Attachment A

Santa Barbara County Department of Behavioral Wellness

Board of Supervisors Semi-Annual Report

April Howard, PhD

SANTA BARBARA COUNTY
DEPARTMENT OF
Behavioral Wellness
A System of Care and Recovery

August 30, 2016

Attachment A

Santa Barbara County Department of Behavioral Wellness
Board of Supervisors Semi-Annual Report

Monitoring metrics and conducting outcome evaluation are critical components to determining the effectiveness of services, ensuring quality care for clients, and assisting the organization with policy decisions and resource allocation. Behavioral Wellness has a 3-year evaluation plan detailing the systemic, programmatic and individual level outcomes that will demonstrate client improvement and system progress toward system transformation. In February 2016, the Board of Supervisors approved the proposed semi-annual report, which was developed collaboratively with the Board of Supervisors and other stakeholders (see Appendix). Below is the report of key performance measures (FY2015/16 Q1-2) in the areas of client care and staff accountability.

Clients Served by Alcohol & Drug and Mental Health Systems of Care

Behavioral Wellness monitors the number and demographics of unique clients served in both systems of care. These data are drawn from admissions and services entered into ShareCare. Data are unique client counts within each region. The YTD total may reflect some duplication due to clients receiving services in more than one region of the county and/or clients receiving services in both systems of care.

	Alcohol & Drug System of Care (FY15/16 Q1-2)				Mental Health System of Care (FY15/16 Q1-2)				
	South	**West**	**North**	**YTD ADP System**	**South**	**West**	**North**	**Out-of-County**	**YTD MH System**
	1,333	566	1,517	3,416	3,568	1,172	3,340	1,032	9,112
Age Group:									
Children (0-15 years)	36	9	26	71	915	218	364	244	1,741
Transitional Age Youth (16-25 years)	327	166	342	835	575	219	1,100	270	2,164
Adults (26-64 years)	930	387	1,114	2,431	1,838	675	1,688	475	4,676
Older Adults (65+ years)	40	4	35	79	234	58	174	43	509
Missing					6	2	14	0	22
Gender:									
Female	445	193	526	1,164	1,597	670	1,607	522	4,396
Male	882	373	991	2,246	1,949	498	1,672	502	4,621
Missing/Other	6	0	0	6	22	4	61	8	95
Ethnicity:									
White	683	231	554	1,468	1,512	525	1,196	398	3,631
Hispanic	536	286	876	1,698	1,524	500	1,655	447	4,126
African American	27	25	33	85	128	77	140	43	388
Multiracial	32	18	16	66	109	32	62	32	235
Native American	16	3	11	30	27	10	19	4	60
Asian	15	1	23	39	64	15	49	22	150
Other	24	2	4	30	204	13	219	86	522
Primary Language:									
English	957	416	1,002	2,375	2,747	993	2,467	800	7,007
Spanish	85	35	139	259	388	139	414	142	1,083
Other	13	7	20	40	38	4	32	13	87
Unknown	278	107	356	741	395	35	427	77	934

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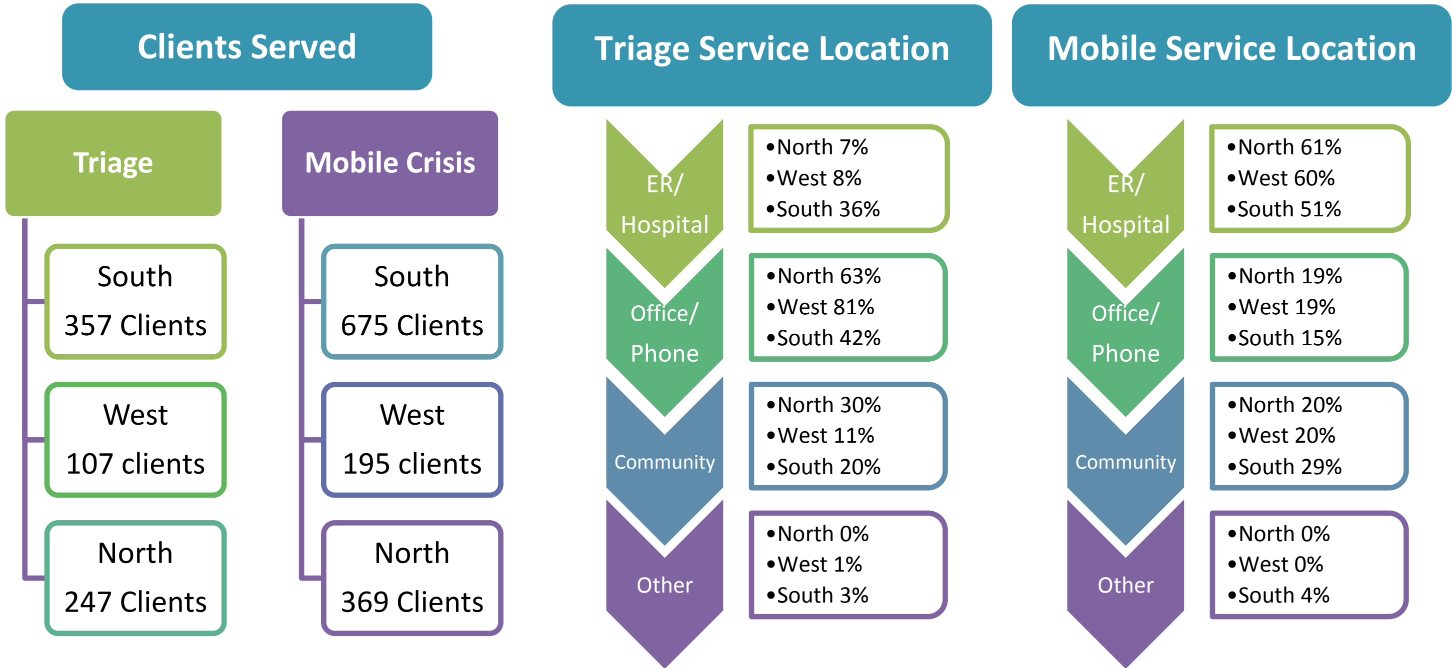
Crisis Service Utilization

In 2014, Behavioral Wellness received a grant of State Mental Health Services Act (MHSA) funding authorized through California Senate Bill 82 (SB 82). This funding has enabled the department to address critical gaps in crisis system access and field response. SB 82 funds have supported the implementation of Crisis Triage Teams based in Santa Barbara, Santa Maria and Lompoc; a Crisis Residential house in Santa Barbara; a 23-hour Crisis Residential Unit in Santa Barbara; and a Mobile Crisis Team in Lompoc serving West/Central County.
Below, are data for the following metrics:

- The number of clients served by the Crisis Stabilization Unit in South County and the Crisis Residential Units in North and South County. Data are drawn from admissions entered into ShareCare by support and clinical staff.
- The percent of clients stabilized at the Crisis Stabilization Unit (CSU) without needing a higher level of care within 30 days. Data are drawn from the CSU discharge date and a subsequent hospital admission date entered into ShareCare. *The CSU opened in January 2016. Data will be presented in the annual report.*
- The percent of crisis services provided in the community and in the hospital emergency rooms by ADMHS Mobile Crisis and Triage Teams by region. Service data are entered by clinicians into Clinician's Gateway as progress notes. Clinicians designate the service location in the progress note.

Crisis Services Q1-2 FY15/16



Crisis Residential Q1-2 FY15/16

- North: 103 clients served
- South: 42 clients served
- 80% of clients were stablized without needing hospitalization within 30 days of Crisis Residential discharge

April Howard, PhD, Dept. of Behavioral Wellness

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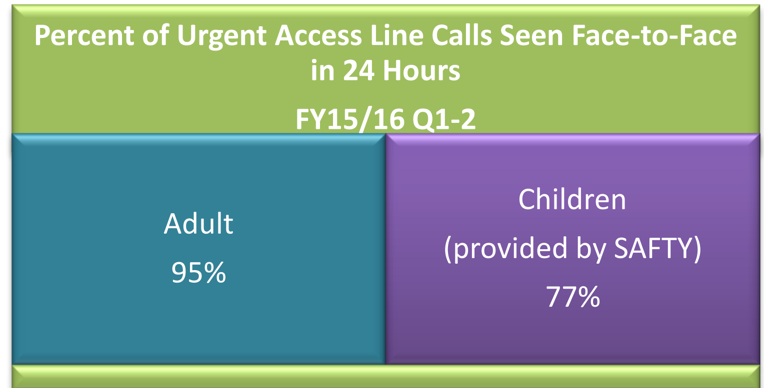
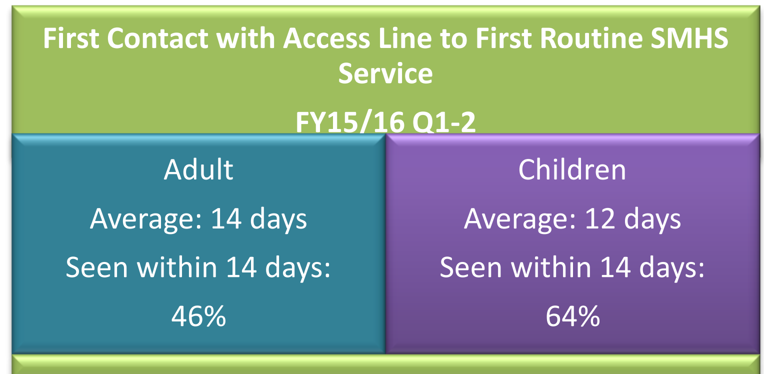
Timeliness to Care

Behavioral Wellness monitors several timeliness to care metrics for State audits and system improvement. Ensuring that clients discharged from hospitals are connected to outpatient services is an important component for continuity of care and reducing hospital readmissions. Likewise, responding quickly to Access Line calls designated as urgent can help stabilize clients without hospitalization and connect them to long-term care. Behavioral Wellness implemented orientation groups in FY15/16 to provide information about services, support and connection to care while waiting for the first appointment. Below are three timeliness metrics that Behavioral Wellness monitors:

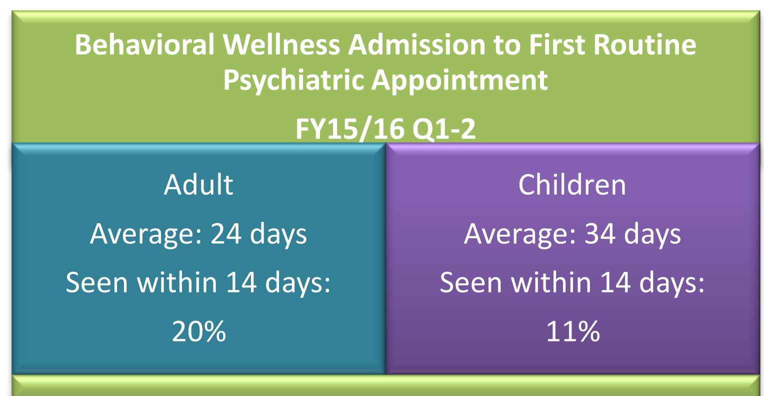
The percent of clients presenting with Urgent needs on the Behavioral Wellness 24-hour Access Line that are seen face-to-face within 24 hours is monitored. The goal is that 100% of Urgent calls are seen within 24 hours, but some clients are referred directly to emergency/hospital care, or are not present when crisis staff arrive. Calls for services to the Access Line are logged in ShareCare with a designation of “Urgent”. The date and time of first service provided post-Urgent call is stored in ShareCare and Clinician’s Gateway.



The time from contact with the Behavioral Wellness 24-hour Access line to first Specialty Mental Health Service (SMHS) is measured. Date of contact with the Access Line and first progress note for a SMHS are drawn from ShareCare and Clinician’s Gateway.



The time from admission to Behavioral Wellness and the first psychiatric appointment is measured. In the Children’s System, clients are routinely referred for a psychiatric consultation after several therapeutic sessions. Children presenting with urgent needs are scheduled with a psychiatrist after an assessment. At present, the electronic system is not designed to capture the date when the referrals was made. Adults with urgent medication needs are seen more quickly than routine appointments. Efforts are underway to address this. Admission date and first progress note by a psychiatrist are drawn from ShareCare.



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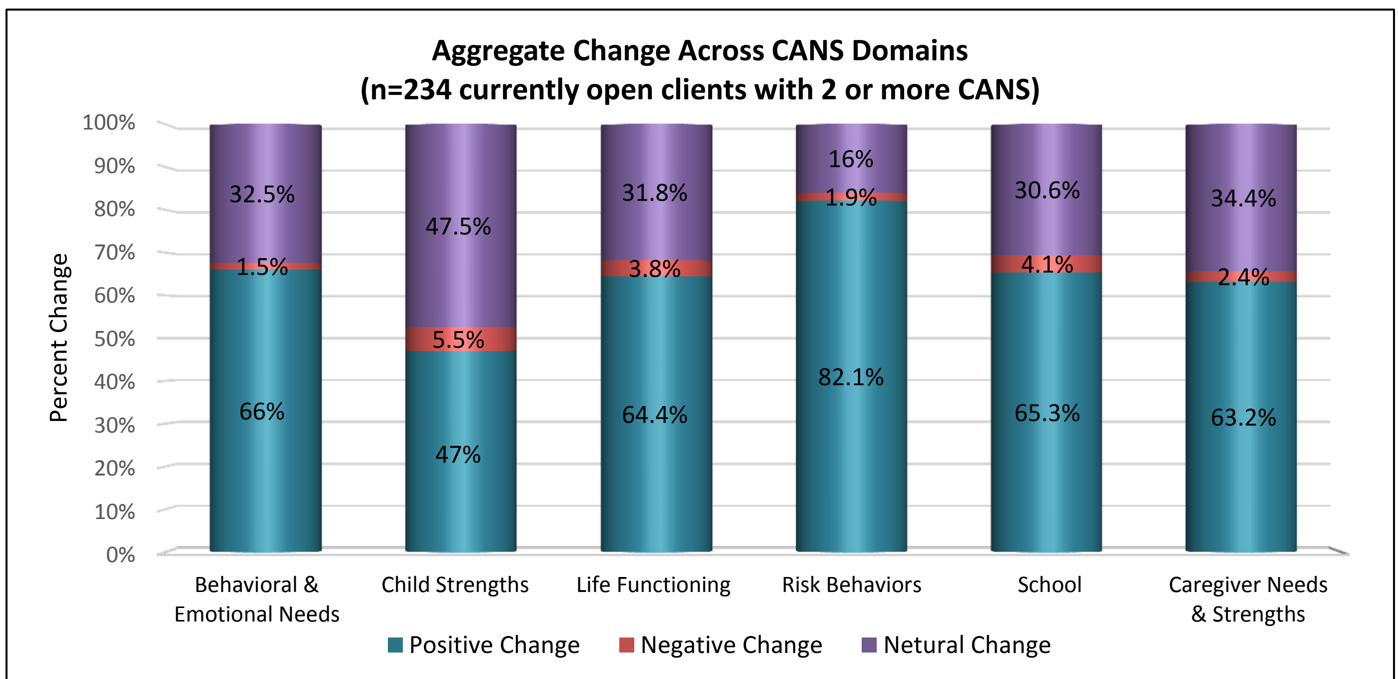
Adult and Children's Outcomes

Child and Adolescent Needs and Strengths (CANS)

The CANS is a multi-purpose communication tool developed for children's services to identify current needs and strengths of the child and family, support treatment planning, facilitate quality improvement initiatives, and monitor client outcomes. The CANS allows for the effective communication with the client/family and other service providers to accurately represent the shared vision for the client's recovery. The tool is organized into 6 primary domains and supplemental sections based on responses to the primary domains. These domains are Life Functioning, Child Strengths, School, Behavioral/Emotional Needs, Risk Behaviors, and Caregiver Needs & Strengths. Each child receives a CANS at intake and every 6 months until discharge from the system.

By the end of Quarter 3 of FY15/16, Behavioral Wellness had 234 currently open clients with two or more CANS. Scores on the initial and last 6-month CANS were compared to determine the percentage of clients that improved on the 6 primary CANS domains. Positive change, or improvement, indicates that clients have increased their strengths and decreased the level of need in the various domains. Conversely, negative change indicates that clients are not improving or increasing strengths and decreasing needs as a result of treatment. As displayed in the chart below, children and caregivers demonstrated statistically significant improvement in all domains.

- The most improvement was seen in Child Risk Behaviors ($F(1,466) = 5.4$, $p = .02$), indicating that children are stabilizing and displaying fewer behaviors such as self-injury/suicide, bullying and delinquent behavior.
- The majority of clients improved in Behavioral/Emotional Needs ($F(1,466) = 21.2$, $p = .00$), suggesting that they are displaying fewer symptoms related to depression, anxiety, psychosis and other conditions.
- School behavior, attendance and grades improved for 65% of children ($F(1,466) = 10.0$, $p = .00$).
- During treatment, children showed improvement in Life Functioning ($F(1,466) = 22.2$, $p = .00$) areas such as ability to communicate/interact with their families, activities of daily living, and health status.
- Child Strengths did not improve as much as the other domains ($F(1,466) = 5.4$, $p = .02$), but 47% were able to develop strengths such as optimism, relationship permanence, talents/interests, and involvement in treatment.
- Finally, a key aspect to children's success is developing the strengths of caregivers and minimizing their needs so that they are more equipped to assist and care for their children. Although not statistically significant ($F(1,466) = 0.35$, $p = .55$), the caregivers of the 234 children improved in the Caregiver Needs & Strengths, indicating that items such as child supervision skills, family stress levels, residential stability, physical/mental health and other areas improved.



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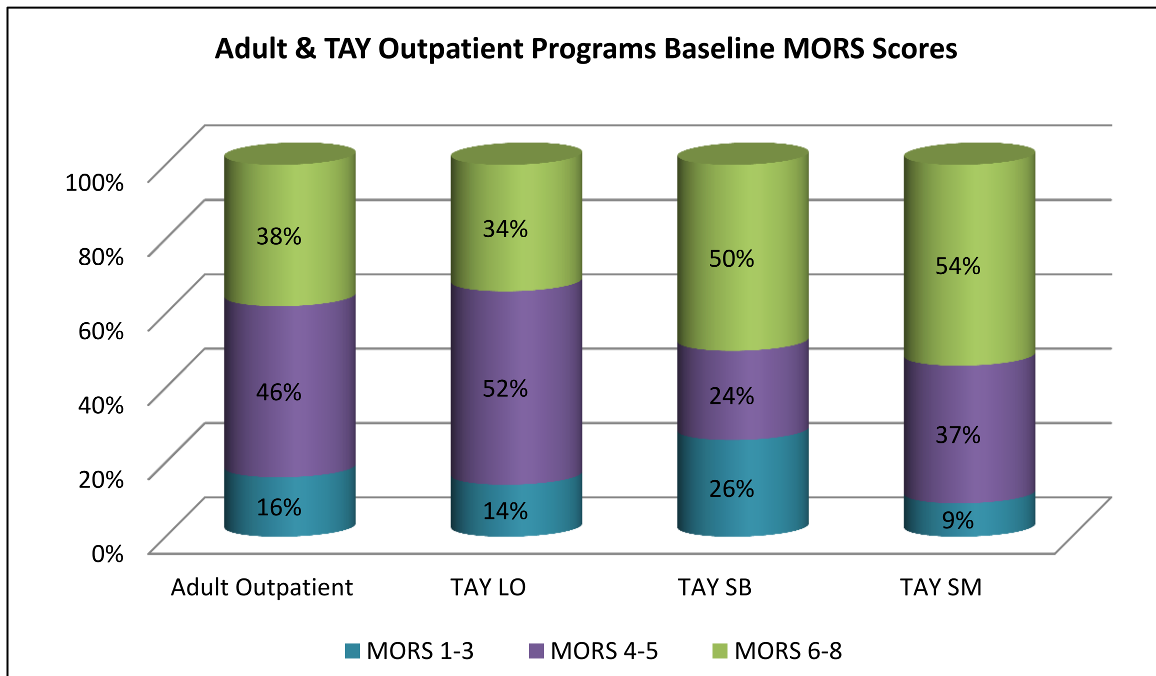
Adult and Children's Outcomes *(continued)*

Milestones of Recovery Scale (MORS)

The MORS is an 8-item tool for identifying stage of recovery and used to evaluate effectiveness in helping adult achieve recovery, and assign clients to appropriate levels of care based on a person-centered assessment of where they are in the recovery process rather than an illness-centered assessment. Scores of 1-3 indicate extreme risk to high risk/engaged; 4-5 indicate poor coping and somewhat engaged; 6-8 indicate coping, early and advanced recovery. Positive change on the MORS indicates that clients have improved their level of engagement, coping skills and stage of recovery. Negative change indicates that clients have not improved as a result of treatment and are less engaged, perhaps at increased risk. Adult System of Care clients receive a MORS score at intake and every 6 months until discharge from the system. Supported Housing and ACT clients receive a MORS every month due to the higher level of care.

The Full Service Partnership (FSP) programs, ACT, implemented MORS in July 2015, but Supported Housing and the outpatient clinics did not begin using MORS until December2015/January 2016. Additionally, the Transitional Age Youth (TAY) programs began using MORS instead of the CANS in spring 2016. Therefore, Supported Housing and ACT clients have multiple MORS from which to analyze change over time. The outpatient clinics have baseline data available. MORS data are entered into Clinician's Gateway.

As the outpatient baseline chart below demonstrates, clients in the adult outpatient clinics with baseline MORS are primarily in two categories of recovery, with 46% being coping with life poorly regardless of level of engagement with services. Thirty-eight percent (38%) of clients are rehabilitating or in early and advanced stages of recovery from mental illness. There are regional differences between the TAY programs. Lompoc TAY has more clients in the poorly copying range of recovery, while Santa Barbara and Santa Maria have more clients in rehabilitating or in early and advanced stages. It also appears that Santa Barbara TAY has the most clients that are at extreme or high risk.



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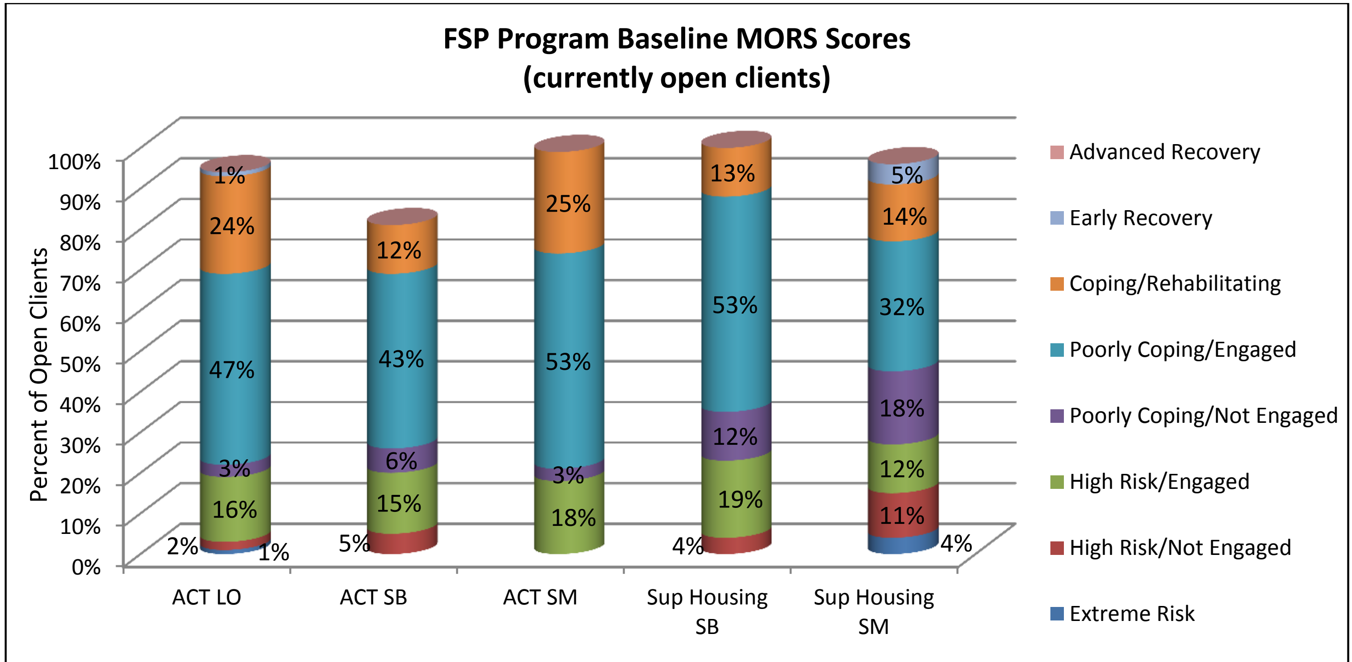
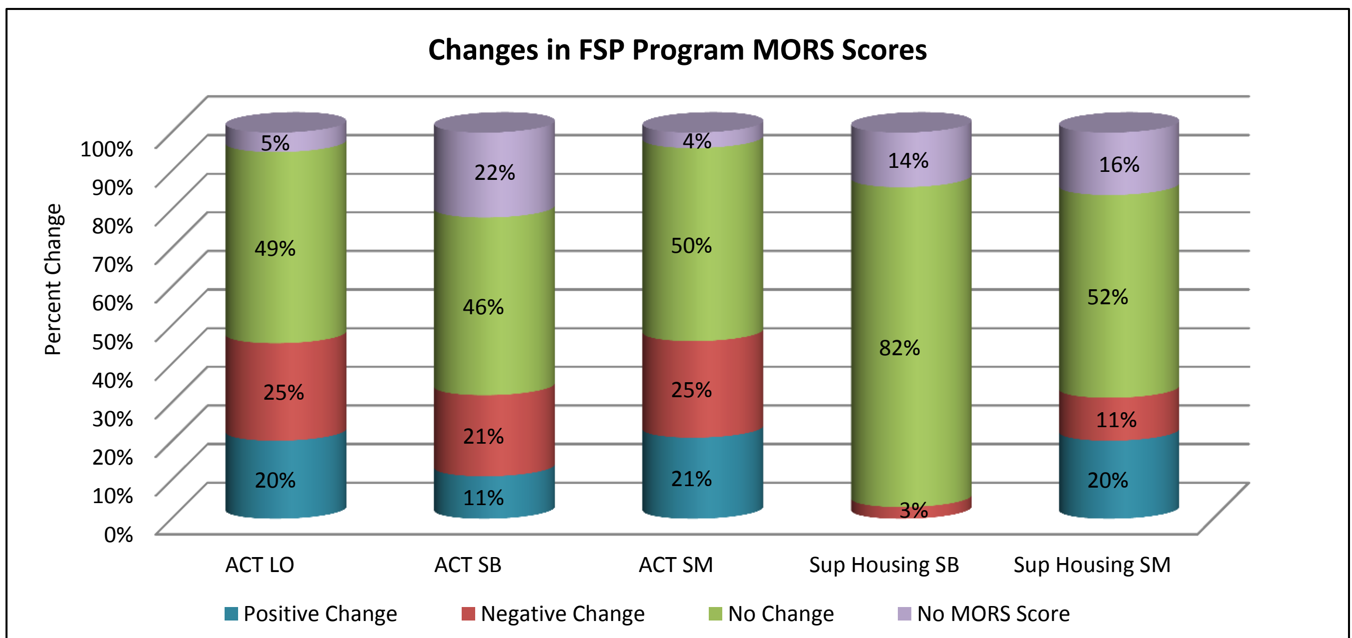
Adult and Children's Outcomes *(continued)*

Milestones of Recovery Scale (MORS)

The FSP programs serve the most challenged clients in the outpatient system, making improvement slower or more up and down. Below are charts displaying baseline MORS scores for FSP clients, as well as changes in MORS scores over time. The data indicate that all but one program had some clients that showed improvement, moving from a lower level to a higher level of recovery, possibly progressing toward graduation to outpatient clinic services. There was no change between initial and last MORS score for many clients. At time of analysis, new clients to the programs may have no or only one MORS score, which is represented as "No MORS Score". Santa Barbara Supported Housing did not fully implement MORS until spring 2016. Therefore, indicators of improvement or declines in MORS scores are based on fewer months of treatment or intervention.





Attachment A

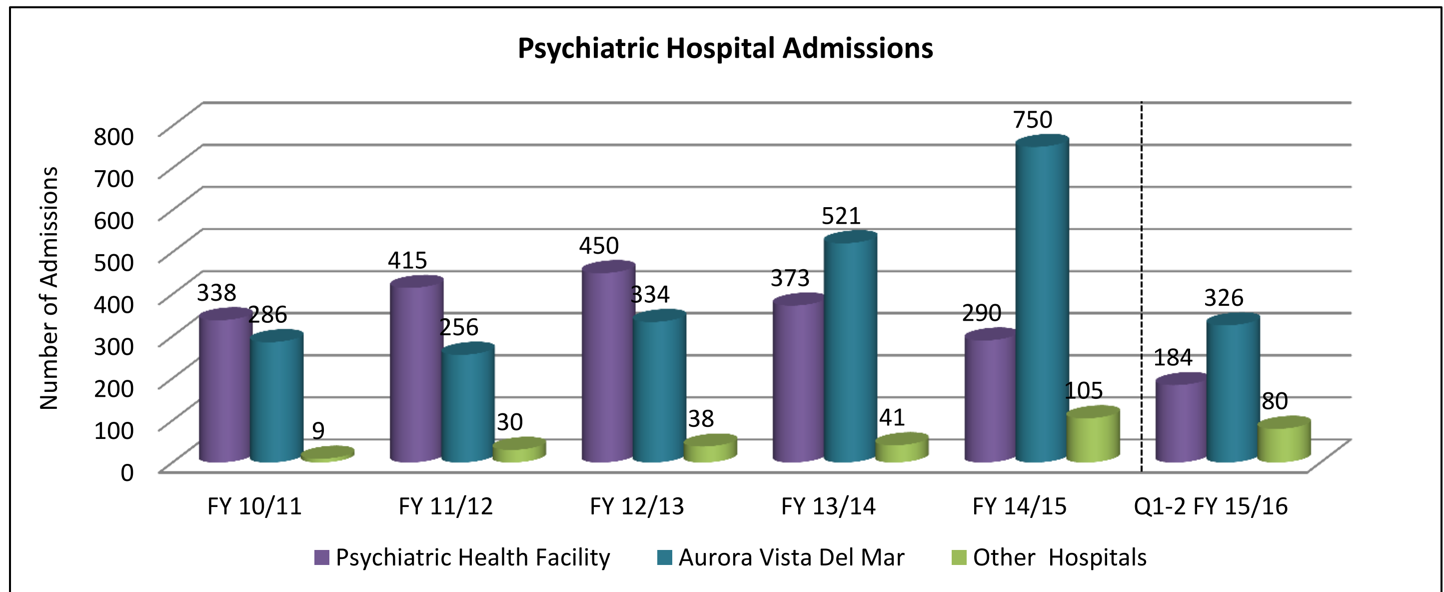
Inpatient Utilization

Behavioral Wellness monitors inpatient utilization closely to address client care issues, spikes in utilization of facilities and financial impacts. Below are some of the key metrics that the department tracks:

- The number of psychiatric hospital admissions for Medi-Cal beneficiaries known to Behavioral Wellness by age group, ethnicity and region of the county. ADMHS monitors the psychiatric hospital admissions for clients open to the department and Medi-Cal beneficiaries that become hospitalized prior to admission to Behavioral Wellness. Hospital Admission data are available for the Psychiatric Health Facility and all other out-of-counties hospitals that report admissions to the department.

Demographics of Clients with Hospitalizations
(*duplicated count; client may have more than one admission in a quarter or across quarters*)

FY15/16	Q1	Q2
Age Group		
Child (0-15 years)	11	7
Transitional Age Youth (16-25 years)	54	52
Adult (26-64 years)	200	171
Older Adult (65+ years)	8	5
Client Residence Region		
South	108	100
West	48	31
North	77	64
Out-of-County	40	40
Ethnicity		
White	135	125
Hispanic	88	75
African American	11	8
Multiracial	11	13
Native American	2	0
Asian	7	7
Other	19	8



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Inpatient Utilization *(continued)*

Behavioral Wellness tracks the percent of clients receiving a Specialty Mental Health Service within 10 days of psychiatric hospital discharge. The time between hospital discharge date and first progress note are measured by the notes entered into ShareCare and Clinician's Gateway. The 10-day metric is pending a Department of Health Care Services decision as to whether counties should measure this variable within 7 or 10 days of discharge.

Timeliness to Care Post-Hospital (FY 15/16 Q1-2)

- 50% of clients discharged from psychiatric hospitals received a Specialty Mental Health Service within 10 days; 13% were seen after 10 days of discharge.
- The average wait time for clients seen within 10 days of hospital discharge was 3 days for Specialty Mental Health care.
- 37% of clients discharged from psychiatric hospitals did not receive a Specialty Mental Health Service after discharge. This is due to multiple factors including clients living outside of Santa Barbara County; clients transferred to a higher level of care post-acute hospital stay; and client no-shows for appointments.

Staff Accountability

A critical element to managing the client electronic health record and maintaining organizational financial stability is documentation of all services provided. The three metrics below are used to monitoring these issues.

- The total number and average number of face-to-face services provided by case-carrying clinical staff. Data will be reported for clinicians and psychiatrists, as well as Mobile Crisis and Triage Teams. Data are drawn from notes entered in Clinician's Gateway. Clinician's designate face-to-face on notes, when applicable.
- The average number of progress notes completed on a daily basis by clinicians and psychiatrists. Data are drawn from progress notes entered in Clinician's Gateway.
- The average length of time between service provision and progress note completion by clinicians and psychiatrists. Data are drawn from notes entered in Clinician's Gateway. Progress notes are date and time stamped for date or service and Clinician's Gateway tracks the date the progress note was written.

Documentation and Timeliness of Progress Notes by Behavioral Wellness Physicians and Non-Physician Clinicians

	FY15/16 Q1		FY15/16 Q2	
	Physician	Non-Physician	Physician	Non-Physician
Total number of progress notes written per month	1,553	10,072	1,391	9,057
Average time between service provision and finalized progress note	2.7 days	14.3 days	4.0 days	14.9 days

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Staff Accountability *(continued)*

FY15/16 Number of and Average Progress Notes Written by Physicians and Non-Physician Clinicians

	Q1						Q2					
All Behavioral Wellness Programs	**Total Notes**	**# of Staff***	**Average Notes per Staff per Qtr.**	**Median**	**Range**	**Average Minutes per Note**	**Total Notes**	**# of Staff***	**Average Notes per Staff per Qtr.**	**Median**	**Range**	**Average Minutes per Note**
Total Clients Served**	**5,030**						**4,837**					
Physicians	4,659	28	166.4	129	10-605	43.6	4,175	23	181.5	135	4-560	41.9
Non-Physician Clinicians	30,217	204	148.1	104	1-865	41.4	27,172	208	130.6	85	1-738	40.2
Subset of Behavioral Wellness Programs												
Triage Teams	2,601	63	41.3	5	1-235	41.7	2,303	50	46.1	6	1-244	40.0
Mobile Crisis	1,534	82	18.7	6	1-117	95.5	1,247	70	17.8	5	1-104	97.5
Contract Provider												
All Non-Physician Clinicians	33,058	271	122.0	103	1-684	104.9	31,743	264	120.2	102	1-651	96.9

**Represents the total number of staff that wrote progress notes during the quarter. The number of staff that wrote notes may be more or less than the total number of FTEs due to staff turnover.*
*** Each quarter is an unduplicated count of clients served in the system. The quarters cannot be summed to determine an unduplicated count of clients served by Behavioral Wellness for the Fiscal Year because clients may be served in more than one quarter of the year.*
Note: PHF notes, client no-show and cancellations notes were excluded from the analysis. Pending and finalized notes were included.

The Board of Supervisors requested a report of the average number of scheduled face-to-face appointments per day and team meeting attendance by staff. At present, the department does not have an electronic system that captures these data elements. Behavioral Wellness is developing a new scheduling system within Clinician's Gateway.

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Appendix
Santa Barbara County Department of Behavioral Wellness
Semi-Annual Report for the Board of Supervisor
(revised to reflect new department name)

Monitoring metrics and conducting outcome evaluation are critical components to determining the effectiveness of services, ensuring quality care for clients, and assisting the organization with policy decisions and resource allocation. Behavioral Wellness has an extensive 3-year evaluation plan detailing the systemic, programmatic and individual level outcomes that will demonstrate client improvement and system progress toward system transformation. The Behavioral Wellness Director will present updates on the evaluation plan annually. Additionally, Behavioral Wellness has prepared a dashboard of key performance measures in the areas of client care and staff accountability for the Board of Supervisors.

Client Care

Clients Served by the System

- The number of unique clients, both Mental Health and Alcohol & Drug Programs, served by age group, ethnicity and region of the county.
    - Data are drawn from admission and service information entered into ShareCare.

Crisis Service Utilization

- The number of clients served by the Crisis Stabilization Unit in South County and the Crisis Residential Units in North and South County.
    - Data are drawn from admissions entered into ShareCare by support and clinical staff.
- The percent of clients stabilized at the Crisis Stabilization Unit (CSU) without needing a higher level of care within 30 days.
    - Data are drawn from the CSU discharged date and a subsequent hospital admission date entered into ShareCare.
- The number of crisis services provided in the community and in the hospital emergency rooms by Behavioral Wellness Mobile Crisis and Triage Teams by region.
    - Service data are entered by clinicians into Clinician's Gateway as progress notes. Clinicians designate the service location in the progress note.

Timeliness to Care

- The time from admission to Behavioral Wellness to the first psychiatric appointment.
    - Admission date and first progress note by a psychiatrist are drawn from ShareCare. Behavioral Wellness measures the mean, median and mode wait time.
- The time from contact with the 24-hour Access line to first Specialty Mental Health Service (SMHS).
    - Date of contact with the Access Line and first progress note for a SMHS are drawn from ShareCare and Clinician's Gateway. Behavioral Wellness measures the mean, median and mode wait time.
- The percent of clients presenting with Urgent needs on the Behavioral Wellness 24-hour Access Line that are seen face-to-face within 24 hours.
    - Calls for services to the Behavioral Wellness 24-hour Access Line are logged in ShareCare with a designation of "Urgent". The date and time of first service provided post-Urgent call is stored electronically for reporting.

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Client Outcomes

- The percent of adult clients demonstrating improved recovery, as measured by the Milestones of Recovery Scale (MORS).
  - MORS data are entered into Clinician's Gateway by clinicians for adult clients.
  - The MORS is an 8-item recovery-based tool for identifying stage of recovery used to evaluate effectiveness in helping clients to recover, and assign clients to appropriate levels of care based on a person-centered assessment of where they are in the recovery process rather than an illness-centered assessment. Clients in the Adult System of Care will receive a MORS score at intake and every 6 months until discharge from the system. Clients in ACT and Supported Housing programs will receive a MORS every month due to the higher level of care need for monitoring progress.
- The percent of youth clients demonstrating positive change on the Child and Adolescent Needs & Strengths (CANS).
  - CANS data are entered into Clinician's Gateway by clinicians for child clients. See attached description.
  - The Child and Adolescent Needs and Strengths (CANS) is a multi-purpose communication tool developed for children's services to identify current needs and strengths of the child and family, support treatment planning, facilitate quality improvement initiatives, and monitor client outcomes. The CANS allows for the effective communication with the client/family and other service providers to accurately represent the shared vision for the client's recovery. Each child will receive a CANS at intake and every 6 months until discharge from the system.

Inpatient Utilization

- The number of psychiatric hospital admissions for Medi-Cal beneficiaries known to Behavioral Wellness by age group, ethnicity and region of the county.
  - Behavioral Wellness monitors the psychiatric hospital admissions for clients open to Behavioral Wellness and Medi-Cal beneficiaries that become hospitalized prior to admission to Behavioral Wellness. Hospital Admission data available for the Psychiatric Health Facility and all other out-of-counties hospitals that report admissions to Behavioral Wellness.
- The percent of clients receiving a Specialty Mental Health Service within 10 days of psychiatric hospital discharge.
  - The 10-day metric is pending a decision by the Department of Health Care Services as to whether counties should measure this variable as within 7 days or 10 days of discharge from the hospital.
  - The time between hospital discharge date and first progress note are measured by the information entered into ShareCare and Clinician's Gateway.

Staff Accountability

Client Service Provision

- The total number and average number of face-to-face services provided by case-carrying clinical staff. Data will be reported for clinicians and psychiatrists, as well as Mobile Crisis and Triage Teams.
  - Data are drawn from progress notes entered in Clinician's Gateway. Clinician's designate on each progress note if the service was conducted face-to-face.
- The average number of progress notes completed on a daily basis by clinicians and psychiatrists.
  - Data are drawn from progress notes entered in Clinician's Gateway.

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- The average length of time between service provision and progress note completion by clinicians and psychiatrists.
    - Data are drawn from progress notes entered in Clinician's Gateway. Progress notes are date and time stamped for date or service and Clinician's Gateway tracks the date the progress note was written.

A request was made to report on the average number of scheduled face-to-face appointments per day and team meeting attendance by staff. At present, Behavioral Wellness does not have an electronic system that captures these data elements. Behavioral Wellness is currently developing an electronic method in Clinician's Gateway.