision making by management. In addition to aligning financial reimbursement by team to determine financial suitability.**

Current State: Currently, the Department utilizes various technology systems and spreadsheets to document and track outcomes across crisis services. For example:

- **EHR System:** Prior to July 2023, the Department utilized Clinician's Gateway as its EHR system. Post July 2023, the Department implemented a new EHR, namely Smartcare. Crisis services staff across Crisis Clinics, Mobile Crisis, and Co-response utilize Smartcare as the sole system for client documentation. The system tracks a variety of data, including but not limited to clients served, presenting issues, length of intervention, average length of service, cancellation/ no shows, and outcomes across all crisis services programs.
- **Vertical Change:** In addition to Smartcare, co-response clinicians also document service interactions in Vertical Change, which was originally implemented to track specific metrics for the purposes of grant funding related to Co-response. Data points tracked include call volumes, response times, call source, and outcomes.
- **Smartsheet:** As a result of the inability of the EHR system to track data related to call response times (travel time, AMR wait time, time spent on call etc.), as well as other key metrics related to Law Enforcement involvement, call outcome, evaluation method undertaken, hold type written, the Department requires mobile crisis and co-response teams to document this data across two Smartsheet documents, through manually data entry once they return to the office from a call or at the earliest opportunity post call completion.

The varying levels of technology/datasets utilized to track crisis services data result in a number of key challenges for the Department:

- There is no single source of truth that the Department can rely upon for information accuracy and for reporting purposes to inform operational decision making and process improvement across teams.
- The Department's current and former EHR systems track data related to crisis services (Crisis Clinics, Mobile Crisis, and Co-response) regionally in aggregate and as a result, it is not possible to separately identify volumes across each individual team and region. This creates challenges in analyzing performance and service demand across teams and regions to inform key operational decisions.
- While the information collected within the Smartsheet spreadsheet surrounding call volumes and call response times is critical, the requirement for manual data entry with limited data validation can result in high risk of error and data integrity issues. For example, based on a review of the Smartsheet data provided to KPMG, a significant number of blanks in the dataset were identified ranging between 14 and 75 percent across certain data categories.
- In addition to the challenges faced regarding the varying solutions utilized to track data on service interaction, the Department also tracks crisis services budgets in an aggregate manner by region. As a result, it is not possible to accurately identify the cost of a service interaction or call by team, which would facilitate operational and fiscal decision-making that is consistently aligned and determine financial sustainable.

Opportunities for Consideration Across All Crisis Services

8.1 **Streamline data input and collection to one source of truth that will allow for effective analysis and decision making by management. In addition to aligning financial reimbursement by team to determine financial suitability.**

Opportunities for consideration:

- **Develop customized reports in Smartcare to track key data points and allow for a single source of truth:** In the future state, the Department should consider utilizing software, such as Crystal reports to develop custom reports in Smartcare. The custom reports would allow mobile crisis and co-response teams to input data related to time of call, time arrive on scene, AMR response time, time call cleared, time returned to office as well as other key data points, such as, facility a client is referred to and Law Enforcement involvement. The input form for the purposes of reporting should not allow a staff member to finalize documentation until all fields are entered. This will prevent mobile crisis and co-response teams from having to enter information in multiple locations (i.e. Smartsheet, Smartcare, Vertical Change). It will also prevent the existence of blanks in the dataset and will help ensure consistent and accurate reporting. In considering the data points that should be collected in the EHR in the future, the Department may wish to consider the 21 data points identified by KPMG during the four-week data collection process as well as the metrics required for collection under any grant funding sources
- **Update EHR system to require staff to document the team that responded to a client.** In the future state, the Department should update its EHR and documentation process to allow staff members to document the team (i.e. Crisis Clinic, Mobile Crisis, Co-response) that provided services to the client as part of their documentation. This will allow Department leadership and management to more accurately determine volumes and service demand across teams.
- **Consider tracking cost by individual crisis services team and region.** Finally, in the future state, the Department should consider tracking costs at the individual crisis team level (i.e. . Crisis Clinic, Mobile Crisis, Co-response). This will provide Department leadership with a greater understanding of the relative cost of service provision at the individual team level as well as the underlying benefit. This will also allow Department leadership to identify opportunities for cost efficiencies and determining where new funding or allocation of funding should be geared. For example, if there is a high demand for the North County Crisis Clinic but low demand in the South County Crisis Clinic, management may wish to shift some of the funding and personnel from the South County Crisis Clinic to North County Crisis Clinic to better meet community needs. This exercise would require the implementation of the previous opportunity for having a system that can effectively track key data points and allow for a single source of truth.

Medi-Cal Crisis Benefit Assessment of Requirements

Background

- The American Rescue Plan Act of 2021 allows states to add qualifying community-based mobile crisis intervention services as a covered Medicaid benefit for a five-year period (April 1, 2022 - March 31, 2027). The California Department of Health Care Services (DHCS) submitted a proposal to the Centers for Medicare and Medicaid Services to establish mobile crisis services as a new benefit in the Medi-Cal program.
- DHCS is not making any changes to the existing crisis intervention services and Substance Use Disorder crisis intervention services benefits covered under the following behavioral health delivery systems, Specialty Mental Health Services, Drug Medi-Cal, and Drug Medi-Cal Organized Delivery System. Rather, Medi-Cal behavioral health delivery systems shall continue covering these services in accordance with existing federal and state, and contractual requirement.
- However, no sooner than January 1, 2023, and upon receiving approval from DHCS, county Mental Health Plans, Drug Medi-Cal counties, and Drug Medi-Cal Organized Delivery System counties (collectively, referred to a “Medi-Cal behavioral health delivery systems” or “Systems in this document) shall provide, or arrange for the provision of, qualifying mobile crisis services in accordance with the requirements outlined on the following pages. Medi-Cal behavioral health delivery systems shall have the benefit fully implemented by **December 31, 2023.**
- As outlined, the requirements for Medi-Cal Crisis Services benefits have been outlined in detail in the following page in line with the structure and categories identified in the Behavioral Health Information Note. The requirements have been assessed against current state practices with future potential opportunities to meet the requirement identified.

DHCS Letterhead Template (ca.gov)

Med-Cal Crisis Benefit Guiding Standards and Requirements

Category	Requirement	Santa Barbara Current State Practice	Potential Opportunities to Meet Expectations
Crisis Services Hotline	• Mobile Crisis Teams must **identify a single telephone number to serve as a crisis services hotline connected to the dispatch** of mobile crisis teams to receive and triage beneficiary calls. • Systems shall document their strategies for establishing a crisis services hotline for use by beneficiaries in crisis and their outreach plans in their mobile crisis services implementation plans.	• Currently, Mobile Crisis **do not operate a crisis services hotline.** • BWell operates an Access Line to connect the community to a variety of required services (i.e. outpatient, detox, crisis etc.). However, the Access Line receives a limited number of crisis calls. • Rather, Mobile Crisis receive calls from Law Enforcement, EDs, Jails to a designated cell phone that is held by the on duty mobile crisis clinician/case worker. This cell phone number is not open to the community.	• In the future state, in the interest of meeting the requirements of Medi-Cal Crisis Benefit, Department and Divisional Leadership may consider designating a specific line within the Access Line as the crisis services hotline for both children, youth, and adults. • Given the requirement for 24-hour service and potential increase in Access Line call volumes as a result of transition, the Department will need to consider hours of operation, staffing levels and whether Protocall will continue to answer calls after 5pm. We understand that the Department is in discussions with a local provider to take over the afterhours call center activity. Based on productivity activity, the County may wish to consider keeping this activity within their current services and not outsource it. Currently, Protocall answers approximately 1.4 calls per hour, with lower volumes experienced between 10 p.m. and 7 a.m. In the future, the Department may consider redirecting the requirement to answer calls from 10 p.m. to Mobile Crisis given the low call volumes experienced by Protocall and low service interactions experienced by Mobile Crisis during the night shift.

Med-Cal Crisis Benefit Guiding Standards and Requirements

Category	Requirement	Santa Barbara Current State Practice	Potential Opportunities to Meet Expectations
Dispatch Tools	• Systems shall require county-operated or contracted mobile crisis services hotline operators to **use a standardized tool and set of procedures to determine when a mobile crisis team should be dispatched** versus when a beneficiary's needs can be addressed via alternative means. DHCS is developing such a tool.	• A standardized tool is not currently utilized to determine when a mobile crisis team should be dispatched and this decision is typically based on the clinician/case worker's judgement with collaboration from Law Enforcement who may be on the scene. This has caused frustration among Law Enforcement for both adult and youth mobile crisis services. It has also caused an additional step to be added for the Access Line where the calls are transferred to a supervisor prior to mobile crisis being dispatched to address refusal by staff.	• In the future, the Department should implement the standardized tool that is to be developed by DHCS and track outcomes on a weekly basis to evaluate and address patterns of refusal by staff.
Crisis Services Live Response	• Systems shall ensure that mobile crisis services providers **have live staff to receive and respond to all calls** from the mobile crisis services hotline. • Mobile crisis services providers **shall not use an answering service.**	• Santa Barbara Crisis Services Team is 24/7/365 and live staff consistently respond to calls. • Protocall answer all calls received to the Access Line after 5 p.m.	• If the Department decides to designate the Access Line as the crisis hotline going forward, they will need to consider whether Protocall or a local provider will answer telephone calls post 5 p.m. or whether the line is directed to a dedicated Mobile Crisis team member that triages and dispatches calls in order to better optimize staffing. The later would be more in line with the Benefits requirement.
Team Requirements	• The mobile crisis team **providing the initial mobile crisis response shall include or have access to a Licensed Practitioner of the Healing Arts (LPHA) or a Licensed Mental Health Professional**, including a licensed physician, licensed psychologist, licensed clinical social worker, licensed professional clinical counselor, licensed marriage and family therapist, registered nurse, licensed vocational nurse, or licensed psychiatric technician.	• SAFTY Youth Crisis Staff are not licensed however, the supervisors are licensed clinical staff. • Mobile crisis teams are made up of a combination of licensed and unlicensed staff. • Each regional team is overseen by a Team Supervisor who is an LPHA.	• SAFTY Crisis staff do consult with licensed supervisors on all calls, therefore meeting the Benefits requirement. • Mobile Crisis staff do not necessarily consult with a licensed supervisor unless the call warrants consultation. This change can be achieved based on current structure but will need to be added to the workflow as part of the teams standardized work practice. Supervisors and manager are currently on call, however, this will increase the number of consultation during off hours.

Med-Cal Crisis Benefit Guiding Standards and Requirements

Category	Requirement	Santa Barbara Current State Practice	Potential Opportunities to Meet Expectations

Team Requirements	• **At least two providers shall be available for the duration of the initial mobile crisis response**. However, systems may allow **one of the two required team members to participate via telehealth** if the following occur:
	  ○ It would otherwise result in a marked delay in response time or
	  ○ It poses no safety concerns for the beneficiary or the single mobile crisis team member who is physically onsite
		• Typically, one mobile crisis staff member attends a crisis call. However, for the vast majority of calls, Law Enforcement are on scene or mobile crisis request Law Enforcement response.
		• Mobile crisis do not use telehealth.
			• Department leadership will need to consider staffing levels, for both youth and adults, once calls from Emergency Departments and jails are removed, in addition to the requirement of face to face contact. Based on the analysis, a high percentage of call volumes come directly from settings that are not covered under the new Benefits. In addition, volumes for youth calls are low per shift (averaging 5 calls excluding bed search calls) with less than 30 percent attended to in-person.
			• The overnight shift volumes for adults are very low. There are two staff members on for the County; therefore, the requirements can be adhered to if one staff member attends the scene while the other joins via telehealth. This will require an advancement in telephone technology, such as Teams or Zoom, for all team members.
			• Another option is to increase the number of Peer Support Workers to the roster.

	• At least **one onsite mobile crisis team member shall be carrying, trained, and able to administer naloxone.**	• Each mobile crisis team member is trained in the use of Narcan and all mobile crisis assigned vehicles have Narcan kits in them. Narcan training refreshers are regularly and Narcan administration information cards are carried by the mobile crisis team.	• Standard is currently met.
	• At least **one onsite mobile crisis team member shall be able to conduct a crisis assessment.**	• Currently all clinical mobile crisis team members are trained to conduct a crisis assessments and write 5150/5585 holds.	• Standard is currently met.

Med-Cal Crisis Benefit Guiding Standards and Requirements

Category	Requirement	Santa Barbara Current State Practice	Potential Opportunities to Meet Expectations

Telehealth	• In addition to the staffing requirements outlined on the prior page mobile crisis teams may utilize telehealth to:
	  ○ Connect the beneficiary with highly trained and specialized practitioners.
	  ○ Connect the beneficiary with a provider who can prescribe medications.
	  ○ Deliver follow up services;
	  ○ Engage translators for beneficiaries who may need American Sign Language or other interpretation services.
		• Mobile crisis do not currently utilize telehealth to connect the client with medications, services, or follow ups. However, Crisis Clinics utilize Telehealth in certain instances and as such, the Department has the capability to expand the use of telehealth to mobile crisis.
		• All follow up by the mobile teams is conducted via telephone or in-person.
		• Referral with highly trained or specialized practitioners are conducted in-person.
			• Division leadership should consider the resources, equipment, training that may be needed to more consistently transition toward telehealth for follow up.
			• Develop and implement telehealth process for mobile crisis, crisis clinic and prescribers as part of follow up care.

Peer Support	• A Peer Support Specialist may participate as a mobile crisis team member if they have a current, State-approved Medi-Cal Peer Support Specialist certification, provide services under the direction of a Behavioral Health Professional, and meet all other mobile crisis services requirements, including required mobile crisis services training.	• Mobile crisis teams are staffed by case managers or clinicians. They do not include peer specialists. However, peer specialists do form part of the Crisis Clinics.	• The Department may consider transitioning toward a model where one of the two required mobile crisis responders is a peer specialist that has achieved the state-approved Medi-Cal certification. This model is seen in other County's and with strong training and supervision, this model is seen as successful in other County's, i.e., LA and Riverside County.

Med-Cal Crisis Benefit Guiding Standards and Requirements

Category	Requirement	Santa Barbara Current State Practice	Potential Opportunities to Meet Expectations
Community Health Workers	• Community Health Workers (CHWs), including community health representatives, navigators, and other non-licensed public health workers, including violence prevention professionals that meet the minimum requirements and complete required mobile crisis services training may provide mobile crisis services.	• Mobile crisis teams are made up of a combination of licensed and unlicensed staff. However, they do not include community health workers.	• The Department may consider transitioning toward a model which includes a mix of case mangers, clinicians, peer support, and CHWs.
Medi-cal Technicians and Paramedics	• Emergency Medi-cal Technicians (EMTs), Advanced Emergency Medi-cal Technicians (AEMTs), Paramedics, and Community Paramedics that are licensed, certified, and/or accredited in accordance with applicable State of California requirements and who complete required mobile crisis services training may provide mobile crisis services.	• Mobile crisis team do not include EMTs, AEMTs, Paramedics, and licensed Community Paramedics. However, BWell is currently in the planning process to develop a Co-Response team staffed with a BWell clinician and a County Paramedic. This team will focus on responding to individuals in crisis or at risk of crisis who may also have co-morbid medical conditions	• There is an opportunity for the Department to consider mobile crisis staffing models that include EMTs, AEMTs, Paramedics, and licensed Community Paramedics. • This opportunity may be achieved through formal partnerships with other Santa Barbara divisions or private providers. The opportunity can be used as cost savings in particularly during low volume periods, i.e., overnight shifts, allowing for economies of scale to be used.

Med-Cal Crisis Benefit Guiding Standards and Requirements

Category	Requirement	Santa Barbara Current State Practice	Potential Opportunities to Meet Expectations

Mobile Crisis Service Encounter	• Each mobile crisis services encounter shall include:
	  ○ Initial face to face crisis assessment
	  ○ Mobile crisis response
	  ○ Crisis planning, as appropriate, or documentation in the beneficiary's progress note of the rationale for not engaging in crisis planning; and
	  ○ A follow up check in, or documentation that the beneficiary could not be contacted for follow up despite reasonably diligent efforts by the mobile crisis team
	• However, teams may de-escalate and stabilize an individual via telephone and make a determination that mobile crisis services are not appropriate or necessary
	• When appropriate, each mobile crisis services encounter shall also include:
	  ○ Referrals to ongoing services; and/or
	  ○ Facilitation of a warm hand-off
		• Currently, mobile crisis conduct initial face to face assessments where considered necessary.
		  • Youth Crisis Calls: Approximately 25% clients receive face to face crisis assessments while the majority, 75% are assessed via telephone.
		  • Adult Crisis Calls: Approximately 42% of clients received face to face crisis assessment. However, 56% of data entries for this data point are blank, therefore it is difficult to accurately determine volume.
		• Crisis Planning is conducted by all teams as part of their initial assessment.
		• Follow up support is provided within 72 hours by all teams when the beneficiary and/or their family is willing.
		• Teams are able to de-escalate and stabilize an individual via telephone; therefore, they may not require a face to face assessment. This assessment is made based on clinical judgement and not a standardized tool. Further, where a response is considered not required, i.e., 'outside of their scope, such as substance use, Mobile Crisis do not engage via phone, rather Law Enforcement deals with the situation.
		• Currently mobile crisis provide clients with the Access Line telephone number to request service via the Crisis Clinics, if required.
			• In the future state, a standardized tool developed by DHCS will be implemented to determine whether a Mobile Crisis response is needed.
			• Further, Mobile Crisis policies and procedures should be updated to note that de-escalation may occur via telephone where a mobile crisis response is not considered necessary. This should also be communicated with staff and training provided.
			• In the future, the Mobile Crisis Team will be required to provide warm hand-off to ongoing services for clients experiencing crisis. Workflows will need to be updated.

Med-Cal Crisis Benefit Guiding Standards and Requirements

Category	Requirement	Santa Barbara Current State Practice	Potential Opportunities to Meet Expectations
Face to Face Encounter	• When delivering a crisis assessment, mobile crisis teams shall use a standardized crisis assessment tool. DHCS will develop a template that Medi-Cal behavioral health delivery systems may use as the standardized crisis assessment tool.	• Mobile Crisis Teams do not use a standardized crisis assessment tool when conducting a crisis assessment.	• In the future, the Department will need to implement the standardized tool that is to be developed by DHCS. • In addition, the review of crisis assessments need to be undertaken by supervisors as part of quality assurance.
Safety Planning	• When appropriate, crisis planning may include the development of a written crisis safety plan. As part of the training and technical assistance process, DHCS will develop a template that Medi-Cal behavioral health delivery systems may use as a standardized tool for writing a crisis safety plan.	• A standardized safety plan template is not currently utilized.	• In the future, the Department will need to implement a standardized safety plan template that is to be developed by DHCS. • In addition, the review of safety plans need to be undertaken by supervisors as part of quality assurance.
Warm Hand-Off	• If a beneficiary requires further treatment at a higher level of care, the mobile crisis team shall connect the beneficiary with the appropriate care option by facilitating a warm hand-off. • The mobile crisis team shall also arrange for or provide transportation to effectuate the warm hand-off, if needed.	• Currently, in certain instances, the mobile crisis team may accompany a client to the ED to provide a warm hand-off or in other instances may contact the ED to provide a verbal handover. However, the EDs indicate that this rarely occurs. • Mobile Crisis does not typically arrange transportation for clients to EDs, this is typically undertaken by Law Enforcement.	• In the future state, the Department will need to consider updating policies and procedures with regards to mobile staff conducting warm hand-off, via in-person or telephone. This will need to be part of the standardized workflow and documented in the client chart. • In addition, the coordination of transportation will need to shift from Law Enforcement to mobile crisis staff. This will also require a change in current workflow process.

Med-Cal Crisis Benefit Guiding Standards and Requirements

Category	Requirement	Santa Barbara Current State Practice	Potential Opportunities to Meet Expectations
Referral to Ongoing Service	• Systems shall ensure that mobile crisis teams refer beneficiaries, as appropriate, to available ongoing mental health and/or SUD treatment, community- based supports, social services, and/or other supports to help mitigate the risk of future crises. • Mobile crisis teams shall identify appropriate services and make referrals or appointments during the initial mobile crisis response if appropriate, or as part of follow-up check-ins, as needed. • Mobile crisis teams shall document all referrals in the beneficiary's progress note. Mobile crisis teams shall coordinate with other providers serving the beneficiary in crisis when appropriate.	• Mobile crisis teams currently triage clients in need to the Access Line to coordinate required services as required. • Mobile Crisis do not engage with clients who are presenting with substance use disorders as they deemed them out of scope. • It is understood that referrals are documented in client progress notes.	• Leadership will need to consider developing workflows for mobile crisis teams to identify and refer clients to appropriate mental health and/or substance treatment, community-based supports, social services and other supports to help mitigate the risk for future crisis. This will change the current workflow from directing clients to the Access Line and giving the responsibility to the mobile crisis teams to complete during initial crisis response or as part of the follow up. • Leadership may wish to consider changing the eligibility for mobile crisis services to include substance use disorders. • Documentation will remain the same as current practice.
Follow up	• Systems shall ensure that beneficiaries receive a follow up check in within 72 hours of the initial mobile crisis response. • Follow up may be conducted in-person or via telehealth, which includes both synchronous audio-only.	• Follow up support is provided within 72 hours by all teams when the beneficiary and/or their family is willing. • Follow up is conducted in-person or via telephone. It is not undertaken by telehealth.	• There is an opportunity for the Department to explore telehealth options for follow up.

Med-Cal Crisis Benefit Guiding Standards and Requirements

Category	Requirement	Santa Barbara Current State Practice	Potential Opportunities to Meet Expectations

Coordination of Care	• During the implementation process, systems shall establish policies and procedures to ensure mobile crisis services are integrated into a whole person approach to care. Policies and procedures may include, but are not limited to:
	  ○ Mobile crisis teams shall alert a beneficiary's Medi-Cal behavioral health delivery system within 48 hours of a mobile crisis response and provide basic information about the encounter
	  ○ The Medi-Cal behavioral health delivery system shall inform the mobile crisis team if they are aware if the beneficiary is receiving care
	  ○ The Medi-Cal behavioral health delivery system shall alert the beneficiary's MCP, if known, of the behavioral health crisis
	• Mobile crisis teams shall ensure that they have the beneficiary's consent for these disclosures in cases where consent is required by applicable law
		• Currently, there are limited defined and formalized policies and procedures in place to promote a whole person approach to care.
		• While Mobile Crisis directs clients to the Access Line when they are not already connected to services. There is limited coordination with clients who are already connected to Behavioral Health Outpatient Services, as this step was not highlighted by the teams during the workflow workshops.
		• Consent was not highlighted as a step that staff undertake during workflow workshops.
			• There is an opportunity for the Department to develop and formalized policies and procedures to ensure mobile crisis services are integrating a whole person approach in their assessments, safety planning and follow up care.
			• Updated workflows will need to ensure that all staff confirm via Medi-Cal other services in place and provide basic information about the encounter. It is our recommendation that this is done via a standardized document that is completed on Smartcare and sent to the provider via Smartcare or secure e-mail.
			• Updated workflows will also need to ensure that consent (verbal or e-docu sign) is provided by beneficiary prior to the disclosure of information. This will require consent and Release of Information protocol, therefore may require the engagement of the County's legal department in the development of these documents.
			• Training will need to be developed by management and undertaken by all staff in order to ensure effective change management and implementation.

Med-Cal Crisis Benefit Guiding Standards and Requirements

Category	Requirement	Santa Barbara Current State Practice	Potential Opportunities to Meet Expectations
Service Setting Restrictions	• Mobile crisis services **shall not** be provided in the following settings due to restrictions in federal law and/or because these facilities and settings are already required to provide other crisis services: Inpatient Hospital, Inpatient Psychiatric Hospital, Emergency Department, Residential SUD treatment facility, Mental Health Rehabilitation Center, PHF, Special Treatment Program, Skilled Nursing Facility, Intermediate Care Facility, Settings subject to the inmate exclusion such **as jails, prisons, and juvenile detention facilities, and** Other crisis stabilization and receiving facilities	• Mobile Crisis currently write holds in Emergency Departments and Jails. • Mobile Crisis also conduct 4011.6 assessments across county jails at the request of the Courts or Justice Alliance.	• For service settings that will be restricted to the mobile crisis benefit, BWell staff note they will continue to provide crisis evaluations and submit claims for reimbursement under the current Crisis Intervention service code when appropriate. • Alternatively, leadership may consider the need for a change in the expectations set of who can issue a 5150/5585 hold, which would allow Law Enforcement, hospital or Jail Mental Health staff to write holds. This would require training to be conducted and staff certification to be complete. This would also require an update to County ordinance to allow Law Enforcement, hospital staff, and WellPath staff to write holds. • If this change were to be implemented, there would be a significant drop in overall volumes. Currently based on the key data points requested for collection by KPMG, a high percentage of calls come from hospitals and jails. This will need to be accounted for when determining mobile crisis staffing structure and will likely require the amalgamation of teams given the low volume. • With already overall low volumes, the removal of high percentage of calls due to the service setting restriction will further impact team productivity. A detailed analysis as a result of the KPMG 4 week data collection period outlining the potential reduction in call volumes has been outlined in further detail within opportunity 2.1.

Med-Cal Crisis Benefit Guiding Standards and Requirements

Category	Requirement	Santa Barbara Current State Practice	Potential Opportunities to Meet Expectations

Response Times	• Mobile crisis teams shall arrive at the community-based location where a crisis occurs in a timely manner.
	  ○ Within 60 minutes of the beneficiary being determined to require mobile crisis services in urban areas, and.
	  ○ Within 120 minutes of the beneficiary being determined to require mobile crisis services in rural areas.
		• Awaiting data to confirm response times; however, staff reported during interview that response times are between 20 minutes and 1 hour.	• The Department should develop a policy for response times and how this will be tracked and monitored. This will require a change in SmartCare so the data is inputted and easily extrapolated by supervisors and management on a regular reporting.
			• Training by management will need to include response time expectations. Performance against targets should be reviewed during monthly staff meetings in order to foster effective change management.

Privacy and Confidentiality	• Mobile crisis teams typically will be health care providers subject to the privacy and security rules under the HIPAA. Systems shall be aware of HIPAA requirements that may limit mobile crisis teams' ability to share such information, such as HIPAA's minimum necessary requirement. • In addition, there may be circumstances where mobile crisis teams are subject to 42 CFR. Part 2. Systems shall inquire whether any of their mobile crisis teams are subject to 42 CFR. Part 2 and, if so, ensure that workflows are in place to ask beneficiaries for their consent, when appropriate.	• Based on workflow discussions, only verbal consent is sought at the initial part of the call by SAFTY Staff. ROI was not stated by any of the teams. • Based on the Benefits plan developed by management, "BWell has a standard ROI but has also developed a universal ROI that can facilitate communication with multiple parties under one ROI which improves care coordination amongst and between multiple providers/entities.". • 42 CFR Part 2 serve to protect patient records created by federally assisted programs for the treatment of substance use disorders (SUD) and has a number of specific requirement regarding documentation and release of information*. Considerations on the application of 42 CFR will be dependent on the future stricture of the Mobile crisis team an whether they engage with SUD. However, will be a consideration for County Counsel.	• The Department should engage with County Counsel to consider whether client consent is required to share information with client service providers going forward under 42 CFR.

*eCFR :: Title 42 of the CFR -- Public Health

Med-Cal Crisis Benefit Guiding Standards and Requirements

Category	Requirement	Santa Barbara Current State Practice	Potential Opportunities to Meet Expectations
Law Enforcement	• Systems shall coordinate with Law Enforcement and share information with Law Enforcement officers about how to request or coordinate mobile crisis dispatch, when appropriate. • Systems shall also work with Law Enforcement to determine how mobile crisis teams and Law Enforcement can best work together to safely resolve and de-escalate behavioral health crises, minimizing the role of Law Enforcement. • As part of their implementation plans, systems shall describe strategies to avoid unnecessary Law Enforcement involvement in mobile crisis services. • Law Enforcement officers may accompany a mobile crisis team when necessary for safety reasons, but they shall not qualify as a member of the mobile crisis team. • Similarly, CRT which include specially trained Law Enforcement officers **may not provide or be reimbursed** for mobile crisis services, unless they meet the mobile crisis team requirements described in section III.	• Currently, Law Enforcement attend the vast majority of calls with Mobile Crisis as they have been called to the scene first or Mobile Crisis request that they attend. Law Enforcement is present for approximately 93% of mobile crisis onsite engagement. • There has been no communication on how the current process will change once the new standards are implemented in order to avoid unnecessary Law Enforcement involvement. From Law Enforcements perspective, every call has a potential for violence, therefore there presence is required.	• Current practice does have collaboration between mobile crisis and Law Enforcement, where information on callers are shared to request their assistance. • Both mobile crisis and Law Enforcement did report effective strategies to de-escalate situations while on scene. • On rare occasions, mobile crisis staff do attend client engagement independently. • The Department, County and Law Enforcement will need to work together to determine how they can minimize the role of Law Enforcement on behavioral health calls. As it stands, Law Enforcement sees all behavioral health calls as calls that they must attend due to “potential violence.”.

Med-Cal Crisis Benefit Guiding Standards and Requirements

Category	Requirement	Santa Barbara Current State Practice	Potential Opportunities to Meet Expectations
Individuals with Intellectual and/or Developmental Disabilities	• To the extent possible, mobile crisis teams are encouraged to include a team member with I/DD expertise or have access to an individual with I/DD expertise (e.g., a Board-Certified Behavioral Analyst) via telehealth, which includes both synchronous audio-only (e.g., telephone) and video interactions. • As part of the implementation process, Systems shall describe how their mobile crisis teams will meet the needs of beneficiaries with I/DD who are experiencing behavioral health crises. They are encouraged to conduct outreach to Regional Centers to promote communication and collaboration (e.g., provision of trainings for county mobile crisis teams, direction of people with I/DD in immediate crisis who contact regional center warmlines to county mobile crisis teams for support).	• As stated in the Benefits Plan developed by management, "Tri-Counties Regional Center (TCRC) serves county beneficiaries with developmental and intellectual disabilities. TCRC contracts for a 24/7 crisis team that can respond in the community when a consumer is experiencing a short-term behavioral crisis. These contracted teams are not designated to write 5150/5585 holds. BWell's crisis teams have worked in conjunction with TCRC's crisis teams when BWell is called out to a crisis evaluation and identifies that the individual is a TCRC consumer but is not meeting criteria for a hold and needs more specialized de-escalation and safety planning." • "BWell also has a number of internal staff including board certified child Psychiatrists who have expertise working with individual with intellectual and developmental disabilities and are available for consult when needed."	• Standard is currently met

Med-Cal Crisis Benefit Guiding Standards and Requirements

Category	Requirement	Santa Barbara Current State Practice	Potential Opportunities to Meet Expectations
Implementation Plan	• Systems must submit a written mobile crisis implementation plan to DHCS outlining its mobile crisis services policies and procedures at least 30 days prior to their proposed launch date, no later than April 30, 2024, for counties who are required to have the benefit fully implemented by June 30, 2024, and no later than October 31, 2023, for all other counties. • System must receive approval from DHCS of its mobile crisis implementation plan prior to delivering mobile crisis services for Medi-Cal reimbursement and require all mobile crisis services providers to complete core training.	• Division leadership has begun developing an implementation plan for Mobile Crisis Benefit. It continues to remain in draft format.	• The Department will be required to finalize their plan by October 31, 2023. • The assignment of the lead responsible for developing the plan, executing on the plan and reporting to leadership on the plan needs to be identify and a project managed. • The plan and project management will need to outline the required core training that must be completed prior to receiving approval from DHCS and prior to the delivery of mobile crisis service for Medi-Cal reimbursement.
Children and Youth	• As part of their implementation plans, Systems shall describe how mobile crisis teams will coordinate with the Family Urgent Response System (FURS), Regional Centers and other dispatch lines to ensure the most appropriate systems are responding to a crisis • Systems shall also describe how mobile crisis service providers will collaborate with and conduct outreach to schools	• During workflow discussions across all teams, there was no mention of engagement of FURS, however based on the Benefits Plan put forward by management, “all calls to FURS that need linkage or support from BWell are forwarded to the Access line. Access line staff are available to provide education, link to services, or contact mobile crisis for field response if the call is determined to be urgent/crisis.”. • SAFTY will engage Child Welfare if a report is required. SAFTY also collaborate with Child Welfare on safety planning, where applicable. • It is not part of SAFTYs current role to collaborate with and conduct outreach in schools.	• The engagement of FURS will need to be added as part of the standardized workflow and effective training and communication will need to be implemented as part of effective change management. • SAFTY will need to develop a detailed plan on how they will collaborate and conduct outreach to schools as part of their role and responsibility.

Med-Cal Crisis Benefit Guiding Standards and Requirements

Category	Requirement	Santa Barbara Current State Practice	Potential Opportunities to Meet Expectations
Reporting	• Medi-Cal behavioral health delivery systems shall provide DHCS with data about each mobile crisis services encounter. The data shall include, but are not limited to: o Beneficiary demographics o Crisis location o Response times o Disposition of encounter (e.g., de-escalated in community-based setting transported to crisis stabilization unit, etc.) o Professional titles of each team member participating in the mobile crisis response o Use of telehealth o If transportation was needed, and if so, what type of transportation was provided o Law Enforcement involvement, and o Information about follow up check-ins	• The Department tracks various data via their EHR, Smartsheet, and Vertical Change. Much of the data points requested are collected; however they are collected inconsistently with many blanks in the dataset. Further, the professional titles of each staff members are not collected on the client chart or via the other tracking mechanisms, as well as the transportation and type of transportation.	• To prevent data collection across multiple locations and the related double entry which can be manual, the Department should consider developing customized reports in its EHR which require the collection of each of these data points. Only the EHR should be used to extrapolate data for reporting.
Satisfaction Surveys	• Counties shall conduct beneficiary satisfaction surveys. DHCS will issue additional guidance on data metrics, reporting processes and methods, and reporting frequency.	• Crisis Services have not utilized a satisfaction survey since 2015, based on a review of the Department's website.	• The Department to develop and implement a satisfaction survey based on DCHS metrics and requirements, outlining reporting processes, methods and frequency of reporting. This will need to be completed as part of the implementation plan.

Appendix

Stakeholder Engagement

Meetings

The following outlines the list of stakeholder meetings conducted, including dates and attendees as well as upcoming meetings.

Meeting Name	Date	Attendees
Shadow West County Crisis Services	July 10, 2023	Anna Schryer
County Crisis Services Workshop	July 10, 2023	Anna Schryer, William Womack, Careena Robb, Margaret Hunt
Shadow Youth Crisis Services – Casa Pacifica	July 11, 2023	Meghann Torres
Youth Services Workshop – Casa Pacifica	July 11, 2023	Sarah Robles, Melana Serka, Meghan Torres
North County Crisis Clinic Workshop	July 11, 2023	Gregory White
Shadow Crisis Intervention Team (Santa Maria)	July 11, 2023	Susanne Newman
Access Line Workshop	July 12, 2023	Margaret Hunt
Shadow Access Line	July 12, 2023	Access Line Call Takers
Shadow Crisis Intervention Team (Santa Barbara)	July 12, 2023	Melissa Miller
Shadow South County Crisis Team	July 12, 2023	William Womack, Jeff Money
BWell Executive Leadership	July 12, 2023	Toni Navarro, John Doyel, John Winckler, Jamie Huthsing
South County Crisis Clinics Workshop	July 12, 2023	Isobel Blagborne, Marisol Fregoso, Emily Reynoso
South County CRT Workshop	July 12, 2023	Marisol Fregoso,
Law Enforcement Workshop	July 13, 2023	Dr Lee, Robert Samaniego, James McKarrell, Agustin Arias, Felix Diaz, Christopher Payne, Anthony Muneton
Crisis Services Supervisor Workshop	July 13, 2023	Margaret Hunt, Anna Schryer, William Womack
Client Interviews	July 13, 2023	Interviews with various clients with lived experience
CRT Data Review	July 18, 2023	Dr. Lee
Emergency Department Workshop	July 25, 2023	Dr. Erikson, Michelle Rieb, Darcy Keep, Ken Dalebout

Meetings

The following outlines the list of stakeholder meetings conducted, including dates and attendees as well as upcoming meetings.

Meeting Name	Date	Attendees
Support Services and Community Partner Engagement	July 25,2023	Tom Franklin, George Kauffman, Monica Ruiz, Celeste Anderson, Enrique Bautista, Lynne Gibbs
West County Mobile Crisis	July 26, 2023	Wesley Boatman
Weekly Meeting on Santa Barbara Crisis Services Review	July 31, 2023	John Doyel, Toni Navarro
Santa Barbara Crisis Services Review – KPMG Touchpoint	July 31, 2023	John Doyel, Toni Navarro, Careena Robb, John Winckler
Mobile Crisis and Crisis Clinic Workflow Review	July 31, 2023	Anna Schryer, Isabel Blagborne, William Womack, Careena Robb, Christina Jaramillo, Krista Davis
Access Line Workflow Review	August 1, 2023	Margaret Hunt
Crisis Services Data Review	August 1, 2023	Whitney Perry
Co-Response Workflow Review	August 1, 2023	Anna Schryer, William Womack, Kara Roberts, Krista Davis, Rosa Cepeda, Melissa Miller
Youth Services Workflow Review	August 2, 2023	Meghann Torres, Melana Serka, Sarah Robles
Crisis Services Supervisor Data Collection Discussion	August 2, 2023	Careena Robb, William Womack, Anna Schryer, John Winckler
Weekly Meeting with Santa Barbara Crisis Services Review	August 14, 2023	John Doyle, Toni Navarro
Meeting with Department CFO	August 15, 2023	Chris Ribeiro
Jail Personnel Workshop	August 22, 2023	Bailey Fogata, Joseph Schimmel, Kenneth Callahan
Meeting with Santa Barbara Crisis Services	August 25, 2023	John Doyle, Toni Navarro, John Winckler
Weekly Meeting with Santa Barbara Crisis Services Review	August 28, 2023	John Doyel, Toni Navarro
Tracy Macuga, Public Defender	September 6, 2023	Tracy Macuga
Casa Pacifica/SAFTY Meeting	September 14, 2023	Meghann Torres, Melena Serka
SBSO, BWell, KPMG, Co-response Findings	October 19, 2023	Dr. Cherylynn Lee, Sheriff Brown, Sgt Erick Rainey, John Doyle, John Winckler, Careena Robb. Toni Navarro

Detailed Data Analysis

Data Sources

Over the course of this review a large number of key datasets were provided to KPMG to support the development of the detailed data analysis outlined in this report A description of these datasets and any data integrity issues identified are outlined in the table below.

Data Source	Data Description
Productivity data	KPMG was provided with aggregate productivity data from January 2021 (Q3 FY20-21) to March 2023 (Q3 FY22-23). KPMG utilized the Department's aggregated data to chart productivity levels by team. This analysis is presented on pages 39 – 54 of this report.
Crisis Clinic data	Crisis Services data from the Department's EHR, Clinician's Gateway was provided in response to a request to provide data for the Department's Crisis Clinic surrounding number of clients served, presenting issues, length of intervention, average length of service, cancellation/no shows etc. While this data was provided over a three-year period (FY20-22), it was not possible to bifurcate Crisis Clinic data from that of Mobile Crisis or Co-response. As a result, the analysis included on page 27 through 38 of this report provides a combined view of performance across the three Crisis Services programs (i.e., Crisis Clinics, Mobile Crisis, and Co-response)
KPMG Data Collection Template	KPMG was provided with two Smartsheet datasets utilized by the Department to track Mobile Crisis and Co-response call volumes, response times, evaluation methods and location, outcomes etc. However, following KPMG review, a number of key data integrity issues were identified, largely related to a high number of blank cells across the datasets provided. As a result, KPMG provided the Department with four weeks to collect 21 key data points on a weekly basis to support a more accurate analysis. This data is referred to as "KPMG Data Collection Template Analysis".
Youth Services data	Casa Pacifica provided KPMG with data from their EHR, which identified call volume by time of day, day of week, month of year, as well as referral source, reason for call, call outcome, length of time to dispatch, travel time over a three-year period (FY20-22).
Access Line data	GNAV data was provided which identifies Access Line call volume by day of week and month of year as well as call type and speed to answer. This data was provided over a three-year period (FY20-22).
Protocall Data	KPMG was provided with Protocall billing reports in PDF format for a one year period from July 2022 to June 2023. These PDF documents identified call volumes as well as cost data. Given PDF does not allow for ease of analysis, KPMG conducted a analysis of call volumes by time of day for a sample period (April 2023 – June 2023).
Financial Budget data	Data on budget breakdown and actual expenditure was provided for a three-year period (FY20-22) for crisis services programs. It was not possible to bifurcate cost by crisis services program (i.e., Mobile Crisis, Co-response, and Crisis Clinics). However, the data provided was used to develop a cost estimate for each program across regions.

Crisis Services Productivity Analysis

Productivity Data Analysis Overview

- KPMG was provided with aggregate productivity data from January 2021 (Q3 FY20-21) to March 2023 (Q3 FY22-23). The Department developed this productivity data by exporting data from the Department's EHR and combining it with employee timecard data to develop a complete understanding of staff time and activity. KPMG utilized the Department's aggregated data to chart productivity levels by team.
- As part of analysis, KPMG compared the employee names per staffing schedules provided with the employee names included on the productivity report. Based on this comparative analysis, **six employees were missing from the productivity report provided**. All six employees are currently assigned to the Crisis Clinics with one employee working in South County, two working in North County, and three working in West County. KPMG requested an updated report fromm the Department which includes the six employees; however, did not obtain an updated report. The exclusion of these six employees skews the productivity analysis for each crisis clinic and may in some cases, particularly West County result in the extreme lows in productivity identified.
- Furthermore, crisis staff members often work across multiple teams to meet peak demand volumes; therefore, supporting the Access Line incoming telephone calls, or conducting activity for mobile crisis service. All activity conducted by front line staff have been included as part of the Department's productivity calculation.
- KPMG understands that the Department's target for client services is 50 percent across programs and this is aligned to industry knowledge for Mobile Crisis and Co-response services, i.e., *direct therapeutic interaction*. Typically, we see higher targets for office based crisis services, as they align with outpatient office based services. As provided by the Department, the table below provides an outline of what is considered to form part of client services for the purposes of calculating performance against target.
- Based on data analysis, Mobile Crisis, Crisis Clinics, and Co-response **rarely meet the departments performance target of 50 percent, with productivity averaging 23 percent across teams over the fiscal years analyzed.**

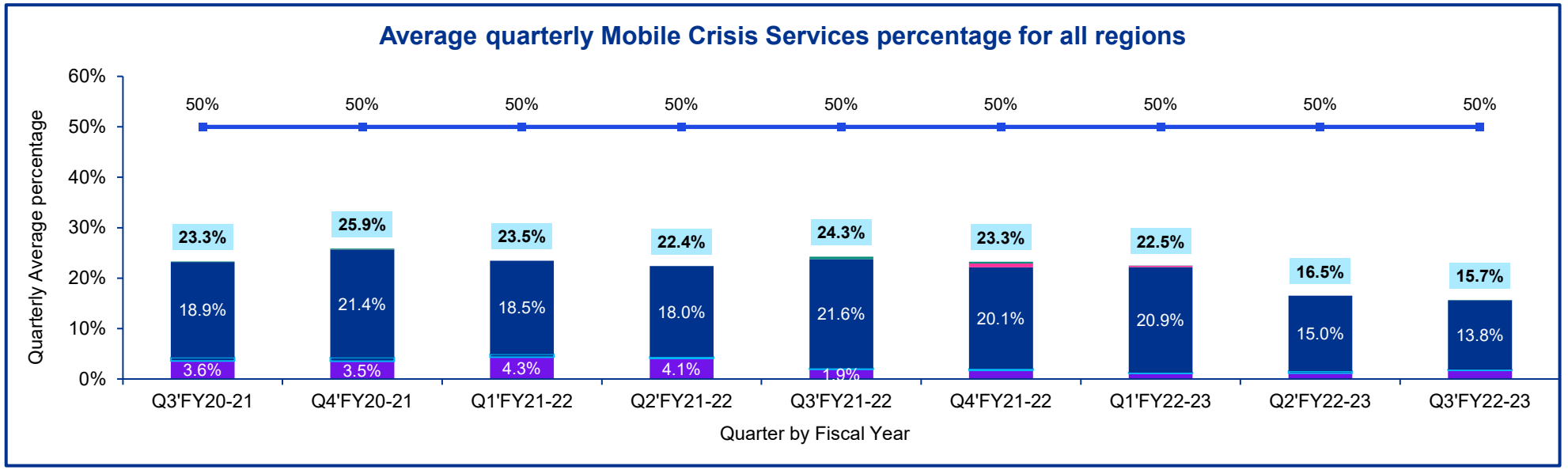
Target	This represents the Department's 50 percent target
Average Mobile Crisis %	This represents the total client services productivity percentage calculated by the Department based on the addition of Direct Services Percentage, Client Support Services Percentage, MCO Percentage, Quality Control Management (QCM) Percentage, and Access Line Hours Percentage. Each of these categories are explained further below.
Direct Services %	This includes all billable services (i.e., billed to Medi-Cal)
Client Support Services %	This relates to non billable activities, i.e. which includes no show note, scheduling, client support, informational, & sometimes transportation.
MCO %	Time billed to MCO. This is extremely rare
QCM %	This relates to documentation time
***Access Line %**	This relates to time spent by crisis services staff answering Access Line phone calls during period of high demand or staff leave.

Mobile Crisis Team Productivity Analysis

Mobile Crisis Teams – All Regions

Key

- Target
- Mobile Crisis Percentage
- Direct Services Percentage
- Client Support Services Percentage
- MCO Percentage
- Quality Control Management (QCM) Percentage
- *Access Line Percentage



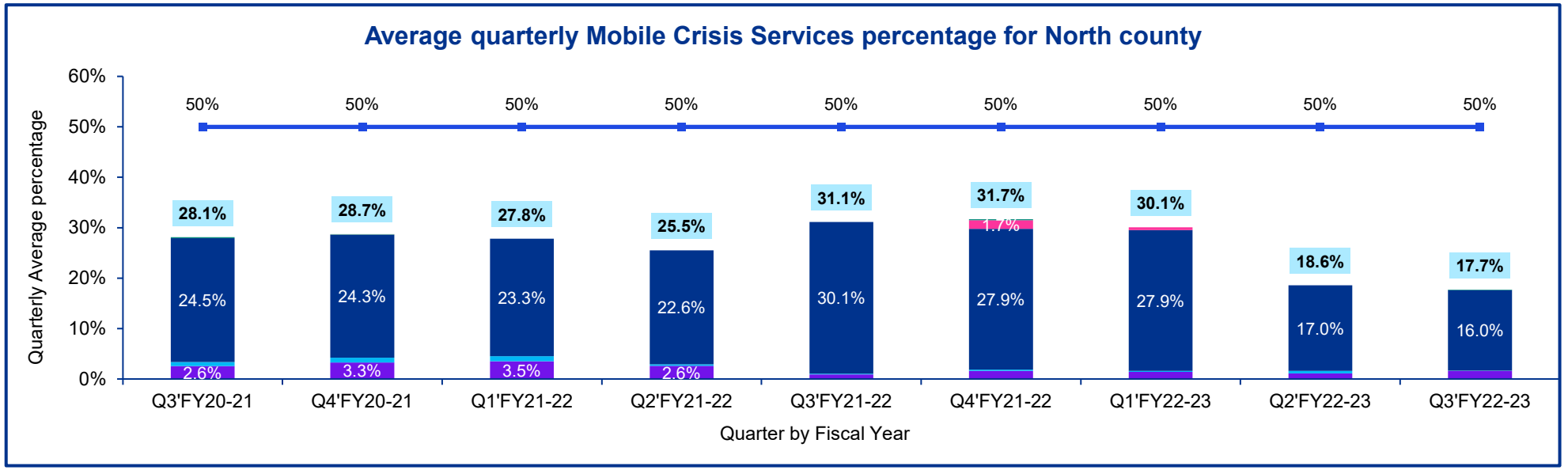
	Q3'FY20-21	Q4'FY20-21	Q1'FY21-22	Q2'FY21-22	Q3'FY21-22	Q4'FY21-22	Q1'FY22-23	Q2'FY22-23	Q3'FY22-23
Target	50%	50%	50%	50%	50%	50%	50%	50%	50%
Average Mobile Crisis Percentage	23.3%	25.9%	23.5%	22.4%	24.3%	23.3%	22.5%	16.5%	15.7%
Average Direct Services Percentage	18.9%	21.4%	18.5%	18.0%	21.6%	20.1%	20.9%	15.0%	13.8%
Average Client Support Services Percentage	0.7%	0.7%	0.6%	0.3%	0.2%	0.3%	0.2%	0.4%	0.1%
Average MCO Percentage	0.0%	0.0%	0.0%	0.0%	0.0%	0.8%	0.3%	0.0%	0.0%
Average QCM Percentage	0.1%	0.2%	0.0%	0.0%	0.5%	0.4%	0.1%	0.0%	0.0%
*Average Access Percentage	3.6%	3.5%	4.3%	4.1%	1.9%	1.7%	1.1%	1.2%	1.7%

	Q3'FY20-21	Q4'FY20-21	Q1'FY21-22	Q2'FY21-22	Q3'FY21-22	Q4'FY21-22	Q1'FY22-23	Q2'FY22-23	Q3'FY22-23
Training Percentage	1.1%	1.7%	0.4%	3.6%	2.5%	1.8%	2.4%	1.0%	2.0%
Meeting Percentage	0.0%	0.4%	0.8%	0.7%	0.9%	1.4%	0.8%	0.9%	0.5%

Mobile Crisis Teams – North County

Key

- Target
- Mobile Crisis Percentage
- Direct Services Percentage
- Client Support Services Percentage
- MCO Percentage
- Quality Control Management (QCM) Percentage
- *Access Line Percentage



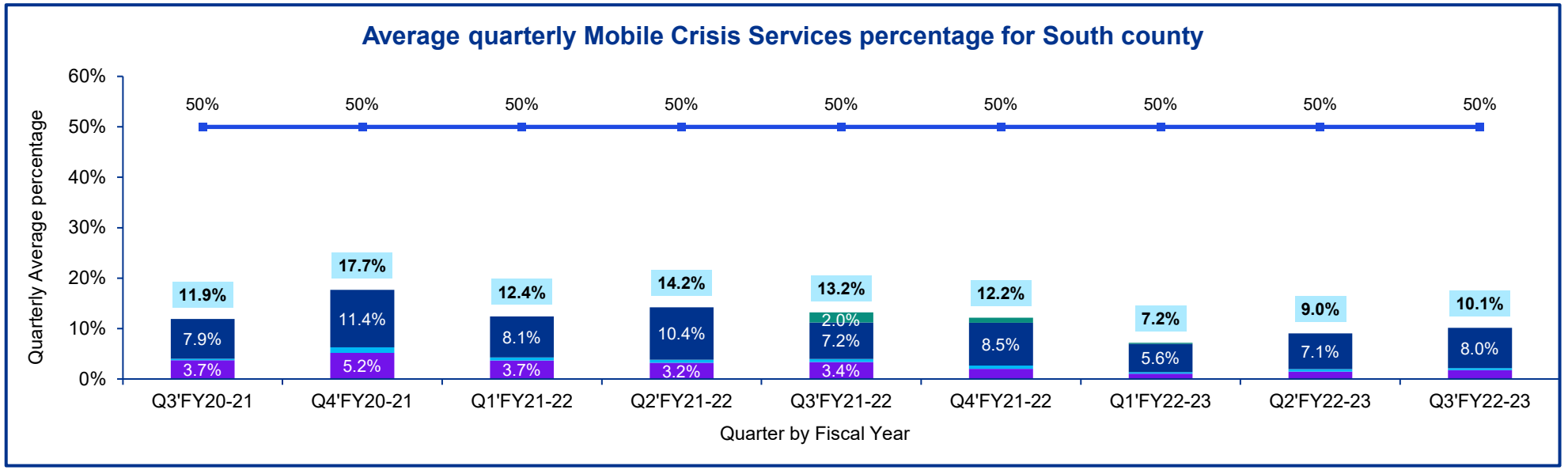
	Q3'FY20-21	Q4'FY20-21	Q1'FY21-22	Q2'FY21-22	Q3'FY21-22	Q4'FY21-22	Q1'FY22-23	Q2'FY22-23	Q3'FY22-23
Target	50%	50%	50%	50%	50%	50%	50%	50%	50%
Average Mobile Crisis Percentage	28.1%	28.7%	27.8%	25.5%	31.1%	31.7%	30.1%	18.6%	17.7%
Average Direct Services Percentage	24.5%	24.3%	23.3%	22.6%	30.1%	27.9%	27.9%	17.0%	16.0%
Average Client Support Services Percentage	0.8%	1.0%	1.0%	0.3%	0.1%	0.2%	0.2%	0.5%	0.0%
Average MCO Percentage	0.0%	0.0%	0.0%	0.0%	0.0%	1.7%	0.6%	0.0%	0.0%
Average QCM Percentage	0.2%	0.1%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	0.1%
*Average Access Percentage	2.6%	3.3%	3.5%	2.6%	0.9%	1.6%	1.4%	1.1%	1.6%

	Q3'FY20-21	Q4'FY20-21	Q1'FY21-22	Q2'FY21-22	Q3'FY21-22	Q4'FY21-22	Q1'FY22-23	Q2'FY22-23	Q3'FY22-23
Training Percentage	1.9%	1.5%	0.5%	2.3%	4.8%	3.4%	4.6%	1.8%	2.8%
Meeting Percentage	0.0%	0.6%	1.8%	1.5%	0.7%	2.1%	0.8%	1.0%	0.5%

Mobile Crisis Teams – South County

Key

- Target
- Mobile Crisis Percentage
- Direct Services Percentage
- Client Support Services Percentage
- MCO Percentage
- Quality Control Management (QCM) Percentage
- *Access Line Percentage



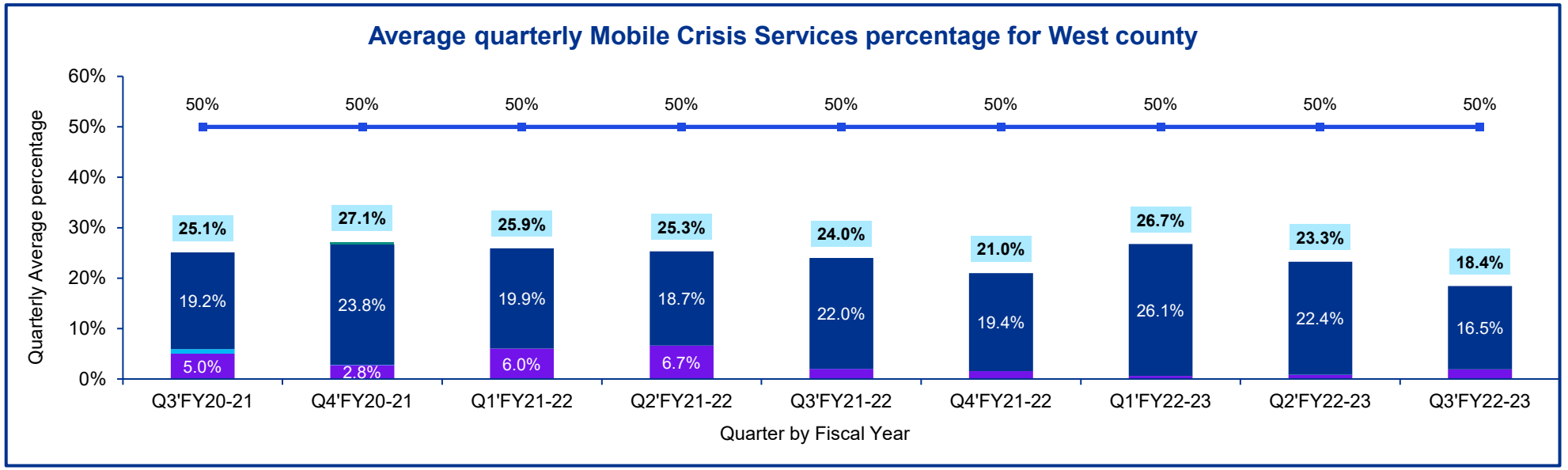
	Q3'FY20-21	Q4'FY20-21	Q1'FY21-22	Q2'FY21-22	Q3'FY21-22	Q4'FY21-22	Q1'FY22-23	Q2'FY22-23	Q3'FY22-23
Target	50%	50%	50%	50%	50%	50%	50%	50%	50%
Average Mobile Crisis Percentage	11.9%	17.7%	12.4%	14.2%	13.2%	12.2%	7.2%	9.0%	10.1%
Average Direct Services Percentage	7.9%	11.4%	8.1%	10.4%	7.2%	8.5%	5.6%	7.1%	8.0%
Average Client Support Services Percentage	0.3%	1.1%	0.6%	0.6%	0.6%	0.7%	0.3%	0.5%	0.4%
Average MCO Percentage	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Average QCM Percentage	0.0%	0.0%	0.0%	0.0%	2.0%	1.0%	0.2%	0.0%	0.0%
*Average Access Percentage	3.7%	5.2%	3.7%	3.2%	3.4%	2.0%	1.1%	1.5%	1.8%

	Q3'FY20-21	Q4'FY20-21	Q1'FY21-22	Q2'FY21-22	Q3'FY21-22	Q4'FY21-22	Q1'FY22-23	Q2'FY22-23	Q3'FY22-23
Training Percentage	0.3%	0.3%	0.5%	0.1%	1.9%	1.1%	0.5%	0.5%	1.5%
Meeting Percentage	0.0%	0.4%	0.1%	0.2%	2.4%	1.7%	1.5%	1.4%	0.9%

Mobile Crisis Teams – West County

Key

- Target
- Mobile Crisis Percentage
- Direct Services Percentage
- Client Support Services Percentage
- MCO Percentage
- Quality Control Management (QCM) Percentage
- *Access Line Percentage



	Q3'FY20-21	Q4'FY20-21	Q1'FY21-22	Q2'FY21-22	Q3'FY21-22	Q4'FY21-22	Q1'FY22-23	Q2'FY22-23	Q3'FY22-23
Target	50%	50%	50%	50%	50%	50%	50%	50%	50%
Average Mobile Crisis Percentage	25.1%	27.1%	25.9%	25.3%	24.0%	21.0%	26.7%	23.3%	18.4%
Average Direct Services Percentage	19.2%	23.8%	19.9%	18.7%	22.0%	19.4%	26.1%	22.4%	16.5%
Average Client Support Services Percentage	0.9%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Average MCO Percentage	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Average QCM Percentage	0.0%	0.4%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
*Average Access Percentage	5.0%	2.8%	6.0%	6.7%	2.0%	1.6%	0.6%	0.8%	1.9%

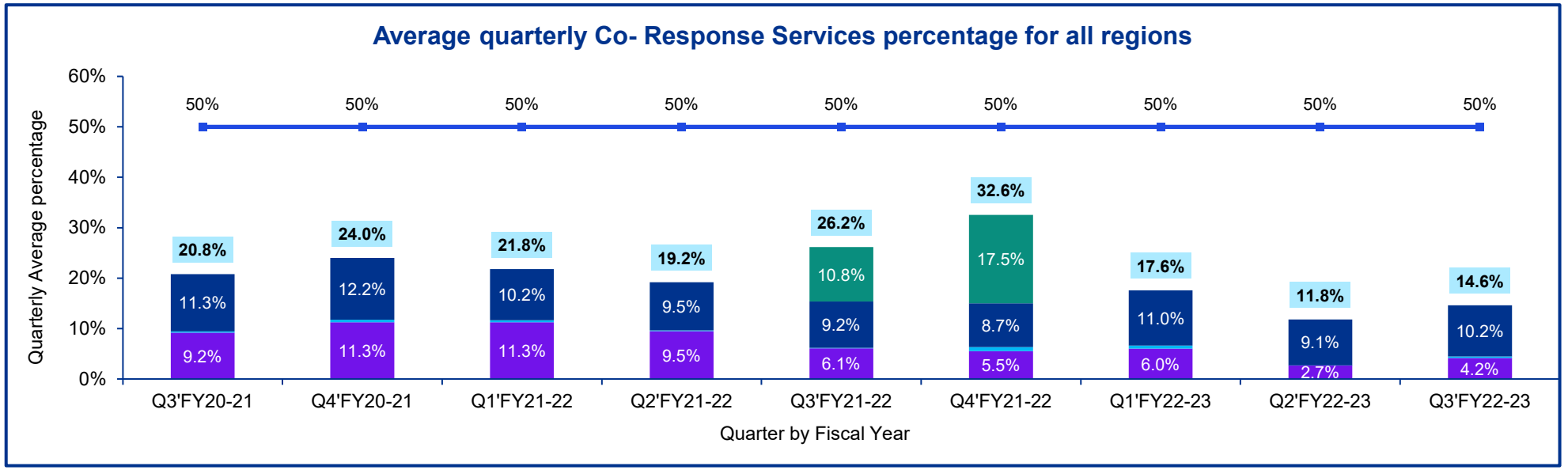
	Q3'FY20-21	Q4'FY20-21	Q1'FY21-22	Q2'FY21-22	Q3'FY21-22	Q4'FY21-22	Q1'FY22-23	Q2'FY22-23	Q3'FY22-23
Training Percentage	0.4%	3.1%	0.2%	8.3%	0.0%	0.0%	0.3%	0.0%	0.8%
Meeting Percentage	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

Co-Response Units Team Productivity Analysis

Co-Response Teams – All Regions

Key

- Target
- Co-Response Percentage
- Direct Services Percentage
- Client Support Services Percentage
- MCO Percentage
- Quality Control Management (QCM) Percentage
- *Access Line Percentage



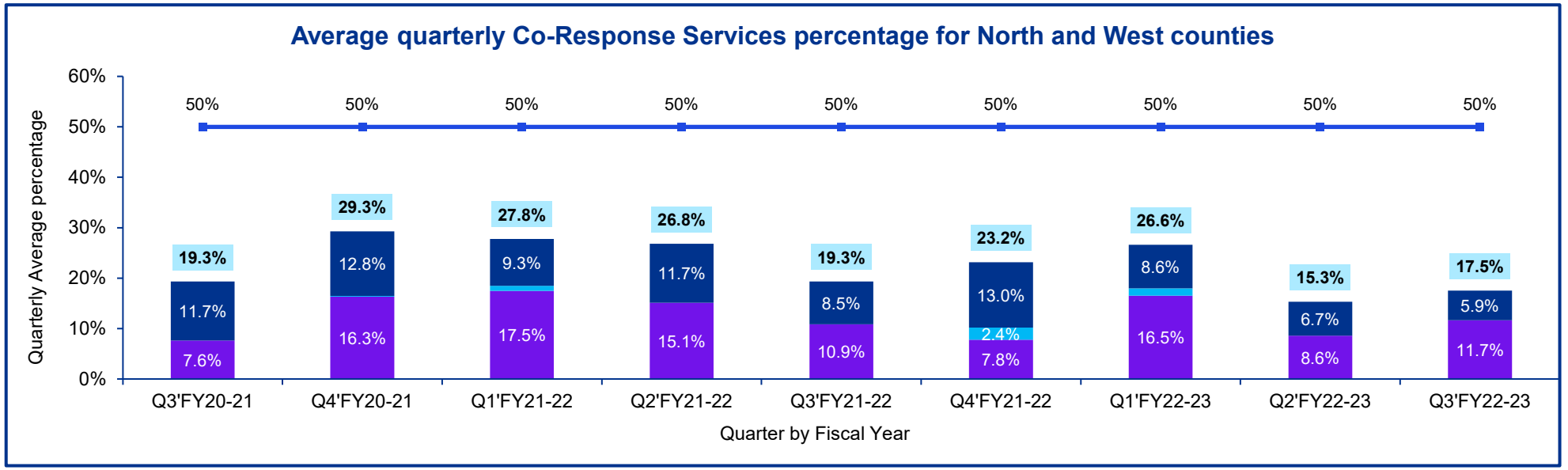
	Q3'FY20-21	Q4'FY20-21	Q1'FY21-22	Q2'FY21-22	Q3'FY21-22	Q4'FY21-22	Q1'FY22-23	Q2'FY22-23	Q3'FY22-23
Target	50%	50%	50%	50%	50%	50%	50%	50%	50%
Average Mobile Crisis Percentage	20.8%	24.0%	21.8%	19.2%	26.2%	32.6%	17.6%	11.8%	14.6%
Average Direct Services Percentage	11.3%	12.2%	10.2%	9.5%	9.2%	8.7%	11.0%	9.1%	10.2%
Average Client Support Services Percentage	0.3%	0.5%	0.4%	0.1%	0.1%	0.8%	0.6%	0.0%	0.3%
Average MCO Percentage	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Average QCM Percentage	0.0%	0.0%	0.0%	0.0%	10.8%	17.5%	0.0%	0.0%	0.0%
*Average Access Percentage	9.2%	11.3%	11.3%	9.5%	6.1%	5.5%	6.0%	2.7%	4.2%

	Q3'FY20-21	Q4'FY20-21	Q1'FY21-22	Q2'FY21-22	Q3'FY21-22	Q4'FY21-22	Q1'FY22-23	Q2'FY22-23	Q3'FY22-23
Training Percentage	2.1%	0.7%	2.2%	1.0%	1.3%	0.6%	1.4%	1.5%	4.2%
Meeting Percentage	0.6%	0.5%	0.8%	0.6%	0.5%	0.2%	0.5%	0.1%	0.2%

Co-Response Teams – North and West Counties

Key

- Target
- Co-Response Percentage
- Direct Services Percentage
- Client Support Services Percentage
- MCO Percentage
- Quality Control Management (QCM) Percentage
- *Access Line Percentage



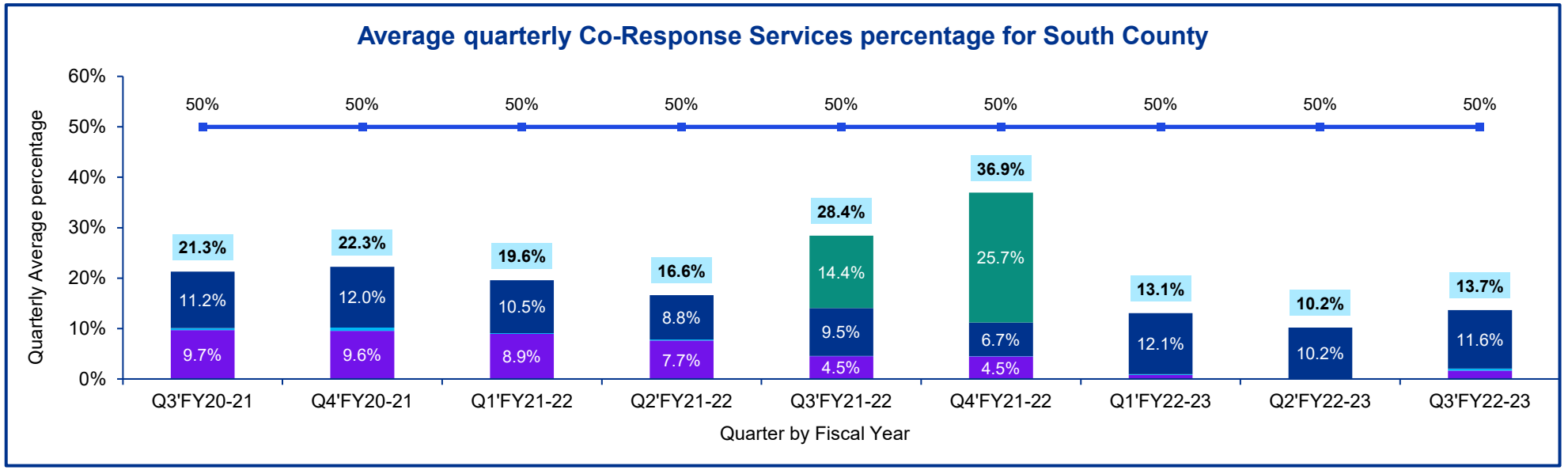
	Q3'FY20-21	Q4'FY20-21	Q1'FY21-22	Q2'FY21-22	Q3'FY21-22	Q4'FY21-22	Q1'FY22-23	Q2'FY22-23	Q3'FY22-23
Target	50%	50%	50%	50%	50%	50%	50%	50%	50%
Average Mobile Crisis Percentage	19.3%	29.3%	27.8%	26.8%	19.3%	23.2%	26.6%	15.3%	17.5%
Average Direct Services Percentage	11.7%	12.8%	9.3%	11.7%	8.5%	13.0%	8.6%	6.7%	5.9%
Average Client Support Services Percentage	0.0%	0.1%	1.0%	0.0%	0.0%	2.4%	1.5%	0.0%	0.0%
Average MCO Percentage	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Average QCM Percentage	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
*Average Access Percentage	7.6%	16.3%	17.5%	15.1%	10.9%	7.8%	16.5%	8.6%	11.7%

	Q3'FY20-21	Q4'FY20-21	Q1'FY21-22	Q2'FY21-22	Q3'FY21-22	Q4'FY21-22	Q1'FY22-23	Q2'FY22-23	Q3'FY22-23
Training Percentage	0.0%	0.0%	6.3%	0.8%	0.0%	0.0%	4.3%	2.4%	0.0%
Meeting Percentage	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

Co-Response Teams – South County

Key

- Target
- Co-Response Percentage
- Direct Services Percentage
- Client Support Services Percentage
- MCO Percentage
- Quality Control Management (QCM) Percentage
- *Access Line Percentage



	Q3'FY20-21	Q4'FY20-21	Q1'FY21-22	Q2'FY21-22	Q3'FY21-22	Q4'FY21-22	Q1'FY22-23	Q2'FY22-23	Q3'FY22-23
Target	50%	50%	50%	50%	50%	50%	50%	50%	50%
Average Mobile Crisis Percentage	21.3%	22.3%	19.6%	16.6%	28.4%	36.9%	13.1%	10.2%	13.7%
Average Direct Services Percentage	11.2%	12.0%	10.5%	8.8%	9.5%	6.7%	12.1%	10.2%	11.6%
Average Client Support Services Percentage	0.4%	0.6%	0.2%	0.2%	0.1%	0.0%	0.1%	0.0%	0.4%
Average MCO Percentage	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Average QCM Percentage	0.0%	0.0%	0.0%	0.0%	14.4%	25.7%	0.0%	0.0%	0.0%
*Average Access Percentage	9.7%	9.6%	8.9%	7.7%	4.5%	4.5%	0.8%	0.0%	1.7%

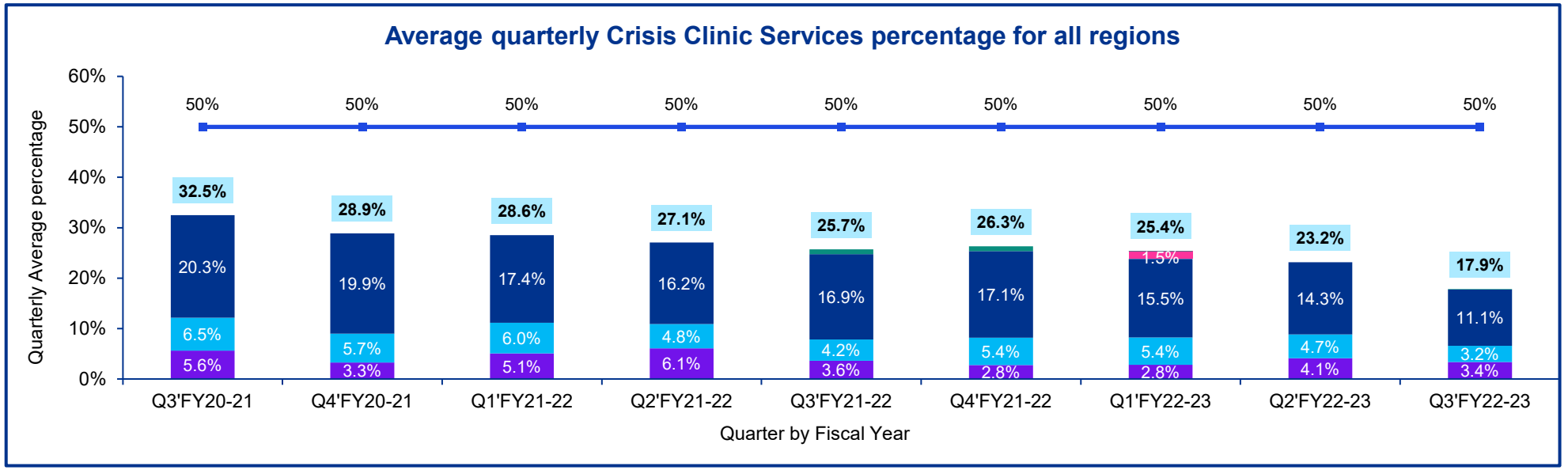
	Q3'FY20-21	Q4'FY20-21	Q1'FY21-22	Q2'FY21-22	Q3'FY21-22	Q4'FY21-22	Q1'FY22-23	Q2'FY22-23	Q3'FY22-23
Training Percentage	2.8%	0.9%	0.7%	1.1%	1.7%	1.0%	0.0%	1.0%	5.6%
Meeting Percentage	0.8%	0.7%	1.1%	0.7%	0.7%	0.3%	0.8%	0.2%	0.2%

Crisis Clinic Team Productivity Analysis

Crisis Clinic Teams – All Regions

Key

- Target
- Crisis Clinics Percentage
- Direct Services Percentage
- Client Support Services Percentage
- MCO Percentage
- Quality Control Management (QCM) Percentage
- *Access Line Percentage



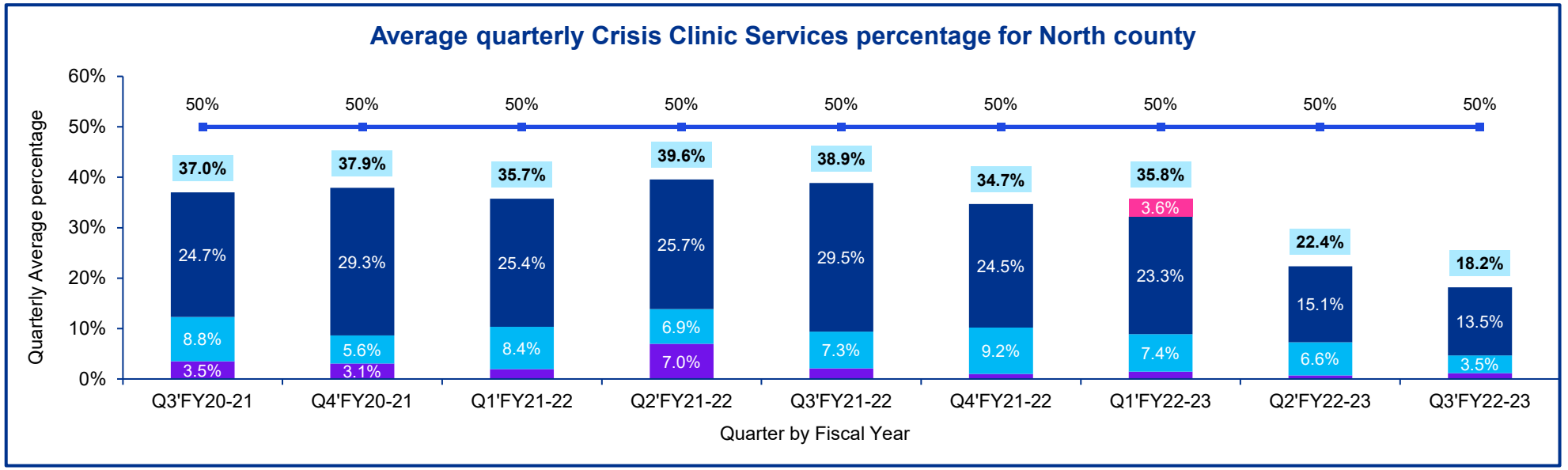
	Q3'FY20-21	Q4'FY20-21	Q1'FY21-22	Q2'FY21-22	Q3'FY21-22	Q4'FY21-22	Q1'FY22-23	Q2'FY22-23	Q3'FY22-23
Target	50%	50%	50%	50%	50%	50%	50%	50%	50%
Average Mobile Crisis Percentage	32.5%	28.9%	28.6%	27.1%	25.7%	26.3%	25.4%	23.2%	17.9%
Average Direct Services Percentage	20.3%	19.9%	17.4%	16.2%	16.9%	17.1%	15.5%	14.3%	11.1%
Average Client Support Services Percentage	6.5%	5.7%	6.0%	4.8%	4.2%	5.4%	5.4%	4.7%	3.2%
Average MCO Percentage	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.5%	0.0%	0.0%
Average QCM Percentage	0.0%	0.0%	0.0%	0.0%	0.9%	0.9%	0.1%	0.0%	0.1%
*Average Access Percentage	5.6%	3.3%	5.1%	6.1%	3.6%	2.8%	2.8%	4.1%	3.4%

	Q3'FY20-21	Q4'FY20-21	Q1'FY21-22	Q2'FY21-22	Q3'FY21-22	Q4'FY21-22	Q1'FY22-23	Q2'FY22-23	Q3'FY22-23
Training Percentage	7.3%	8.5%	4.6%	6.3%	3.8%	3.7%	1.7%	4.5%	9.4%
Meeting Percentage	10.9%	11.1%	9.8%	10.2%	8.2%	7.7%	6.8%	8.3%	10.7%

Crisis Clinic Teams – North County

Key

- Target
- Crisis Clinics Percentage
- Direct Services Percentage
- Client Support Services Percentage
- MCO Percentage
- Quality Control Management (QCM) Percentage
- *Access Line Percentage



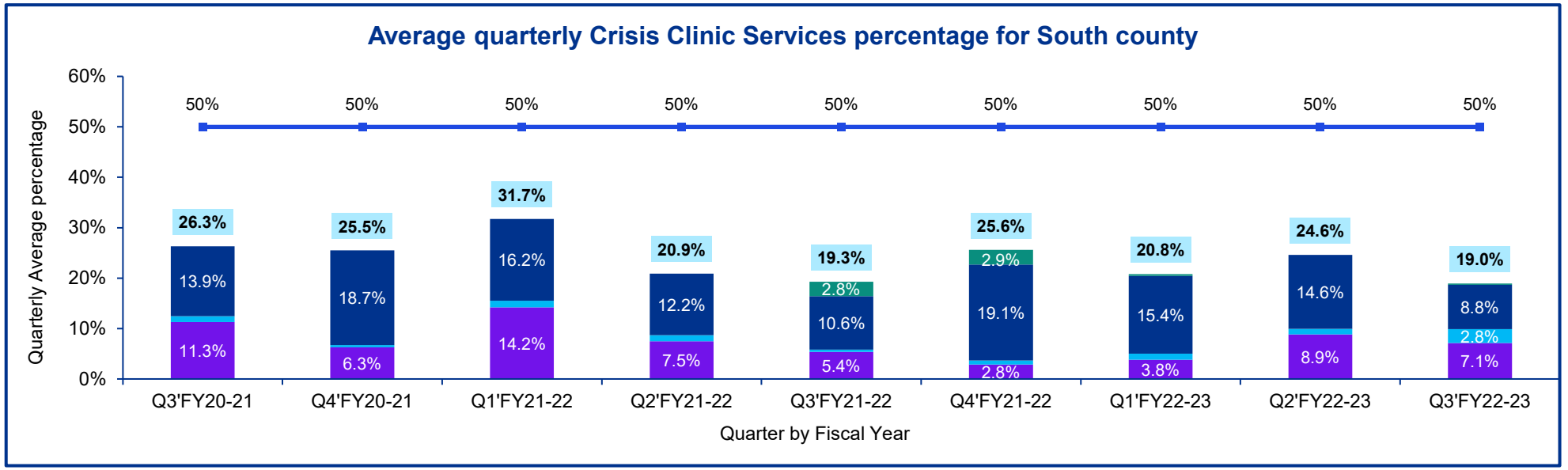
	Q3'FY20-21	Q4'FY20-21	Q1'FY21-22	Q2'FY21-22	Q3'FY21-22	Q4'FY21-22	Q1'FY22-23	Q2'FY22-23	Q3'FY22-23
Target	50%	50%	50%	50%	50%	50%	50%	50%	50%
Average Mobile Crisis Percentage	37.0%	37.9%	35.7%	39.6%	38.9%	34.7%	35.8%	22.4%	18.2%
Average Direct Services Percentage	24.7%	29.3%	25.4%	25.7%	29.5%	24.5%	23.3%	15.1%	13.5%
Average Client Support Services Percentage	8.8%	5.6%	8.4%	6.9%	7.3%	9.2%	7.4%	6.6%	3.5%
Average MCO Percentage	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	3.6%	0.0%	0.0%
Average QCM Percentage	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
*Average Access Percentage	3.5%	3.1%	2.0%	7.0%	2.1%	1.0%	1.5%	0.7%	1.2%

	Q3'FY20-21	Q4'FY20-21	Q1'FY21-22	Q2'FY21-22	Q3'FY21-22	Q4'FY21-22	Q1'FY22-23	Q2'FY22-23	Q3'FY22-23
Training Percentage	6.1%	7.8%	3.2%	6.9%	5.2%	5.7%	2.2%	7.1%	14.0%
Meeting Percentage	8.0%	8.6%	9.6%	10.7%	11.4%	10.8%	11.7%	14.0%	17.2%

Crisis Clinic Teams – South County

Key

- Target
- Crisis Clinics Percentage
- Direct Services Percentage
- Client Support Services Percentage
- MCO Percentage
- Quality Control Management (QCM) Percentage
- *Access Line Percentage



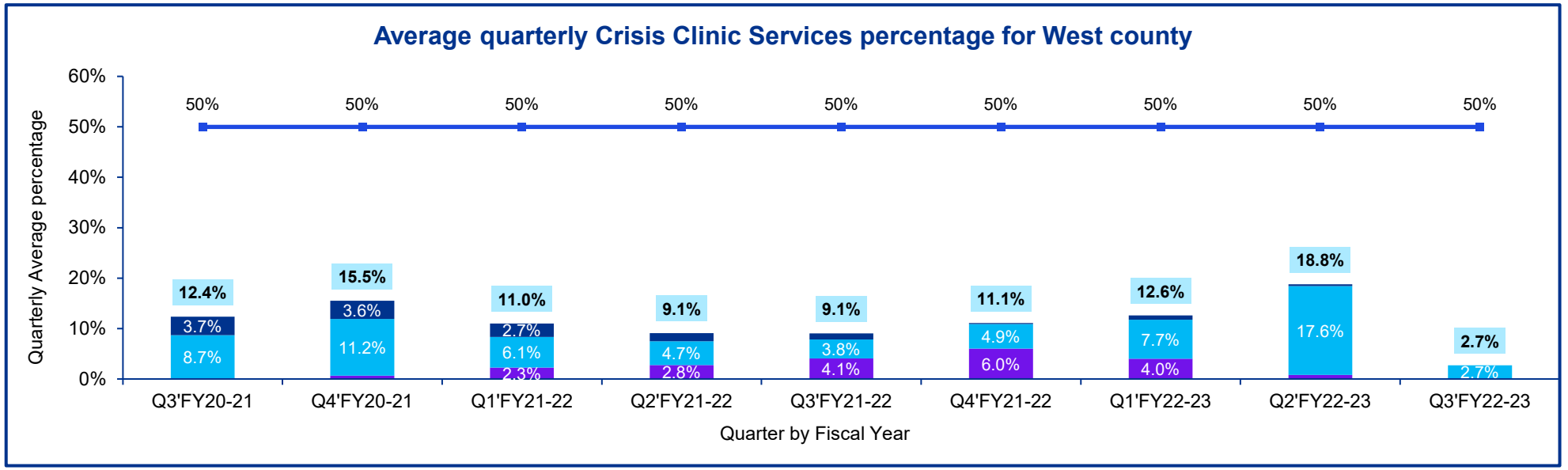
	Q3'FY20-21	Q4'FY20-21	Q1'FY21-22	Q2'FY21-22	Q3'FY21-22	Q4'FY21-22	Q1'FY22-23	Q2'FY22-23	Q3'FY22-23
Target	50%	50%	50%	50%	50%	50%	50%	50%	50%
Average Mobile Crisis Percentage	26.3%	25.5%	31.7%	20.9%	19.3%	25.6%	20.8%	24.6%	19.0%
Average Direct Services Percentage	13.9%	18.7%	16.2%	12.2%	10.6%	19.1%	15.4%	14.6%	8.8%
Average Client Support Services Percentage	1.2%	0.5%	1.3%	1.2%	0.5%	0.8%	1.2%	1.1%	2.8%
Average MCO Percentage	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Average QCM Percentage	0.0%	0.0%	0.0%	0.0%	2.8%	2.9%	0.3%	0.0%	0.3%
*Average Access Percentage	11.3%	6.3%	14.2%	7.5%	5.4%	2.8%	3.8%	8.9%	7.1%

	Q3'FY20-21	Q4'FY20-21	Q1'FY21-22	Q2'FY21-22	Q3'FY21-22	Q4'FY21-22	Q1'FY22-23	Q2'FY22-23	Q3'FY22-23
Training Percentage	9.4%	13.0%	11.8%	8.1%	3.0%	2.8%	2.1%	1.5%	3.0%
Meeting Percentage	17.9%	15.6%	14.0%	13.1%	3.3%	1.4%	1.8%	1.7%	0.9%

Crisis Clinic Teams – West County

Key

- Target
- Crisis Clinics Percentage
- Direct Services Percentage
- Client Support Services Percentage
- MCO Percentage
- Quality Control Management (QCM) Percentage
- *Access Line Percentage



	Q3'FY20-21	Q4'FY20-21	Q1'FY21-22	Q2'FY21-22	Q3'FY21-22	Q4'FY21-22	Q1'FY22-23	Q2'FY22-23	Q3'FY22-23
Target	50%	50%	50%	50%	50%	50%	50%	50%	50%
Average Mobile Crisis Percentage	12.4%	15.5%	11.0%	9.1%	9.1%	11.1%	12.6%	18.8%	2.7%
Average Direct Services Percentage	3.7%	3.6%	2.7%	1.6%	1.2%	0.2%	0.9%	0.3%	0.0%
Average Client Support Services Percentage	8.7%	11.2%	6.1%	4.7%	3.8%	4.9%	7.7%	17.6%	2.7%
Average MCO Percentage	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Average QCM Percentage	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
*Average Access Percentage	0.0%	0.7%	2.3%	2.8%	4.1%	6.0%	4.0%	0.8%	0.0%

	Q3'FY20-21	Q4'FY20-21	Q1'FY21-22	Q2'FY21-22	Q3'FY21-22	Q4'FY21-22	Q1'FY22-23	Q2'FY22-23	Q3'FY22-23
Training Percentage	10.6%	5.5%	0.0%	2.9%	2.3%	1.3%	0.0%	0.0%	3.2%
Meeting Percentage	7.5%	11.2%	6.0%	5.8%	9.2%	10.4%	4.8%	0.0%	9.7%

Clinician's Gateway Analysis

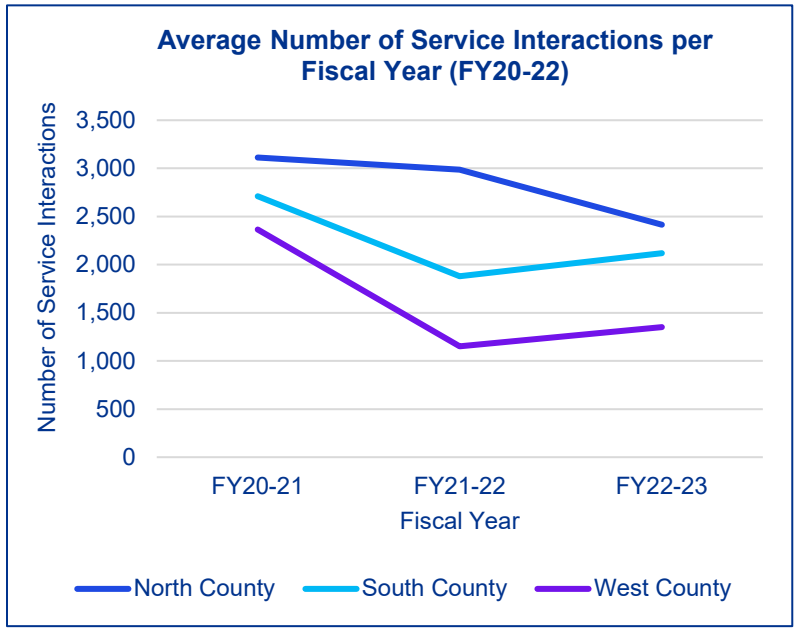
Overview of Crisis Services Data

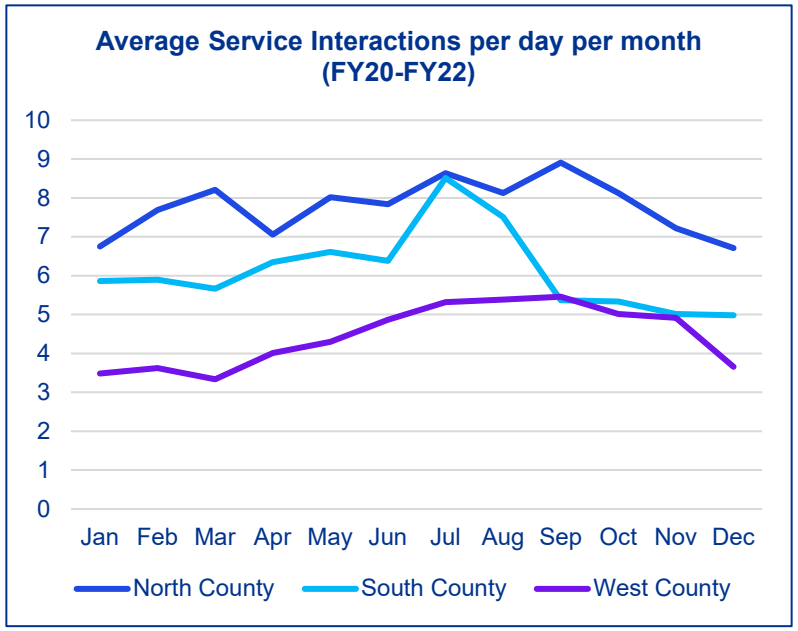
- Crisis Services data from the Department's EHR, Clinician's Gateway was provided in response to the request to provide crisis clinic related data surrounding number of clients served, presenting issues, length of intervention, average length of service, and cancellation/no shows.
- However, the **data provided does not separately identify whether client contact was with Mobile Crisis, Co-response, or Crisis Clinics**. Based on several discussions engagement with Quality Control Management and Program leadership, a number of steps were undertaken to try to identify a mechanism to bifurcate the data by services for the purposes of analysis. However, these mechanisms did not yield accurate results.
- Therefore, the KPMG team analyzed data related to mobile crisis, co-response, and crisis clinics in aggregate. This creates a number of challenges:
  - It **prevents analysis at the more granular regional/team level** to understand team level volumes/demand.
  - It **does not allow for targeted analysis by team, for example, differing data points are analyzed based on team function**. For example, no shows/cancellation is a key metric to analyze for crisis clinics; however, would not be relevant for mobile crisis or co-response.
  - Given that mobile crisis operate 24/7, while co-response and crisis clinics operates from 8 a.m.– 6 p.m.**, it limits and skews the analysis in order to understand volume demand and opportunities for staff optimization by team.** As a result of this limitation, all analysis related to volume per hour has been calculated on a 24-hour basis. However, this may not be reflective of volume per hour of day and based on engagement with mobile crisis teams, we understand volume are significantly lower overnight.
- Despite, the challenges outlined above, KPMG also analyzed no show/cancelation rates per region. Analysis identified significantly low no show/cancelation rates not reflective of industry standards or staff interviews. As such, KPMG engaged with staff to understand reasons behind low no show/cancelation rates. KPMG were advised that often times, **staff members do not accurately code or document cancelation/no show rates in their system**. As an example of how this impacts utilization, staff indicated that approximately 80 percent of referrals from hospital emergency departments do not attend crisis clinic appointments; however, the data does not support this statement. While KPMG have made recommendations on how to improve client attendance, data is required to understand improvement efforts.
- As a result of these data limitations, KPMG engaged with the Department to implement a four-week data collection process, incorporating mobile crisis and co-response. Following the completion of the four-week data collection period, KPMG utilized mobile crisis and co-response volumes identified to extrapolate crisis clinic volumes from data within the Department's EHR. This analysis has been included on page 167. However, included the analysis of the followings pages to illustrate total volumes across all crisis services over a three-year period. It is important to note that volumes appear to be low across crisis teams and do not significantly differ from the analysis under over a four-week period by KPMG.

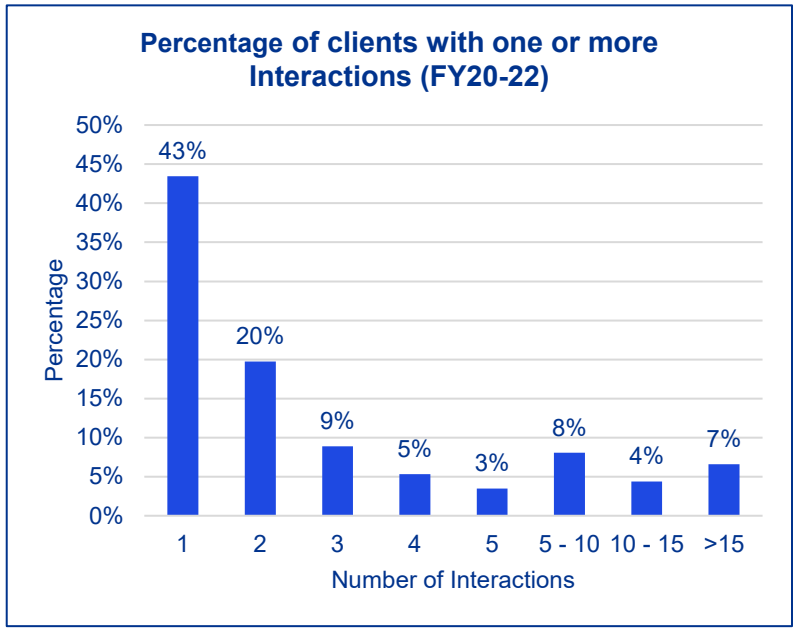
County Crisis Services

The Crisis Services Program including mobile crisis, co-response, and crisis clinics experienced average annual volumes of 6,699 interactions between FY20-23. However, volumes have declined by an average of 28 percent between FY20 and FY22.

FTES*	Average Annual Service Volume (FY20-22)	Average Daily Service Volume (FY20-22)	Average Daily Service Volume per hour (FY20-22)	Average % Face- to Face Contacts (FY20-22)	Average % Cancels/ No shows* (FY20-22)	% Clients with more than one Visit (FY20-22)	Average Time per In-person Visit (FY20-22)	Average Time per Phone/ Telehealth Visit (FY20-22)	Average Travel Time per Visit (FY20-22)	Average Documentation Time per Visit (FY20-22)	Min. Length of Service (FY20-22)	Average Length of Service (FY20-22)	Max. Length of Service (FY20-22)
39.25	6,699	18	2	81%	2%	57%	51 mins	21 mins	14 mins	26 mins	0 days	22 days	1,764 days







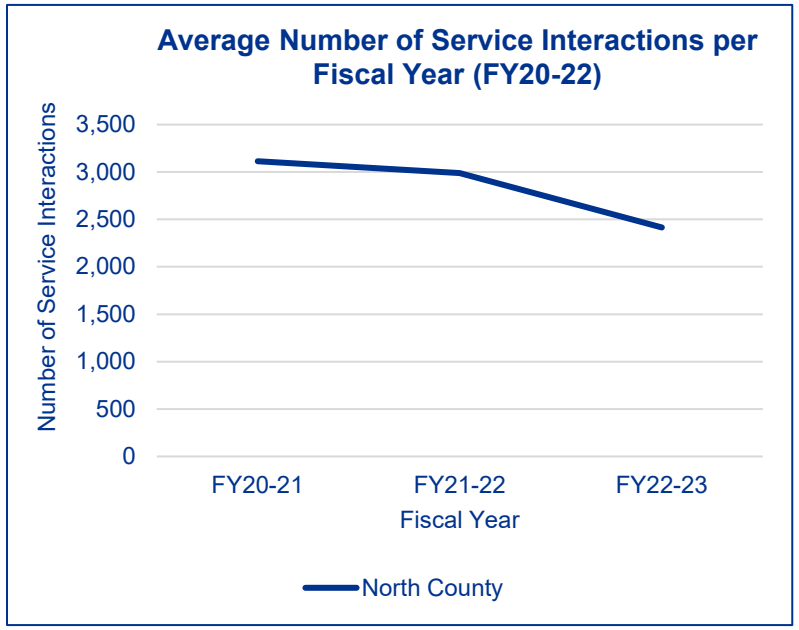
***FTEs exclude management, supervisory and administrative staff across teams given they do not provide crisis services. It is assumed that EXH staff are 0.5 FTE, and 1.25 FTE has been included for prescribers across North, South, and West County**

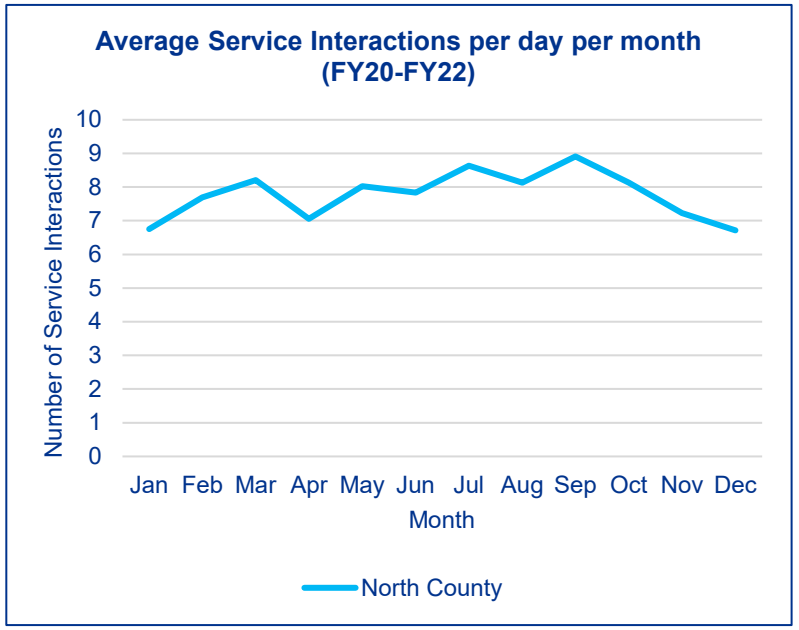
**During Interviews, staff reported that cancelation and no shows may not be documented as accurately. Therefore, average percentage cancels/no shows is likely understated.

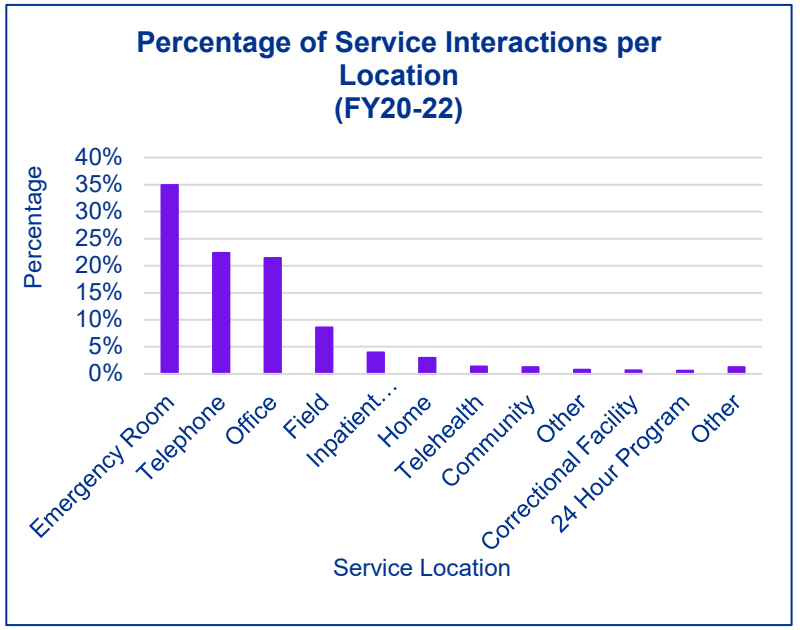
North County– Crisis Services

North County Crisis Services represents 43 percent of total volume with an average of 2,838 service interactions per year. However volumes has declined by an average of 22 percent since FY20. Across Regions, North County have the highest average time per service interaction at 61 minutes and the lowest average length of service at 13 days. Among the three teams, they also have the highest referral source and interactions in Emergency Department(s).

North County FTES*	Average % Total Volume	Average Annual Service Volume (FY20-22)	Average Daily Service Volume (FY20-22)	Average Daily Service Volume per hour (FY20-22)	Average % Face-to Face Contact (FY20-22)	Most common Service Location (FY20-22)	% No Show/ Cancel rate (FY20-22)	Average Time per In-person Visit (FY20-22)	Average Time per Phone/ Telehealth Visit (FY20-22)	Average Travel Time per Visit (FY20-22)	Average Documentation Time per Visit (FY20-22)	Min. Length of Service (FY20-22)	Average Length of Service (FY20-22)	Max. Length of Service (FY20-22)
15.5	43%	2,838	8	1	77%	ER	1%	61 mins	25 mins	19 mins	25 mins	0 days	13 days	365 days







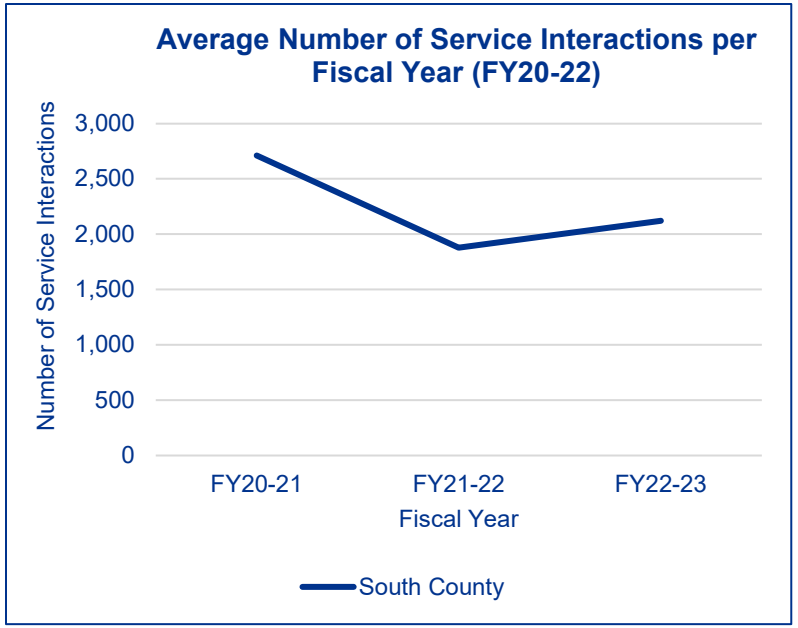
***FTEs exclude management, supervisory and administrative staff across teams given they do not provide crisis services. It is assumed that EXH staff are 0.5 FTE, 0.5 FTE has been included for prescribers within the North County Clinic and 0.5 FTE for the North and West County Co-response Team with the other 0.5 FTE being included within West County**

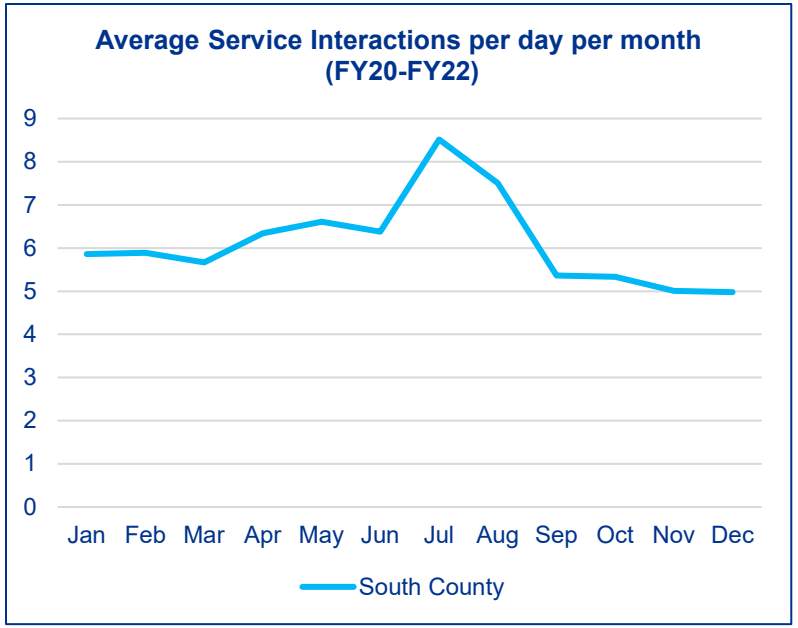
**During Interviews, staff reported that cancelation and no shows may not be documented as accurately. Therefore, average percentage cancels/no shows is likely understated.

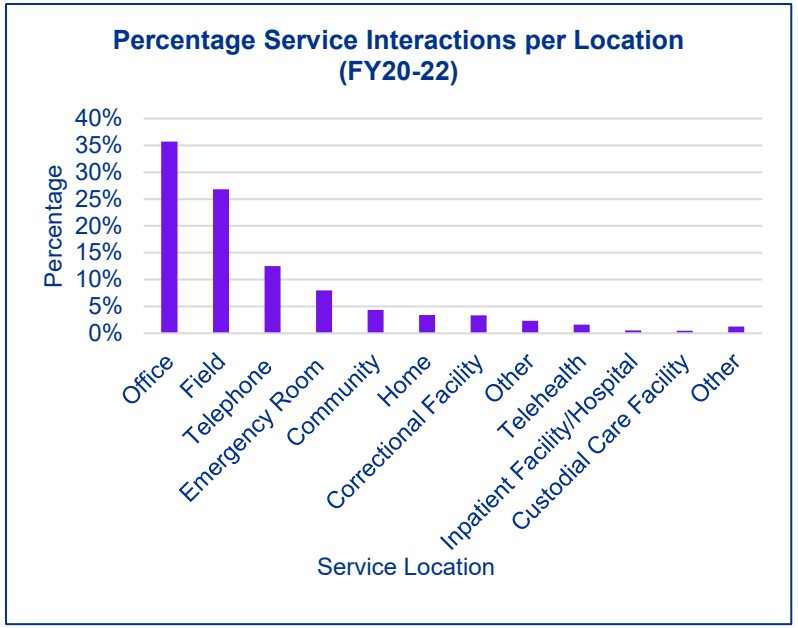
South County- Crisis Services

South County Crisis Services represents 33 percent of total volume on average with an average of 2,237 service interactions per year. While volumes declined by 30 percent between FY20 & FY21, they have begun to increase by 13 percent in FY23. Across Regions, South County have the lowest average time per service interaction at 38 minutes and the highest average length of service at 29 days. Approximately 47 percent of the teams interactions occurs in the office & via telephone.

South County FTES*	Average % Total Volume	Average Annual Service Volume (FY20-22)	Average Daily Service Volume (FY20-22)	Average Daily Service Volume per hour (FY20-22)	Average % Face-to Face Contact (FY20-22)	Most common Service Location (FY20-22)	% No Show/ Cancel rate (FY20-22)	Average Time per In-person Visit (FY20-22)	Average Time per Phone/ Telehealth Visit (FY20-22)	Average Travel Time per Visit (FY20-22)	Average Documentation Time per Visit (FY20-22)	Min. Length of Service (FY20-22)	Average Length of Service (FY20-22)	Max. Length of Service (FY20-22)
14	33%	2,237	6	0.7	85%	Office	2%	38 mins	17 mins	9 mins	25 mins	0 days	29 days	1,764 days







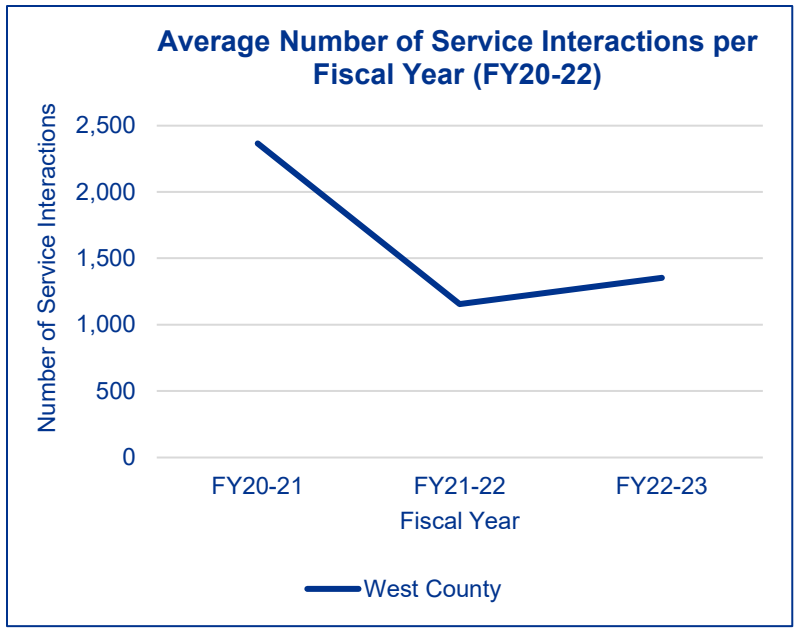
*FTEs exclude management, supervisory and administrative staff across teams given they do not provide crisis services. It is assumed that EXH staff are 0.5 FTE, 0.5 FTE has been included for prescribers within the South County Clinic

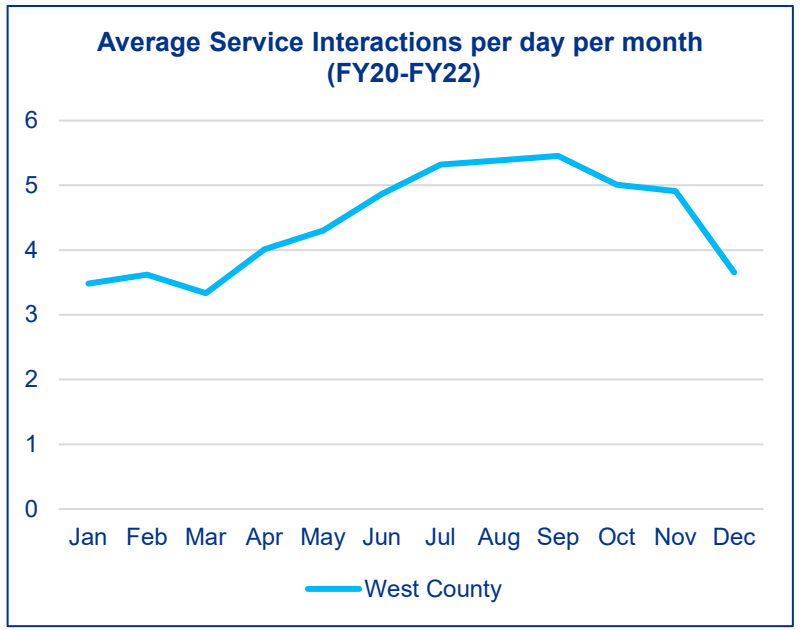
**During Interviews, staff reported that cancelation and no shows may not be documented as accurately. Therefore, average percentage cancels/no shows is likely understated.

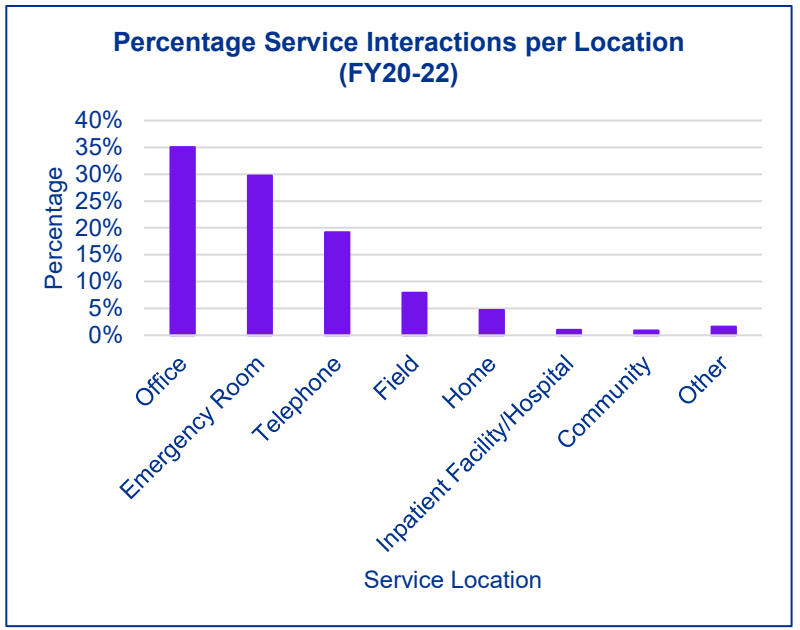
West County– Crisis Services

West County Crisis Services represents 24 percent of total volume on average with an average of 1,624 service interactions per year. However volumes has declined by an average of 43 percent since FY20. Across Regions, West County averages four interactions per day which represents 0.4 interactions per staff member. Approximately 54 percent of the teams interactions occur in the office and by telephone.

West County FTES*	Average % Total Volume	Average Annual Service Volume (FY20-22)	Average Daily Service Volume (FY20-22)	Average Daily Service Volume per hour (FY20-22)	Average % Face-to Face Contact (FY20-22)	Most common Service Location (FY20-22)	% No Show/ Cancel rate (FY20-22)	Average Time per In-person Visit (FY20-22)	Average Time per Phone/ Telehealth Visit (FY20-22)	Average Travel Time per Visit (FY20-22)	Average Documentation Time per Visit (FY20-22)	Min. Length of Service (FY20-22)	Average Length of Service (FY20-22)	Max. Length of Service (FY20-22)
9.75	24%	1,624	4	0.5	81%	Office	2%	52 mins	18 mins	13 mins	27 mins	0 days	23 days	366 days







*FTEs exclude management, supervisory and administrative staff across teams given they do not provide crisis services. It is assumed that EXH staff are 0.5 FTE, 0.25 FTE has been included for prescribers within the West County Clinic and 0.5 FTE for the North and West County Co-response Team with the other 0.5 FTE being included within North County

**During Interviews, staff reported that cancelation and no shows may not be documented as accurately. Therefore, average percentage cancels/no shows is likely understated.

KPMG Data Collection – Analysis

Overview of Data Collection process

- As outlined throughout this report, KPMG received a large number of datasets for the Crisis Services Program, which consisted of volumes, referral sources, call outcomes, response times, travel time, time spent in the field etc. However, based on the data received several data Imitations were identified, relating to a significant number of blanks across certain datasets, as well as the inability to bifurcate data across individual crisis services teams (crisis clinic. mobile crisis, co-response) to provide a more in-depth team level assessment of performance.
- Furthermore, an initial analysis of Crisis Services Program productivity data suggested significantly low volumes across crisis teams which did not appear to align with staff reports during interviews. As a result, KPMG engaged with the Department to implement a four-week data collection process, incorporating mobile crisis and co-response . As part of this process, the following key steps were undertaken:.
    - KPMG provided the Department with a list of 21 data points required for collection.
    - KPMG held meetings with team supervisors to walk through the meaning of each data point and the importance of accurate documentation.
    - KPMG also attended a team meeting during which management advised mobile crisis and co-response teams of the requirement to track the key data points identified by KPMG. During this call, KPMG answered a number of questions regarding the data collection.
    - Under this process, each supervisor was required to review the data collected for completeness on a daily basis and provide the data to KPMG each Monday for the previous week. The first week of data collection began on August 7, 2023 with the data collection process ending on September 3, 2023.
    - KPMG reviewed the data for completeness, developed key insights and visualized the data which has been included on the following pages.

It is important to note that the results of this four-week analysis did not significantly differ from the original productivity analysis undertaken with the Crisis Services Program experiencing low volumes across teams. Following the completion of the four-week collection period, data-driven insights were combined with other analysis and utilized to identify opportunities for consideration identified in this report.

Mobile Crisis & Co-response Overview (Aug 7 – Sept 3, 2023)

North County Mobile Crisis had the highest call volume across each week coupled with the longest average time spent on a call averaging 22 calls per week and 107 minutes per call. South County Co-response had the highest call volume across the four weeks, averaging 10 calls per week with the lowest average time spent on each call at an average of 82 minutes. Co-response Team Call volumes for all regions decreased between week 3 and week 4.

Mobile Crisis

	North County			South County			West County		
	FTES*	Weekly Calls/ Avg. Daily Vol.	Avg. time spent on call	FTES*	Weekly Calls/ Avg. Daily Vol	Avg. time spent on call	FTES*	Weekly Calls/ Avg. Daily Vol	Avg. time spent on call
Week 1 Aug 7-Aug13	6	25/3.6	110 mins	5.5	18/2.6	61 mins	5.5	17/2.4	83 mins
Week 2 Aug 14-Aug 20		15 / 2.1	104 mins		8/1.1	70 mins		12/1.7	97 mins
Week 3 Aug 21-Aug 27		20 / 2.9	108 mins		11/1.6	91 mins		18/2.6	131 mins
Week 4 Aug 28-Sep 3		26/3.7	107 mins		13/1.9	72 mins		12/1.7	107 mins

Co-response Teams

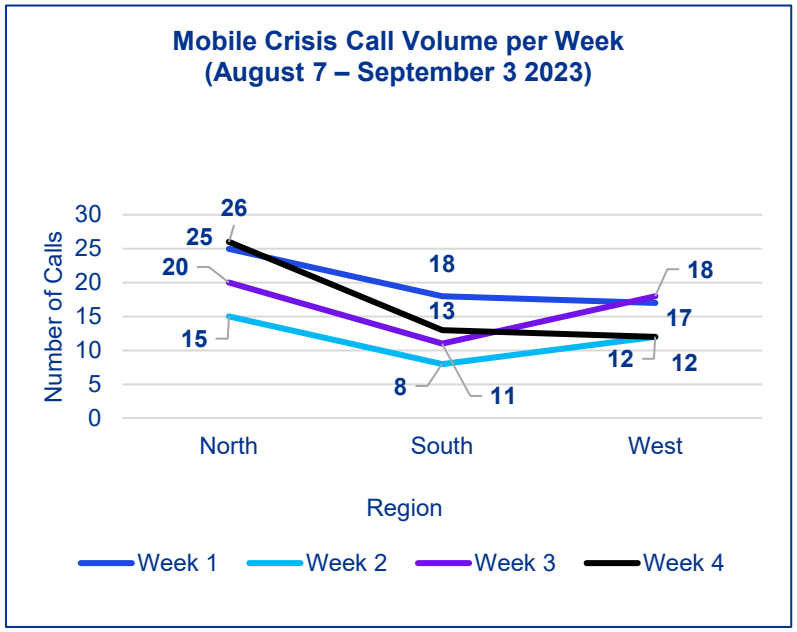
	North County			South County			North and West County		
	FTES*	Weekly Calls/ Avg. Daily Vol.	Avg. time spent on call	FTES*	Weekly Calls/ Avg. Daily Vol.	Avg. time spent on call	FTES*	Weekly Calls/ Avg. Daily Vol.	Avg. time spent on call
Week 1 Aug 7-Aug13	1	No calls due to staff on sick leave. Mobile Crisis responded		3	17/2.8	56 mins	1	5/1	135 mins
Week 2 Aug 14-Aug 20		5/1	122 mins		5/1	99 min		No calls, due to co-response deputy on vacation	
Week 3 Aug 21-Aug 27		5/1	55 mins		9/1.8	88 mins		3/0.6	71 mins
Week 4 Aug 28-Sep 3		4/1	66 mins		7/1.8	85 mins		2/0.5	61 mins

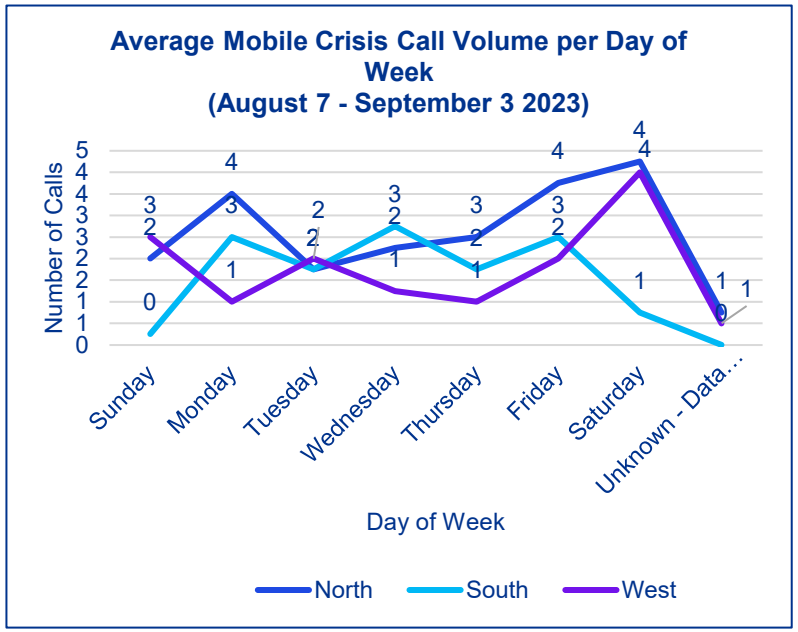
*FTEs exclude management, supervisory, and administrative staff given they do not typically provide frontline services

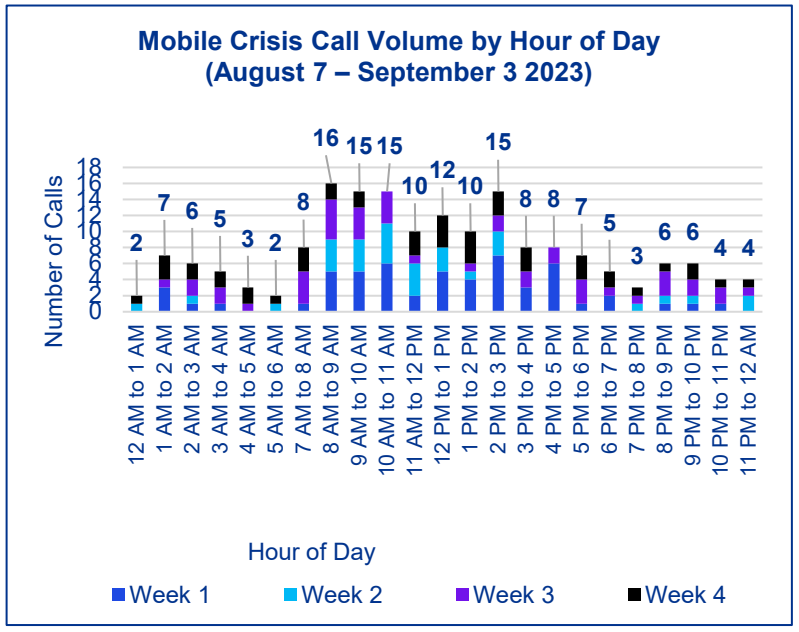
Mobile Crisis Data Analysis (Aug 7 – Sept 3, 2023)*

In total, Mobile Crisis Services received a total of 195 calls over the four-week period analyzed, this equates to an average of 49 service interactions per week, 16 service interactions per week per team or 2 service interactions per day per team. On average, Saturday was the busiest day of the week across teams with Sunday representing the day with the lowest call volumes. 47 percent of all calls resulted in a hold and 67 percent of the calls occurred in settings that will not be reimbursable post Medi-Cal Crisis Benefit Implementation.

Total Mobile Crisis FTES**	Average Weekly Call Volume per Team	Average Weekly Daily Volume per Team	Busiest Day of the Week	Busiest Hour of Day	% Law Enforcement Involvement	% Face- to-Face Contact	Most common Service Location***	Most common Service Outcome	Average Response Time	Average Time Spent of Call	Average AMR Response Time
17	16	2	Saturday	8AM – 9AM	43%	87%	ER(50%)	Hold (47%)	21 mins	98 mins	28 mins







*Please note while these slides have been included in the body of the report, they have also been included here to support the explanation of approach and methodology in completing this four-week analysis

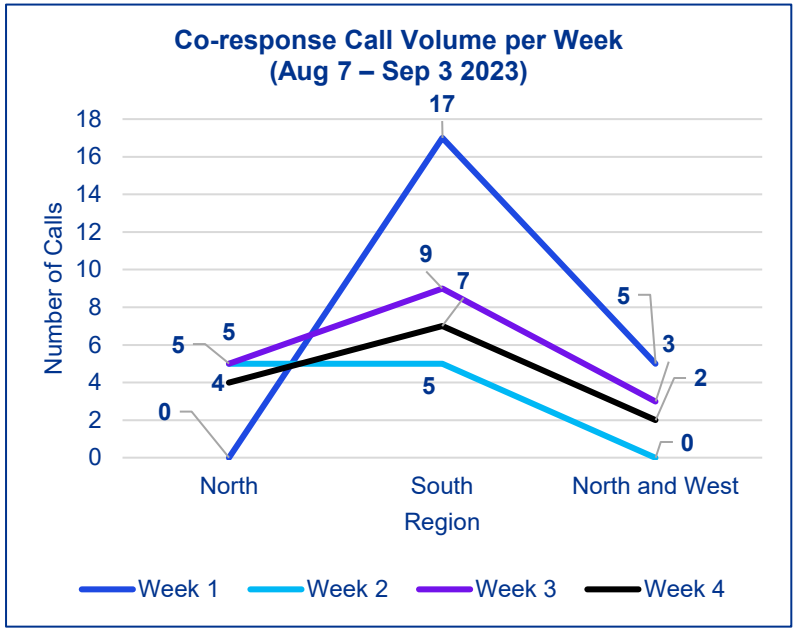
**FTEs exclude management, supervisory, and administrative staff given they do not typically provide frontline services

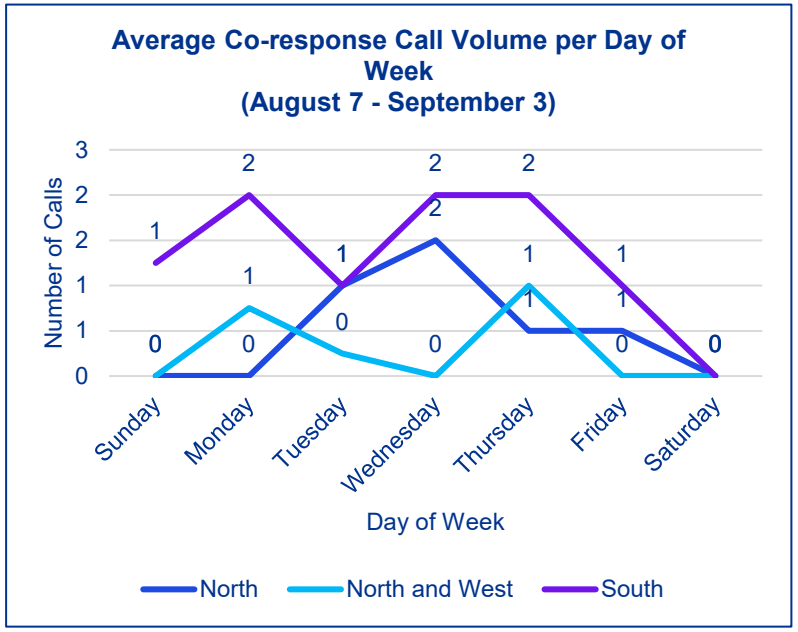
***Please refer to slide 173 for a breakdown of location for all calls received across each region

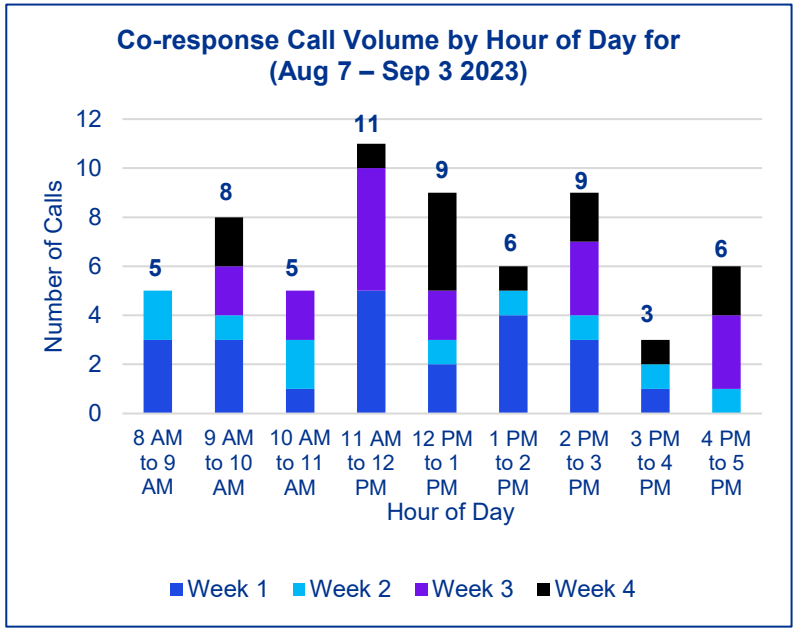
Co-Response Crisis Data Analysis (Aug 7 – Sept 3, 2023)*

In total, Co-response received a total of 62 calls over the four-week period analyzed, this equates to an average of 16 service interactions per week, 5 service interactions per team per week or 1 service interaction per day across each team. Overall, the highest number of calls were received on Wednesdays and Thursdays with the no calls received on Saturdays and no calls received between 5 p.m. and 6 p.m. across teams over the four-week period. 86 percent of all interactions (53 calls) were In-Person (Face to Face) interactions.

Total Mobile Crisis FTES**	Average Weekly Call Volume per Team	Average Weekly Daily Volume per Team	Busiest Day of the Week	Busiest Hour of Day	Average % Face- to Face Contact	Most common Service Location	Most common Service Outcome	Average Response Time	Average Time Spent of Call	Average AMR Response Time
5	5	1	Wednesday & Thursday	11AM – 12PM	86%	Community (53%)	Other (39%)	15 mins	77 mins	25 mins







*Please note while these slides have been included in the body of the report, they have also been included here to support the explanation of approach and methodology in completing this four-week analysis

**FTEs exclude management, supervisory, and administrative staff given they do not typically provide frontline services

Partnership with Santa Maria Police Department: Team operates Tuesday to Friday 8 AM - 6.PM
Partnership with South County Sherriff's Office: Team operates seven days a week, from 8 AM – 6 PM
Partnership with North County Sherriff's Office: Team operates Monday to Thursday from 8 AM – 6 PM

Crisis per Service Location per Team and Region

- As a result of the transition to Mobile Crisis Medi-Cal Benefit, there are a number of settings in which Mobile Crisis **will not be permitted to provide services**.
- These include inpatient hospital, inpatient psychiatric hospital, emergency department, residential SUD treatment and withdrawal management facility, mental health rehabilitation enter, PHF, special treatment program, skilled nursing facility, intermediate care facility, settings subject to the inmate exclusion such as jail, prison and juvenile detention facility, and other crisis stabilization and receiving facilities.
- If the Department wishes to continue providing services in such facilities, Leadership will need to consider how such activities will be funded given they will not be Medi-Cal reimbursable expenses. Funding sources to be considered may include MHSA, Realignment etc.
- Alternatively, Leadership may consider the need for a change in the expectations set of who can issue a 5150/5585 hold, which would allow Law Enforcement, hospital or Jail Mental Health staff to write holds. This would require training to be conducted and staff certification to be complete. This would also require an update to County Ordinance to allow Law Enforcement, hospital staff, and WellPath staff to write holds. **If this change were to be implemented, there would be a significant drop in overall volumes. Based on data received over the four-week period, 81 percent of calls in the North Region, 69 percent in the West Region, and 34 percent of crisis services calls in the South Region were undertaken in restricted settings.**
- The following tables provide an estimate of the number of interactions/visits that may become non-reimbursable post Medi-Cal Benefit based on the four-week data analysis conducted by KPMG.

Crisis per Service Location per Region (Aug 7– Sept 3 2023)*

The tables below outlines the calls/interactions per service location highlighting settings which will be “restricted” under Medi-Cal Crisis Benefit over the four-week period of analysis.

North County Mobile Crisis Services: *81 percent of the total services (70 calls)*.

North County Mobile Crisis - # of Calls per Service Location					
Service Location	# Calls				% Calls
	Wk. 1	Wk. 2	Wk. 3	Wk. 4	Wk.1-4
Hospital ER	18	10	11	17	65%
Inpatient Hospital	1	0	4	0	6%
Telephone	1	0	0	0	1%
Asstd. Living	1	0	0	0	1%
Prison	1	1	1	4	8%
Community	1	2	1	3	8%
24H Program	1	1	0	0	3%
Home	1	0	1	1	3%
Office	0	1	1	0	3%
Other (incl Undefined)	0	0	1	1	2%
Total	**25**	**15**	**20**	**26**	**100%**

North County - Estimate Future Reimbursable Visits by service Location	
Service Location	**# of Calls**
Total Service Interactions	86
Number of non-reimbursable services post Medi-Cal Crisis Benefit	70
Future potential weekly Medi-Cal reimbursable services	**16**

South County Mobile Crisis Services: *34 percent of the total services (17 calls).*

South County Mobile Crisis - # of Calls per Service Location					
Service Location	# Calls				% Calls
	Wk. 1	Wk. 2	Wk. 3	Wk. 4	Wk.1-4
Community	7	1	2	7	34%
Hospital ER	2	0	0	0	4%
Prison	2	4	6	2	28%
Office	2	0	1	0	6%
Home	2	1	0	2	10%
Community Mental Health	1	0	0	0	2%
Telephone	1	1	2	0	8%
Homeless Shelter	1	0	0	0	2%
Other	0	1	0	2	6%
Total	**18**	**8**	**11**	**13**	**100%**

South County - Estimate Future Reimbursable Visits by service Location	
Service Location	**# of Calls**
Total Service Interactions	50
Number of non-reimbursable services post Medi-Cal Crisis Benefit	17
Future potential weekly Medi-Cal reimbursable services	**33**

West County Mobile Crisis Services: *69 percent of the total services (41 calls).*

West County Mobile Crisis - # of Calls per Service Location					
Service Location	# Calls				% Calls
	Wk. 1	Wk. 2	Wk. 3	Wk. 4	Wk.1-4
Hospital ER	11	8	10	9	64%
Office	2	0	0	0	3%
Telephone	1	0	3	0	7%
Prison	1	0	0	0	2%
Community	1	2	1	0	7%
Home	1	1	1	1	7%
Inpatient Hospital	0	1	0	0	2%
24H Program	0	0	1	0	2%
Other (incl Undefined)	0	0	2	2	7%
Total	**17**	**12**	**18**	**12**	**100%**

West County - Estimate Future Reimbursable Visits by service Location	
Service Location	**# of Calls**
Total Service Interactions	59
Number of non-reimbursable services post Medi-Cal Crisis Benefit	41
Future potential weekly Medi-Cal reimbursable services	**18**

*Please note while these slides have been included in the body of the report, they have also been included here to support the explanation of approach and methodology in completing this four-week analysis

Crisis Clinics Analysis

Crisis Clinic Service Interaction Volumes

- As noted throughout this report, based on a review of the data provided and discussions with Department leadership, it was not possible to bifurcate crisis clinics data from that of mobile crisis and co-response to conduct an in-depth analysis of service interaction volumes across specific crisis services programs.
- As a result, KPMG engaged with the Department to implement a four-week data collection process which incorporated mobile crisis and co-response teams and required the collection of 21 key data points. This data was collected between August 7, 2023 and September 3, 2023. In an effort to prevent additional clinician workload, a similar data collection process was not implemented across crisis clinics as KPMG considered that the mobile crisis and co-response data collected could be extrapolated from total volumes within the Department's EHR to identify crisis clinic volumes.
- Considering the above, KPMG estimated crisis clinic service interaction volumes between August 7, 2023 – September 3, 2023 utilizing the following key steps:
    - **Step 1:** KPMG obtained total service interaction data across mobile crisis, co-response, and crisis clinics from the Department's newly implemented EHR, SmartCare between August 7, 2023 – September 3, 2023.
    - **Step 2:** KPMG subtracted the mobile crisis and co-response service interaction volumes collected during the four-week data collection period outlined above from the total service interaction volumes identified under step 1 above to identify crisis clinics Volumes.
    - **Step 2:** As a result, the following crisis clinic volumes were identified across regions. A more in-depth analysis of crisis clinic volumes across regions is outlined on the following pages.

Crisis Clinic Volumes (August 7, 2023 – September 3, 2023)					
	Week 1	**Week 2**	**Week 3**	**Week 4**	**Total**
North County Crisis Clinic	28	12	32	14	86
South County Crisis Clinic	3	19	24	31	77
West County Crisis Clinic	20	15	4	16	55
Total	**51**	**46**	**60**	**61**	**218**

Mobile Crisis and Co-response Variance Analysis

- As noted, KPMG utilized SmartCare data provided between August 7 and September 3, 2023 to extrapolate crisis clinic data and identify the estimate volumes outlined on the prior page.
- However, in addition, KPMG also conducted an analysis of the procedures documented in the Smartcare data and endeavored to map each procedure to either mobile crisis//co-response or crisis clinic based on procedure type. This mapping was undertaken based on KPMG's experience in engaging with other clients who provide similar services and is outlined in the table below.
- KPMG then compared this analysis to the mobile crisis and co-response volumes collected during the KPMG data collection period. The purpose being to identify the potential for large variances between data documented in SmartCare and collected as part of the KPMG data collection process, which may in turn effect crisis clinic volumes. Overall, there was a variance of four total service interactions across regions. This is a relatively low number and as such, would not significantly effect crisis clinic volumes.

Procedure level Mapping	
Procedure per Smartcare	**Mobile Crisis/Crisis Clinic**
Client Non Billable Srvc Must Document	Crisis Clinic
TCM/ICC	Crisis Clinic
Crisis Intervention/Mobile Crisis	Mobile Crisis
Medication Support Existing Client	Crisis Clinic
Medication Training and Support	Crisis Clinic
Psychosocial Rehab - Individual	Crisis Clinic
Individual Therapy	Crisis Clinic
Prolonged Office or Other Outpatient EM Service(s)	Crisis Clinic
Team Case Conference with Client/Family absent	Crisis Clinic
Targeted Outreach	Mobile Crisis
Brief Emotional/Behavioral Assessment	Crisis Clinic
Family Therapy - client present	Crisis Clinic
Medication Support New Client	Crisis Clinic
Care Coordination Outside System of Care	Crisis Clinic
Oral Medication Administration	Crisis Clinic
Comprehensive Multidisciplinary Evaluation	Crisis Clinic
Assessment LPHA	Mobile Crisis
Assessment Contribution non-LPHA	Crisis Clinic
Interactive Complexity	Crisis Clinic

North County - Estimate Crisis Clinic Volumes					
	Week 1	**Week 2**	**Week 3**	**Week 4**	**Total**
Mobile Crisis/Co-response Volumes per Procedure Mapping	32	15	36	32	115
Mobile Crisis/Co-response Volumes per KPMG Data Collection	28	20	27	31	106
Variance	**4**	**(5)**	**9**	**1**	**9**

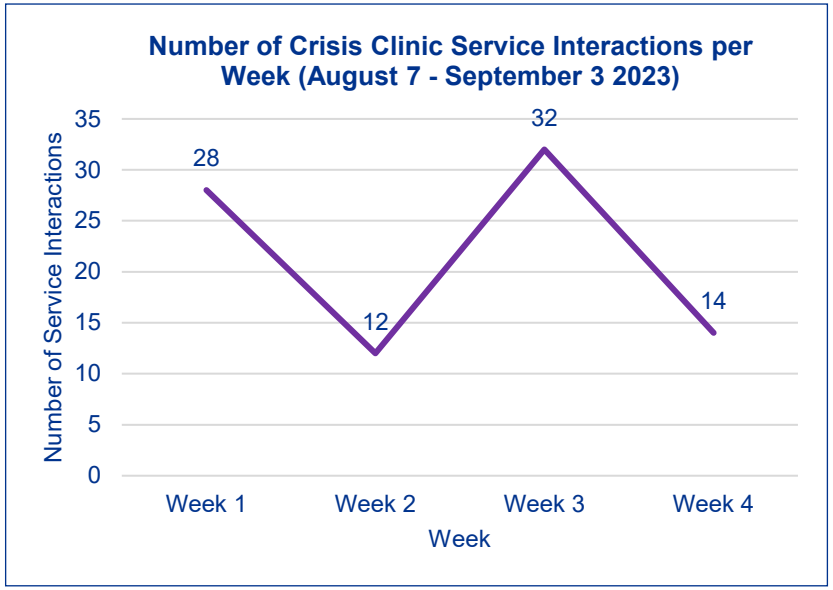
South County - Estimate Crisis Clinic Volumes					
	Week 1	**Week 2**	**Week 3**	**Week 4**	**Total**
Mobile Crisis/Co-response Volumes per Procedure Mapping	23	14	17	24	78
Mobile Crisis/Co-response Volumes per KPMG Data Collection	35	13	20	20	88
Variance	**(12)**	**1**	**(3)**	**4**	**(10)**

West County - Estimate Crisis Clinic Volumes					
	Week 1	**Week 2**	**Week 3**	**Week 4**	**Total**
Mobile Crisis/Co-response Volumes per Procedure Mapping	17	11	17	16	61
Mobile Crisis/Co-response Volumes per KPMG Data Collection	20	12	19	13	64
Variance	**(3)**	**(1)**	**(2)**	**3**	**(3)**

North County Crisis Clinics Analysis (Aug 7 – Sept 3, 2023)

In total, North County Crisis Clinic experienced a total of 86 service interactions over the four-week period analyzed, this equates to an average of 22 service interactions per week, or 4 service interaction per day. Across the same period, the Clinic's prescriber had an average of 2.5 service interactions per week or less then 1 interaction per day. On average each service interaction took an average of 38 minutes. Based on the average number of weekly service interactions, this equates to 14 hours or 0.35 FTEs, based on a 40-hour week, against the 8 FTEs employed.

North County Total Crisis Clinic FTES*	Total Service Interaction Volume	Average Weekly Service Interaction Volume	Average Daily Service Interaction Volume**	Average Daily Service Interaction Volume per FTE	Average Prescriber Service Interactions per week	Average Prescriber Service Interactions per day**	Average No Show Rate***	Average Cancellation Rate***	Average Service Minutes****
8	86	22	4	0.5	2.5	0.5	4%	2%	38 minutes



North County - Estimate Crisis Clinic Volumes					
	Week 1	Week 2	Week 3	Week 4	Total
Total Service Interaction Volume – (Smart Care Data)	56	32	59	45	192
Mobile Crisis and Co-response Service Interaction Volume – (KPMG Data Collection Template)	28	20	27	31	106
Variance - repersents Crisis Clinic Volumes	**28**	**12**	**32**	**14**	**86**

Engaging with new clients, particularly as it relates to initial assessment, medication support, and oral medication administration can take significantly longer than providing follow up services to an existing client. For example, based on KPMG experience, an initial assessment can take up to 120 minutes while follow up appointments may take up to 30 minutes. However, based on an analysis of procedure level data, North County Crisis Clinics provided a small number of such appointments to new clients (2%) over the 4 week period. This would appear to align with the average service minutes per interaction of 38 minutes and would suggest there is additional capacity to take on new clients.

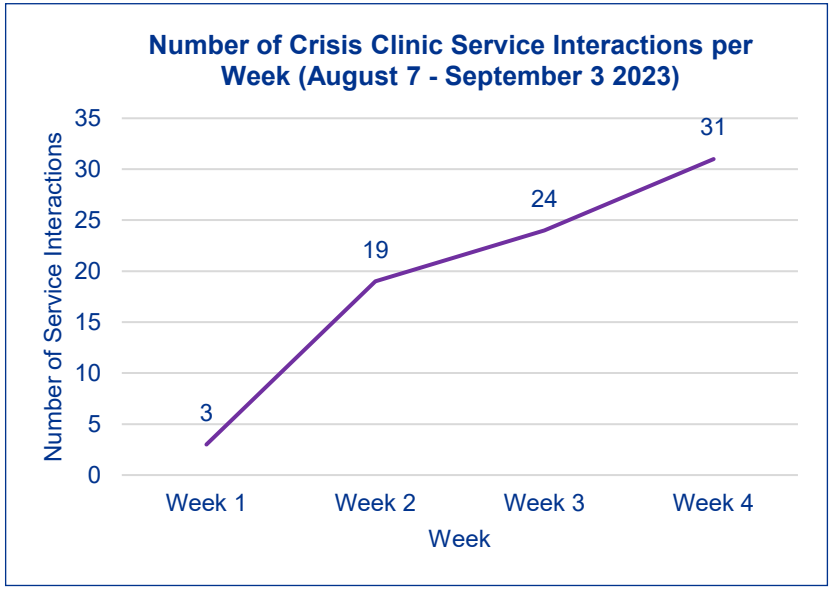
North County New Client Medication Volumes		
Procedure Type	**Number of Service Interactions**	**Percentage of Total Services**
Medication Support New Client	3	2%

*FTEs exclude all Administrative Office Professionals (AOPs) and supervisory./management staff given they would not provide front line clinic services. However, includes 0.5 FTE Prescriber.
**Crisis Clinics operate from Monday to Friday between 8a.m. and 6p.m. Average daily service interactions are calculated based on a five day week.
*** Across Interviews, staff reported that cancellation and no shows rates are not always correctly documented within the Department's EHR, therefore they may not accurately reflect actual cancellation/no show rates.
****Average Service Minutes are based on the service minutes experienced across all procedures.

South County Crisis Clinics Analysis (Aug 7 – Sept 3, 2023)

In total, South County Crisis Clinic experienced a total of 77 service interactions over the four-week period analyzed, this equates to an average of 19 service interactions per week, or 3.8 service interaction per day. Across the same period, the Clinic's prescriber had an average of 6 service interactions per week or over 1 interaction per day. On average each service interaction took an average of 22 minutes. Based on the average number of weekly service interactions, this equates to 7 hours or 0.2 FTEs, based on a 40-hour week, against the 5.5 FTEs employed, including a 0.5 FTE prescriber.

South County Total Crisis Clinic FTES*	Total Service Interaction Volume	Average Weekly Service Interaction Volume	Average Daily Service Interaction Volume*	Average Daily Service Interaction Volume per FTE	Average Prescriber Service Interactions per week	Average Prescriber Service Interactions per day**	Average No Show Rate***	Average Cancellation Rate***	Average Service Minutes****
5.5	77	19	3.8	0.7	6	1.2	2%	1%	22 minutes



South County - Estimate Crisis Clinic Volumes					
	Week 1	Week 2	Week 3	Week 4	Total
Total Service Interaction Volume – (Smart Care Data)	38	32	44	51	165
Mobile Crisis and Co-response Service Interaction Volume – (KPMG Data Collection Template)	35	13	20	20	88
Variance - represents Crisis Clinic Volumes	**3**	**19**	**24**	**31**	**77**

The increase in Clinic Services interactions over the four-week period outlined above is likely due to clinicians becoming increasingly familiar with the new EHR system, Smartcare.

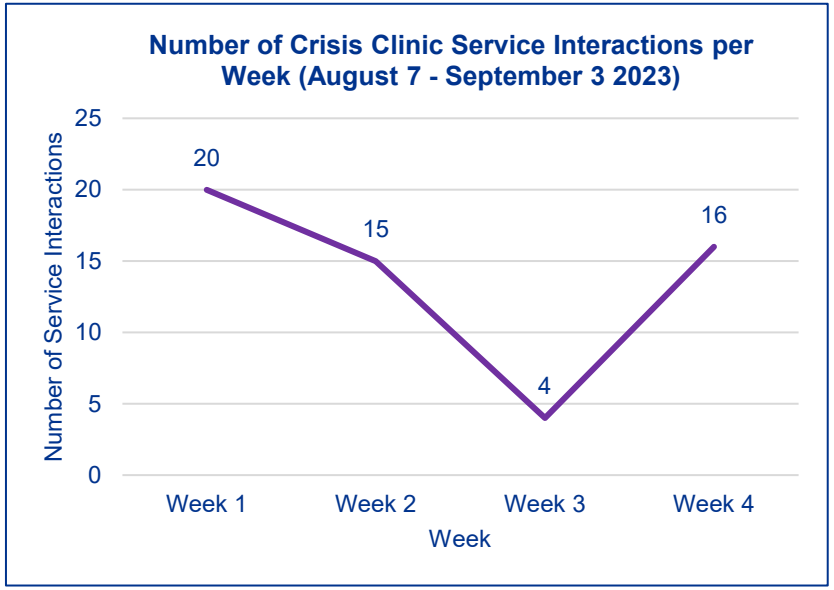
As noted, engaging with new clients, particularly as it relates to initial assessment, medication support, and oral medication administration can take significantly longer than providing follow up services to an existing client. However, based on an analysis of procedure level data, South County Crisis Clinics did not intake any new clients over the 4 week period. This would suggest there is additional capacity within the team to take on new clients.

*FTEs exclude all Administrative Office Professionals (AOPs) and supervisory./management staff given they would not provide front line clinic services. However, includes 0.5 FTE Prescriber.
**Crisis Clinics operate from Monday to Friday between 8a.m. and 6p.m. Average daily service interactions are calculated based on a five day week.
*** Across Interviews, staff reported that cancellation and no shows rates are not always correctly documented within the Department's EHR, therefore they may not accurately reflect actual cancellation/no show rates.
****Average Service Minutes are based on the service minutes experienced across all procedures

West County Crisis Clinics Analysis (Aug 7 – Sept 3, 2023)

In total, West County Crisis Clinic experienced a total of 55 service interactions over the four-week period analyzed, this equates to an average of 14 service interactions per week, or 2.8 service interaction per day. Across the same period, the Clinic's prescriber had an average of 2 service interactions per week or less than 1 interaction per day. On average each service interaction took an average of 21 minutes. Based on the average number of weekly service interactions, this equates to 5 hours or 0.1 FTEs, based on a 40-hour week against the 3.75 FTEs employed.

West County Crisis Clinic FTES*	Total Service Interaction Volume	Average Weekly Service Interaction Volume	Average Daily Service Interaction Volume**	Average Daily Service Interaction Volume per FTE	Average Prescriber Service Interactions per week	Average Prescriber Service Interactions per day**	Average No Show Rate***	Average Cancellation Rate***	Average Service Minutes****
3.75	55	14	2.8	0.7	2	0.4	3%	0%	21 minutes



West County - Estimate Crisis Clinic Volumes					
	Week 1	Week 2	Week 3	Week 4	Total
Total Service Interaction Volume – (Smart Care Data)	39	27	23	29	118
Mobile Crisis and Co-response Service Interaction Volume – (KPMG Data Collection Template)	19	12	19	13	63
Variance - represents Crisis Clinic Volumes	**20**	**15**	**4**	**16**	**55**

As noted, engaging with new clients, particularly as it relates to initial assessment, medication support, and oral medication administration can take significantly longer than providing follow up services to an existing client. However, based on an analysis of procedure level data, West County Crisis Clinics provided a small number of such appointments to new clients (3%) over the 4 week period. This would appear to align with the average service minutes per interaction of 21 minutes and would suggest there is additional capacity to take on new clients.

West County New Client Medication Volumes		
Procedure Type	**Number of Service Interactions**	**Percentage of Total Services**
Medication Support New Client	4	3%

*FTEs exclude all Administrative Office Professionals (AOPs) and supervisory./management staff given they would not provide front line clinic services. However, includes 0.25 FTE Prescriber.
**Crisis Clinics operate from Monday to Friday between 8a.m. and 6p.m. Average daily service interactions are calculated based on a five day week.
*** Across Interviews, staff reported that cancellation and no shows rates are not always correctly documented within the Department's EHR, therefore they may not accurately reflect actual cancellation/no show rates.
****Average Service Minutes are based on the service minutes experienced across all procedures outlined

Medication Support

The following tables provide a breakdown of the types and volumes of medication support provided to clients by each crisis clinic over the four-week period reviewed. Across interviews, stakeholders consistently reported that clients experienced difficulty and prolonged timelines in obtaining medication support from crisis clinics. As such, as part of analysis, KPMG calculated the average service minutes associated with each procedure based on the EHR data provided to calculate the average service hours spent on medication support on a weekly basis. The results of this analysis are outlined below and appears to suggest there is significant capacity for the provision of these services across teams. For example, over the four-week period analyzed, South County staff expended an average of four hours on medication related support, followed by North County at 2.5 hours and West County at 1.9 hours per week

South County - Medication Support Procedures

Procedure	Week 1	Week 2	Week 3	Week 4	Total	Estimate service minutes per procedure	Total service minutes	Average service hours per week
Interactive Complexity	0	0	0	1	1	36	36	0.2
Medication Support Existing Client	1	4	11	4	20	37	740	3.1
Medication Training and Support	0	0	1	1	2	26	52	0.2
Prolonged Office or Other Outpatient EM Service(s)	0	0	0	1	1	43	43	0.2
Total	**1**	**4**	**12**	**7**	**24**	**142**	**871**	**4**

North County - Medication Support Procedures

Procedure	Week 1	Week 2	Week 3	Week 4	Total	Estimate service minutes per procedure	Total service minutes	Average service hours per week
Medication Support Existing Client	3	1	1	2	7	37	259	1.1
Medication Support New Client	1	1	1	0	3	69	207	0.9
Oral Medication Administration	1	0	2	0	3	41	123	0.5
Total	**5**	**2**	**4**	**2**	**13**	**147**	**589**	**2.5**

West County - Medication Support Procedures

Procedure	Week 1	Week 2	Week 3	Week 4	Total	Estimate service minutes per procedure	Total service minutes	Average service hours per week
Medication Support Existing Client	1	2	0	1	4	37	148	0.6
Medication Support New Client	1		0	3	4	69	276	1.2
Oral Medication Administration	0	1	0	0	1	41	41	0.2
Total	**2**	**3**	**0**	**4**	**9**	**147**	**465**	**1.9**

Youth Services (SAFTY) Analysis

Youth Services Service Interactions

Percentage Service Interactions by Contact Type (FY20-22)

The table below outlines the percentage service interactions by contact type. Currently, SAFTY Youth Services conduct face to face in the field assessments and can also provide information and in certain cases evaluations over the phone. Across FY20-21 and FY22-23, an average of 73 percent of service interactions were resolved over the phone

Percentage Contacts by Contact Type			
Contact Type	**FY20-21**	**FY21-22**	**FY22-23**
Telephone	73%	76%	70%
Face to Face	27%	24%	30%
Total	**100%**	**100%**	**100%**

Percentage Service Interactions by Call Priority/Status (FY20-22)

The table below outlines the percentage call volume by call priority or status. Between FY20-21 and FY22-23, approximately 69 percent of all calls received on average related to information requests, while crisis calls represented an average of 24 percent of calls, followed by urgent calls at 5 percent.

Of note, when reviewing this data with SAFTY leadership, they indicated that the County has not provided data definitions for the below categories. For example, Request info/other may be crisis calls and can be categories under Crisis. As the categories are not well defined, the analysis, conducted based on data provided from SAFTY, is most likely not accurate, however, they did indicate that the breakdown to the left (telephone vs. face to face) accurately reflects practice.

Percentage Calls by Call Priority			
Status	**FY20-21**	**FY21-22**	**FY22-23**
Requesting Info/Other	67%	73%	68%
Crisis	29%	21%	29%
Urgent	5%	6%	4%
Grand Total	**100%**	**100%**	**100%**

Youth Services Service Interactions

Percentage Calls by Caller Type (FY20-22)

The table below outlines the percentage calls received by caller type. Between FY20-21 and FY22-23, approximately, 24 of all calls received came from the Emergency Room, followed by families or guardians at 19 percent and schools at 17 percent. Based on the changes required under the new Medi-Cal Benefits, SAFTY may lose approximately 30% of their total volumes based on location of interventions. This will further impact staff utilization.

Percentage Calls by Caller

Caller	FY20-21	FY21-22	FY22-23
Emergency Room/ICU	21%	25%	25%
Family or Guardian	23%	16%	18%
School	9%	22%	21%
Other	14%	9%	9%
Law Enforcement	9%	7%	7%
CARES	7%	5%	2%
Client	6%	4%	3%
SB BWell	4%	3%	3%
Medi-cal Office	2%	4%	3%
Unknown	1%	2%	4%
Cim	1%	2%	2%
Access Line	2%	1%	2%
Child Welfare	0%	0%	0%
Total	**100%**	**100%**	**100%**

Call Volumes by Caller (FY20-22)

The table below outlines the average visits/interactions per caller. Between FY20 and FY23, 32 percent of the total services (671 visits) were provided in settings which will be “restricted” under Medi-Cal Crisis Benefit. These restricted setting are highlighted in red the table below.

Call Volumes by Caller

Caller	FY20-21	FY21-22	FY22-23	Average	Percentage
Emergency Room/ICU	414	560	540	505	24%
Family or Guardian	457	362	386	402	19%
School	172	503	448	374	18%
Law Enforcement	181	160	158	166	8%
CARES	134	123	52	103	5%
Client	108	91	63	87	4%
SB BWell	79	65	72	72	3%
Medi-cal Office	46	80	56	61	3%
CIM	15	43	50	36	2%
Access Line	35	15	35	28	1%
Child Welfare	9	6	10	8	0%
Other	278	205	185	223	11%
Unknown	29	42	88	53	3%
Total	**1,957**	**2,255**	**2,143**	**2,118**	**100%**

Estimate Future Reimbursable Visits by Caller

Average service interactions FY20-22	2,118
Average number of non-reimbursable services post Medi-Cal Crisis Benefit	680
Estimate Future Medi-Cal reimbursable services	**1,438**

Youth Services Service Interactions

Percentage Calls by Call Resolution (FY20-22)

The table below outlines the percentage calls by call resolution type between FY20-21 and FY22-23. Across fiscal years, an average of 22 percent of calls were resolved via phone while an average of 19 percent were non-crisis contacts.

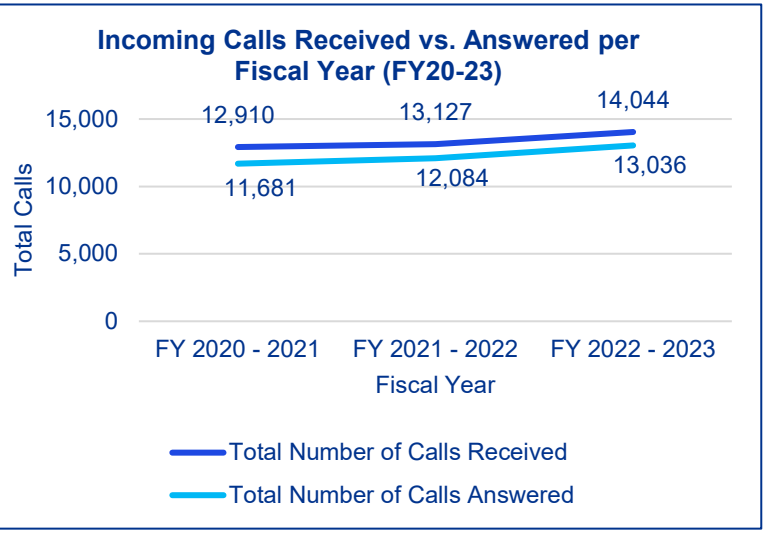
Percentage Calls by Call Resolution			
Call Resolution	**FY20-21**	**FY21-22**	**FY22-23**
Situation Contained by Phone	21%	24%	21%
Non-Crisis Contact	20%	20%	16%
Contained, Client remained; Safety plan	14%	14%	20%
Bed Search	10%	14%	9%
Referral outside scope	5%	4%	5%
Placed on hold	4%	4%	5%
Re-assessment hold remains	4%	3%	4%
Hold rescinded	4%	3%	2%
5150/5585	4%	2%	2%
Client / Caregivers refused intervention	2%	2%	3%
Adult Crisis Team Dispatched	2%	2%	2%
Other	1%	1%	3%
Third party, have family call hotline	1%	1%	2%
Re-assessment via telehealth	1%	2%	1%
Youth Crisis Triage Dispatched	1%	1%	1%
In-Person Follow up	2%	0%	1%
Client in ER, No Medi-cal Privileges	1%	0%	1%
5150/5585 written via Telehealth	1%	0%	0%
Law Enforcement Called	1%	0%	0%
Total	**100%**	**100%**	**100%**

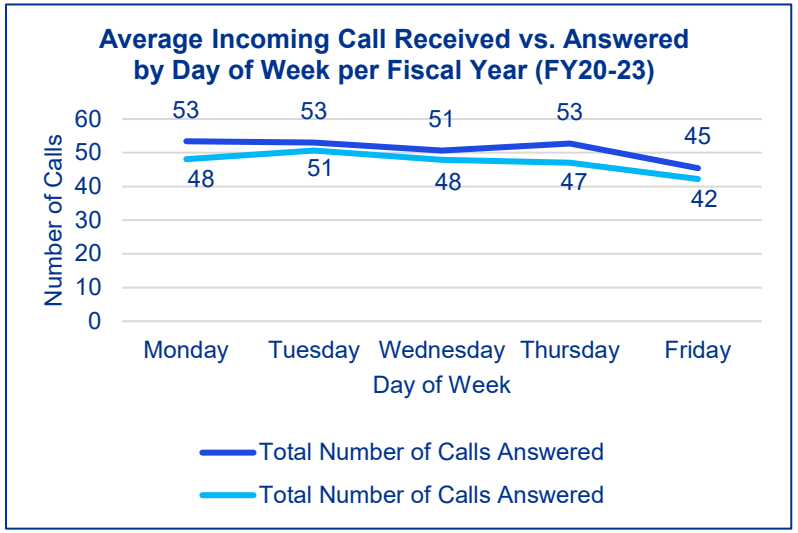
Access Line Data Analysis

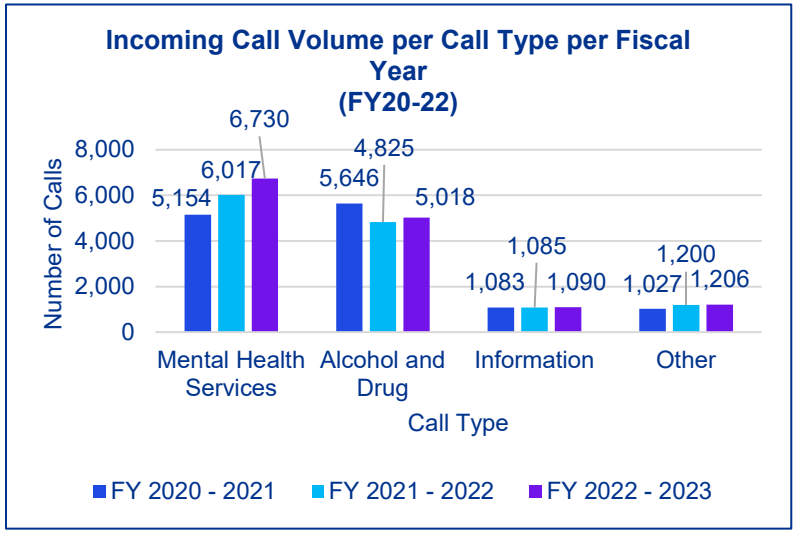
Access Line – Call Volumes (Incoming Calls) (FY20-22)

The number of incoming calls received increased by 9 percent between FY20 and FY23 with an average of 51 calls received per day or 6 calls per hour. 92 percent or 47 of these calls were answered per day or 5 calls per hour. It is also important to note that incoming call volumes drop by average of 12 percent on Fridays. Calls unanswered by the Access Line transition to Protocall for call handling.

Annual Average Call Volume	Average Annual Calls Answered	% Incoming Calls Answered	Average Calls Received vs. Answered per day (per 9-hr. shift)	Average Calls Received vs. Answered per hour (per 9-hr. shift)	% Spanish Speaking Call Volume	Busiest Day of Week	Most Common Call Type	Min-Max Talk Time	Mean Talk Time	Median Talk Time	Min-Max Call Handling Time	Mean Call Handling Time	Median Call Handling Time
13,360	12,267	92%	51/47	6/5	6%	Monday & Thursday	Mental Health (46%)	4 secs – 1 hr. 22 mins	9 mins	8 mins	30 secs – 4.5 hrs.	28 mins	25 mins



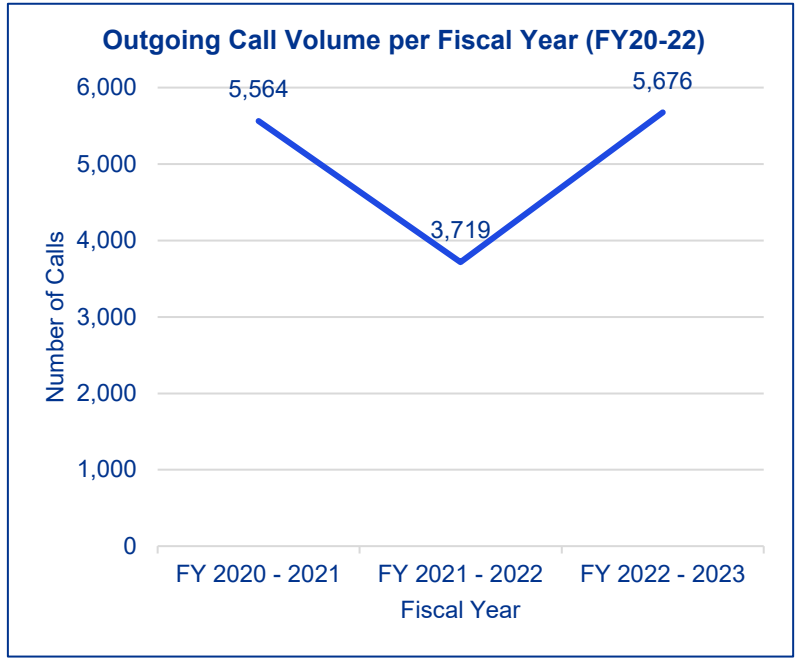


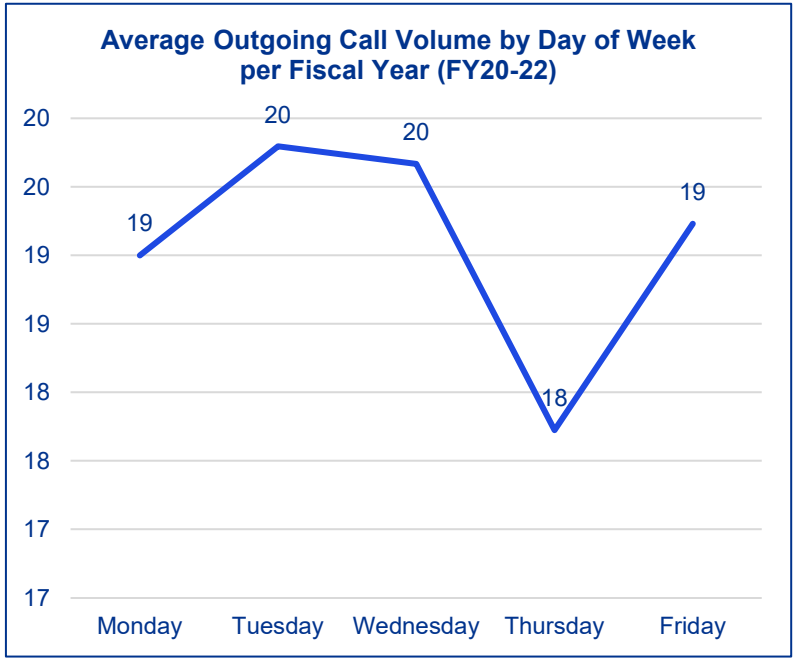


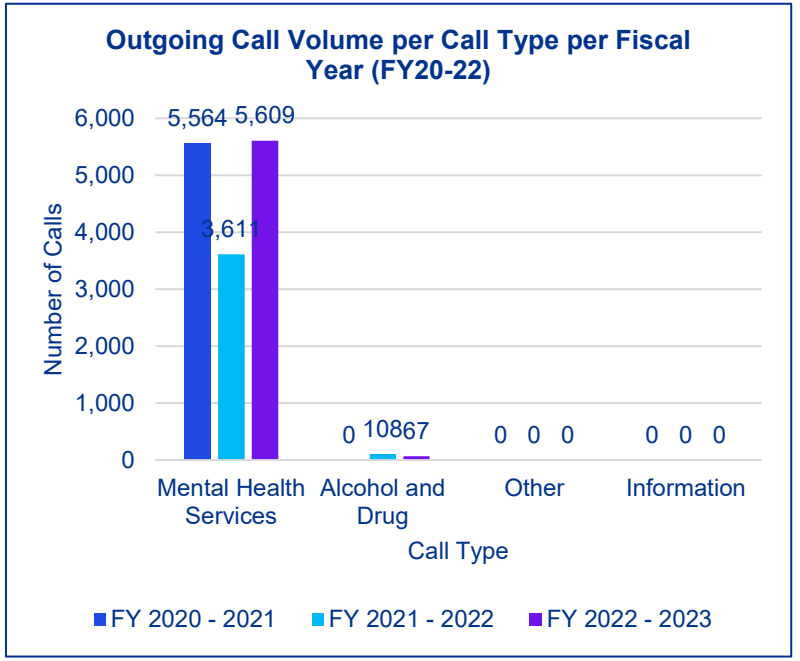
Access Line – Call Volumes (Outgoing Calls) (FY20-22)

The number of outgoing calls handled increased by 52 percent between FY21 and FY23 having decreased by 33 percent between FY20 and FY21. On average, they undertake 19 outgoing calls per 9 hour shift and day or 2 calls per hour. Based on discussions with the Department, the decrease in outgoing call volumes between FY20 and FY21 was driven by the transition of the Access Line operations under Crisis Services Program Management. At the outset of this transition, crisis services staff would complete call backs to clients on an overflow call list during periods of downtime. The callbacks were undertaken from the Mobile Crisis Offices and cellphones therefore, were not recorded in the telephony system.

Annual Average Call Volume (FY20-22)	Average Call volume per day (per 9-hr. shift) (FY20-22)	Average Call Volume per hour (per 9-hr. shift) (FY20-22)	% Spanish Speaking Call Volume(FY20-22)	Busiest Day of Week (FY20-22)	Most Common Call Type (FY20-22)	Min-Max Talk Time (FY20-22)	Mean Talk Time (FY20-22)	Median Talk Time (FY20-22)
4,986	19	2	0%	Tuesday, Wednesday	Mental Health (98%)	48 secs – 22 mins	5 mins	4 mins







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