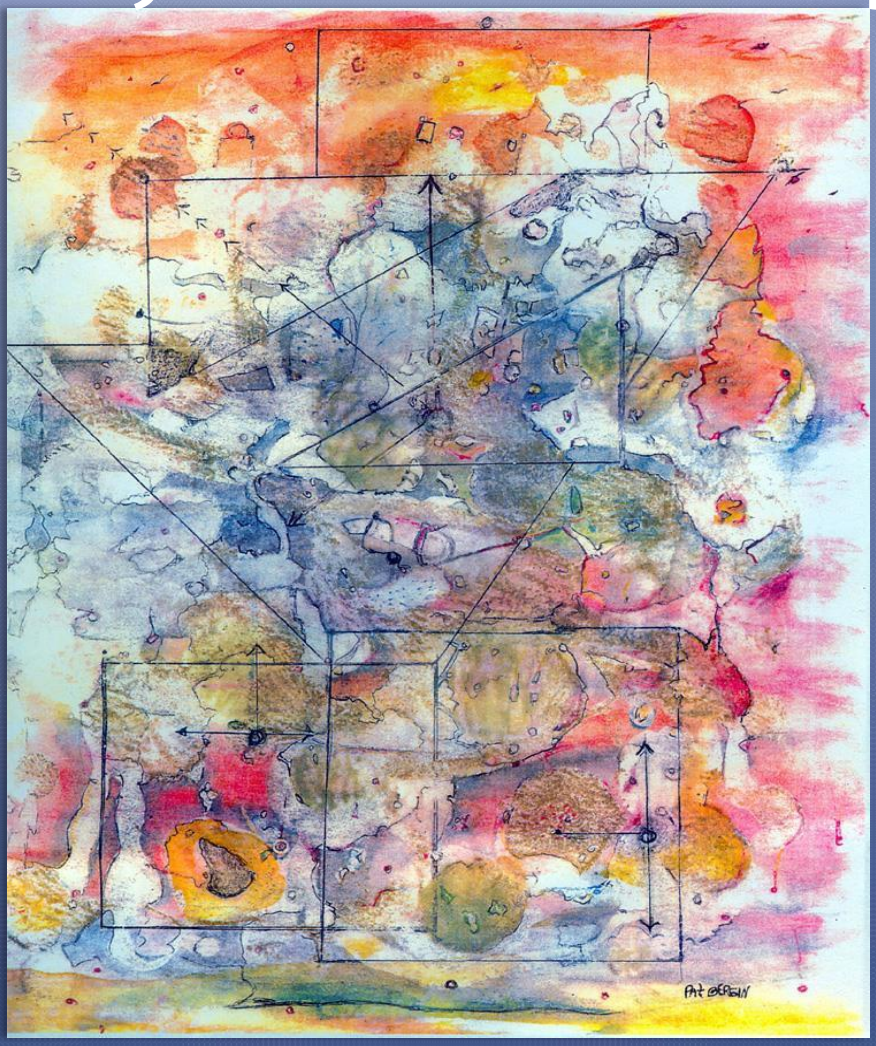
Attachment A

Systems Change Project Summary



Artwork by Patrick Bergin

Presented to the Santa Barbara County Board of Supervisors on December 15, 2015

Santa Barbara County Department of Alcohol, Drug and Mental Health Services (ADMHS)
300 N. San Antonio Road, Santa Barbara CA 93110
www.admhs.org | (805) 681-5220

ADMHS Progress Report 2 on Systems Change

Overview

System Change is a complex and multi-layered endeavor, with many important needs and demands. ADMHS has therefore created mechanisms to address various priorities, and is working to ensure progress throughout the system. This is a challenging process, as staff and stakeholders can easily become overwhelmed by the perception and reality of competing priorities. Therefore, the department has attempted to set realistic, achievable goals that will create and sustain a positive work environment, while maintaining focus on longer-term strategies, and prioritizing efforts that will save lives, reduce suffering, stabilize high need clients, increase timely access to care, and utilize data to provide objective evidence of success or failure. Despite wide-ranging accomplishments and progress in achieving change, the Department continues to face significant challenges to reach full change success within the five year timeframe.

Challenges include the need to provide services that are supported by state and federal funding, and to be in full compliance with all funding requirements. The lack of ongoing flexible funding resources makes it difficult for the system to develop innovative practices as clinical efforts must be linked to an existing revenue source. Increased staffing in FY13-14 was designated to expand crisis services. However, there is a need for additional funded and budgeted positions to provide essential outpatient services. The historical departmental fiscal challenges, including multiple millions of dollars in audit liabilities, have required the department and County to allocate significant funds to resolve. Therefore, the department has been unable to build and sustain reserve accounts as compared to comparable counties.

Currently, the high volume of mentally ill involved in the criminal justice system along with existing demand for high intensity/high cost services (inpatient, locked IMD) have destabilized the department's budget. Additionally, many of these out of county services do not have a funding source beyond County general funds. Therefore, as individuals with mental health and substance abuse issues cycle repeatedly through emergency, inpatient, criminal justice, substance abuse and mental health services, the associated cost to the County of Santa Barbara escalates.

A proven means of providing mental health treatment services to high need clients is an evidence based practice called Full Service Partnership (FSP). Locally, a version of FSP has been implemented – Assertive Community Treatment, or ACT. FSPs were mandated to be implemented across the state through the Mental Health Services Act (MHSA) service funds. Most counties began FSP implementation in 2005, with the stated goal to provide "whatever it takes" to keep a client stable in a community setting, including appropriate

housing, a dedicated team of MH staff (including those with lived experience as family members or in recovery), medication support, and employment assistance. With this high intensity of support and resources, FSP clients were envisioned to be able to lead stable, productive and fulfilling lives within their communities. The fidelity of FSP program implementation has varied widely across the state. Santa Barbara County is currently proactively engaged in evaluating program fidelity to address necessary improvements. Improving ACT services and expanding access to these services is both a priority and challenge for the department, but necessary to provide adequate care to clients who are high users of multiple systems (HUMS).

Securing adequate in-county housing for HUMS and other mental health clients needing various levels of support is a significant challenge everywhere, but particularly in Santa Barbara County where the estimated monthly room rental rate is approximately @$1200.00. Although there are likely many different causal factors, in Santa Barbara County, HUMS clients are also increasingly becoming involved in the criminal justice system, including a large volume of clients declared Incompetent to Stand Trial (IST). The county has a long history of innovative court practices to serve the needs of clients with mental health and/or substance abuse issues, so there are currently a large number (9) of specialty courts where HUMS clients may appear. These voluntary courts see clients with special needs, and refer them to treatment, leveraging resolution of the legal issues with client compliance with treatment. Most of these courts originated with special grant funding, but many no longer have grant funds available. In addition, some involuntary services, such as administration of psychiatric medications without the client's consent, cannot be accomplished through the specialty court system. Improved coordination of these courts with behavioral health resources is necessary to improve care for complex clients.

A final challenge is the increasing rate of prescription drug and heroin use, and the related increase in both fatal and non-fatal overdose. Additional emerging patterns of drug use, particularly synthetic drugs which have unpredictable mental and physical consequences, are a challenge as the Drug Treatment system begins to design expanded Drug Medi-Cal services funded through the Affordable Care Act.

System Change Timeframe

According to the System Change timeline originally presented by ADMHS to the Board of Supervisors, the Department is on schedule for the expected progress, in that the foundation for core systems are being established (including policies and procedures, and fidelity to evidence based practices and regulatory requirements), and the partnerships that have been created have demonstrated successful performance in some core areas, such as cultural competency, crisis response and housing. The Department is moving into the *innovative tier* where the programs and partnerships should lead to increased service delivery and maximize the opportunities for collaborative system change activities.

Administration

Administration activities focus on creating the structure and capacity to oversee and support key ADMHS clinical operations and business practices (financial management and compliance function in support of the system of care).

Key Accomplishments

- **Organized System Change Structures to insure inclusive participation in system transformation**
- **Hired Director, Developed new Organizational Chart**
- **Developed mechanisms to improve system communications**
- **Hired key staff for system expansion**

System Change Structures

System Change involves collaboration of partners across the system of care and recovery. A model has been developed that shows the major structures of the system change process, how each relates to the others, how partners participate in the change process, and key work structures of the department. The Transformation of ADMHS is guided by the Steering Committee which has representation from key System Stakeholders, including the Mental Health Commission, the Alcohol and Other Drug Advisory Board, Family members, consumers, and other county departments. It is Co-Chaired by the Deputy CEO, CBO Leaders, and the Medical Director. This body designated System Values and Guiding Principles for Change, many of which derive directly from the Mental Health Services Act (MHSA, or Proposition 63), which was a voter initiative that passed in 2004, and was intended to transform California's Mental Health system. The Board of Supervisors approved adoption of these in April, 2014. The Guiding Principles also reflect key parameters required by the state body that oversees county mental health and substance abuse services, the Department of Health Care Services (DHCS). Insuring system transformation in keeping with these principles

will facilitate compliance with funding requirements and system audits. As the vast majority of department funding comes from state and federal resources, compliance is essential for sustaining system viability.

The Steering Committee created Action Teams to work in partnership on specific system components that require coordinated system change problem-solving and action steps. Action Teams are typically co-lead by ADMHS staff and external system leaders, with membership open to stakeholders. The Action Team structure allows stakeholders to prioritize work on specific change activities, and is designed to be an inclusive process. The designated Action Teams are: Forensic, Children's System of Care, Crisis Services, Cultural Competency and Diversity, Housing (known as HEART), and Peer Action Teams. Action Teams goals are guided by the Steering Committee.

A central component of System Change is the Change Agents- a diverse volunteer group of staff, supervisors, CBOs, family members, consumers, administrators, and other system partners dedicated to developing skills necessary to serve clients with complex mental health and substance abuse needs, and creating system practices and structures that support this integrated care. This process has been actively led by the change agents themselves with support from Zia partners- who were part of the original TriWest consultants. Change Agents participate on each Action Team, and also update the Steering Committee on Change Agent-led system change activities. Action Teams and Change Agent Leadership report to and receive guidance from the Steering Committee.

Because regional resources and relations can facilitate or limit services for clients with mental health and/or substance abuse issues, Regional Partnerships were formed in 2015 for North, West and South County. ADMHS Regional Managers convene meetings with local Mental Health and Substance Abuse Community Based Organizations, as well as service and health stakeholders, and other county partners (e.g. Public Health, Social Services). Partnership meetings are intended to promote regional problem-solving on key issues of concern for complex clients.

Created in 2105, the ADMHS Leadership Team has enhanced the original Executive Team by providing a broader base of staff input into departmental prioritization and decision making. Leadership meets weekly, and now includes additional representation of peer, cultural competency, IT, clinical program management, housing, evaluation, system planning, contracts and administration staff. An ADMHS Director was hired in December, 2014, and a new departmental organizational chart has been developed to reflect the new leadership structure.

The Steering Committee provides guidance to ADMHS Leadership which has developed a range of workgroups to activate necessary steps to change procedures and practices to transform the system. For example, the Action and Transitions Workgroup has developed uniform interventions to pilot in clinical settings in order to improve both timeliness and access to services. The two Quality Improvement committees for inpatient (QAPI) and outpatient (QIC) services analyze system performance to improve quality care in compliance with mandated service requirements. Clinical Leads and Medical Practices analyze existing practices for service fidelity and improvement opportunities. Workgroups are oriented to implementing new practices in a continuous quality improvement manner (i.e. Plan, Do, Study, Act), in accordance with the system change commitment to make data-driven decisions, and create accountable services. ADMHS staff leads and are the primary members for workgroups where the central focus is on internal work procedures and outcomes. External stakeholders participate in workgroups that have broader system impact. For example, the CBO Collaborative meeting is a monthly opportunity to improve communication on issues impacting organizations that receive funding through ADMHS contracts. The Communication committee creates strategies to insure important Systems Change information reaches all stakeholders.

Communications

Monthly Directors' Report

In February 2015 a monthly Director's Report was initiated. The report contains short updates on ADMHS and community-based organizations (CBOs), legislative changes, and other items. The report is presented to the Mental Health Commission and subsequently distributed to all ADMHS staff members and stakeholders in the ADMHS database.

Behavioral Health Guiding Principle Posters

At the suggestion of the ADMHS Communications Workgroup, the Behavioral Health Steering Committee Guiding Principles were re-stated in "plain language." Posters in English and Spanish were distributed for display at all ADMHS service sites county-wide.

Principles in Practice

Each month a document is prepared focusing on one of the Behavioral Health Guiding Principles, with an emphasis on application and operational examples. Each Principles in Practice document is discussed by staff members and posted to the ADMHS website.

Website Redesign

The ADMHS website is being redesigned to feature a more user-friendly experience for consumers and families and to feature more educational materials about behavioral health. It is planned for completion in the summer of 2016.

Policy & Procedure Initiation

Quality Strategy Management staff persons created and distributed a Policy Request Form and Policy & Procedure Flow Chart designed to advance inclusiveness. As each ADMHS policy is initiated or modified, a dedicated policy and procedure development staff person has met with interested staff and stakeholders to ensure maximum input and responsiveness to departmental and community needs.

Staff Guides

In 2015 a series of guides, *About ADMHS*, *On the Job*, and *Clinician's Toolbox* were prepared to offer ADMHS staff members comprehensive information about the department's background, administrative tools, client and family resources, and other information. It was presented in both PDF format and as web links to individual components.

Orientation Groups

One-time sessions held at ADMHS adult and children's clinics led by clinical or peer staff are designed to acquaint new clients and family members with the behavioral health service system and community resources.

New Client Brochure

A three-fold brochure answering basic questions posed by new clients and family members has been developed with considerable input from the Communications Workgroup and peer and clinical staff. It should be distributed to ADMHS and CBO service sites in January.

Carpinteria Outreach

At the request of HopeNet of Carpinteria, ADMHS prepared a series of articles on behavioral health topics that were published in *Carpinteria Coastal View News*. A comprehensive directory of ADMHS Programs and Services for Carpinterians was also prepared and distributed.

Increased Stakeholder Communications

Email communications to ADMHS staff, community providers and other stakeholders sharing departmental and community news continue to increase and have become an important resource for the Santa Barbara behavioral health community.

Key positions hired by ADMHS include a Full Time Human Resources manager in June 2015, replacing a .5 FTE who was shared with Public Health. Given the high volume of over 100 staff slated to be hired for service expansion, strong HR leadership was essential to staff crisis services and to reduce the department –wide vacancy rate to 16%. Recruitment of psychiatrists continues to be challenging across the country, and although Santa Barbara County has fared well compared to other counties regionally with 18 positions filled using a combination of civil service, contract and locums psychiatrists, the occupancy rate is 78%. Recently enhanced recruitment incentive may further improve these rates.

Additional Administrative goals of the TriWest report to **make targeted administrative enhancements to improve Utilization Management** oversight and payer identification have been addressed by several actions. The Quality Care Management has been moved to the Office of Quality and Strategy Management for clinical oversight of the Mental Health Plan requirements. To facilitate compliance activities across the Mental Health and Substance Abuse treatment system, a Utilization Review and Contract Monitoring function is being developed in OQSM. A Quality Care Management Manager is being recruited. Patient Representative staff is trained to qualify clients for all possible coverage benefits. Regular meetings of the Quality Improvement Committees for inpatient and outpatient services have been convened.

A major challenge for ADMHS has been to determine the **appropriate organizational structure** for long-term management of the Department. To facilitate an inclusive management process, a Leadership Team began to meet weekly on system improvement and management concerns, and to facilitate communication across administrative elements. A redesigned ADMHS Organizational Chart was created to provide appropriate oversight of key functions (i.e. Quality and Strategy, CFO, Operations/Administration, IT, Behavioral Health, and Clinical Operations). ADMHS consulted with County IT services to analyze the departmental IT/MIS structure and determine qualifications for IT management. ADMHS continues to recruit skilled staff for key system positions.

Finance

ADMHS strives to maintain and strengthen sound fiscal planning and practices, support clinical operational needs, and establish sufficient financial reserves. Areas of focus include: Capacity and performance, Medi-Cal, billing cycle, patient mix, denials, and broader financial / revenue management.

Areas of focus for Fiscal Division

In order for ADMHS to focus on the Medi-Cal reimbursement, the billing cycle, denials, patient mix and overall Revenue Management, a Revenue Management team was formed. This team developed standard practices to address the most critical aspects of the revenue cycle. While this revenue cycle initiative was originally kicked-off as a revenue cycle committee, it became clear that the solution to effective revenue cycle management was to have a dedicated and permanent interdisciplinary revenue management team rather a committee that convenes intermittently, with limited direct/timely operational impact. As with the majority of revenue cycle issues, timing is of utmost importance. The initial goals of the committee were to document all significant revenue cycle stages and processes, evaluate each, and implement improvements where possible; these goals were accomplished via the Revenue Management team, and are now recognized formally as standard operating procedures.

Within the Revenue Management Team, continuous process review and improvement is incorporated into the regular meeting of the Revenue Management team as convened weekly via the Billing Issues Group (BIG) meeting. All notable billing and claiming issues (e.g., denied services, client payor mix, unclaimed services, Third Party billing, etc.) are reviewed weekly as they occur, to ensure the most effective, expedient resolution, thereby ensuring minimal disruption in cash flows, maximizing approved claims from Medi-Cal, Medicare and Private Insurance, and client fees collection.

Continuing (and improving) robust financial planning:

With the goals of continuing robust financial planning and functionality, and improving transparency and communication, in respect to financial operations and budgeting, ADMHS has arranged and continue to convene bimonthly meetings with the CEO's office and Auditor Controller's office, during which all significant budgetary and revenue cycle issues are reviewed and addressed. ADMHS continues to develop a balanced budget using most recent Medi-Cal claim information that reflects ACA impacts. Process improvements included implementing a $1 million per year inpatient reserve with support from CEO's office although ADMHS was unable to establish ongoing 5% realignment reserve due to increasing inpatient costs.

MH Cost reports continue to be submitted on time and an additional Cost Analyst staff was hired for Mental Health cost report to ensure robust contract compliance and fiscal succession planning.

A key future project includes developing plans for expansion of Drug Medi-Cal through the Organized Delivery System. This will require a comprehensive plan of service delivery, and the development of reimbursement rates to ensure that all services are reimbursed at a practical rate, and within state mandated requirements.

Affordable Care Act Impact Mental Health Medi-Cal & Drug Medi-Cal:

The implementation of the Affordable Care Act (ACA) in ADMHS Mental Health Programs resulted in approved MH Medi-Cal services for 1,437 unique ADMHS clients, and generated approximately $5,531,767 worth of Federal Medi-Cal revenue for the 18 month period from January 1, 2014 to June 30, 2015. For the most recent reportable fiscal quarter of April 1, 2015 through June 30, 2015, ACA clients comprised 17.2% (660 out of 3,845) of total MH Medi-Cal clients receiving services in that quarter; ACA MH Medi-Cal revenue from this quarter was $1,141,307.

ACA revenue for MH is growing, although the drop in FY 1415 Q2 is due to implementation of a Compliance decision rule to block billing if a Treatment Plan was not in place. This produced a temporary reduction in billed services which has since recovered. FY14/15 QTR4 FFP revenue is still growing (and will increase due to retroactive eligibility, and services that are claimed to Private Ins/Medicare – this may increase by another 3-4% due to the services that have multiple payors billed prior to Medi-Cal.)

The implementation of the Affordable Care Act in ADMHS Alcohol & Drug Programs resulted in approved Drug Medi-Cal services for 1,130 unique ADMHS clients, and generated approximately $2,081,038 worth of Federal Drug Medi-Cal revenue for the 18 month period from January 1, 2014 to June 30, 2015. For the most recent reportable fiscal quarter of April 1, 2015 – June 30, 2015, ACA clients comprised 41.0% (618 out of 1,476) of total Drug Medi-Cal clients receiving services in that quarter; ACA Drug Medi-Cal revenue from this quarter was $453,014.

ACA has had a huge impact on ADP, and actual ACA Medi-Cal FFP now significantly exceeds traditional Medi-Cal FFP revenue. The drop in Traditional Drug Medi-Cal (DMC) FFP from FY13/14 to FY1415 is primarily due to the removal of the 15% Administrative Fee from the DMC rate.

MIS collaboration with fiscal and programs for improved reporting

In order to ensure that MIS division resources are sufficient, a review of capability and capacity was completed. The results of this review indicated that MIS was both under resourced, and did not contain sufficient specialty within certain technical areas. Subsequent to this review, MIS added 2.0 FTE additional Programmer Analyst FTE and 1.5 FTE in the

previously unused classification of EDP Office Automation Specialist of staff to address the more technical aspects of developing and maintaining the many complex IT systems that the department utilizes. General Services ICT has provided consultation on IT/MIS structure and the department is moving forward on hiring of a new IT/MIS manager. ADMHS also completed a comprehensive IT risk assessment, reviewing all aspects of the IT systems. This risk assessment is used to evaluate all IT security measures, identify any deficiencies, and ensure that all security measures are brought up to county and health care industry standard where necessary. In order to better align specific critical reporting needs, MIS staff was reassigned directly to fiscal reporting, and clinical data evaluation. This has resulted in more effective billing and clinical data management. Two key projects were ICD 10 implementation, and the implementation of a vendor contract for development of a Clinical Reporting System (CRS). ICD 10 was implemented 10/1/2015 nationwide, and will remain a focus for the upcoming months, as we evaluated the results and any unforeseen impacts to reporting needs.

Compliance

ADMHS has placed a considerable focus on the completion of Assessment and Treatment Plans for all individuals receiving services through ADMHS Mental Health programs – an area of regular critique by the State. The objective is to ensure that the Assessment is correlated to the Treatment Plan and includes a clear diagnosis, captures clients' functional impairments, sets out clients' goals to overcome these impairments and enhances clients' strengths in a culturally appropriate manner. In the past year, there has been significant training of clinical staff in this area. A Documentation Manual was developed to guide staff on the standards for quality documentation. As a safeguard against inappropriate billing of claims, in November 2014 the department implemented a "Business Rule," which blocks services that have been provided without an Assessment and Treatment Plan from billing to the State for reimbursement.

The Pharmaceutical Program has been revamped to enhance controls over pharmaceutical management, while empowering clients to better understand and use their medications. Policies and Procedures have been updated to current legal requirements; medication rooms and controls have been enhanced in all clinics and regular monitoring of pharmaceutical practices has been instituted. Moreover, as a result of clients, rather than Psychiatric Technicians, taking greater responsibility for medication management, billing for Medication Support services has dropped to levels of similarly-sized counties. All Psychiatrists have been trained to use the e-prescribing tool RxNT, which is capable of providing comprehensive data of clients' medication history and current medications. A new pharmaceutical disposal method is being implemented to comply with the updated Drug Enforcement Agency requirements that went into effect in October 2014.

Upon the designation of a full-time Privacy Officer within ADMHS, the County Privacy Program was transferred from County Risk Management to ADMHS. The Privacy Officer provides HIPAA/Privacy support to the Covered Entities of the County, which include the Public Health Department, Fire-EMS, and ADMHS and its contracted providers (community-based organizations). The Privacy Officer provides countywide trainings, responds to reports of potential privacy breaches, reports breaches to Federal and State authorities when required, is working on updating Privacy and Security Policies & Procedures for ADMHS and is available to consult on HIPAA questions and concerns to proactively protect against breaches.

To enhance compliance with Mental Health Plan requirements for operating a 24/7 Access Call Line, in December 2014 ADMHS augmented its Access Call coverage by contracting with ProtoCall Services Inc., a company dedicated to behavioral health access call response. ProtoCall responds to Access Line calls during evenings, weekends and holidays and ensures that callers are seamlessly provided responses to questions about the Mental Health Plan, are directed to community resources as needed or are transferred to Crisis Services through a warm-handoff. Data reports on calls are provided to ADMHS Managers on a daily basis.

Now scheduled on a more routine basis, the Chief of Compliance and contract review teams are meeting with community-based organizations to review contracted programs, to discuss program operations, validate compliance with contract terms and brainstorm about service delivery improvements. These meetings provide an opportunity for open discussion about which areas of the contract are working and which are not, with the goal of achieving feasible solutions. Considerations for future contract modifications are also noted.

ADMHS Medical Records is converting paper charts to electronic health records to ensure compliance with the Meaningful Use requirements set forth under the Affordable Care Act. A lot of the medical forms have been added to Clinicians Gateway. The PHF and Alcohol and Drug Program community- based organizations are now using Clinicians Gateway to create electronic health records. All of these efforts will improve continuity of care and thereby quality of care for clients.

Since October 2014, ADMHS reports MHSA Full Service Partnership (FSP) data to the State as required by law; ADMHS is also tracking the completion of the required FSP reports monthly. FSP providers also receive these reports and can follow-up with staff when there have been challenges with completing the required reports. Once reporting is consistent, the goal is to use the FSP data as another means of tracking client outcomes, including improvements and setbacks.

The Compliance *Safety & Risk Subcommittee* has been working diligently to address safety issues in the clinics, including recommending facility upgrades, working to revise Policies and Procedures to enhance staff safety, progressing with the adoption of Universal Response Codes for all clinics and continuing to collaborate with the Public Health Department on safety issues unique to the Calle Real campus. During the 2015 calendar year, approximately 30 clinic staff participated in the Fred Pryor training "*Safety and Security Begins at the Front Desk*"; 46 staff members have received *Crisis Prevention Institute* training; and two ADMHS staff members have received CSAC *Safety Management Certification Training*. The *Safety & Risk Subcommittee* continues to investigate different approaches to training staff and ensuring that staff members are prepared to address the myriad of issues that arise in the clinic setting.

Clinic staff members have worked diligently to close out cases that have remained open in the medical record system dating back to 2008. Data reports indicate that between January and August 2015, more than 1,240 cases have been closed out of the system; between June and August 2015 alone, 200 inactive cases have been closed. Maintaining cases as open when there is no client contact for years not only skews the reportable number of active cases, but prevents the department from obtaining accurate caseload demographics per region, per clinic and per clinician. Even more important, efforts to contact clients and confirm their intention to separate from ADMHS services have resulted in some clients re-engaging with their clinical teams. A fundamental department goal is to ensure that clients in active treatment with ADMHS are being appropriately served based on their level of need; clients who have progressed in their recovery are supported as they transition to lower levels of care. The Compliance Committee will continue to monitor the closing of cases as part of its 2015-2016 Audit Plan.

Systemic

Systemic progress involves addressing overarching system performance and long-standing system level problems through the development and implementation of potential solutions.

Key Accomplishments:

- **Developed MOU with CenCal for care and transitions of Mild/Moderate Mental Illness**
- **Developed policy overview of coverage for services as a results of changes due to Affordable Care Act (ACA) and Parity Laws**
- **Improved process for participation in state and federal audits**
- **Training on Evidence Based Practices (EBPs) and Core System functions provided to staff and stakeholders**

- **Change Agents trained to use Continuous Quality Improvement strategies to test and evaluate change activities**
- **Continued to expand employment and involvement of clients and families with lived experience in service delivery and systems change**
- **Addressed Cultural Competency and Diversity for clients and staff through guidelines and assessment strategies**
- **Commitment demonstrated to using data to plan, assess, and address system needs**
- **Developed and implemented a more efficient, collaborative process for contract development, communication, monitoring and management**

ADMHS has achieved a broad array of progress in this area. The vision for the ADMHS System of Care and Recovery is to provide crisis and inpatient care to all individuals requiring an immediate response to urgent mental health issues, as well as outpatient and intensive outpatient (ACT/FSP) care to the severely mentally ill and individuals with substance abuse issues that meet medical necessity criteria for Medi-Cal services. Prevention and early intervention services for mental health and substance abuse concerns are also available. The vast majority of services are provided through federal and state funding sources which have strict service delivery and documentation standards, consistent with the System Change principles.

To the extent funding is available, non-urgent services in locked facilities for severely mentally ill are provided as well as housing resources for individuals requiring intensive services and support. Primary Care providers are responsible for mild-moderate mental health issues for those with Medi-Cal coverage**. Per an established Memorandum of Understanding (MOU), Cen-Cal Health,** Santa Barbara County's Medi-Cal intermediary, has contracted with the Holman Group to coordinate the behavioral health care of individuals with mild-to-moderate mental health conditions.

Since the implementation of the Affordable Care Act, the number of individuals that qualify for Medi-Cal covered services has increased significantly in Santa Barbara. In addition, to help end discriminatory insurance coverage of mental health and substance use services, Congress passed the Wellstone-Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) in 2008. The new Parity Law requires most insurance plans to cover both mental health and substance abuse services at parity with covered medical services, therefore, many behavioral health services not previously available through private insurance are now required under Covered California and other insurance plans.

As a result of these laws, very few individuals lack coverage for mental health and substance abuse services. In California, the majority of residents receive health insurance through ACA's Covered California program or an employer's private health insurance plan. Community

members with these types of coverage are eligible for mental health and substance use services through primary care physicians (PCPs) and network providers, including services for severe and persistent behavioral health conditions. A very small portion of the community will not be eligible for ACA but may still be eligible for Medi-Cal coverage for certain services, such as emergency psychiatric hospitalization and mental health services for pregnant women. In the event that these individuals who meet SMI/SED and Medical Necessity criteria have no reliable insurance source, Mental Health Services Act (MHSA) program funds are allocated to cover treatment service costs.

It is important to insure clients are connected to the appropriate coverage source for full health service access, and it is equally important to educate staff, clients, family, stakeholders and the community about these changes and the potential increased availability to services. **A clear policy describing parameters of accessing services and integration of care has been recently developed.** System transformation includes necessary fiscal, beneficiary, assessment, documentation, monitoring, and performance evaluation activities resulting from ACA changes. ACA will also bring significant expansion of Drug Medi-Cal services in Santa Barbara through the development of an Organized Delivery System that will further the ADMHS goals for integrated and co-occurring services. Increased availability of federal and state funded services will improve access to care for clients with mental health and substance abuse concerns, but will also increase the importance of fidelity to approved models of care, assessment standards, documentation requirements, and outcomes required. ADMHS has begun the process of analyzing all service practices and working with staff and system partners to bring the system into full compliance with all requirements.

Since December 2014, ADMHS has participated in **six state or federal reviews or audits** of its mental health or alcohol and drug Medi-Cal programs and services. Each of these reviews has increased staff confidence in the quality and integrity of their services, while highlighting continued significant areas for improvement. The feedback from the reviews has also been revealing in the reduced amount of concerns and the increased positive feedback received from the inspectors as compared to comparable prior audits. Considering that the QCM division has been under staffed during the same time period, the changed departmental response and approach to the audit and inspection process has been laudable. However, the system continues to be vulnerable to loss of revenue primarily due to 1) failure of clients to meet medical necessity for services and 2) failure to adequately document assessment, treatment plans, and service delivery. For example, a recent DHCS audit of the PHF found that none of the clients declared Incompetent to Stand Trial (IST) that were admitted to the PHF met Medical Necessity criteria for inpatient services; therefore all Medi-Cal charges for Acute and Administrative days were denied.

The Department has continued its collaboration with Zia Partners, part of the TriWest consultant group, to promote staff and stakeholder education and the focus on the key principles of System Transformation and integrated services. **Numerous training opportunities have been offered throughout the county to enhance staff skills** in providing services recognized by state and federal funders as effective in treating mental health and substance use disorders (Evidence Based Practices or EBPs). Specialized Crisis Intervention Training (CIT) for Law Enforcement partners has been provided with strong participation from stakeholders in all regions of the county, with peers and family members leading part of the training.

ADMHS has continued to **expand employment and involvement of clients and families with lived experience in service delivery and systems change**. Peers are consumers that have received mental health and substance use services. Family members provide support to consumers who have received these services and all provide "lived experience." A peer supporter is someone who has experienced the healing process of recovery from psychiatric, traumatic and/or substance use challenges and, as a result, can offer assistance and support to promote another peer's own personal recovery journey. "Peer support services are an evidence-based mental health model of care which consists of a qualified peer support provider who assists individuals with their recovery from mental illness and substance use disorders. CMS recognizes that the experiences of peer support providers, as consumers of mental health and substance use services, can be an important component in a State's delivery of effective treatment," (*Centers for Medicare and Medicaid Services, August 15, 2007).* MHSA funding supports Workforce Development Education & Training component which *"provides the means for developing and maintaining a culturally competent workforce, to include clients and family members, which is capable of providing client- and family-driven services that promote wellness, recovery and resilience, and lead to measurable, values-driven outcomes."* ADMHS has significantly increased employment opportunities for individuals with lived experience over the past three years. Peer and family members also influence the system through participation on Recovery Learning Center Guidance Councils, Mental Health Commission, Alcohol and Other Drug Advisory Board, and interview panels for key ADMHS Administration, Clinical and Leadership positions.

Both TriWest and the Access survey stressed the need to **provide access to surveys in a client's preferred language**, and cited a lack of adequate bi-lingual services in crisis and long-term programs. In addition, the need for culturally responsive intake/assessment has been observed. Guidance for cultural issues with selected items from the APA Cultural assessment has been made available in the Clinician's Gateway Electronic Health Record. The full APA cultural competency and diversity screening and in-depth assessment items are under development for inclusion in the CG intake screens by 2016. This will enable data collection on these items. An objective assessment using the language line has been pilot tested for determining staff bi-lingual capacity for providing services in multiple languages. The assessment can provide

feedback on basic language ability as well as clinical level language skills in multiple languages. Pilot languages have included Spanish and Russian. A Staff survey has been conducted to quantify language capacity and bi-lingual pay- current capacity for Spanish speaking staff in Clinical Programs average 35.4% with a range from 18%-62% and average of 31% for Administrative settings ranging from 21%-43%. Capacity for any language other than English in Clinical programs averages 40.1% (range from 33%-65%), with Administrative staff averaging 41.3% (range of 30%-44%). The survey found that more staff speak and use Spanish in their work than actually receive bi-lingual pay, which suggests more staff should be assessed and receive bi-lingual pay. Additional Language abilities of staff include: Arabic, Bulgarian, Cantonese, German, Greek, Hindu, Japanese, Mixteco, Nepalese, Polish, Portuguese, Romanian, Russian, Sign, Serbian, Tagalog, and Urdo. Mapping language abilities of existing staff may help ADMHS provide culturally responsive services for clients who prefer to receive services in non-threshold languages, such as Cantonese. Hiring of bi-lingual Spanish-speaking staff has been emphasized for crisis services.

TriWest maintained that the County and ADMHS leadership must visibly **commit to the creation of a performance and quality improvement-driven culture**. Numerous examples of developing and using data are now in place as ADMHS strives to become a data-driven system. Performance outcome measures were incorporated into in all contracts for FY15-16. The comprehensive CANS assessment has been implemented in children's Mental Health services, and @36-38% of children have now been assessed. The adoption of the Milestones of Recovery Scale (MORS) has been launched with training for all programs, and is in use at all ACT/FSPs programs. A Comprehensive outcome tool (HOMS) is being pilot tested in Santa Maria for potential adoption system-wide. The FSP Fidelity assessment has been conducted with the ACT contractors, and is in progress at SBACT. Results of this process will help target key areas to improve ACT/FSP services. Data reports in use for client contacts, deadlines, productivity and documentation requirements for staff and supervisors.

The TriWest report suggested that ADMHS articulate an operational vision in which both clinical efficacy and financial responsibility are embraced by defining the construct of "value of care" as the primary "product" of ADMHS, with clinical, financial and regulatory compliance functions defined as best practice "supports" to the value equation. Progress has been made by training staff and Change Agents on welcoming, integrated, and client centered care, according to MHSA principles. Documentation requirements are viewed in the context of creating the client medical record as well as fulfilling compliance functions. Staff is given audit feedback and training that emphasizes connecting assessment, treatment plan, and interventions. An ADMHS

Documentation manual has been published, and staff has attended statewide training. To improve compliance with documentation standards, a "Treatment plan decision rule" in the EHR and billing process was launched in October 2014. Although the rule initially blocked Medi-Cal billing, the data was used to help staff identify clients whose treatment plans needed updates, and billing rates are now increasing. Implementation of new crisis services has provided immediate access to care and MD contact in all regions of the county.

Fiscal Year 2015-2016 Contract Renewal

Based on feedback that the prior year's submission of a large number of contracts on a single Board agenda was onerous for all parties, ADMHS revamped the Fiscal Year (FY) 2015-2016 contract renewal to facilitate a more efficient, effective and program-driven process.

To kick-off the FY 2015-2016 process, a planning team consisting of members from ADMHS Program, Contracts and Fiscal teams coordinated a series of collaborative contract review meetings with community-based organization (CBO) partners to integrate contract discussion with both Alcohol Drug Program (ADP) and Mental Health (MH) service partners, foster ongoing two-way communication between providers and ADMHS and strengthen partnerships. The contract renewal process on the Statement of Work portion of the contracts began in January 2015 with input from key stakeholders, including CBO and ADMHS program leadership. Additional contract review meetings were held in March and April 2015 to discuss the fiscal component of the contracts and engage with CBOs in a collaborative conversation to define measurable performance objectives.

As part of the ADMHS commitment to increased accountability in transforming the system of care and recovery, ADMHS launched an initiative to revise contract performance objectives to reflect measurable, outcome oriented deliverables. Working collaboratively with the CBOs, many process objectives have been updated to target measurable outcomes. When existing data were available, the objective was based on prior historical achievements. When data have not been previously established, targets were selected based on similar program outcomes or a baseline objective was designated. Each CBO worked with the ADMHS system evaluator to define the performance outcomes that are now included in the ADMHS service contracts.

Contracts renewals were scheduled across several Board of Supervisors (BOS) hearings in June and July 2015, with the focus of prioritizing Medi-Cal contracts for review before the beginning of the fiscal year. Extensive engagement with CBOs in group and individual meetings helped improved process for finalization of contract language, decreasing the "back-and-forth" processing of drafts. No contracts were delayed by questions or incompleteness. Several supervisors commented on how smoothly the process went. The Chair of the Board recognized the ADMHS contract process and content as a model for other departments. In addition, Supervisor Adam commented positively on the measureable performance outcomes that were included in the contracts.

For the FY 2016-2017 process, ADMHS is working to increase the number of contracts that have multiple year terms as part of future Request for Proposal (RFP) processes; the renewals for services can then be staggered so that the Board does not see all contracts every year.

Contract Management and CBO Communications

As part of the process of ongoing contract monitoring, ADMHS collects staffing reports and programmatic data from contracted providers quarterly, which are available to program leadership for review. By developing an integrated FY 2015-2016 contract renewal process with service providers from both the Alcohol and Drug Program (ADP) and Mental Health systems of care, ADMHS is working on extending the current established contract management process used by the ADP team to include both ADP and Mental Health contracted partners.

In September 2015, ADMHS adopted a template developed by the CBO Coalition, a group founded in June 2013 to voice the interests of behavioral health contract agencies in Santa Barbara County. The template is used to report on programmatic performance, narratives and trends. The template is not only being used as a tool for reporting quarterly and annual outcome performances for each contracted programs, but is also used as evaluation instrument in the newly established Collaborative Contract Review (CCR) meetings. The objectives of the CCR meetings are to strengthen collaboration between CBO and ADMHS and to ensure that programmatic, contractual and fiscal issues are resolved timely and judiciously. Moreover, the agenda for the CCR meetings are developed jointly with CBO and ADMHS program, fiscal and contracts leadership to make certain that the meetings are meaningful and productive. The first three CCR meetings were held in October 2015. The plan is to schedule CCR meetings with approximately four CBOs each month.

Furthermore, beginning March of 2014, the Chief of Compliance implemented Contract Compliance Review meetings with contract provider staff to determine whether contract providers were delivering services in a manner consistent with the terms of their agreement. Provider programs were selected for review based on the number of compliance complaints

received. Reviews are conducted by an ADMHS team including the Chief of Compliance, Quality Control Manager, the Regional Manager over the region where the program operates, and the Chief of Administrative Services. An audit protocol is applied to track each section of the contract. To date, seven program contracts have been reviewed.

Information is shared in a monthly ADMHS Director's Report, in updates from CBO Leaders, and during a monthly CBO Collaborative meeting chaired by the ADMHS Director. These meetings are held at the Santa Barbara campus with video conferencing available in the north and central campuses. The CBO Collaborative meetings offer an informal forum for CBOs and ADMHS to exchange timely communication and discuss concerns.

Information exchanges have focused on key departmental initiatives affecting contracted partners, such as (1) the planning for an Organized Delivery System (ODS) to ensure improved integration of alcohol, drug and mental health services, (2) the transition to the new International Classification of Diseases 10 (ICD-10) code set which is required by the Health Insurance Portability and Accountability Act (HIPAA) for service providers, health plans, etc. and

(3) the training sessions for the rollout of the Measure of Recovery Scale (MORS) to the Adult Mental Health System of Care.

Contractor satisfaction with ADMHS has improved considerably according to the annual CBO Coalition survey.

Clinical Operations

Examples of Change Agent Projects

Change Agents participate in monthly training meetings where ideas are generated for system change projects specific to programs where the change agent works. The following are examples of projects developed and tested by change agents in a quality improvement approach (PDSA) to address particular issues at the work site in a manner consistent with system change values and principles. As change projects are successful in one region, other sites may adopt the intervention to produce standard improvements across the system of care.

Clinica Latina

In response to the TriWest report's call for systems change, the Santa Barbara Calle Real Adult Clinic initiated a pilot program to improve the provision of mental health treatment for un-served and under-served populations. Clinica Latina seeks to increase cultural competence and provide early intervention for at-risk individuals to reduce patient, family and community suffering. The program offers a dedicated team and treatment space designed to provide care

to monolingual individuals and those who prefer to speak Spanish. Individuals experiencing mild-to-moderate mental illness, often with co-occurring conditions, are served by the new program.

Without any increased personnel costs to the County, Clinica Latina provides up to 30 hours per week of face-to-face client services. This is accomplished by using graduate students pursuing Antioch University's Master of Arts program in clinical psychology with a Latino emphasis. Currently, four bilingual/bicultural graduate students work under the clinical supervision of Santa Barbara Adult Clinic Team Supervisor Jonathan Eymann and the cultural competence supervision of Francisco Palencia, ADP Service Specialist. The graduate students provide additional Spanish-language services to about a dozen existing ADMHS clients in the South County region. In addition, group, family, couple and individual therapy and rehabilitation treatment are being offered to new clients now being referred directly to the program from the Public Health Department, from Casa de la Raza and from El Nuevo Amanecer, a Latino support group.

In the first month since opening to direct referrals, 12 new, previously un-served and under-served clients have been engaged in treatment, and five more are about to be enrolled.

Seamless, Same-Day Integration between Public Health Clients and ADMHS Santa Barbara Adult Outpatient Clinic Advanced

Clients seen at Public Health who are found to need a mental health screening may receive screening and care from the Santa Barbara ADMHS Outpatient Adult Mental Health Clinic. A dedicated fax number has been established at the ADMHS clinic for use by Public Health in transmitting medical orders and referral paperwork for direct referrals. A two-way Release of Information form was developed by Public Health to expedite the transmission. In addition, the "green line" connecting the ADMHS Adult Clinic to the Public Health Building was repainted to improve its usefulness as a navigational guide.

Orientation Groups – All regions

Orientation groups are designed to help clients and family members/friends to understand how the system works, meet peers in recovery, provide a personal connection to staff, provide opportunities for "warm hand offs" to other services and staff members, introduce participants to local resources and support groups, demystify the system, and increase sustained engagement. The goals are to support people immediately as they seek help, empower them to continue their recovery process and decrease in no-shows.

Suggestion Boxes – All Regions

Suggestion boxes are placed in each the lobbies of each clinic, PHF and ADMHS Administration. The goal is to collect information from clients on their satisfaction with ADMHS services. This initiative was a collaboration between Change Agents & and the ADMHS Quality Care Management (QCM) unit as part of Quality Improvement (QI) FY 14-15 Work Plan, Goal #1 Improving Client Experience & Satisfaction. QCM is the only entity with access to the locked boxes. The suggestions are gathered, concerns are addressed and accolades are reported. The feedback and information is reviewed in the Quality Management Committee.

Lobby Change Projects

Creating a warm and welcoming atmosphere to enhance client engagement and recovery– Six out of eight clinics participated in some form of the redesign process by using a continuous quality improvement process – Plan-Do-Study-Act (PDSA). The steps in the process included conducting a pre- and post-test by surveying clients and family members, analyzing the data and making changes to their lobbies, including painting, updated furniture, new art and new displays. As a result, staff members became more aware of the experience that clients/families have when they seek support in our clinic sites.

TAY Employment

This was designed to increase employment levels for youth 16-25 who were clients at the Lompoc Clinic. This continuous quality improvement project used the NIATX PDSA process. It was designed to help clients achieve treatment plan goals, increase TAY access to employment, reduce the workload for transition-age youth (TAY) staff around employment services, increase collaboration with employment resources in the community and allow staff to improve access to care due to quicker completion of treatment.

Staff members continue to collaborate and invite Employment Development Department (EDD), Department of Rehabilitation (DOR) and Workers Investment Board (WIB) to visit the clinic on a quarterly basis. Staff members review client's employment plans and goals and support TAY in their efforts, continue to work with WIB, DOR and EDD to identify ways we can address obstacles/barriers to success around employment goals.

Access and Transitions Workgroup

The Access and Transitions Workgroup (ATW) has launched various pilot projects to improve access to care and transitions between services.

Team Based Care: The ATW developed a framework and a guide for teams at each outpatient clinic to more fully implement the team-based approach within the already established Medical Integration/Older Adult, Co-Occurring, and Wellness, Recovery & Resiliency teams. The teams are pilot-testing a team-based approach with a small group of clients. Team based care in outpatient clinics is intended to provide an approach consistent with the Team approach in ACT/FSP models, so that clients and staff share a common understanding of the care model across the outpatient system, facilitating more seamless transitions between levels of care and programs.

In Santa Maria, clients were educated on the new team approach. The clinic created cards for each client with the team name and the name of each team member. Teams meet each morning to staff each case, change treatment plans as needed and assign case workers specific tasks for client care; i.e., help clients riding bus, finding employment and teaching clients to manage ADLs (Activities of Daily Living) in their home. Future work on clinic based team care will create uniform interventions for specific teams (i.e. group curriculum for Co-occurring clients, standard interventions for healthy diet, physical activity and smoking cessation for the Medical Integration team, and WRAP groups for Wellness and Recovery teams).

Orientation Groups were developed with the goal of providing clients with an immediate opportunity to connect with the clinic and learn about available services. Groups are offered in English and Spanish, and family members are welcome to attend.

For example, Santa Maria has been conducting weekly orientation groups, with six or more attending each session. Staff members from the Recovery Learning Community have been joining the group to offer family support groups and immediate connection to a family advocate. Lompoc Children's developed a "welcome package" to help clients navigate services, understand the guiding principles of ADMHS and identify their team members.

Medication groups have been launched at some sites to help clients access MD services earlier than 3-4 months. Groups are typically facilitated by nurses, and the client has a brief MD visit, if necessary.

High-Intensity Programs: Along with the ACT fidelity assessment conducted by program and QCM staff, the ATW is reviewing the structure and model of the system's Assertive Community Treatment (ACT and Supported Housing teams) to determine how best to meet the needs of the clients. Preliminary recommendations include expansion of substance abuse services in these programs, developing specific programming for personality disorders and creating a tiered model for ACT that would allow for step- down approaches to service delivery.

Alcohol and other Drug Programs

Integration Efforts and Accomplishments

ADMHS began integrating services before the Tri West report was finalized. The County of Santa Barbara ADP Division (ADP) had long been an advocate of Dr. Kenneth Minkoff's theories and practices – that all clients present with complex issues, that co-occurring mental health and substance use disorders (COD) was the expectation rather than the exception, and that treatment services needed to address both mental health and substance use issues simultaneously when providing treatment interventions. In that spirit, formal individual and group COD services had been established at the Calle Real and Lompoc mental health clinics. Alcohol and other drug (AOD) counselors had been providing COD services at both CARES clinics, and many of our contracted alcohol and other drug (AOD) had been upgraded to become COD capable and even enhanced. Specifically, Coast Valley Substance Abuse Treatment Center (CV SATC) was fully integrated with the Lompoc MH clinic, providing evidenced based COD services, including psychiatry, to all indicated clients.

After the Tri West report, integration accelerated at a rapid pace. True integration includes primary care or physical health as well as mental health and substance use treatment. County ADP assisted the County Public Health Department (PHD) develop a Screening and Brief Intervention and Referral to Treatment (SBIRT) program. ADP organized formal SBIRT trainings, including SBIRT certification, helped the PHD choose an evidenced based screening tool (AUDIT) and has developed a formal referral process for PHD clients to enter AOD treatment services in Santa Barbara. In Santa Maria, ADP and MH staff created a COD group and helped the SM clinic provide COD services to clients.

ADP Program Administrator John Doyel wrote a formally researched White Paper on Integration and administered a formal assessment of integration efforts throughout all ADMHS and ADMHS contracted agencies. The research and assessment indicated that ADMHS was more integrated and that COD services were being provided more than previously believed. Mental health practitioners were providing AOD services and AOD counselors were providing MH services though these services were not considered as such. In order to standardize COD, an integration policy and procedure was developed and COD teams became part of the recent MHSA Plan. The Santa Maria MH clinic dedicated itself to providing COD services and now provides numerous standardized practices and interventions for all of its clients.

Formal COD trainings have been established and provided throughout our entire system of care – to internal ADMHS practitioners and contracted providers.

Overdose Prevention

The County of Santa Barbara ADMHS has been acutely aware of the increase of prescription drug abuse (PDA), heroin abuse and resulting overdoses in the county over the past several years. Santa Barbara County reflects a disturbing national trend in opioid abuse and has taken quick and tangible steps to address the issue.

Prevention and Administrative Staff captured tracked and analyzed treatment data from 2010 – 2014 which indicated a sharp increase in heroin and prescription drugs as the drug of choice in a growing number of clients entering County ADP treatment programs. Heroin and PDAs are now the drugs of choice for 30% of clients entering ADP treatment programs. As a result, PDA prevention was included as one of the top four (4) priorities in the County of Santa Barbara Strategic Prevention Plan.

The ADP Advisory Board on Alcohol and Other Drug Problems reconvened its Education and Prevention sub-committee to address PDA. As a result, three (3) Town Hall meetings were organized to address PDA in 2013 - 2014. Panels included representatives from the Sherriff's department, Emergency Room Doctors from Cottage and Marian Hospitals, addictions psychiatrists, alcohol and other drug prevention and treatment experts and affected members of the community. The meetings were a resounding success. The County Board of Supervisors passed a resolution recognizing International Overdose Awareness Day, August 31st; members of Families Act were present to be recognized for their work in increasing awareness of overdose in Santa Barbara County.

OD Prevention and Reversal training is now required in all ADP Treatment contracts. Intensive, day long Overdose Prevention and Reversal Trainings were provided by a leading agency in the field, the Los Angeles Community Health Project, to "train the trainers" in addressing opioid addiction and providing OD reversal skills. Naloxone administration was included in the training. Approximately forty five targeted individuals (who were most likely to witness an overdose) attended the training and provided positive feedback. As part of the process, OD Prevention and Reversal brochures have been developed in English and Spanish and have been distributed throughout our system of care.

Narcotic Replacement / Treatment Programs (NTP) have been allocated increased funding to treat opioid dependence and in the process have increased availability of naloxone to reverse opioid overdose. In addition, these NTPs are beginning to pilot Suboxone medication as an alternative to methadone.

County ADP has developed a formal OD prevention program. ADP has written a draft policy and procedure on overdose prevention and reversal and is currently in the process of purchasing intranasal and injectable naloxone to distribute throughout the community to reverse overdoses.

County ADP staff is working with selected ADMHS psychiatrists and PHD physicians to develop a pilot Office Based Opioid Treatment (OBOT) that will provide alternative medicated assisted treatment options to opioid dependent individuals. In the meantime, ADMHS psychiatrists are becoming certified to provide Suboxone and Subutex to opioid individuals and have begun to write prescriptions for these medications to clients in need.

Finally, Alice Gleghorn, PhD, an expert in OD Prevention and Reversal, was hired to direct ADMHS and has provided guidance and instruction in developing additional programming to address OD Prevention and Reversal.

Crisis Action Team (CAT)

The CAT identified key issues and divided into workgroups to address peer involvement, children's crisis services, law enforcement relations, medical clearance policies, residential treatment bed needs and developing a more welcoming operating system.

The participation of persons with lived mental illness experience (peers) has been shown to improve outcomes for clients undergoing mental health challenges. Peers constitute three of the seven personnel on each of the three crisis triage teams. The CAT peer subgroup defined the duties and functions of peers working on the crisis triage teams.

Like most California counties, Santa Barbara County does not have an inpatient psychiatric hospital for children. The CAT aligned with the Children's System of Care Action Team to develop a presentation to the Mental Health Services Oversight and Accountability commission regarding the current state of, and need for, children's crisis services in Santa Barbara County; in particular, the need to prevent the out-of-county hospitalization of children.

We estimate that 10 - 20% of the population in our jail has serious mental illness, and the percent of those with any mental illness may be as high as 50%. The CAT spearheaded the initiation of meetings with law enforcement to increase communication among our organizations to provide mental health interventions for appropriate individuals, rather than arrest.

There were misunderstandings from emergency rooms in Santa Barbara County regarding the specific criteria that would allow a person to be admitted to the Psychiatric Health Facility. This was especially true where there were co-morbid medical and substance intoxication or withdrawal problems. A workgroup of the CAT collaborated with leaders in emergency rooms to develop the policy "Medical Clearance Screening."

Using survey results, the CAT Welcoming Workgroup identified a public perception that crisis services are not seen to be welcoming. An adequate sample size of a repeat survey is currently being collected.

There was no policy in place for the process of involuntary psychiatric hospitalization (5150). Stakeholders in the CAT and community participants collaborated to develop two policies ("Crisis Assessment Procedures" and "5150 Application and Placement") that will standardize the process throughout the county.

PHF Enhancements

There have been many positive changes at the Psychiatric Health Facility (PHF) in last 18 months.

Physical plant improvements include: Painting the entire unit to ADMHS approved color scheme including a chalk board painted wall in the inner patio for patient self-expression through art, outpatient staff donated their time to create a beautiful and bright painted mural in the day room, new flooring was installed in the day room and nurses' station, the Lobby/reception area was renovated with new paint, furniture and flooring which presents the PHF to the public in an up to date professional manner, installation of monitoring equipment throughout the unit (excluding patient rooms and restrooms) to allow improved monitoring of the unit for patient and staff safety, installation of improved stereo and sound system in the day room and Comfort room – providing improved quality sound for music for client enjoyment, the staff break room was moved off the unit to allow for a more restful place for staff to recharge during their shift, replacement of counter tops and lighting in Recreation Therapy room, changed lighting to LED in an effort to improve energy efficiency, relocation of medication room to improve work environment for the staff and allow easier access for patients to the medication nurse, addition of a Comfort room to patient space - utilized by many patients as a calming space within the milieu, the addition of a sound system allows patients to select music that will sooth or comfort them, provision of a Computer kiosk for patient use allowing increased contact with family and friends as well as to educate about medications and aftercare opportunities, new Cordless phones replaced outdated pay phones and allow patients to utilize the telephone in a more convenient and private way, available cordless radio headphones for patient personal use, and Pet therapy was offered biweekly to patients.

PHF programming has been modified to reflect system change principles to provide client centered treatment. The Director of Nursing and the Director of Social Services developed a "Patient Engagement Tool" that has modified the admissions process. The "Patient Engagement Tool" allows the patient to choose from a menu of services offered. This source document is used to form treatment interventions that will enable determination of the degree and intensity of individualized treatment provided as well as enhance treatment provided to be patient driven and strengths based. Additionally, this tool enhances the interdisciplinary team's ability to measure change in the patient as a result of goals identified and interventions selected by the patient. Training has been provided to social service and nursing staff on change of admission process and utilization of the "Patient Engagement Tool" in treatment planning. Training has been provided to interdisciplinary staff on the development of individualized short term and long term goals within the treatment planning process. Enhancement of patient's active treatment has also been developed; when patients choose not to participate in regularly scheduled groups offered or are too acute to participate, then individualized alternative groups are routinely offered to patient by interdisciplinary staff including licensed staff, recreational therapy staff, nursing and recovery assistant staff. Forms and processes to improve communication between and amongst staff have been developed to further capture and document all active treatment provided to patients. The Director of Social Services is working with QCM department in the development of an "Administrative Status" waiver form allowing for enhanced reimbursement for longer lengths of stay at the PHF. This has been developed as a result of patients who are difficult to place in the community (in county or out-of-county) as a result of serious mental illness and behavioral issues.

Additional PHF enhancements include: Implementation of a therapeutic garden-used as a therapeutic tool with patients as of May 1, 2014, Composting of green waste was initiated October 2015, A 7 circuit labyrinth has been installed on PHF's patio. PHF labyrinth is registered with the Labyrinth Society and is now one of 16 labyrinths in this area (including UCSB, Cal Lutheran and St John's Regional Medical Center). PHF became a non-smoking facility on May 1, 2013 – the first locked facility in the region to do so. Several counties have asked PHF leadership for guidance as they too move towards a non-smoking environment. Social Services is now providing treatment and support 7 days a week, including 20 hours of coverage spanning Saturdays and Sundays. Since the hiring of a well-qualified Dietician and Certified Diabetes Educator for the PHF in 2014, the following changes have been made to encourage healthy eating on the unit: 1) one portion per meal, 2) fruits and other healthy items for snack, using the dessert provided with lunch as the evening snack. Data from the MCE study show an average of 46% less weight gain during a patients hospitalization with the changes implemented. The RDN is also developing a malnutrition screening assessment/protocol and a bowel regimen/constipation assessment/protocol to identify and treat our clients who present to the PHF with malnutrition and constipation. The RDN has also been reaching out to other

departments within ADMHS and the County (including WIC and Public Health) to bring relevant nutrition and health programs into the PHF and to act as a nutrition resource for the Community and Santa Barbara County.

PHF has added a part-time psychologist who provides individual and family therapy to contribute to sustainability of mental health improvements achieved during hospitalization. The psychologist also administers psychological assessments, provides Dialectic Behavioral Therapy and psycho-education, and designs behavioral modification programs appropriate for specific patients, who are long-term and resistant to the minimum requirements of group living. In addition the psychologist is available to assess organizational systems, policies, and practices to identify opportunities for improving effectiveness and efficiency, as well as to enhance collegial cooperation across disciplines.

Recent developments include: Dr. Courtney Stallings has accepted the position of Acute Care Discharge Coordinator. She will be starting on January 4, 2016 and will work throughout ADMHS to streamline discharge placements from acute hospitals with the goal of decreasing length of stay. The PHF "Change Project" has been initiated and is in the data collection and analyzing phase. The project aims to bridge any identified gaps between discharge of patients and linkage to outpatient treatment and community resources. PHF also successfully completed of Safety, State and Federal tri-annual audits. PHF medical staff charting is now through Clinician's Gateway, our electronic medical record. Social service documentation will be next to go on line in early 2016 followed by nursing. CPI (Crisis Prevention Institute) Nonviolent Crisis Intervention training is now provided by in-house trainer, Mark Lawler – training is now offered throughout ADMHS and is specific to job site. 80 staff will have completed training by end of 2015. The supervisor/schedule has been streamlined- In October 2014, the PHF nursing schedule was modified to all 12 hour shifts and a "block" schedule selected by staff. This change as resulted in improved continuity of care provided to the patients as well as improved staff satisfaction with their work schedule In September 2014, direct floor supervision was increased with the addition of 5 Team Supervisor positions for the PHF. There are now 4 RN Team Supervisors who oversee the team of staff they are assigned to as well as 1 LPT Team Supervisor who oversees unlicensed staff (Recovery Assistants) and is the PHF Safety Officer, CPI trainer for the PHF and ADMHS department as a whole.

The PHF staff has also worked closely in the development of the new Crisis Stabilization Unit, collaborating with key CSU staff in the development of the CSU program and hiring all new CSU staff. Ongoing supervision of all PHF and CSU social workers and nursing staff will be provided by supervisory staff from PHF.

Children's System of Care (CSOC) Action Team

Multiple agencies and community-based organizations (CBOs) have taken part in the CSOC Action Team. CSOC has been able to engage a broad range of service providers that includes leaders in ADMHS, Probation, Child Welfare Services, Education, and the CBO community.

SOC has worked closely with the ADMHS training coordinator to provide ongoing training and train the trainers for all CSOC providers on trauma-informed care. SOC has helped to support a countywide training of all children's service providers in trauma-informed service delivery. The Trauma-Informed System of Care workgroup continues to provide information to schools, agencies, and the community on trauma-informed services available in the community.

CSOC played a role in developing a training plan for evidenced-based practice identification and the planning of the core model that will be required of all new employees and training that will be required as ongoing training annually. CSOC began the development of system-wide evidenced-based practice identification, implementation, and training that included all CBOs and ADMHS. The Department will eventually use RELIAS for assignment of training, tracking, and for running reports of trainings that have been completed.

CSOC also formed a collaborative workgroup to design the system map for each agency. CSOC developed System maps for Children's MH Services, Probation, and Child Welfare Services. CSOC also helped improve School District participation, bringing the Education Department to the CSOC table and and getting schools to host the meeting at their mid-county facility.

Probation, ADMHS, and Social Services have worked together on a co-location charter. CSOC outlined a process to get ADMHS, Probation, and Child Welfare Services (CWS) co-located in one facility to help with coordination and cooperation among partner agencies.

CSOC also worked closely with Community Action Commission to research and provide updated agency information uploaded to the 211 website. The workgroup is working to have a link added to each of the agency's websites. The workgroup is also continuing to ensure that the information is updated as needed. CSOC developed a service provider index to be shared on 211 to make services identifiable, qualifying criteria understandable and contacts available.

Katie A

Katie A mandates that county child welfare and county mental health work together to address the mental health needs of children/youth and families in the child welfare system. It is intended to facilitate a common strategic and practical framework that integrates the planning, delivery, coordination, and management of services for children involved in multiple service systems.

ADMHS began screening all children coming in to the CWS system in January 2014. In the first six months, 611 children were screened for mental health needs. 115 met the criteria for sub-class and were provided more intensive mental health services.

In fiscal year 2014/15, 359 children were screened and 200 met the criteria for sub-class. The average rate of referrals countywide is approximately 35 per month, with the majority of referrals in the north county.

The collaboration with CWS has been excellent. Combined meetings and trainings throughout the process have facilitated increased communication and coordination of services resulting, in improved care for our most vulnerable youth. We continue to collaborate to improve the screening, referral, assessment and treatment process.

Trauma-Informed System of Care Trainings

Three staff members became Trauma-Informed System Trainers in April 2014. They, in turn, trained 24 ADMHS and CBO staff to be trainers across the county. CBOs represented were: Family Service Agency, CALM, Santa Maria Valley Youth and Family Center, CAC, and Family Care Network.

Between October 2014 and March 2015, the 24 trainers provided instruction in their respective agencies, resulting in approximately 250 people being trained.

In August 2014, CWS and ADMHS started collaborating to create community-wide symposia, which resulted in three regional symposia. About 230 individuals participated, representing a broad spectrum of the community agencies that serve youth.

As a result of the symposia, we now have data from participants asked to formulate their vision of a trauma-informed children's system of care.

MHSA RISE Project (Resiliency Interventions for Sexual Exploitation)

The purpose of the Mental Health Service Act (MHSA) is to "expand mental health services in California. Funds may not be used to supplant existing state or local funds that are currently directed toward public mental health services". The priority populations served by the RISE Project will include females aged 10-19 and their families; specifically targeting our underserved African-American, Asian/Pacific Islander, Latino, Native American/Tribal, and the LGBTQ girls who are "at" and "in" risk of sexual exploitation (sex trafficking) in each region of Santa Barbara County. CSEC identified boys will not be turned away.

Treatment will focus on:

- Female youth who are “at risk” of sexual exploitation
- Female youth at risk of out of home placement or are residing in Juvenile Hall, foster care or group homes
- Female youth identified as commercially sexually exploited

The RISE project will seek to develop and utilize an interagency, multi-layer treatment/training/education approach which includes partners/supports throughout the community, including Law Enforcement, Juvenile Probation, Courts, Public Defender, District Attorney, Rape Crisis, DSS, Victim Witness, SB County Human Trafficking Task Force, ADMHS, Local Schools, CALM, UCSB, Medical Community, EMT’s, Community Based Organizations, Guardians, Foster Parents, Peers/Mentors, Spiritual Community and others. A comprehensive female specific/trauma-informed model of services, resources, protocols, education and training will be collaboratively developed, implemented and tested for efficacy.

The RISE Project will cover early intervention strategies, outreach for underserved populations, education, training, 24/7 intensive best practice/evidenced based interventions, peer supports, outcome measurements and ongoing multi-agency CQI/QA (Continuous Quality Improvements/Quality Assurance). We believe the RISE Project will help us gain a better understanding of the full impact of early childhood and adolescent sexual trauma as well as learn new and innovative ways to treat this population more effectively, thereby reducing the intergenerational and costly cycle of childhood sexual abuse, particularly commercial sexual exploitation of children.

While intensive multi-disciplinary teams/services are not unique in our county, this program is distinctive in that it will target female youth “at” and “in” risk of sexual exploitation/trauma by providing a best practice/evidence based “female-specific” approach by a mostly all female treatment team. Evidence shows that female-specific treatment for sexual trauma exposed girls is most effectively facilitated by trauma-trained female providers. By including a collaborative CQI component, we believe RISE will also serve as a learning tool to develop more effective ways of successfully treating this high risk population as well as provide insight into preventative measures.

Cultural Competency Action Team

The overarching objective of the Cultural Competency Action Team (CCAT) is to establish culturally and linguistically appropriate policies, and procedures that are infused throughout the organization's planning and operation. The Action Team has been meeting since early 2014 and is composed of a diverse group of individuals representing ADMHS staff, partner agencies, CBO's, faith-based community representatives, consumers and family members. The Latino Advisory Committee serves as a subcommittee of the CCAT.

Since its creation, the CCAT has been responsible for spearheading multiple efforts. The group's initial effort focused on attempts to revise ADMHS Policy #73. This policy created disparities in access to services by uninsured populations. The CCAT further recommended that services to clients should be determined by clinical necessity and not by the ability to pay. A policy describing access to care made possible by the Affordable Care Act has been developed by ADMHS.

The access survey referenced in the TriWest Report and conducted by the Latino Advisory Committee identified the need for culturally responsive intake and assessment, as well as a need to increase bilingual services in crisis and long-term care programing. As a response, the CCAT assisted in the integration of a supplemental questionnaire to the Electronic Health Record based on items identified by the American Psychiatric Association (APA). The questionnaire serves as an additional resource to be used during client assessments. The questionnaire is intended to improve the accuracy of clinical assessments for diverse clients by incorporating and standardizing culturally specific assessment questions that are divided into areas related to: 1) Ethnicity; 2) Language; 3) Migration Status; 4) Sexual Orientation; and 5) Physical Health Issues. This provides guidance to staff.

Other efforts associated with these findings included an assessment of language capacity for ADMHS staff. Currently, 34.5% of all ADMHS staff are bilingual Spanish speakers, and 6.1% of all staff are bilingual in other languages including, but not limited to, Mixteco, Arabic, Russian, Tagalog, and Japanese. However, only 21.5% of staff receives bilingual pay. Another action item that complements this effort is the development of a new language assessment and testing procedure for multiple languages. ADMHS has implemented a new language assessment process that has been standardized using an objective third party. The testing process also allows the department to evaluate/assess language capabilities of staff in almost any language.

Additional projects supported or implemented by the CCAT include the incorporation of Cultural Competency Trainings into the existing training plan and the coordination of the second annual Interpreter Training conducted in partnership with SLO County. CCAT members also partnered with JSA Consulting to improve and ensure that the Crisis Risk Assessment Tool used by ADMHS crisis teams addresses the cultural needs of diverse populations, and future efforts will involve additional focus on diverse populations.

Forensic Action Team

Much has happened with regard to the improvement of forensic mental health services since the inception of the Forensic Action Team. Its purpose was to create organized community collaboration through a coordinated committee to ensure accountability, efficiency, and ongoing quality improvement for services targeting mentally ill adults involved in the criminal justice system.

One of this team's top priorities was/is to decrease the number of Incompetent to Stand Trial (IST) defendants court-ordered to receive restoration services at the Psychiatric Health Facility (PHF). The most efficient way to do this is to provide accessible prompt outpatient treatment in the first place. We have made improvements in that area as a whole. The Forensic Action Team is also more engaged in the courts and the jail. Defense attorneys are informing our Justice Alliance Team when their clients are showing signs of a mental disorder and we are making every effort to engage them in treatment before a doubt is declared as to their competence to stand trial.

When a declaration of doubt is inevitable and a defendant is declared IST, Justice Alliance staff continues their efforts to engage them in treatment and/or maintain treatment compliance and provide restoration education in an effort to restore their competency. ADMHS is required to provide a placement recommendation regarding whether the defendant should be required to undergo involuntary inpatient treatment, or be treated in a voluntary outpatient setting. Justice Alliance staff conducts a face-to-face evaluation of the defendant and reviews all available records prior to submitting recommendations to the Court. Once the Court approves the recommendation, the defendant is committed to either inpatient or outpatient treatment for restoration services.

The Forensic Action Team has developed a weekly tracking system for all IST defendants to ensure timely transfers to the PHF. We are also tracking defendants who are in the 1368 process, but not yet declared IST to intervene as early as possible to prevent, or at least decrease IST commitments. Wait times for PHF commitments have decreased significantly.

The Justice Alliance Team holds a standing weekly meeting with the Sheriff and Corizon's mental health team to provide continuity of care for inmates entering and exiting the jail, and to ensure that inmates identified as exhibiting mental health symptoms are offered treatment as quickly as possible. The Justice Alliance Team participates in regular Mental Health Treatment Court Core Committee meetings in collaboration with our criminal justice partners to identify gaps in services, improve collaboration among multiple agencies, and streamline services for mentally- ill defendants.

Very soon, the Justice Alliance Team will be fully staffed and more of a courtroom presence than ever before. We will maintain collaborative relationships with our criminal justice partners and be seen as an immediate resource for mentally-ill defendants. Under development is a referral form for court personnel, prosecutors, defense attorneys, and probation officers to streamline the referral process and ensure clients are screened and linked to appropriate services as needed.

Heart Action Team

The goals of the Housing, Empowerment, Action and Recovery Team (HEART) are to establish baseline data for function and interaction of mental health, ADP, and housing; improve specialization of ADMHS housing coordination across programs and study and recommend existing housing expansion options for ADMHS participants.

ADMHS has adopted a number of approaches to expand safe and stable housing. Priorities include exploring options to re-establish Board and Care-level housing for clients receiving county Mental Health services and facilitate better community re-entry and linkage by establishing an Institution for Mental Disease (IMD) in Santa Barbara County. In addition, ADMHS works with community partners to increase Inpatient bed availability within the county and seeks the capacity for inpatient care for children within the county.

Another important goal is expanding the options for supported independent living with mental health services offered onsite and greater provision of intensive department support to resolve housing issues for those with higher level needs. Also, ADMHS continues to collaborate with C3H /Milpas/ Downtown projects to increase engagement. Finally, ADMHS prioritizes the development of independent living units using remaining MHSA housing funds.

HEART conducted an analysis of existing housing and treatment services that reveals limited resources in these key areas: group homes, residential treatment services and transitional housing.

As a part of addressing these issues, the department has taken a number of key steps in during the past year. Eight new transitional housing beds were added with the opening of the Anka South County Crisis Residential facility. Two new facilities serving as step-down options for individuals discharged from inpatient care, Cottage Grove and Alameda House, were established. They add the capacity to assist 12 individuals with community re-entry. Using remaining MHSA housing funding, ADMHS has also worked with local and county housing authorities to develop options for long-term independent living. In partnership with the County Housing Authority, the new Pescadero Lofts provides 32 units and onsite services for individuals who were formerly homeless.

In the coming year, ADMHS will focus efforts on working with community partners to re-establish small board and care facilities that offer residents supportive services. Strategies will involve master leasing, coordinating with development agencies and expanding community-based organization housing options.

Homeless Outreach

ADMHS has collaborated with the Milpas/State Street Projects since inception, including participation in weekly case management meetings and membership on their newly formed Advisory Board. A memo of understanding (MOU) is in process to further clarify and define our work together.

Homeless Outreach provides targeted outreach to individuals with high Vulnerability Index scores including participation in a bi-weekly homeless services collaborative meeting organized by the Housing Authority. Homeless Outreach and the South County Regional Manager lead trainings for hundreds of Common Ground volunteers who conduct the VI survey on topics including mental health, substance use, outreach/engagement tips, and self-care. ADMHS staff participates in the VI Survey bi-annually as team leaders for groups of volunteers.

Homeless Outreach and CARES consistently engage people who are chronically homeless and found to need mental health services. The goal is to build trust and assist with accessing basic needs, including food, shelter, and clothing, including service to individuals who are not amenable to mental health treatment. This engagement process can be lengthy and measured in tiny, incremental steps, but has been successful in reaching and addressing the needs of some of the most vulnerable and chronically homeless individuals in the county. Homeless Outreach coordinates with other providers as needed, including Public Health, Doctors Without Walls, and Common Ground in Santa Barbara, Carpinteria and Goleta.

Homeless Outreach and CARES routinely and systematically coordinate with community partners to address a variety of needs, including housing, jobs, clothing, medical services, food, benefits, Alcohol and Other Drug/Mental Health treatment and legal concerns. Some of our

partners are City and County Housing Authority, People's Self-Help Housing, Rescue Mission, Department of Rehabilitation, Catholic Charities, Public Health, Neighborhood Clinics, Unity Shoppe, Social Security Administration, Department of Social Services, Sanctuary Psychiatric, Phoenix of Santa Barbara, Project Recovery, Legal Aid and many others. Homeless Outreach coordinates with Restorative Court, law enforcement, and the ADMHS Justice Alliance to meet the needs of homeless clients and reduce incarceration.

Homeless Outreach serves the community at Pescadero Lofts, PATH (formerly Casa Esperanza), Salvation Army, the Mental Wellness Center and Rescue Mission daily or weekly, depending on the site. We assist with connection to ADMHS services, clinical assessments, community referrals and crisis evaluations.

Homeless Outreach coordinates bed placements at PATH (20) and Salvation Army Hospitality House (5), including treatment plan coordination with the residential team, providing mental health psycho-education to staff and triaging with discharge planners from PHF, Vista, Hillmont, 5 East, Cottage Hospital, Mobile Crisis, jail, and other ADMHS teams.

To improve the Homeless Outreach program and access to services, the South County Regional Manager has recently created a system for collaboration between Homeless Outreach and ACTOE (ACT Outreach and Engagement), which includes cross-team case consultation and direct admission into ACT when it is determined that level of care is needed.

Peer Integration/Peer Action Team

According to Farkas, Ashcraft, & Anthony, 2008, "Programs that make good use of peer support demonstrate a culture that embraces a recovery-orientation, fosters collaborative relationships among staff and program participants, and strives to be a learning community." Thanks to Mental Health Services Act (MHSA) funding, in 2007 three Peer Recovery Specialists and three family advocates were hired. They provide support to clients and family members and serve as a peer resource.

In 2009 the Consumer Empowerment (CEM) Manager was hired. The original CEM function was to supervise peer employees and serve as a voice for clients and family members at a management/policy level. In 2012, 2.5 Peer Recovery Specialists were hired into the MHSA Innovation project that helped clients obtain medical benefits.

In 2013 three FTE positions were added to implement a Peer Expert Pool, which is a vocational/ return- to-work program that employs 10 peers, 10 hours a week. They conduct groups, offer navigation to clients and family members throughout the community and to the system; and assist with crisis services. In 2014-15 we hired approximately 11 peer staff to work in Crisis Triage, Anka Crisis Residential and the new Crisis Stabilization Unit. Approximately 28 peers

work at ADMHS, and approximately 22 for CBOs. We continue to hire peers to maximize the value of lived experience. Integrating peers into the public behavioral health workforce is an evidence-based practice that enhances the delivery of effective treatment.

Peer Programs and Activities

10-Day Peer Support Training: During 2010, 2011 and 2012, the ADMHS MHSA Workforce Education and Training (WET) component supported an annual Peer Support Training serving a total of approximately 100 peers (consumers and family members). Each training consisted of 80 hours of instruction and was conducted over a 10-day period. Persons with lived experiences

learned how to facilitate groups and were introduced to the code of ethics for para-professionals and system navigation. Following each training, six people were hired in internships to provide supports to clients and continue to learn about public behavioral health. Most who applied to the 10-day WET Peer Support Training were accepted, and half were bilingual.

OSHPD Peer Training Grant: In 2015 ADMHS received a grant from the Office of Statewide Health Planning and Development to offer a wide variety of trainings to consumers and family members working in public mental health. We partnered with 16 community providers throughout the county to offer four or five trainings. In addition, individualized training support will be offered to 58 consumers and family members. OSHPD grant funds have also been allocated to training community health educators to offer support groups in under-served and un-served communities.

CFMAC**:** Meeting monthly, the 22 voting members of the ADMHS Client and Family Member Advisory Committee (CFMAC) advises ADMHS on issues of concern and offers an important source of in

CIT: Supported by the Workforce, Education and Training (WET) component of the MHSA, peers have coordinated the annual Crisis Intervention Training (CIT). In May 2015, law enforcement professionals and other first responders, including Probation, the Sheriff's office and the Santa Barbara Police Department were trained. Dr. Joel Fay, a retired police officer and psychologist addressed trauma and self-care for officers. Clients and family members shared real life perspectives. ADMHS staff members provided training in relevant alcohol and drug, mental health issues.

Peer Action Team Accomplishments

The Peer Action Team meets monthly to address five goals related to the TriWest Report and the systems change initiative.

Strengthening Peer Voices in ADMHS Decision-Making

In January 2015, the ADMHS Consumer Empowerment Manager (CEM) began participating in the ADMHS Leadership Team, strengthening the Action Team goal of providing a greater voice for the Consumer and Family Member Advisory Committee (CFMAC).

Establishing a Guidance Council for the Recovery Learning Communities (RLC)

In March 2014 the Guidance Council for the South County RLC began operating. The Guidance Council is designing a survey to evaluate its effectiveness.

Increasing Employment Opportunities for Peer Support Specialists who graduated from the 10-day WET trainings

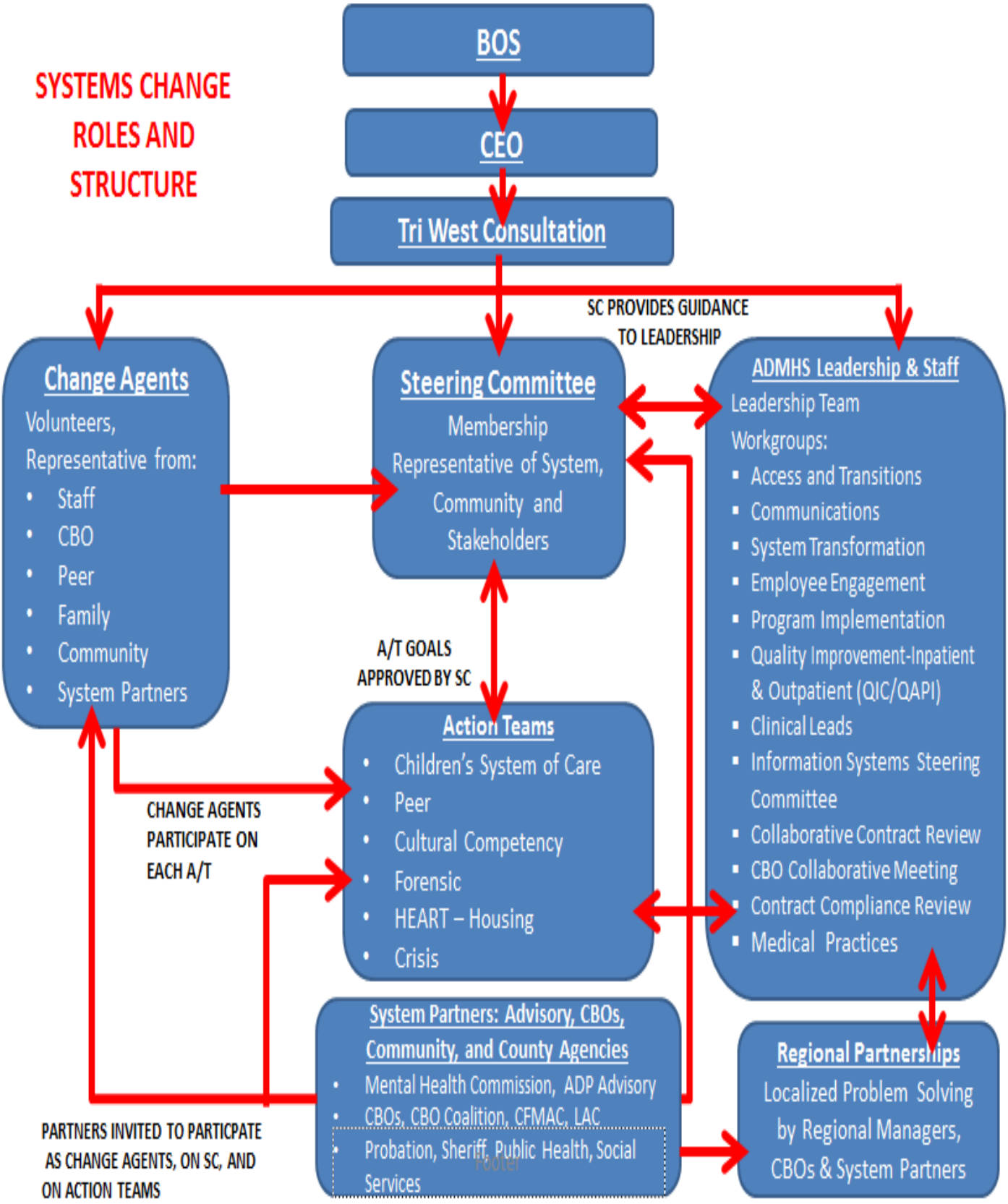
Three FTE peer support specialists continue to work at ADMHS under the WET-funded Peer Expert Pool.

Creating a Peer Career Ladder

We completed a career ladder proposal for ADMHS currently under consideration.

Advancing the Adoption of a Recovery Model at ADMHS

The CEM promoted recovery principles at a Clinical Supervisor Training in April 2014. In September 2014 the ADMHS Peer Recovery Specialists and CEM trained new staff in recovery principles. In October 2014 new ADMHS peer staff were oriented in recovery principles.


SYSTEMS CHANGE ROLES AND STRUCTURE
BOS
CEO
Tri West Consultation
SC PROVIDES GUIDANCE TO LEADERSHIP
Change Agents
Volunteers, Representative from:
• Staff
• CBO
• Peer
• Family
• Community
• System Partners
Steering Committee
Membership Representative of System, Community and Stakeholders
ADMHS Leadership & Staff
Leadership Team
Workgroups:
▪ Access and Transitions
▪ Communications
▪ System Transformation
▪ Employee Engagement
▪ Program Implementation
▪ Quality Improvement-Inpatient & Outpatient (QIC/QAPI)
▪ Clinical Leads
▪ Information Systems Steering Committee
▪ Collaborative Contract Review
▪ CBO Collaborative Meeting
▪ Contract Compliance Review
▪ Medical Practices
A/T GOALS APPROVED BY SC
Action Teams
• Children's System of Care
• Peer
• Cultural Competency
• Forensic
• HEART – Housing
• Crisis
CHANGE AGENTS PARTICIPATE ON EACH A/T
System Partners: Advisory, CBOs, Community, and County Agencies
• Mental Health Commission, ADP Advisory
• CBOs, CBO Coalition, CFMAC, LAC
• Probation, Sheriff, Public Health, Social Services
Regional Partnerships
Localized Problem Solving by Regional Managers, CBOs & System Partners
PARTNERS INVITED TO PARTICPATE AS CHANGE AGENTS, ON SC, AND ON ACTION TEAMS