County of Santa Barbara Comprehensive Analysis and Assessment of Alcohol, Drug and Mental Health Services

Project 2 and 3 Final Report

County of Santa Barbara
May 2013
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Recommendation F-1: Maintain the current Medi-Cal cost reporting and reconciliation process.

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Executive Summary

TriWest Group (TriWest) was engaged by the County of Santa Barbara (SBC) as part of an effort to obtain a comprehensive assessment of the overall performance of SBC’s Alcohol, Drug and Mental Health Services Department (ADMHS) System of Care. Three projects were commissioned, one focused on the inpatient system (Project 1), a second focused on county-run and contract clinical programs (Project 2), and a third focused on business and compliance practices (Project 3). TriWest was awarded Projects 2 and 3.

Methods and Approach
Given the complexity of the assessment, the TriWest team employed an iterative approach through which data was gathered, hypotheses regarding findings (and, eventually, recommendations) developed, and additional data gathered to test and revise findings (and recommendations). Over 400 contacts via phone and in-person interviews, group meetings, forums, and emails were carried out with: County and ADMHS leadership; the CEO Advisory Committee for Behavioral Health; ADMHS managers and key staff from administration, fiscal and clinical areas; Department of Public Health (DPH) leadership and medical staff; Community Based Organizations (CBOs) contracting with ADMHS; leaders and staff from other county and municipal departments not represented on the Advisory Committee (including the Probation Department, Adult Services Division and Juvenile Services Division; the Sheriff’s Department/Main Jail; Department of Social Services; Housing Authority of the City of Santa Barbara); the Santa Barbara County Mental Health Commission; NAMI sponsored a forum for consumers, families, and advocates; consumer and family leaders; specialty MHSA Services providers; residential and crisis services providers (both ADMHS and CBO); homeless services providers; the Consumer and Family Advisory Committee; and the Santa Ynez Tribal Health Clinic of the Santa Ynez Band of Chumash Indians. In addition, to address concerns identified by the Latino Advisory Committee, meetings were added with representatives of the Latino Advisory Committee, Latino leaders in North County, community agencies serving the Latino community, and Latino consumers and family members convened by El Nuevo Amanecer.

Conceptual Framework for the Report
There are several key concepts that frame the TriWest team’s approach to this report. Taken together, these concepts form an essential conceptual framework critical to understanding the evidence base underlying our findings and recommendations. These include:

• **Quality and Performance Improvement.** One key concept framing our approach is the increasing emphasis on quality improvement associated widely with the landmark publication of the national Institutes of Medicine “Crossing the Quality Chasm” report. The premise of the report is that the health care industry must move from a traditional command and control model to a continuous quality improvement model. The report
argues convincingly that these quality gaps cost the U.S. upwards of $750 billion in 2009 in poor, inefficient, wasteful, and ineffective care. The need for systematic change is clear and stark. In many ways gaps are more severe for mental health (MH) and substance use disorders (SUD).

- **Best Practices for Fiscal, Compliance and Clinical Operations.** In addition to quality and performance improvement, we also emphasize best practices for fiscal, regulatory compliance, and clinical operations.

**Systemic Findings and Recommendations**

**Overall Finding: Significantly Suboptimal Performance at ADMHS.** In spite of many excellent programs, clinicians and physicians, and in spite of significant successes improving core functions in the fiscal and compliance areas, the ADMHS adult and child systems of care are not producing the clinical outcomes for the citizens of Santa Barbara County (SBC) that would demonstrate the most effective utilization of available resources. The overall recommendation is that SBC needs to move as quickly as possible to initiate a comprehensive performance improvement-driven transformation process at ADMHS that can quickly begin to address all of these issues at every level of the system simultaneously to produce better outcomes and reduce inefficient resource expenditures, all within a context of a continued high level of fiscal oversight and improved regulatory/financial compliance monitoring.

**Finding S-1: A Dysfunctional ADMHS Organizational Climate.** The primary challenge that ADMHS must overcome is a robust internal and external perception of being a top-down, crisis-driven organization that has de-emphasized service-driven, customer-oriented values and performance, along with effective clinical operational management, to focus primarily (though not inappropriately) on financial and procedural controls. ADMHS has faced long-standing pressure and external skepticism of its effectiveness, and there has been particular pressure related to the events of Fiscal Year 2008. On the positive side, SBC and ADMHS developed much more robust financial and contractual oversight processes to ensure the soundness of future Medi-Cal cost reporting and external contract oversight. But on the negative side, these events appear to have exacerbated a broader, longer-standing culture of reactivity and negativity that is interfering with implementation of successful customer-oriented approaches to service system design.

**Recommendation S-1: County and ADMHS leadership must visibly commit to the creation of a performance and quality improvement-driven culture for ADMHS.** Among the key changes necessary to create a quality-driven culture, the first step would be a visible leadership commitment to such a culture change. Note that the TriWest team is not recommending a shift
back to pre-2008 organizational functioning; progress in financial and contract oversight is a key competency to build upon.

Finding S-2: ADMHS lacks effective empowered partnerships to help it articulate a core vision and improve system level performance and outcomes through mission-driven continuous improvement. A direct effect of the system-wide experience of an ADMHS leadership culture as crisis-driven, reactive, and overly focused on command/control processes has been a lack of the empowered partnerships at multiple levels that would be needed to engage in organized performance improvement activities to improve outcomes.

Recommendation S-2: Create a transitional structure to develop a quality improvement partnership framework to address current and future system development challenges through an intensive, time-limited process (e.g., six months) at two levels:

- Countywide Level: Evolve the CEO Advisory Committee on Behavioral Health to become a System Change Steering Committee to ensure shared ownership of the partnership process and to monitor progress of the overall levels.
- ADMHS Level: Evolve the Tiger Team into a formal transitional internal management partnership under the direction of the CEO and advised by the Steering Committee until a permanent ADMHS executive leader is in place.

Finding S-3: There is a profound lack of effectively organized clinical leadership within ADMHS, and a consequent lack of clinical support to financial and compliance functions. At the System Level, there is a lack of a clearly articulated process to advance near-term strategic goals related to improvement of overall access and engagement of individuals and families with challenging and complex needs. Within ADMHS, there is a lack of operational clinical leadership, a dramatic lack of clinical operational / policy frameworks, numerous examples where current system approaches lead to inefficient resource utilization, and an underperforming compliance function in clinical areas.

Recommendation S-3: Articulate an operational vision for ADMHS 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.

Detailed Findings and Recommendations: Clinical Operations

Finding CO-1: There are many clinical strengths and evidence-based practices currently in use by ADMHS clinical operations and contract service providers. Our review of clinical operations at ADMHS and the CBOs identified strong staff and efforts to promote evidence-based practice
in every setting. While we also identified practice improvement opportunities in each setting, the primary limiting factors we identified were the systemic factors described in the previous section.

**Recommendation CO-1.1: Build on existing clinical strengths by involving ADMHS staff and CBO leaders and staff as partners in transitional and ongoing quality improvement efforts.** As noted at the outset of this section, ADMHS and CBO strengths are a base to build upon, and we expect that the systemic shift toward improved collaboration and quality improvement will yield many near-term (e.g., three to six months) improvements.

**Recommendation CO-1.2: Carry out a wage and benefit study comparing the costs of ADMHS clinical staff to those in comparable California counties and other comparable health providers in Santa Barbara County.** The pressure to control health care costs will only grow given implementation of the Affordable Care Act, and ADMHS needs to be able to assure potential purchasers of its services that the quality and value of its staff is comparable to those of other counties and health care providers. The goal of this study would be to document the relative differences and inform efforts to improve and demonstrate the value of ADMHS services.

**Finding CO-2.1: Transitions between treatment programs are a major area of challenge both within ADMHS and between ADMHS and other contract and hospital providers.** At the system level, the SBC outpatient continuum of care (both ADMHS and CBO services) is not designed to meet the needs of people served and is striking in its level of disconnectedness between system components. This approach is costing the county too much in high-end service use, with just 222 high-cost Medi-Cal beneficiaries in FY 2012 driving over $10 million in claims; this is 35.2% of all Medi-Cal claims (well above the statewide rate of 25%).

**Finding CO-2.3: Despite impressive improvements in the number of bilingual Spanish-speaking staff hired and the number of Latino / Hispanic people served each year, significant disparities related to race, ethnicity and culture persist.** Despite progress, multiple disparities were found. While over 50% of people served (and even more people in need) are Latino/Hispanic, only 37.2% of clinical staff speak Spanish. In addition, outreach to broader diverse populations is much less developed. Of greatest concern is the fact that the 2010 Cultural Competence Plan has not been formally adopted and implemented as an ADMHS policy/procedure and is not organizationally visible. Opportunities for improvement include:

- Promotion more broadly through multiple methods of welcoming, responsive services by “a person who speaks my language and understands my culture;”
- Expansion of support groups such as El Nuevo Amanecer, specifically targeting expansion across North County, Lompoc and South County;
• “Providing care where people are” – community settings, family resource centers, cultural centers, churches and faith-based settings, and primary care clinics; and
• Partnering with other agencies to support staff recruitment.

Finding CO-2.4: Detailed clinical policies are lacking to guide routine clinical service delivery, including uniform standards for initial and continued access to care by level of care, standards to guide transitions between levels of care, and functioning of interdisciplinary teams. At a more detailed level, there are multiple clinical policy gaps; in fact, a consistently used set of clinical policies and procedures was simply not available to the review team. Nearly every clinical policy requested was either not provided, provided in draft form (often quite good) by a discrete program or individual manager, limited in scope, old, or not currently used.

Finding CO-2.5: Access to specialized supports for people with complex needs is lacking. There are critical gaps in capacity for recovery/resiliency supports, co-occurring MH/SUD treatment, people with complex health needs, people involved in the criminal justice system, people served by the PHF, people in need of employment supports, homelessness, and children with multi-agency needs (including DSS and juvenile justice).

Finding CO-2.6: Collaboration is better for the Alcohol and Drug Program (ADP), but access is lacking in key areas. In terms of interagency collaboration, reportedly things work better on the ADP side than they do for ADMHS, likely due at least in part to ADP being a much smaller program and the much simpler fee-for-service reimbursement model used by ADP for Medi-Cal. Despite this, there is limited investment in substance abuse treatment, and primary substance use treatment gaps abound: limited physician availability, limited detoxification resources, very limited to non-existent access to newer medication management approaches to controlling addictions, and very limited access to residential treatment compared to other counties.

Finding CO-2.7: Access to psychiatry services is lacking. There is inadequate management of psychiatric capacity and performance. Given the number of psychiatrists available, access to appointments for current and new referrals is very low, compared to other counties. The current EQRO report indicates that the time to the first psychiatrist appointment is 66 days for adults and 73 days for children.

Recommendations in Response to CO-2 Findings:
• Recommendation CO-2.1: Develop specific work groups as part of the broader quality improvement-driven System Change initiative to guide implementation of short-term changes (one to three months) and longer-term plans (six to 12 months and beyond) to systematically address the Clinical Operations findings (CO-2.1 to CO-2.7).
• **Recommendation CO-2.2: Develop improved metrics and routine management reports based on them focused on improving clinical practice and outcomes.**

**Detailed Findings and Recommendations: Financial**

**Finding F-1: The Medi-Cal cost reporting process is sound.** Analysis of the Medi-Cal cost reporting process has confirmed its soundness. The overall processes and data used to prepare the Medi-Cal Specialty Mental Health Cost Report should result in accurate cost finding consistent with federal and state requirements.

**Recommendation F-1: Maintain the current Medi-Cal cost reporting and reconciliation process.**

**Finding F-2.1:** ADMHS has increased overall spending since FY 2009 by 5.9% due to a $8 million increase in MHSA programs at the same time that county-operated MH clinical programs expenditures were cut 2.4%, contract MH outpatient expenditures were cut 4.9%, non-MHSA MH administration expenditures were cut 10.3%, and ADP administration expenditures were cut 20.4%.

**Finding F-2.2:** MH revenue from FY 2012 to FY 2013 is projected by ADMHS to be up 13.2% overall due to growth in all revenue streams, but Geiss Consulting analysis projects MH revenue for FY 2013 to be up 19% ($3.23 million more as a result of more Realignment and MHSA funding than originally projected and slightly less growth in Medi-Cal revenue) and MH revenue for FY 2014 to be flat (down 1.5% from FY 2013); ADP revenue growth is flat.

**Finding F-2.3:** Santa Barbara County is more dependent on Medi-Cal funding for MH than are most California counties. While overall funding available to Santa Barbara County for Medi-Cal and Realignment is fairly consistent with funding available to other comparative counties, Santa Barbara has the among the highest percentages across counties in terms ofr outpatient direct service costs reimbursed with Medi-Cal Federal Financial Participation (38% compared to other counties ranging from 24% to 37%).

**Finding F-2.4:** ADMHS faces additional risk related to revenue currently and looking forward. Key among these include expanded service delivery needs in 2014 following Medicaid expansion and implementation of the ACA.

**Finding F-2.5:** A lack of strong, working relationships at the organizational level between ADMHS and other county agencies restricts the ability of the County to leverage MH and SUD funds across departments.
Finding F-2.6: Most comparison counties selected for this study spend more County Funds per capita to support MH and ADP services than does Santa Barbara County. The demand for services for people without insurance keeps rising, and ADMHS has increased its services to this population. From FY 2008 to FY 2012, service delivery to people without insurance has increased 22.4% (from 2,474 to 3,028) while service delivery to Medi-Cal members has dropped 6.2% (from 5,809 to 5,449). Despite the recent 43.3% increase in County General Funds for uninsured people, funding for indigent care is widely perceived across the stakeholders we interviewed as too limited to support demand. Analysis of per 1,000 population rates adjusted for population size puts Santa Barbara well below two out of three comparison counties.

Finding F-2.7: Most comparison counties maintain reserves for Medi-Cal audit exceptions and variability in MHSA funding. Santa Barbara County depleted its realignment reserve account used to fund outstanding Medi-Cal liabilities due to the 2008 challenges and has not, as of the time of this analysis, restored it. Benchmark/best practice counties report that it is a prudent business practice to establish and maintain a reserve account to address routine Medi-Cal audit exceptions from prior years due to inconsistent application and promulgation of state billing “rules” by state offices, as well as variability in MHSA revenue.

Recommendation F-2: Given continued uncertainties in the current and future expenditure and revenue projections primarily related to the ACA, ADMHS should: 1) continue its robust financial planning functionality, 2) reestablish and maintain its realignment reserve to at least 5% of Medi-Cal FFP, and 3) carry out a clinically-informed planning process to project likely FY 2014 Medi-Cal revenue increases related to the ACA.

Finding F-3.1: Use of the Clinic Model as a productivity enhancement tool has failed to improve rates of direct service provision and led to multiple unintended negative impacts. Despite the assertive use of the productivity reports of the Clinic Model in recent years to increase rates of direct service provision, direct provision has dropped continuously for five years (33% since FY2008). This seems to relate to the decision to try to use an elegant and extremely useful tool for revenue and expense modeling, projection, and monitoring (the Clinic Model) in a secondary role as a productivity enhancement tool. While well suited for its primary use to model and project revenue and expenses, as a productivity tool it puts too much emphasis on direct service provision rather than the full range of clinical performance.

Finding F-3.2: More broadly, management information reporting is seen by clinical managers and staff as unreliable. Overall, management data reporting is not seen as reliable, and multiple respondents report that most staff (and many managers) simply do not believe the
data in currently available reports. At the very least, MIS data is in need of task prioritization, and it is not clear if MIS has the expertise and capacity currently to carry out an expanded role.

**Recommendations F-3.1:** Financial and clinical managers should collaborate to develop and implement (with necessary training supports) by 7/1/2013 a replacement revenue assurance report that is readily understood by clinical managers and staff and that only tracks metrics relevant to ensure adequate Medi-Cal revenue, such as the proportion of Medi-Cal to non-Medi-Cal direct billable units and the number of uninsured people seen who could potentially qualify for Medi-Cal coverage.

- Fiscal, medical and clinical operational management should work together to develop a replacement revenue assurance report. It must be readily understandable, consistently and routinely produced, and accurate.
- Fiscal, medical and clinical operational management should also work together to develop and shape supportive policies, set standards, develop necessary training supports, train staff, and be involved in monitoring and management.
- Additional metrics should be developed in accord with Recommendation CO-2.2 above to address client flow for ACT, Supported Housing, clinics, and psychiatrists in particular.

**Recommendation F-3.2:** The Tiger Team should employ MIS experts from the County to 1) determine if ADMHS MIS expertise and capacity is sufficient and 2) develop a plan to ensure appropriate oversight of MIS within the developing ADMHS organizational structure.

**Finding F-4:** The current ADMHS budgeting and strategic planning does not include meaningful input from clinical managers and MHSA planning efforts.

**Recommendation F-4.1:** Align the System Change initiative to incorporate MHSA planning requirements and result in meaningful input by 10/31/2013 to inform the FY 2014-15 budget process.

**Recommendation F-4.2:** Improve budget planning by development of a “Revenue Cycle Committee” (or similar structure). A Revenue Cycle Committee involving a cross-functional team of finance, compliance and clinical leadership should be incorporated into the budget development process. ADMHS should immediately establish a committee focused solely on the revenue cycle, building on its current Programs Implementation Meeting (PIM) Committee.

**Detailed Findings and Recommendations: Administration**

**Finding A-1:** ADMHS financial and contract oversight operations are comparable in scope to other California counties and functioning well. SBC expenses 11% of its total mental health
program spending on administration, consistent with the resources dedicated to contract monitoring and management, as well as the detailed level of financial and contract monitoring. Given its history, this level of commitment to financial and contract oversight is reasonable.

**Recommendation A-1:** ADMHS should maintain its current robust financial operations and contract oversight capacity and build upon it by moving oversight of contracts to the finance area. There should be no reduction in resources or priority assigned to fiscal and contract oversight for the foreseeable future.

**Finding A-2:** There are substantial gaps in clinical administration. There is an absence of senior clinical positions to support the work of the regional managers and develop program policy and standards for services for adult/older adult, child/family, and culture-specific populations. There is a part-time Medical Director without adequate time for required functions. There has been a long-term vacancy for the Assistant Director for Mental Health. Clinic supervisors have too many direct reports (13 to 25 FTEs each), and their role needs to be better articulated. The Quality Manager reports outside of clinical operations and has too many responsibilities that dilute the focus on quality management.

**Recommendation A-2.1:** To improve management of clinical operations, immediately address critical gaps, including: a) appointing a full-time Medical Director, b) designating Assistant Medical Directors in key outpatient areas, c) repurposing and filling the vacant Assistant Director of Mental Health as an Assistant Director for Clinical Operations over both MH and SUD, and d) reorganizing existing administrative resources to support additional clinical supervisor time sufficient to reduce spans of control to 8 to 12 FTEs (with an average of 10).

**Recommendation A-2.2:** Over the longer term (by 10/1/2013), the Tiger Team should determine the appropriate organizational structure for long-term management of ADMHS.

**Finding A-3:** Denial rates are comparable to other California counties, but the utilization management system is underdeveloped. The ADMHS Utilization Management (UM) system is lacking. Consequently, clinical resources are poorly assigned based on need and both under- and over-utilization are likely, contributing to the high costs per case reported above.

**Recommendation A-3:** Make targeted administrative enhancements to improve UM oversight and payer identification. Collaborative development of an improved utilization management system and payer identification by finance, compliance and medical/clinical leadership should be incorporated into the broader quality improvement planning process, focusing on: analysis of the 222 top utilizers described in the section on Clinical Operations to inform UM planning; routing monitoring of wait lists, wait times, and capacity; and a plan to collaboratively develop and implement standardized UM decision support tools.
Detailed Findings and Recommendations: Compliance

Finding C-1.1: Despite focused improvements (such as in EQRO compliance), there are multiple gaps in clinical compliance processes. The Compliance Officer role has operational responsibilities and is not independent. ADMHS needs to make a concerted effort to reverse the widely held perception that the organization, through its compliance program, does not adequately address concerns, questions, and negative reports. There is no formal, written annual assessment of compliance risk completed by the Compliance Officer with input/approval of senior managers. As a result, the compliance program lacks focus and fails to systematically assess risk. The current medical record review and audit activities of the compliance program and the quality management (QM) programs need to be redesigned and basic claims audits introduced. The Compliance Committee is inefficiently focused.

Finding C-1.2: Training in support of compliance and more broadly is inadequate. The training materials lack clarity and are too focused on avoiding mistakes rather than providing clear guidance to promote compliant practice. Training time must be supported by the productivity tracking system so that staff do not perceive time spent in training as “non-productive,” and adequate training budgets need to be established for both clinical programs and ad hoc needs.

Recommendation C-1: Address short term compliance needs by carrying out a written compliance risk assessment over the next three months and develop a plan by 10/1/2013 to address remaining compliance gaps.

Finding C-2: Despite improvements in financial oversight for CBOs, substantial gaps remain in oversight that impede development of productive working relationships. ADMHS has improved the core mechanics of its contracting and contract oversight process. However, at an organizational level the overall climate between ADMHS and its CBOs is one of mutual distrust, undermining the partnership necessary for optimal performance.

Recommendation C-2: Immediately shift participation in the CBO Scorecard process to a voluntary basis and establish a System Change Work Group focused on improving the ADMHS / CBO working relationship over the short and longer term. Collaborative re-tooling of the ADMHS / CBO relationship needs to be a central focus of the quality improvement planning process described in Recommendation S-1. However, it is imperative that ADMHS continue to monitor and adjust rates; the quarterly reconciliation process should continue. The immediate focus should be on developing a broader, collaborative performance monitoring system.
Background and Methods

Background
TriWest Group (TriWest) was engaged by the County of Santa Barbara (SBC) as part of an effort to obtain a comprehensive assessment of the overall performance of SBC’s Alcohol, Drug and Mental Health Services Department (ADMHS) System of Care. The goal of the assessment was to determine whether the system as a whole was performing optimally in using its limited resources appropriately to best meet the needs of individuals and families in Santa Barbara County with behavioral health conditions. The assessment was intended to cover all aspects of ADMHS system functioning, including overall service system design and system performance, financial processes, inpatient and outpatient clinical program and service delivery operations, service delivery options, internal control and support systems, procedures and practices including revenue cycle management (intake, coding, and billing), and fiscal/cost reporting strategies to ensure optimal service delivery and compliance with all generally accepted government accounting and auditing standards and legal, contractual and regulatory requirements of the state and federal government. In order to obtain a comprehensive assessment, three projects were commissioned, one focused on the inpatient system (Project 1), a second focused on county-run and contract clinical programs (Project 2), and a third focused on business and compliance practices (Project 3). TriWest was awarded Projects 2 and 3, and they are the focus of this report.

To address the comprehensive assessment requirements for Projects 2 and 3, TriWest assembled a team of consulting firms and consultants with both deep expertise across complementary competencies of financial, regulatory compliance and clinical operations, including national leaders in system evaluation (TriWest), managed care practices (Sternbach Consulting), clinical integration and system effectiveness (ZiaPartners), and regulatory and business operations (Mary Thornton and Associates – MTA).

The scope of work described in the original Request for Proposal (RFP) was massive, and in developing our proposal and negotiating the final scope of work for the engagement, the TriWest team carefully considered how best to approach the two projects in a way that would allow us to identify critical issues and to make actionable recommendations based on a robust probe into the areas of operations targeted in each project, and using our experience to focus on more likely areas of strengths, risk or weakness, using proxies to substitute for more expensive types of review and analysis, and drilling down into operations only when we believed it would result in additional pertinent information. In particular, for Project 3 we did not carry out an extremely time consuming gap analysis to determine compliance with all state and federal regulations, but instead evaluated the effectiveness of the ADMHS compliance program and the robustness of ADMHS quality assurance activities to determine if sufficient
and appropriate resources had been dedicated to on-going assessment of regulatory compliance with adequate attention and support from senior and middle management to assure that findings would be addressed in a timely manner.

During contract negotiations, it became clear that additional expertise was required regarding cost reporting and compliance with California-specific mandates (including Short-Doyle Act reporting requirements), so the TriWest work plan was developed based on a partnership between the TriWest team and Geiss Consulting, the recognized top expert regarding California Medi-Cal and public sector behavioral health financing. In order to fit the scope of the TriWest study within available funds, it was also agreed to eliminate the detailed review of information system and technology capacity originally proposed and to eliminate all resources that had been proposed for data analysis, instead relying on ADMHS, county-level capacity, and external reports (for example, the annual EQRO reports required for all California counties) for all quantitative trend analysis.

The report is organized by major conceptual areas of findings and recommendations, as follows:

- First, at the overall system level, the report describes our overarching findings related to the performance of the ADMHS system as a whole and makes recommendations for how to develop a successful process to improve this overall performance within available resources, beginning with building a transformative change process within ADMHS embedded in a system-wide culture of quality and performance improvement.
- In the next four sections, the report describes specific findings and recommendations in the areas of clinical operations, finance, administration, and compliance.

The table below provides a cross walk of the areas of specific findings to the statement of work requirements from the original Request for Proposals (RFP) defining the areas of recommendation sought by SBC. Areas of limitation negotiated in the final development of the statement of work for the project are noted.
<table>
<thead>
<tr>
<th>Recommendations Required by RFP</th>
<th>TriWest Recommendations</th>
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<td><strong>Project 2:</strong> Perform a comprehensive analysis and assessment of the ADMHS Outpatient systems service delivery for adult and children systems of care and clinic operations and contract provider services</td>
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<tr>
<td>1. Current outpatient system <strong>internal clinic</strong> operations.</td>
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<td><strong>A. Financial Operations</strong></td>
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<tr>
<td>1) Analysis of funding sources and structure for programs to ensure sources are utilized in most beneficial manner.</td>
<td>Recommendation S-2</td>
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<tr>
<td></td>
<td>Recommendations F-2, F-3.1, F-4.2</td>
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<tr>
<td>2) Review of comparable county funding sources and program structures.</td>
<td>Recommendation F-2</td>
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<td></td>
<td>Recommendation A-1</td>
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<tr>
<td>3) Analysis of patient/payer mix and sustainability of current service model.</td>
<td>Recommendation F-2</td>
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<td></td>
<td>Recommendation A-3</td>
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<tr>
<td>4) Evaluate completeness of billing cycle/charges (including federal and state, patient, insurance, as applicable).</td>
<td>Recommendation F-4.2</td>
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<td>5) Evaluate processes and procedures for claiming Medi-Cal reimbursement.</td>
<td>Recommendation F-1</td>
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<td>6) Analysis of denial rates and reasons for denials.</td>
<td>Recommendation A-3</td>
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<td>7) Analysis of revenue management practices and financial management activities across funding streams utilized including reimbursements, grants, private pay and outside insurance companies.</td>
<td>Recommendations F-3.1, F-4.2</td>
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<td></td>
<td>Recommendation A-3</td>
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<tr>
<td>8) Analysis of compliance with all legal contractual and regulatory requirements of federal and state governments.</td>
<td>Recommendation F-1</td>
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<td>Recommendation C-1</td>
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<tr>
<td><strong>B. Programmatic Operations</strong></td>
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<td>1) Identify opportunities for optimum service delivery for outpatient internal clinic systems.</td>
<td>Recommendations S-1, S-2, S-3</td>
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<td>2) Evaluate client referral processes.</td>
<td>Recommendations CO-1.1, CO-2.1</td>
</tr>
<tr>
<td>3) Evaluate composition of staffing, including analysis of productivity, deployment, and staff qualifications needed to provide services.</td>
<td>Recommendation F-3.1</td>
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<tr>
<td></td>
<td>Recommendations CO-1.1, CO-2.1</td>
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<tr>
<td>Recommendations Required by RFP</td>
<td>TriWest Recommendations</td>
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<tr>
<td>4) Compare the current staffing model to other counties and provide recommendations.</td>
<td>Recommendations CO-1.1, CO-1.2, CO-2.1 Recommendations A-2.1, A-2.2</td>
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<tr>
<td>2. Current outpatient system’s contracted (provider) operations.</td>
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<tr>
<td><strong>A. Financial Operations</strong></td>
<td></td>
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<tr>
<td>1) Analysis of funding sources and structure for programs, including use of Mental Health Services Act funds to ensure that sources are utilized in the most beneficial manner.</td>
<td>Recommendation S-2 Recommendations F-2, F-4.1, F-4.2 Recommendation C-2</td>
</tr>
<tr>
<td>2) Review comparable county funding sources and program structures.</td>
<td>Recommendation F-2 Recommendation A-1 Recommendation C-2</td>
</tr>
<tr>
<td>3) Analysis of patient mix and the sustainability of the current service model.</td>
<td>Recommendation F-2 Recommendation A-3</td>
</tr>
<tr>
<td>4) Evaluate completeness of billing charges (including federal and state, patient, insurance, as applicable).</td>
<td>Recommendation F-4.2</td>
</tr>
<tr>
<td>5) Evaluate processes and procedures for claiming Medi-Cal reimbursement.</td>
<td>Recommendation F-1</td>
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<tr>
<td>6) Analysis of denial rates and reasons for denials.</td>
<td>Recommendation A-3</td>
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<tr>
<td>7) Analysis of revenue management practices and financial management activities across funding streams utilized including reimbursements, grants, private pay and outside insurance companies.</td>
<td>Recommendations F-3.1, F-4.2 Recommendation A-3</td>
</tr>
<tr>
<td>8) Analysis of compliance with all legal contractual and regulatory requirements of federal and state governments.</td>
<td>Recommendation F-1 Recommendations C-1, C-2</td>
</tr>
<tr>
<td><strong>B. Programmatic Operations</strong></td>
<td></td>
</tr>
<tr>
<td>1) Identify opportunities to provide optimum service delivery for outpatient clinic contracted (provider) systems.</td>
<td>Recommendations S-1, S-2, S-3 Recommendations CO-1.1, CO-2.1, CO-2.2</td>
</tr>
<tr>
<td>2) Review client referral processes.</td>
<td>Recommendations CO-1.1, CO-2.1</td>
</tr>
<tr>
<td>3) Evaluate composition of staffing, including analysis of productivity, deployment, and staff qualifications needed to provide services.</td>
<td>Recommendation F-3.1 Recommendations CO-1.1, CO-2.1</td>
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</tbody>
</table>
### Recommendations Required by RFP

**4) Compare the current staffing model to other counties and make recommendations.**

<table>
<thead>
<tr>
<th>TriWest Recommendations</th>
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<tbody>
<tr>
<td>Recommendations CO-1.1, CO-2.1 Recommendations A-2.1, A-2.2</td>
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</table>

**Project 3: Perform a comprehensive analysis and assessment of the business practices of ADMHS’ systems for its adult and children systems of care considering compliance with all state and federal standards and guidelines.**

<table>
<thead>
<tr>
<th>TriWest Recommendations</th>
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<tbody>
<tr>
<td>Given budget concerns, TriWest originally proposed a functional review to evaluate the effectiveness of the ADMHS compliance program and the robustness of its quality assurance activities to determine if SBC and ADMHS have sufficient resources dedicated to on-going assessment of regulatory compliance, with adequate attention and support from senior and middle management to assure that findings will be addressed in a timely manner. For the final scope of work, detailed analysis of technology (Task 3) was eliminated, and efforts to assess internal accounting controls (Task 4) and cost reporting (Task 6) were focused primarily on Medi-Cal requirements, as described below.</td>
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### Systems and Support

<table>
<thead>
<tr>
<th>Recommendations</th>
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<tbody>
<tr>
<td>1) Adequacy of intake procedures, including charting and coding, ensuring that adequate information is efficiently captured to meet billing and compliance requirements.</td>
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<tr>
<td>Recommendation C-1 Recommendation F-3.2</td>
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<tr>
<td>2) Capacity to produce reports and meet billing needs.</td>
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<tr>
<td>Recommendation CO-2.2 Recommendation F-3.1, F-3.2</td>
</tr>
<tr>
<td>3) Technology systems capacity and strategy.</td>
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<tr>
<td>A detailed review of information and related technology systems was cut from the scope given recent county reviews of these capacities. The TriWest review focused only on functional capacity and gaps identified through the broader review of business practices. Recommendation F-3.2</td>
</tr>
<tr>
<td>Recommendations Required by RFP</td>
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<tr>
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<tr>
<td><strong>4)</strong> Internal controls and compliance with generally accepted accounting standards and state and federal standards and guidelines.</td>
</tr>
<tr>
<td><strong>5)</strong> Business practices and Quality Assurance processes. External service provider contracting, oversight and program compliance.</td>
</tr>
<tr>
<td><strong>6)</strong> Cost reporting practices, include an evaluation of opportunities for improvement and identify any areas that may be at risk of audit adjustment.</td>
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</tbody>
</table>

**Methods and Approach**

Given the complexity of the assessment, the TriWest team employed an iterative approach through which data was gathered, hypotheses regarding findings (and, eventually, recommendations) developed, and additional data gathered to test and revise findings (and recommendations). The primary components of this process included:

**September and October: Initial Site Visit and Interviews.** The project began with on-site interviews with County and ADMHS leadership and members of the CEO Advisory Committee for Behavioral Health (see Appendix 1 for a list of members). Because not all Advisory Committee members were able to schedule interviews during the initial site visit, the TriWest team interviewed all members by phone in September and October. Additional interviews were also carried out with ADMHS managers and key staff from administration, fiscal and clinical areas; Department of Public Health (DPH) medical staff; Community Based Organizations (CBOs) contracting with ADMHS; and leaders and staff from other county and municipal departments not represented on the Advisory Committee (Department of Social Services, Housing Authority of the City of Santa Barbara). A total of 35 people were interviewed. See Appendix 3 for a copy of the interview protocol.
October and November: Data Request and Analysis. A data request for the project’s initial desk review was also developed and submitted in October (see Appendix 4 for a copy of the original data request document). The ADMHS response to the data request was delayed and extended into November. The ADMHS response served as the basis of the TriWest team’s desk review of existing documents, reports, policies, and protocols. Desk review findings were then used to develop the schedule for the initial on-site review in December.

December: Initial Site Visit and Follow-Up Data Request. The primary on-site review took place from December 10 through 13, 2013 and was carried out by each of the project co-leads (Ms. Sternbach, Dr. Minkoff, Dr. Keller, and Ms. Thornton). An integrated team approach was used, leveraging the expertise of each team member across the entire set. For the most part, team members conducted their interviews and reviews independently, while taking time each day to compare notes and emerging hypotheses. During this primary on-site review, project co-leads were able to meet with a broad array of stakeholder groups and obtain key information in the following areas: MHSA Services, cultural/linguistic competency, consumer issues, contract and claims oversight, quality assurance, compliance, provider network services (for mental health as well as alcohol and drug services), outpatient clinical services (for adults and children, including input from ADMHS services as well as CBOs), residential and crisis services, homeless services providers, criminal justice system (including the County of Santa Barbara, Probation Department, Adult Services Division and Juvenile Services Division and the Santa Barbara County Sheriff’s Department, Main Jail), public health leadership, and physicians from both ADMHS and public health. A critical component of this primary site visit was the inclusion of open community forums with consumers, family members and advocates, and providers. An open forum for CBOs was held on December 10 and NAMI sponsored a forum for consumers, families, and advocates on December 11. During the course of this site visit, over 100 people participated in interviews and forums. Based on the site visit results and data needs identified, a follow-up data request was developed (see Appendix 5).

January: Follow-Up Site Visit to Present Initial Findings. On January 22 and 23, 2013, a two day follow-up site visit was held to present initial findings and gather feedback and additional data in response to them. Findings were reviewed with a broad range of stakeholders, including the CEO Advisory Committee, the Consumer and Family Advisory Committee (with Santa Maria participating by video conference), and individual meetings with several consumer/family peer specialists, other consumer representatives, the Santa Ynez Tribal Health Clinic of the Santa Ynez Band of Chumash Indians, and CBOs. These meetings involved over 30 individuals.

In addition, to address concerns identified by the Latino Advisory Committee, additional meetings were added with representatives of the Latino Advisory Committee, Latino leaders in North County, community agencies serving the Latino community, and Latino consumers and
family members that participated in an evening forum hosted by El Nuevo Amanecer. An additional TriWest team member with bicultural expertise in delivery of services to Latino communities (who was bilingual Spanish-speaking) helped facilitate these meetings. Additional input was received through this process from over 35 consumer, family, advocate, provider, and community member representatives.

February and March: Revise Report and Third Site Visit to Review Updated Recommendations. During February, revised findings and updated, detailed recommendations were developed, incorporating stakeholder feedback and input from the independent financial consultant, Mike Geiss. A third site visit was conducted on March 13 through 15, 2013, to validate findings and detailed recommendations with the stakeholder groups involved in the process prior to finalizing this report. Briefings were conducted with the CEO Advisory Committee, the Santa Barbara County Mental Health Commission, the joint ADMHS/DPH “Tiger Team” providing interim leadership for ADMHS, ADMHS medical staff, ADMHS managers, and ADMHS line staff. These meetings involved over 70 people. Given the breadth of the findings and the County’s commitment to review draft findings with all groups participating in the process, the CEO Advisory Committee recommended to the CEO that additional meetings be scheduled for April to continue the community feedback process, and the CEO’s Office decided to extend the process for community input by one month.

April: Additional Community Feedback, Final Site Visit and Report Finalization. In response to the decision to extend the community input process, additional meetings were held by phone in March and April and on site in April with the CEO Advisory Committee, CBO representatives from South and North County (North County participated by videoconference), the Tiger Team (two meetings – one by phone in March and one during the April site visit), clinical managers, the Consumer and Family Advisory Committee, a group of consumers and peer specialists, and Latino community leaders at an evening meeting hosted by El Nuevo Amanecer. Over 80 people participated through these meetings and forums.

In addition, an open invitation to ADMHS managers, staff, CBOs, and the community for additional feedback was offered and feedback was received from over 50 people, including: 22 ADMHS managers, 23 ADMHS staff (including administrative staff, clinical staff, peer specialists, and psychiatrists), six CBO leaders and staff, and four advocates. Dozens of additional documents were submitted by ADMHS managers and the County and reviewed in reference to specific questions raised during the review process. All additional information received was incorporated into the final report.

A draft of the final report was completed in early May, and reviewed by the CEO Advisory Committee from May 9 through May 14, 2013. Input from the CEO Advisory Committee received through May 14, 2013, was also incorporated into the report.
Conceptual Framework for the Report

There are several key concepts that frame the TriWest team’s approach to this report. Taken together, these concepts form an essential conceptual framework critical to understanding the evidence base underlying our findings and recommendations. This framework is built on the latest concepts and research on how complex multi-layered health and behavioral health systems can (and should) engage in quality-driven processes to design themselves within limited resources and in the context of fast-changing local, state, and federal funding and regulatory requirements to routinely provide programming and practices that best meet the needs of and produce hopeful and successful outcomes for customers with complex challenges who require services. The goal of this report is to provide guidance to Santa Barbara County AMDHS regarding how to do just that.

Quality Improvement and Health Care: A New Paradigm

In 2001, the Institutes of Medicine (IOM) fundamentally changed the national dialogue regarding the design of health care systems through the landmark publication of their “Crossing the Quality Chasm”\(^1\) report, which became the first in a series of subsequent IOM publications that have helped shape our understanding of the need for a fundamental shift in operational priorities and health care delivery organization commitment to ongoing quality improvement. The premise of the report is in many ways quite simple – the health care industry must move from a traditional command and control model to a continuous quality improvement model. These are lessons that the U.S. manufacturing sector had to learn and apply in the 1980s and 1990s, building on the work of pioneers such as Edward Deming and leading to a variety of standards and frameworks now widely used across industry (e.g., ISO 9001:2008\(^2\)).

The Quality Chasm series built upon prior reports in the late 1990s demonstrating the serious quality gaps in the U.S. health care system, many associated with the shift in treatment to greater numbers of chronic illnesses (vs. acute illnesses), an important subset of which includes addictions, serious mental illnesses for adults, and serious emotional disturbances for children. The series focuses on applying the broader framework of performance and quality improvement to the delivery of health care services. The report argues convincingly that these quality gaps cost the U.S. upwards of $750 billion in 2009 in poor, inefficient, wasteful, and ineffective care. The need for systematic change is clear and stark.


\(^2\) For example, see: http://www.iso.org/iso/06_implementation_guidance.pdf.
In 2006, the Quality Chasm series focused its attention on mental health (MH) and substance use disorders (SUD),\(^3\) documenting severe system level quality gaps and describing a framework for improving them. The report was quite explicit in its findings, both in demonstrating the existence of effective treatment and the woeful inadequacy of most MH/SUD delivery systems in effectively promoting it:

> Effective treatments exist and continually improve. However, as with general health care, deficiencies in care delivery prevent many from receiving appropriate treatments. That situation has serious consequences—for people who have the conditions; for their loved ones; for the workplace; for the education, welfare, and justice systems; and for the nation as a whole.

The report goes on to note that the challenges facing MH/SUD systems are in many ways more severe than those facing the broader health system due to “. . . a number of distinctive characteristics, such as the greater use of coercion into treatment, separate care delivery systems, a less developed quality measurement infrastructure, and a differently structured marketplace.” (page 2) Nonetheless, the IOM recommended clearly that the advised shift from “command and control” models of quality assurance to customer-oriented quality improvement was not only necessary but possible within behavioral health systems, with similar capacity as in health care to produce better outcomes with lower costs.

The implications of the IOM’s recommended shift from command and control models to continuous quality improvement is not just about improving the quality of care delivery – it is also essential to controlling costs, as documented in one of the latest reports in the Quality Chasm series.\(^4\) The report states the matter in the series’ characteristically direct manner, as quoted below:

> Consider the impact on American services if other industries routinely operated in the same manner as many aspects of health care:
> - If banking were like health care, automated teller machine (ATM) transactions would take not seconds but perhaps days or longer as a result of unavailable or misplaced records.
> - If home building were like health care, carpenters, electricians, and plumbers each would work with different blueprints, with very little coordination.

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• If shopping were like health care, product prices would not be posted, and the price charged would vary widely within the same store, depending on the source of payment.

• If automobile manufacturing were like health care, warranties for cars that require manufacturers to pay for defects would not exist. As a result, few factories would seek to monitor and improve production line performance and product quality.

• If airline travel were like health care, each pilot would be free to design his or her own preflight safety check, or not to perform one at all.

The point is not that health care can or should function in precisely the same way as all other sectors of people’s lives – each is very different from the others, and every industry has room for improvement. Yet if some of the transferable best practices from banking, construction, retailing, automobile manufacturing, flight safety, public utilities, and personal services were adopted as standard best practices in health care, the nation could see patient care in which:

• records were immediately updated and available for use by patients;
• care delivered was care proven reliable at the core and tailored at the margins;
• patient and family needs and preferences were a central part of the decision process;
• all team members were fully informed in real time about each other’s activities;
• prices and total costs were fully transparent to all participants;
• payment incentives were structured to reward outcomes and value, not volume; errors were promptly identified and corrected; and
• results were routinely captured and used for continuous improvement.

An Evidence-Based Approach for Transforming Behavioral Health Systems by Building A Systemic Customer-Oriented Quality Management Culture and Process:

Comprehensive, Continuous, Integrated System of Care (CCISC)

Multiple methods have been developed for improving quality management in organizations, building on Deming’s original Plan-Check-Act-Do model, including the ISO 9001:2008 standards for manufacturing noted above, various specific quality planning approaches (e.g., kaizen, lean, six sigma, etc.), and quality frameworks for healthcare more broadly (e.g., the National Committee for Quality Assurance). It was noted above that the challenges in behavioral health systems are specific and in some ways more complex. Fortunately, over the last 15 years a specific model for behavioral health system design and implementation, consistent with the core quality improvement principles of the IOM framework, has been developed and replicated in numerous public behavioral health systems.
The Comprehensive, Continuous, Integrated System of Care (CCISC) model was developed over the past 15 years by ZiaPartners. It is an evidence-based model\textsuperscript{5} that has been identified by SAMHSA as a “best practice” for system design, and has been used in dozens of local and state systems of care internationally, in over 25 states across the U.S., and in 10 California counties. CCISC is designed to create a framework for systems to engage in this type of vision-driven transformation. It is built on the framework of the IOM Quality Chasm series, which has recommended the need for a customer-oriented quality improvement approach to inform all of health and behavioral health care. Below are the key elements:

1. The system must be built to fulfill the biggest possible vision of meeting the needs and hopes of its customers: both the individuals and families who are seeking help, and the system partners (e.g., criminal justice, child welfare, juvenile justice, homeless services, public health, etc.) that share the responsibility to respond. The emphasis always begins with those individuals and families who the system is currently not well designed to serve (people with co-occurring issues, people with cultural diversity, people in complex crisis, etc.).

2. The whole system must be organized into a horizontal and vertical continuous quality improvement partnership, in which all programs are responsible for their own data-driven quality improvement activities targeting the common vision that all programs become person/family-centered, recovery/resiliency-oriented, trauma-informed, complexity capable (that is, organized to routinely integrate services for individuals and families with multiple complex issues and conditions), and culturally/linguistically competent. In addition, all the major processes and subsystems (e.g., crisis response) must be reworked within this quality improvement partnership to be better matched to what people need.

3. The whole process is designed to implement a wide array of best practices and interventions into all the core processes of the system at an adequate level of detail to ensure fidelity and achieve associated outcomes. This is not about simply "funding special programs," but rather about defining what works and making sure, within the systemic continuous quality improvement (CQI) practice improvement/workforce development framework, that what works is routinely provided in all settings.


4. The whole process is data driven. Each CQI component, whether at the program level, the subsystem level, or the overall system level, is driven by commitment to measurable progress toward quantifiable objectives.

5. The whole process is built within existing resources. All systems need more resources, but it is critical to challenge ourselves to use the resources we have as wisely as possible before acquiring more. In most behavioral health systems, as noted by the IOM, poor system design produces inefficient and ineffective results, and then more resources are invested to work around the poorly designed system. The goal of CCISC is to create processes to move beyond that over time.

6. The whole process is built with the assumption that every piece of practice and process improvement needs to be anchored firmly into the supporting operational administrative structure and fiscal/regulatory compliance framework. This includes not only clinical instructions, but also resource and billing instructions, quality and data instructions, paperwork and documentation requirements, and so on. The fiscal/regulatory compliance framework can be the biggest supporter of quality-driven change, if the same rigidity that may hold ineffective processes in place is "re-wired" to hold improved clinical processes in place that are consistent with the overall values and mission of the systems. Many systems think that this cannot occur, and therefore stop trying. CCISC challenges systems to discover the ways that financial integrity and value-driven practice can be anchored into place simultaneously.

The whole CCISC process begins with a big vision of change and puts in place a series of change processes that proceed in an incremental, stepwise fashion over time. However, because the design of the process is to create organized accountability for change at every level of the system concurrently, thereby increasing the total activation and personal responsibility for improvement by both customers and staff (both front line and managers), even though each part of the system may only take small steps, the whole system starts to make fundamental changes in its approach to doing business. Although a transformation process is by design “continuous improvement” and will involve significant changes over several years, the shift to implementation of a quality-driven framework process can occur in a relatively short time frame (e.g., six to 12 months).

Evidence-Based Practices Underlying the TriWest Team Recommendations
The CCISC model is the most systematic, evidence-based, and widely applied model of which our team is aware for helping MH/SUD delivery systems redesign themselves to best utilize existing resources at every level to produce better outcomes across an entire system. CCISC implementation involves both a shift in the culture and design of clinical practice to be more...
welcoming, hopeful, strength-based, and integrated, and a shift in the culture and design of organizational practice from a command and control model to the empowered partnerships characteristic of a customer-oriented continuous quality and performance improvement paradigm endorsed by the IOM and the Quality Chasm series. One of the authors of CCISC (Dr. Ken Minkoff) is a member of the TriWest consulting team assembled for this project, and has presented on the CCISC model in Santa Barbara County previously, with positive response. Respondents in our assessment have indicated hope that a model like CCISC might be able to be implemented in Santa Barbara County. Consequently, our team’s recommendation of that model for SBC is based on those findings, as well as the published evidence and the recommendations of many of our clients and associated industry representatives, and is a joint recommendation all four firms represented on our team (TriWest Group, Sternbach Consulting, Mary Thornton and Associates, and ZiaPartners).

In addition to the conceptual frameworks described above for overall system design and improvement, our team also grounds the recommendations in this report in the following sets of specific best practices for fiscal, regulatory compliance, and clinical operations.

**Fiscal Practices.** The benchmarks used to analyze fiscal practices of ADMHS is based on comparisons with other counties using cost report data, data from the External Quality Review Organization, data from the State Controller’s Office and State Department of Finance, and the experience of lead consultant Mike Geiss of Geiss Consulting with the majority of the counties in California. Also, the approach considered relevant state statutes, regulations, Policy Letters, Information Notices, and Cost Report Instruction Manuals as well as federal statues, regulations, and the Provider Reimbursement Manual, when analyzing Santa Barbara County’s fiscal practices. The fiscal evaluation also included the use of best practices for revenue-based budgeting and the fiscal oversight of subcontractors.

**Regulatory Compliance Practices.** Regulatory compliance programs are governed by certain federal laws (in particular the Deficit Reduction Act of 2005) and by the ADMHS state contract. While there is some variation in requirements, since passage of the Affordable Care Act most compliance programs are evaluated on their implementation of seven elements of “effective” compliance programs that are detailed in the Federal Sentencing Guidelines, Chapter 8. These guidelines are revised annually, but the most recent substantive changes to Chapter 8 occurred in 2010.

The Federal Sentencing Guidelines, Chapter 8, have been largely incorporated into all federal advice on the development of compliance programs within health care organizations. Specifically, the Office of the Inspector General for the Department of Health and Human Services (OIG) has issued a number of guidelines for provider types that are based on these sentencing guidelines. These OIG compliance guidelines amplify the guidance given in Chapter
8. There is no specific guideline for behavioral health care but the hospital, third party billing company, small physician practice, and nursing facility guidelines all have levels of applicability because of the many types of programs being provided or subcontracted.

In addition to its compliance guidelines, the OIG has also issued a number of fraud alerts and special publications for boards of directors and other oversight governing structures. The OIG also issues public reports of its audits and audit findings. These are of considerable value for behavioral health as they are the only specific information compliance programs have about the OIG’s perspective on case management, rehabilitation services, home and community based waiver services, and other services relevant to functioning behavioral health programs. In addition, behavioral health has been the target of many OIG audits.

The information available about behavioral health care and compliance risk has been addressed in publications by Mary Thornton, who was our project lead for the review of the compliance program at ADMHS. Her publications include the book *Ahead of the Game, Compliance for Behavioral Healthcare* and numerous articles in ComplianceWatch, a newsletter publication of the National Council for Behavioral Healthcare. Mary Thornton was the executive editor for the initial three years of this publication. In addition, in evaluating the compliance program, Ms. Thornton also drew on her experience as a national trainer and consultant on corporate compliance in behavioral healthcare. In particular, she was asked to evaluate the compliance program at ADMHS to determine if it was robust, attentive to the corporate culture, valued by staff within various departments of ADMHS, and capable of protecting the organization from significant audit, regulatory, and legal risk.

Clinical Operations and Practices. While clinical quality improvement is a core focus of the CCISC model, an important component of CCISC is promoting successful implementation of appropriate clinical practices across the entire clinical system. CCISC is an “equal opportunity best practice employer.” All available and appropriate best practices should be utilized as part of the design of each program in the system and applied rigorously within the overall quality improvement framework for system improvement, monitoring, and oversight.

Two sets of clinical operations best practices were emphasized by our review team. The first set comprises managed care best practices. For public mental health, these are developed out of the standards for external quality review activities of federally-funded managed care plans first articulated in the final regulations for the federal Balanced Budget Act of 1997 (BBA) and have evolved into the External Quality Review (EQR) requirements under 42 CFR 438. These are the same standards used by APS Healthcare’s California External Quality Review Organization (CAEQRO); the TriWest team has applied these standards in dozens of health plan reviews over the past decade for both MH and SUD plans.
The second set is comprised of evidence-based clinical practices and interventions for specific behavioral health conditions. There are hundreds of evidence-based practices available for MH and SUD treatment, and the most definitive listing of these practices is provided by the federal Substance Abuse and Mental Health Services Administration (SAMHSA) through the National Registry for Evidence-based Programs and Practices (NREPP). The NREPP includes MH and SUD treatment approaches ranging from prevention through treatment. While the NREPP is, in its own description, “not exhaustive,” it is the most complete source on evidence-based practices of which we are aware. The NREPP refers to all practices in the registry as “evidence-based,” using the following definition: “Approaches to prevention or treatment that are based in theory and have undergone scientific evaluation.” The NREPP then rates each program and practice on a multi-point scale across multiple domains to characterize the quality of the evidence underlying the intervention. Thus, many approaches formerly termed “promising” are now included in the NREPP, albeit with lower scores in some domains. The California Institute for Mental Health (CiMH) has identified a subset of these evidence-based practices (EBPs) for adults/older adults, children and families, transition age youth, and multicultural populations that it describes and promotes for use by California counties.

There is a direct connection between implementation of clinical operations best practices of either type and the overall customer-oriented quality improvement framework within CCISC. In particular, there is also growing evidence that successful promotion of evidence-based practice requires a broad-based, rigorous organizational commitment to quality. Such infrastructures engage front line workforce as empowered partners in the implementation of practices and processes, while simultaneously involving policy, procedural, and funding mechanisms at the system and program levels to anchor and sustain the capacity of the workforce to deliver evidence-based interventions as part of “business as usual.” These infrastructures need to be based in system and organizational cultures and climates that value the use of information and data tracking as a strategy to improve the quality of services and increase the likelihood of achieving desired outcomes. CCISC exemplifies these approaches.

This is also reinforced by the emerging evidence from the field of implementation science. A widely cited systematic study by Fixsen and his colleagues of efforts to promote a wide range of EBPs found mixed results in the promotion of EBPs and key factors related to successful implementation. Their seminal review describes a multi-year, six stage process involving (1)

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6 The NREPP’s searchable database can be found at: http://www.nrepp.samhsa.gov/.
7 The CiMH website contains separate pages for each population and can be accessed at: http://www.cimh.org/Services.aspx.
exploration and adoption, (2) program installation, (3) initial implementation, (4) full operation, (5) innovation, and (6) sustainability. The process of moving from one stage to the next involves a complex interplay of organizational capacities, technical expertise, and quality improvement over time. Fixsen and his colleagues describe three levels of influence that together determine successful implementation: (1) core implementation components, including specific training, coaching and performance measurement related to the practice being implemented; (2) organizational components, including staff selection practices, program evaluation capacity, administrative capacity, and ability to carry out systems interventions; and (3) external influence factors at the social, economic and political level. The summary provides a wealth of insight into the complex technical, organizational, and broader system factors influencing best practice implementation, but the core implication for systemic efforts to address health disparities is this: change is multi-determined and dependent on sustained organizational commitment and broader organizational capacity over time.

Successful EBP promotion also requires understanding of the real world limitations of each specific best practice, so that the understandable stakeholder concerns that emerge can be anticipated and incorporated into the best practice promotion effort. This process is sometimes called “using practice-based evidence” to inform implementation and is a core feature of continuous quality improvement. The reasons for stakeholder concerns at the “front line” implementation level are well documented and significant.9 One major issue is that the literature prioritizes randomized clinical trials (RCTs) that address efficacy in controlled research settings, whereas practitioners require research evidence on effectiveness in typical practice settings. This “efficacy-effectiveness gap” was clearly defined in the 1999 U.S. Surgeon General’s report on mental health services in America10 and centers on the much more complex realities that practitioners face in the field. Toward that end, research that addresses the complexities of typical practice settings (for example, staffing variability due to vacancies, turnover, and differential training) is lacking, and the emphasis on RCTs is not very amenable to exploration of clinically relevant constructs like engagement and therapeutic relationships.11 Related uncertainties about implementing EBPs in children’s mental health include a lack of clarity about the interactions of development and ecological context with the interventions. While it is generally accepted that development involves continuous and dynamic interactions between children and their environments over time, and is inextricably linked to natural

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contexts such as families, schools, and communities, the efficacy research literature is largely silent on these relationships.\textsuperscript{12} Because of this, practitioners must in many cases extrapolate from the existing research evidence.

One of the biggest concerns about EBPs – and one that is certainly highly relevant in SBC – involves application of practices to individuals and families from diverse cultural and linguistic backgrounds. There are inherent limitations in the research base with regard to diversity that often lead providers, people receiving services, and other stakeholders to question the extent to which the research evidence supporting much-vaulted EBPs is applicable to their communities and the situations they encounter on a daily basis. Further, there is wide consensus in the literature that too little research has been carried out to document the differential efficacy of EBPs across culture.\textsuperscript{13} Given that few EBPs have documented their results in sufficient detail to determine their effectiveness cross-culturally, it makes sense that EBPs be implemented within the context of ongoing evaluation and quality improvement efforts to determine whether they are effective – or more accurately, how they might need to be adapted to be maximally effective – for the local populations being served. The California Institute for Mental Health has compiled an analysis regarding the cross-cultural applications of major EBPs.\textsuperscript{14} There is also increasing recognition of best practices for refugee and immigrant communities.\textsuperscript{15}

It is also therefore critical to ground best practice promotion in specific standards for culturally and linguistically appropriate care. The most well-known national standards related to health disparities focus on services for members of ethnic minority groups. The National Standards for Cultural and Linguistically Appropriate Services in Health Care (CLAS Standards)\textsuperscript{16} were adopted in 2001 by the U.S. Department of Health and Human Services’ (HHS) Office of Minority Health (OMH) with the goals of “equitable and effective treatment in a culturally and linguistically appropriate manner” and “as a means to correct inequities that currently exist in the provision of health services and to make these services more responsive to the individual needs of all patients/consumers” in order “to contribute to the elimination of racial and ethnic health disparities and to improve the health of all Americans.” They include 14 standards addressing

\textsuperscript{12} Hoagwood K., Burns B.J., Kiser L., et al. (2001).
\textsuperscript{14} See http://www.cimh.org/Services/Multicultural/ACCP-Project.aspx.
the broad themes of culturally competent care, language access, and organizational supports for cultural competence. A range of standards for specific populations is also available, but the CLAS standards are most widely recognized in the broader health field. In mental health, a set of SAMHSA standards for African American, Asian American / Pacific Islander, Hispanic / Latino, and Native American / American Indian groups is also available. CiMH highlights specific EBPs for multicultural applications in California as well.

Within the broader context of CCISC and EQRO, we will reference specific evidence-based practices as relevant within this report. Appendix 2 also includes a summary of major child and family and adult EBPs increasingly used in public behavioral health settings.

**Application in this Report**

The conceptual framework described in this section provides the context and assessment framework from which the findings and recommendations in subsequent sections of this report were derived. While the report provides dozens of recommendations, it is critical that the recommendations be viewed as a whole.

An important implication of the evidence-based literature on quality improvement is that SBC should not attempt to fix problems identified by this report piece-meal; a comprehensive approach is needed. If any of the specific recommendations are addressed separately from a broader systemic quality and performance improvement framework, we would expect that any reform effort would simply perpetuate findings documented below of a long-term cycle of repeated partial fixes that do not result in sustained organizational change (and can potentially set back progress). However, in the context of a deliberate commitment to quality-driven transformation, these same discrete improvements can become the early wins that propel and catalyze long-term change.

The report is organized as follows. **Systemic Findings and Recommendations** are offered first to provide a framework for describing overarching system performance, understanding long-standing system level problems, and developing potential solutions for overall system improvement. This is followed by:

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17 The New York City Department of Health and Mental Hygiene has compiled a helpful listing of various sources that are readily accessible: http://www.nyc.gov/html/doh/downloads/pdf/qi/qi-ccpriority-resources.pdf.
19 See http://www.cimh.org/Services/Multicultural.aspx for the overall site and http://www.cimh.org/Services/Multicultural/ACCP-Project.aspx for specific EBPs demonstrated in California.
• **Clinical Operations Findings and Recommendations** from our analysis and assessment of ADMHS outpatient service delivery systems of care (for both adults and children), focusing both on clinical operations and contract provider services;

• **Administrative Findings and Recommendations** regarding the structure and capacity of ADMHS to carry out business practices (management, financial, and compliance) in support of its adult and children systems of care;

• **Financial Findings and Recommendations** reviewing capacity and performance in the areas of funding, the billing cycle, patient/payer mix, Medi-Cal reimbursement, denial rates, revenue management, broader financial management capacity across funding streams, compliance with fiscal requirements (particularly Medi-Cal cost reimbursement), management information reporting capacity and strategy (including functional analysis of key technology systems) for both management and finance, fiscal controls, and financial business practices more broadly; and

• **Compliance Findings and Recommendations** focusing on documentation (intake, charting, coding, etc.), internal controls related to clinical system compliance with state and federal guidelines, quality assurance processes, and compliance monitoring more broadly for both county-run and contract clinical services.
Systemic Findings and Recommendations

Overall Finding: Significantly Suboptimal Performance at ADMHS

In spite of many excellent programs and clinicians, and in spite of significant successes improving core functions in the fiscal and compliance areas, the ADMHS adult and child systems of care are not producing the clinical outcomes for the citizens of Santa Barbara County (SBC) that would demonstrate the most effective utilization of available resources. There are many contributors to this suboptimal performance, which will be outlined in more detail in the specific sections that follow. There are also ways in which fiscal and compliance functions can be more effectively integrated to support clinical and administrative operational success. However, perhaps the most fundamental contributor to the fact that the system is underperforming is that the organizational climate has substantially interfered with the development of the performance improvement culture and processes (both administrative and clinical) necessary to result in the following capabilities:

- Capacity to design (and continuously improve over time) internal ADMHS clinical program operations and systems to best respond to the needs of individuals and families, particularly those with high levels of complexity and crisis;
- Capacity to engage contracted CBOs most effectively as system design partners to maximize utilization of all available ADMHS resources to support overall customer experience and outcomes; and
- Capacity to develop the intersystem partnerships with other agencies in the county (e.g., public health, child welfare, housing, criminal justice, juvenile justice, etc.) that are necessary to leverage all available resources to achieve successful results for individuals and families with complex and overlapping needs.

The overall recommendation is that SBC needs to move as quickly as possible to initiate a comprehensive performance improvement-driven transformation process at ADMHS that can quickly begin to address all of these issues at every level of the system simultaneously to produce better outcomes and reduce wasteful resource expenditures, all within a context of a continued high level of excellent fiscal oversight and improved regulatory/financial compliance monitoring.

These findings and the strategies for implementing this recommendation will be more clearly illustrated in the specific discussion below.

Finding S-1: A Dysfunctional ADMHS Organizational Climate

One of the major findings of this report centers on pervasive and systemic ADMHS organizational challenges that impact day-to-day operations and contribute to dysfunction. To establish any successful and productive large scale change process within ADMHS, these
organizational climate issues must be addressed. The ADMHS organizational challenges impact both internal ADMHS clinical operations and the operations of contracted providers and community-based organizations (CBOs). These organizational issues must be addressed, or implementing the detailed recommendations will not produce desired results and may, in fact, set back progress further.

The primary challenge that ADMHS must overcome is a robust internal and external perception of being a top-down, crisis-driven organization that has de-emphasized service-driven, customer-oriented values and performance, along with effective clinical operational management, to focus primarily (though not inappropriately) on financial and procedural controls. To establish any successful and productive, large scale change process within ADMHS, this organizational perception must be addressed with equal attention to internal employees and external CBOs. The “command and control” functions that are (and remain) essential for compliance have inhibited the empowered partnership conversations that are necessary for customer-oriented performance improvement that is essential for designing a successful overall system of care. It is now important to reinstitute the core focus on “customers” and “quality improvement” throughout the system, without losing the progress that has been made in financial management and compliance.

As our opening conceptual review identified, systemic barriers to quality service delivery are endemic to the health care industry generally and behavioral health service delivery in particular. However, in our team’s history of reviewing dozens of county and regional behavioral health systems, we have never encountered a more uniform set of beliefs related to the presence of a system culture and internal process that interferes with successful clinical operational improvement and problem solving. This uniform set of beliefs applies across internal (managers and staff) and external (CBOs and county partners) stakeholders. While informants varied to some degree in assessment of the contributors to this culture, and of the ways in which this culture interferes with optimization of system performance, the dozens of people we spoke with were essentially unanimous in this conclusion. It was also demonstrated repeatedly through the conduct of our assessment through repeated delays and partial responses to our team’s requests for information, seemingly related to a reluctance to share information, and nearly universally expressed concerns on the part of external contractors, Advisory Board members, and ADMHS staff at all levels – line staff, physicians, managers, and county-level at the highest levels of the organization – that if their views were attributed to them, there could be negative implications. This type of concern is predictive of the inability of the organization to appropriately engage all of its internal and external stakeholders in the type of creative quality and process improvement activities that result in sustainable change and produce better and more efficient outcomes.
The contributors to this extremity of the organizational cultural factors appeared to be both long-standing and more recent. ADMHS has faced long-standing political pressure and external skepticism of its effectiveness, and there appears to be particular animus related to the events of Fiscal Year 2008. That year, ADMHS experienced major financial and regulatory challenges related to assessed payback by the state in two areas:

1. A “Self-Disclosure” to the state regarding an array of billing irregularities and
2. Findings related to partner billing practices developed under the Multiagency Integrated System of Care (MISC).

The original assessed financial impact of these two issues was estimated to be over $31 million initially, and over $20 million has been paid by SBC to settle these matters. As of June 2012, an estimated $5.2 million in liability remained. While ADMHS and the County appealed these decisions and successfully reduced their liability substantially, the impact of such large paybacks was severe. The impact was both tangible in terms of financial flexibility and intangible in that it affected management’s assessment of their risk tolerance levels. And once exposed to audit risk in such a significant way, the five-year “look-back” structure of Medi-Cal cost-report settlements by the State of California has resulted in a series of additional liability findings every year since FY 2008-09. Only now in 2013 has a full five years elapsed since the discovery of the original audit findings.

The response to these dramatic events was understandably strong. On the positive side, SBC and ADMHS developed much more robust financial and contractual oversight processes to ensure the soundness of future Medi-Cal cost reporting and external contract oversight. The successful development of these capacities is documented in more detail in the Financial findings section of this report.

But on the negative side, these events appear to have exacerbated a broader, longer-standing culture of reactivity and negativity that is interfering with implementation of successful customer-oriented approaches to service system design. Furthermore, along with an understandable need to augment financial oversight, clinical operational management and oversight appears to have been deprioritized (more on this in the section on Clinical findings).

In discussions with internal ADMHS staff, county partners, and CBO representatives about these events, the TriWest team found utility in viewing current ADMHS dysfunction at the organizational culture level through the lens of organizational trauma. The events of 2008 and the repeated audits and paybacks that followed them were real, repeated traumas that necessitated a rapid and effective response to address them. However, the need to institute

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20 ADMHS 11/18/2008 Departmental Agenda Letter to the SBC Board of Supervisors, page 2.
21 ADMHS Excel Report: “5 Historical liability schedules going back to FY 2002-03.”
necessary fiscal and compliance controls has spilled over into a broader organizational emphasis on command and control that goes beyond the necessary remedies developed in response to the fiscal and compliance gaps exposed in FY 2008. There are numerous examples of this “over-generalization” of the command/control response throughout this report, but we cite here two examples that are illustrative:

• Our team found repeated barriers cited by leaders of partner child-serving agencies (Department of Social Services, Probation, child-serving CBOs) to collaborative planning and effort. While collaboration certainly occurs, leaders frequently referenced the “MISC experience” as a barrier to closer work. While the collaborative planning and service delivery that was a hallmark of the MISC program is a best practice, there was caution and hesitancy to reengage at an organizational level. These repeated examples of generalizing concerns about a specific aspect of the MISC financing approach (an approach which all parties and the consultant team agree was misguided, though also reportedly sanctioned at some level originally by the State\(^\text{22}\)) to cast a negative light on broader clinical collaboration is an example of overgeneralization in response to a trauma.

• At an even broader level, overgeneralization limits the utility of one of the most positive outgrowths of the revitalized emphasis on fiscal planning and control developed in the aftermath of the many ADMHS and contract oversight deficiencies that led to the “Self-Disclosure.” The “Clinic Model” is a financial modeling tool developed by the ADMHS finance area that ties projected Medi-Cal revenue for ADMHS programs to expenditures. It is an effective, dynamic budgeting tool used for both planning and expenditure/revenue monitoring, including support of Medi-Cal cost reporting.\(^\text{23}\) One secondary use of the model is to derive “productivity reports” that track a variety of factors regarding how individual clinical staff spend their time – the percentage of Medi-Cal to non-Medi-Cal services and the proportion of documentable time to total time worked. While forecasting the level of Medi-Cal services that will be provided is a critical factor in estimating the amount of Medi-Cal revenue that will be received during the fiscal year, productivity reporting from the Clinic Model should be only one of many factors used by clinic managers when determining the productivity and effectiveness of programs. However, current management practice has the effect of emphasizing “productivity” as the primary performance metric, so there is a widespread perception that if clinical staff are not “productive”, Medi-Cal revenue will fall. In this manner the system “overgeneralizes” the understandable concern about ensuring Medi-Cal revenue

\(^{22}\) Verifying the degree to which the state sanctioned the MISC financing approach was beyond the scope of our study, but multiple respondents with tenure and relevant experience extending back to the pre-2008 period asserted that this was so.

\(^{23}\) It is also important for ADMHS to maintain at least a minimum level of direct Medi-Cal billable time during the year to draw down sufficient Medi-Cal Federal Financial Participation (FFP) provisional payments to cover costs, and the Clinic Model allows for accurate determination of interim reimbursements.
and distorts clinical practice in multiple ways unrelated to appropriate revenue maximization (for example, leading many bilingual staff reportedly to reduce time available to provide interpretation supports because it is not “productive”).

Our team’s findings and the well-documented evidence about the limitations of a command and control culture within clinical settings documented in the IOM Quality Chasm reports cited in the previous section clearly underscore that ADMHS needs to move past the “crisis culture” stimulated by the 2008 challenges. However, interviews with staff with histories at ADMHS and the County that pre-dated 2008 noted that the command and control culture was firmly rooted at ADMHS prior to 2008. This is not surprising given its pervasive presence across behavioral health and health care systems in California and nationally (as documented in the IOM reports). For example, there is evidence from as early as 2001 of negative staff perceptions (4:1 ratio of negative to positive perceptions of organizational culture, including low morale, a command and control environment, and many issues currently of concern to ADMHS staff).24 As a result, changing the culture will not simply be a matter of “getting past” the 2008 events; it will likely require a specific commitment to comprehensive organizational change.

**Recommendation S-1: County and ADMHS leadership must visibly commit to the creation of a performance and quality improvement-driven culture for ADMHS.**

The IOM Quality Chasm series underscores a set of key changes necessary to create systems that produce better results and manage limited resources more effectively. The first step is to transition health care organizations from command/control to quality-driven cultures, and the first step of that is a visible leadership commitment to such a culture change:

> An organization’s leadership sets the tone for the entire system. Leaders’ visibility makes them uniquely positioned to define the organization’s quality goals, communicate these goals and gain acceptance from staff, make learning a priority, and marshal the resources necessary for the vision to become reality. Furthermore, leadership has the ability to align activities to ensure that individuals have the necessary resources, time, and energy to accomplish the organization’s goals. By defining and visibly emphasizing a vision that encourages and rewards learning and improvement, leadership at all levels of the organization prompt its disparate elements to work together toward a common end.25

Note that the TriWest team is not recommending a shift back to pre-2008 organizational functioning. Financial processes clearly were not sound (as demonstrated by the millions of dollars of paybacks), and CBO and ADMHS leaders alike acknowledge that, while relationships

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24 September, 2001. “Raw Data from ADMHS Employee Focus Groups.”
may have been less contentious in many ways prior to 2008, there were major gaps in contract and performance oversight. These gaps have been significantly and successfully addressed, as illustrated in the following data. The 2008 report by the state’s external quality review organization (EQRO) that monitors county behavioral health departments’ organizational oversight of managed care functions and contractors for Medi-Cal mental health services found six of 10 (60%) factors related to basic organizational processes as “not present” (the lowest of three ratings) and the remaining four only “partially present,” as well as “not present” findings in the critical Performance and Quality Management areas of “Routine business process analysis,” “Contract and network providers are paid timely and accurately for services rendered,” and “Integrity of Medi-Cal claim process, including determination of beneficiary eligibility.” All related areas measured for the most recent EQRO report (FY 2012-13) received the highest score (“present”).

Based on this finding, which will be further elaborated in the Financial and Compliance sections of this report, the TriWest team views the progress in financial and contract oversight as a key competency to build upon. Ensuring reliable and sound financial oversight and reporting is essential to an organization’s ability to act confidently and support necessary customer-oriented delivery system design, clinical practice improvement, and continuing innovation. County and ADMHS leadership needs to visibly commit to building on this core capacity and ensuring that there is no regression in this area, while engaging in the process of instituting an organization-wide quality improvement culture for the purpose of broad system redesign.

Finding S-2: ADMHS lacks effective empowered partnerships to help it articulate a core vision and improve system level performance and outcomes through mission-driven continuous improvement.

The commitment of top leadership to performance and quality improvement is only one step in the process of instituting needed quality improvement practice. The IOM reports focus on “leadership at all levels,” including managers and front-line workers, with a particular emphasis on middle managers:

Thus while senior leadership is responsible for setting and advancing the aim of the organization, a continuously learning organization also requires leadership on the part of the managers and front-line workers who translate that aim into practice. Middle managers play a crucial role in on-the-ground, day-to-day management of a hospital’s departments and services— the units that, collectively, make up the organization. These managers form the critical bridge between senior leaders and front-line staff and bear

primary responsibility for translating executives’ vision into action by aligning department goals with the strategic goals of the organization.\textsuperscript{28}

Furthermore, the mandate of ADMHS prioritizes attention to individuals and families in severe crisis, as well as ongoing services for adults with serious mental illness (SMI), children with serious emotional disturbances (SED), and individuals with the most serious substance use disorders (e.g., IV drug users and pregnant/parenting women with addiction), many of whom have complex health and human service needs involving other county and community organizations such as child welfare, juvenile justice, education, criminal justice, homelessness services, employment, immigrant and refugee supports, and treatment of chronic health conditions. Consequently, an effective MH/SUD service-delivery system requires effective partnerships with a wide array of organizations. As the 2005 IOM report section focused on MH/SUD describes:

\textit{... the ways in which M[H]/SU[D] and other health care providers are separated are more numerous and complex than is the case for other health care generally. Not only is M[H]/SU[D] care separated from general health care, but health care services for mental and substance-use conditions are separated from each other despite the high rate of co-occurrence of these conditions. Also distinctive are the location of services needed by individuals with more severe mental and substance-use illnesses in public-sector programs apart from private-sector health care, and reliance on the education, child welfare, and juvenile and criminal justice systems to deliver M[H]/SU[D] services for many children and adults. These disconnected care delivery arrangements necessitate numerous patient interactions with different providers, organizations, and government agencies. They also require multiple provider “handoffs” of patients for different services, and the transmittal of information to and joint planning by all these providers, organizations, and agencies if coordination is to occur. Yet effective structures and processes to ensure coordination of care across clinicians and organizations are not in place.}\textsuperscript{29}

A direct effect of the system-wide experience of an ADMHS leadership culture as crisis-driven, reactive, and overly focused on command/control processes has been a lack of the empowered partnerships at multiple levels that would be needed to engage in organized performance improvement activities to improve outcomes:

- There is a lack of an internal empowered partnerships within the ADMHS county system with middle managers, psychiatrists, clinical staff, and support staff;
- There is a lack of empowered partnerships with CBOs; and

• There is a lack of effective partnerships with other county organizations and systems.

As noted above, the near unanimity in describing current dysfunctional relationships by staff at all levels, county partners, and CBOs was striking, suggesting that ADMHS faces even greater challenges currently in this area than most MH/SUD service organizations. At the same time, these same respondents were nearly as unanimous in their desire to work together more effectively to improve the situation. Despite challenges, there was evidence of tremendous interest in building such partnerships because of the commitment of ADMHS managers, psychiatrists and staff to the mission of the organization and the widespread recognition within the community of the importance of effective MH/SUD service delivery. Potential partners stand ready to help address multiple key issues, including:

• Health care reform and behavioral health (BH)/ physical health (PH) integration: The “Tiger Team” established by the County to provide interim leadership to ADMHS through a joint management team of senior ADMHS and Department of Public Health (DPH) managers has in just the few months since its establishment initiated a joint work group focused on preparation for Affordable Care Act (ACA) implementation, providing a ready platform to build upon.

• Child and Family Systems of Care: ADMHS and the Department of Social Services (DSS) have a focused planning process to address Katie A. Settlement implementation activities that is sound, but in need of broader participation by child-serving agencies in the county (e.g., juvenile probation) and CBO partners.

• MH and substance use disorder (SUD) services integration: There is a strong working relationship between the Alcohol and Drug Program leadership and other clinical managers within MH, and this will permit the development of a more successful system improvement approach to address the need for broader capacity to deliver integrated services for individuals and families with co-occurring MH and SUD conditions across all programs.

• Recovery-oriented care: Regarding system efforts to promote person/family-centered, strength-based care using the vision of the recovery model, there is an emerging capacity for consumer/family empowerment that needs to be further leveraged across the system. There is willingness within county-operated services to improve recovery-oriented services, but as yet there has been no organized quality improvement process to do so. CBO partners are willing partners as well, and as expected are in some ways ahead and some ways behind ADMHS. The entire service array (including hospitals) needs to – and for the most part, wants to – be involved in promoting improved approaches to system, program, and practice development within a recovery-oriented framework.

• Cultural/linguistic competence: CBOs are key allies and community agencies such as La Casa de La Raza have strong community ties and expertise essential to “meeting people
where they are.” While MH/SA funds have been used to establish some focused collaboration, there is need of a broader strategic organizational improvement approach to address current health disparities and promote health equity more successfully within available resources.

- Housing/homelessness: While ADMHS has used MHSA funding to support homeless housing programs and clinical managers regularly participate in work groups and planning related to housing and homelessness, multiple respondents noted the lack of senior ADMHS manager participation in these efforts and the County of Santa Barbara has housing experts requesting ADMHS to step up and play a stronger role. Furthermore, there is an opportunity to better address the MH/SUD needs of homeless individuals at shelters and other places they congregate in the community.

**Recommendation S-2:** Create a transitional structure to develop a quality improvement partnership framework to address current and future system development challenges through an intensive, time-limited process (e.g., six months) at two levels:

a) **Countywide Level:** Evolve the CEO Advisory Committee on Behavioral Health to become a System Change Steering Committee to ensure shared ownership of the partnership process and to monitor progress of the overall levels.

b) **ADMHS Level:** Evolve the Tiger Team into a formal transitional internal management partnership under the direction of the CEO and advised by the Steering Committee until a permanent ADMHS executive leader is hired.

Both efforts should be chartered and the roles of each entity defined, including clarity of the relationship among the System Change Steering Committee (which we recommend be responsible for community-level vision and accountability), the DPH/ADMHS Tiger Team (which should support executive decision-making by the interim Director, Dr. Wada, and joint monitoring), and ADMHS Senior Management (which must remain responsible for implementation and daily operations). Furthermore, DPH and ADMHS senior management staffing must be adequate and some transitional staffing support will be needed during the interim.

The System Change Task Force would coordinate a systemic partnership for quality improvement that would involve all programs engaging in measurable improvement activities and take deliberate steps toward implementation of practices and processes that would improve customer outcomes, both within and between programs. In addition, there would be a team of change agents representing front line staff and consumers/families that would be empowered to partner in the process of implementation. Finally, there would be an array of work groups comprised of change agents from across ADMHS (managers, psychiatrists,
clinicians, and non-clinical staff, both MH and SUD), county partners (DSS, probation, criminal justice, juvenile justice, homeless providers, vocational rehabilitation, schools, etc.), CBOs, hospitals, other providers, and supportive community organizations such as foundations and higher education. Based on the detailed findings of this report described in subsequent sections, it is expected that work groups or action teams could be formed in multiple areas:

- ACA implementation and primary care / MH / SUD service integration;
- Katie A. Settlement implementation and child/family systems of care;
- Eliminating health disparities through cultural/linguistic competent systems of care;
- Intake and crisis system redesign, including improved coordination with the PHF and inpatient facilities;
- Improved access to psychiatric/psychopharmacologic evaluation and management;
- Improved movement between levels of care across ADMHS and CBO programs (both MH and SUD contractors);
- Improved coordination between ADMHS and CBOs at an organizational level;
- Expansion and integration of recovery/resiliency-oriented supports and the MHSA Primary Supports within the core clinic and CBO service array;
- Improved treatment for people involved with the criminal justice system;
- Improved treatment of SUD and co-occurring MH/SUD disorders, viewing primary substance use as a priority population, especially where there are treatment gaps in the CBO system;
- Improved treatment and supports for people who are homeless;
- Improved treatment and supports for employment.

It is also critical that the process of implementation is sound:

- One instructive past effort, due by virtue of its failure, was the short-lived effort of the 2009 Redesign Committee, which lacked strong Board of Supervisors/CEO support and reportedly was overwhelmed in its efforts due to intensive conflict in its initial months of operation. It seems likely that the newly identified MISC and self-disclosure challenges, and the need to repay over $30 million, exacerbated the conflicts.
- In addition to this strong support, the process should also build on the positive energy and involvement of prior MHSA planning processes and should be used to directly drive the MHSA Plan. It is important, though, that MHSA planning not drive the process – the MHSA Plan will be one important outcome of the planning process, but the MHSA Plan is just one of many projects to be driven by the work groups.
- Finally, the System Change initiative should incorporate an explicit communication strategy and include development of a formal communication plan to ensure coordination across groups.
In addition to being informed by past efforts, the research underlying the CCISC model demonstrates the importance of beginning the process with an initial inspiring vision with which to guide and inform the system change activities. While we recommend that the System Change Steering Committee take ownership of this vision-setting process, we recommend that it be broad and inclusive of all behavioral health needs and resources in the county (for example, beginning with a statement such as: Help all ADMHS and contractor programs become welcoming, recovery/resiliency-oriented, culturally competent, trauma-informed, and complexity capable). The vision should be firmly rooted in the MHSA Guiding Principles:

- **Community collaboration**: Individuals, families, agencies, and businesses work together to accomplish a shared vision.
- **Cultural competence**: Adopting behaviors, attitudes and policies that enable providers to work effectively in cross-cultural situations.
- **Client- and family-driven system of care**: Adult clients and families of children and youth identify needs and preferences that result in the most effective services and supports.
- **Focus on wellness, including recovery and resilience**: People diagnosed with a mental illness are able to live, work, learn and participate fully in their communities.
- **Integrated service experiences**: Services for clients and families are seamless. Clients and families do not have to negotiate with multiple agencies and funding sources to meet their needs.\(^{30}\)

It should be noted that several stakeholders expressed a concern that this interim process should not substitute for a focused effort to recruit and hire a new ADMHS Director. The TriWest team agrees that, regardless of how eventual leadership of ADMHS and DPH may be consolidated or aligned over time, the specialized nature of behavioral health financing and care delivery requires a dedicated executive leader charged with responsibility for the functioning of that system. Every major insurance company and health system of which our team is aware (including integrated health plans and delivery systems) maintains an executive leader responsible for behavioral health operations and generally a separate division for managing behavioral health services within an integrated organizational health care mandate.

However, we do not see this gap as urgent. The position should be thoughtfully recruited as part of the community-wide transformation process in order to build community buy-in for the new leader and ensure that the position description reflects the new emphasis on care integration and quality improvement. Moving thoughtfully and systematically will help model an alternative to the current “crisis-driven” management culture at ADMHS. Furthermore, if adequately defined, structured, and resourced, the interim leadership structure led by Dr. Wada can provide a transitional state that can continue for several months in a positive way. It

\(^{30}\) The ADMHS commitment to these values is described at: http://www.countyofsb.org/admhs/admhs2.aspx?id=37228&id2=38600.
is critical that precipitous changes not simply introduce new top-down controls or additional chaos into an already challenged system. The search for a new Director must be driven by a clear vision developed and shared across the community. The most important next step is to formally charter and establish the Tiger Team and ADMHS Senior Management team, including defining meeting times and structure, roles, staff support, decision-making and reporting processes.

Finding S-3: There is a profound lack of effectively organized clinical leadership within ADMHS, and a consequent lack of clinical support to financial and compliance functions.

It is important to qualify this finding in several ways:

- **It is not the case that ADMHS lacks effective clinical leaders.** Senior medical, clinical, and middle management clinicians demonstrated multiple strengths and many successes managing within a challenging environment. However, as described in detail in the subsequent sections of this report, there is a lack of effective organization and empowerment of the clinical leaders, so that they are unable to work collaboratively to manage across boundaries to produce effective system outcomes. Three findings in particular underscore this: the fact that all clinical operations have formally reported for nearly five years to a vacant position on the executive team, the medical director on the executive team is less than a half-time position, and the span of control of clinical supervisors (the critical “middle managers” highlighted in the IOM report) involves supervision of 13 to 25 full time equivalent (FTE) staff (by way of comparison, an Assertive Community Treatment team supervisor oversees only 10 to 11 FTEs).

- **It is also not the case that “clinical” entails only traditional medical supports.** A contributing finding was that many staff reported that ADMHS clinicians too often define “clinical” service as different from (and in some cases in opposition to) recovery/resiliency-oriented supports. As described in more detail below, integration of “clinical” and “recovery/resiliency supports” is lacking. MHSA Principal Supports, including housing, employment, Recovery Learning Centers, outreach/engagement, co-occurring peer supports, and peer-run programs are too often defined as “non-medical” (perhaps because many are currently defined as not covered by Medi-Cal), as opposed to essential components of contemporary behavioral health practice.

- **It is also not the case that clinical leadership is an alternative to financial leadership. Both are essential.** As noted above and described in more detail in the Financial section, ADMHS and the County have made important strides in establishing improved and robust financial processes and leadership. The problem is not too much financial leadership, but rather a lack of organized and effective clinical leadership to work alongside financial leaders to manage the organization effectively. Numerous examples of how a lack of clinical leadership impedes financial performance are noted throughout.
this report. For example, despite visible and robust efforts to increase the proportion of direct service delivery, that proportion has actually dropped and fewer Medi-Cal recipients are seen now than four years ago. Effective reporting of financial data is not enough; there must be empowered clinical managers to direct service delivery to organizational priorities. Looking forward, another example involves current financial projections related to expanded service delivery in 2014 following Medicaid expansion and implementation of the ACA. These assumptions were done as part of the budget development process and are understandably only initial estimates. One of the assumptions of this analysis was that ADMHS has a historical practice of serving anyone with a serious mental illness, regardless of their ability to pay, so there was no expectation of “pent up demand” for service translating into increased numbers of people seeking service. This is an assumption that, while perhaps sufficient for initial budget projections, needs to be examined by clinical leadership to determine its validity as part of the ACA preparation activities in 2013. While it was not within the scope of our study to verify this, numerous consumer, advocate, CBO, and county partner informants described perceived limitations in access to ADMHS services for people without insurance, analysis of trends by payer (described later in this report) show that SBC provides a much higher proportion of its services to people with Medi-Cal than do other comparison counties (suggesting lower service levels overall to people without insurance), CBOs for the most part are allowed to serve very few people without Medi-Cal, and ADMHS currently limits the service array to adults without Medi-Cal to a subset of its services (e.g., CARES and crisis/PHF services). To carry out this more informed analysis, ADMHS financial leaders are in need of clinically-informed counterparts.

With those three qualifications in mind, our third major systemic finding is that clinical leadership is lacking at two levels:

• **At the System Level,** there is a lack of a clearly articulated process to advance near-term strategic goals related to improvement of overall access and engagement of individuals and families with challenging and complex needs, including acute care and crisis system planning, preparation for health care reform, children’s system of care development (including implementation of Katie A. Settlement activities), behavioral health/physical health (BH/PH) integration, MH/SUD integration, recovery-oriented care promotion, cultural/linguistic competence development and disparity reduction efforts, and effective service delivery to adults in the criminal justice system and those who are homeless.

• **Within ADMHS:**
  - There is a lack of operational clinical leadership (e.g., a lack of clarity of the link of clinical operations to the executive management team, limited Medical Director
time, a need for clear roles for senior/regional/system-level managers, etc.) with a contemporary recovery/resilience vision,

- There is a dramatic lack of clinical operational / policy frameworks (e.g., person flow, quality management/utilization management [QM/UM] frameworks, capacity management, contract management clinical priorities, integrated MHSA supports, etc.),
- There are numerous examples where current system approaches lead to inefficient resource utilization (e.g., crisis design, lack of flow between service levels, etc.), documented in more detail in the next section, and
- There is an underperforming compliance function in clinical areas (internal and contract), documented in more detail in the final section of this report.

Recommendation S-3: Articulate an operational vision for ADMHS 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.

Because of the successes of the past five years in establishing basic financial and contract oversight processes, ADMHS is at the point of development where it can now focus additional effort on its core “product”: effective clinical service delivery. ADMHS has made progress in its financial risk management and establishment of sound core business capacity. However, substantial risks remain and many new ones (including ACA and Katie A. Settlement preparations) confront the organization currently. Many of these risks require informed clinical judgment to carry out adequate financial planning and risk mitigation preparation. Current budgeting and contracting processes provide a highly structured financial management process around which to build a fully functional management team that aligns finance and compliance to support clinical priorities. Articulating this as a core component of the County’s vision for ADMHS is critical.

It can be expected that some members of the community may be understandably concerned that this shift involves a “backing away” from rigorous financial and compliance processes. County leadership must not allow this to be the case. As noted above, finance and clinical priorities need not be in conflict. The concern to be remedied is not “too much” financial competence, but rather insufficient organization and application of clinical competence. The concept of “value of care” may offer a construct to blend both clinical and financial responsibility: “As fiduciaries with responsibility for the organizations’ clinical and financial performance, governing bodies are accountable for the value of care delivered, and in turn can
hold organizational leaders accountable for achieving that aim.” The concept of value has perhaps been most famously articulated in a key organizing construct of health care reform known as the “Triple Aim,” a simple and very challenging three-fold simultaneous goal:  

- Improve the health of the population,
- Enhance the patient experience of care (including quality, access, and reliability), and
- Reduce, or at least control, the per capita cost of care.

The IOM holds out a similar hope for organizations making the transition to quality-driven, learning organizations:

A learning organizational culture has been shown to be predictive of successful financial performance, and studies have found that financially successful organizations score highly on organizational health metrics, including training and development, communication, flexibility and openness to change, job satisfaction, managers facilitating and recognizing staff performance, and customer satisfaction (Barney, 1986; Boan and Funderburk, 2003; Fisher and Alford, 2000; Gordon and Ditomaso, 1992; Keller and Price, 2011; Rotemborg and Saloner, 1993; Senge, 1990). In addition, several health care organizations have found that embracing business practices that promote continuous learning and improvement enhances quality and reduces costs (Cosgrove et al., 2012).

As emphasized in the prior section on evidence-based practice, the TriWest team recommends that SBC approach the detailed findings in the following sections of this report within this systemic framework. Again, we reiterate: SBC and ADMHS should not attempt to fix problems identified in the following sections of this report piece-meal. If specific recommendations are addressed separately from the broader systemic quality and performance improvement framework articulated in Recommendations S-1 through S-3, reform efforts risk perpetuating (and perhaps exacerbating) the command and control culture that has compromised past efforts to improve.

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Detailed Findings and Recommendations: Clinical Operations

Finding CO-1: There are many clinical strengths and evidence-based practices currently in use by ADMHS clinical operations and contract service providers.

Our review of clinical operations at ADMHS and the CBOs identified strong staff and efforts to promote evidence-based practice in every setting. While we also identified practice improvement opportunities in each setting, the primary limiting factors we identified were the systemic factors described in the previous section. The implication of this is that a systemic shift toward improved collaboration and quality improvement has immediate potential to leverage the existing strengths of the system.

One clearly evident strength of this system’s clinical operations is the quality of staff we met. Medical, clinical and support staff without exception presented as professional, resilient, hopeful and very engaged in getting their work done despite a difficult environment and lack of clear policies. In fact, the over two dozen medical and clinical staff that specifically reached out to our assessment team to offer concrete suggestions for practice and process improvement (over 15% of the clinical workforce) was in our experience an unprecedented level of response to a study of this type. We see this as evidence of both the interest and ability of staff to participate in positive change, as well as the current lack of other forums for staff to offer their input and suggestions.

The take-away from our many interviews, sample chart reviews, and data analysis is that clinical operations (both county-run and contract) are supported by committed staff serving people with complex needs. In the county in particular, many have long tenures of service and many years of experience. Furthermore, despite concerns expressed among many staff that levels of turnover and burnout are high, review of data provided by human resources did not find this to be the case. Turnover is relatively low for ADMHS employees, and use of leave is comparable to other county departments.

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Employees</th>
<th>Number Of Voluntary Separations</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>267</td>
<td>9</td>
<td>3.4%</td>
</tr>
<tr>
<td>2011</td>
<td>275</td>
<td>17</td>
<td>6.2%</td>
</tr>
<tr>
<td>2010</td>
<td>269</td>
<td>19</td>
<td>7.1%</td>
</tr>
<tr>
<td>2009</td>
<td>284</td>
<td>19</td>
<td>6.7%</td>
</tr>
<tr>
<td>2008</td>
<td>266</td>
<td>15</td>
<td>5.6%</td>
</tr>
</tbody>
</table>

Analysis (“ADMHS Turnover 3-29-2013”) provided by ADMHS Human Resources on 4/9/2013.

Employee Count is based on number of filled positions as of Pay Period 15 of each year.

Voluntary Turnover includes all voluntary separation reasons except for retirement.
Lost Time\(^{37}\) by Select County Department\(^{38}\)

<table>
<thead>
<tr>
<th>Year</th>
<th>ADMHS</th>
<th>Public Health</th>
<th>Social Services</th>
<th>Probation</th>
<th>Sheriff</th>
<th>Public Works</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>5.3%</td>
<td>5.4%</td>
<td>6.1%</td>
<td>6.2%</td>
<td>5.4%</td>
<td>5.2%</td>
</tr>
<tr>
<td>2011</td>
<td>5.0%</td>
<td>5.9%</td>
<td>6.3%</td>
<td>5.7%</td>
<td>5.7%</td>
<td>5.0%</td>
</tr>
<tr>
<td>2010</td>
<td>4.6%</td>
<td>4.3%</td>
<td>6.3%</td>
<td>5.6%</td>
<td>5.4%</td>
<td>4.7%</td>
</tr>
<tr>
<td>2009</td>
<td>4.6%</td>
<td>4.9%</td>
<td>6.5%</td>
<td>4.9%</td>
<td>4.5%</td>
<td>4.5%</td>
</tr>
</tbody>
</table>

Keep in mind that ADMHS staff maintain this level of effort despite a difficult job and a challenging workplace culture, exacerbated by the severe financial challenges of the past five years. Staff clearly are committed to their jobs and every staff member we spoke with was demonstrably mission-driven in their presentation. County employees are also relatively well paid and county benefits are substantial, in comparison to verbal reports by multiple informants comparing county to CBO staff costs. While it was beyond the scope of our study to carry out a wage and benefit comparison, we did review county pay and benefit levels, and county human resource costs were cited as a primary reason for the Probation Department deciding to contract its mental health services to a private vendor rather than ADMHS for FY 2013-14. The benefits of county employment in terms of a relatively stable workforce are clear, but the costs do limit the perceived competitiveness of ADMHS from strictly a cost perspective.

Another major area of strength is the progress that has been made in implementation of evidence-based practices (EBPs). In particular, ADMHS has used MHSA and other funds to develop best practices at ADMHS clinics and through specific CBOs for adults (ACT, Supported Housing/SH, peer support, supported employment), children and families (Transition Age Youth/TAY, fidelity-basedwraparound, trauma-specific care), culturally-informed care models (promotores, interpreter training), co-occurring MH/SA and SUD treatment models (harm reduction, strong co-occurring models in ADP, medication interventions, Motivational Interviewing), and primary care / behavioral health integration (pilots using MHSA funds at Community Health Clinics of the Central Coast). In addition, CBOs have initiated their own efforts to develop specialized EBP capacity, including trauma-specific care, parent-child interaction therapy, and other approaches. The local National Alliance on Mental Illness (NAMI) chapter is very active and a key partner to ADMHS. The commitment of ADMHS to training and employing peer specialists is a particular strength of the organization, as is employment of a peer leader on its senior management team. This strength is a foundation upon which more system-wide implementation of best practice can take place.

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\(^{37}\) Lost Time includes all hours lost due to the following types of leave, as a percentage of all available time in the department: Sick and Medical, Workers Comp, Leave of Absence.

\(^{38}\) Analysis ("Lost Time – Summary by Functions") provided by ADMHS Human Resources on 4/9/2013.
Recommendation CO-1.1: Build on existing clinical strengths by involving ADMHS staff and CBO leaders and staff as partners in transitional and ongoing quality improvement efforts.

As noted at the outset of this section, ADMHS and CBO strengths are a base to build upon, and we expect that the systemic shift toward improved collaboration and quality improvement will yield many near-term (e.g., three to six months) improvements as current strengths are better leveraged. Also, our recommendation is to build upon strengths rather than initiate new programs. Improving practice within existing programs should be the immediate first goal, and any program development should first consider development of capacity within existing ADMHS and CBO programs before pursuing new program development. This is not to say that more in-depth review over time might not result in re-procurement or substantial program redesign. In fact, our findings related to the crisis system described below suggest that substantial redesign of these programs may be necessary over the medium term (six to 12 months). However, we recommend that this be driven by a collaborative planning process involving staff and external stakeholders, including CBOs. In a quality improvement process, identifying staff representing each program to be “change agents” in the process is an effective way of developing an empowered team to partner with leadership in these efforts. It is important to remember, however, that being a change agent can be accomplished without compromising attention to core job requirements. Change agent teams generally meet no more often than monthly, and most of the work of individual change agents occurs during the normal “flow” of work in their own programs.

Recommendation CO-1.2: Carry out a wage and benefit study comparing the costs of ADMHS clinical staff to those in comparable California counties and other comparable health providers in Santa Barbara County.

As noted above, staff costs are perceived to be high and were cited as a reason why one other county department chose not to contract with ADMHS to provide mental health services. It was beyond the scope of our study to assess staff compensation, so we inquired with human resources and found that it has been many years since such a study was carried out. While the TriWest team recognizes and affirms the value of competitive compensation for county employees and the advantages in terms of workforce stability gained by strong benefits (including retirement), the pressure to control health care costs will only grow given implementation of the Affordable Care Act. ADMHS needs to be able to assure potential purchasers of its services that staff costs are comparable to those of other counties. From a strategic perspective, ADMHS would also be better informed if it could compare staff costs to those of other Santa Barbara County health care providers, including CBOs, hospitals, and private vendors. The goal of this study would not be to match these costs, but rather to document the relative differences and inform efforts to improve and demonstrate the value of ADMHS services.
Finding CO-2.1: Transitions between treatment programs are a major area of challenge both within ADMHS and between ADMHS and other contract and hospital providers.

At the system level, the SBC outpatient continuum of care (both ADMHS and CBO services) is not designed to meet the needs of people served and is striking in its level of disconnectedness between system components. This also affects flow between crisis and acute care services and outpatient services of various types, thus contributing to back up and overutilization of those expensive high-end services.

Individual clinical programs function independently without a framework of shared values and without specific policies to guide transitions between and interactions with other programs. Each discrete treatment program (county and CBO) operates without the overarching, county-level set of policies and coherent service-driven vision necessary to coordinate treatment progress across programs, from routine or crisis entry, through an array of integrated services at multiple levels of intensity, on to recovery and support of housing, employment, and relational goals. Despite pockets of excellence within every discrete program reviewed, flow between programs for every person served must therefore be individually negotiated (even between internal ADMHS programs), which is time consuming, confusing, inefficient, and counter to systemic efforts.

As a result, every program is disconnected and non-integrated, requiring ADMHS to use its flexible funds (e.g., MHSA) for targeted enhancements when the overall system is in many ways clinically foundering, resulting in excessive use of high cost services within and outside the system. The low use of the crisis residential program at CARES North is a particularly compelling example of poor positioning, design and under-performance.

Performance ranges from inadequate to poor, with a lack of guiding policies at all transition points across the system of care:

- For referral into CARES, there is a lack of timeliness and poor psychiatry access (data on this is provided in subsequent findings).
- For transitions from CARES to clinics, there is a lack of timeliness, poor psychiatry access (ongoing care and mobile crisis oversight), a lack of consistent access standards and admission criteria, and external criticism of mobile crisis team responses to law enforcement and hospitals (more on this below).
- For transitions from ADMHS to CBOs, there is no uniformity of standards for referral to CBOs versus county programs.
• For transitions from PHF to clinics, there is a lack of standards for access to outpatient care (e.g., there are waits of over one month for outpatient care due to lack of access, despite room on ACT teams).

• For transitions between Public Health and ADMHS, there are emerging standards to coordinate referrals, but they are not reliably implemented according to medical staff in both departments, nor are there guidelines for cross consultation and collaboration.

• Despite reports of good collaboration for open cases, there are problematic transitions from community partners (e.g., homeless providers, law enforcement, DSS, probation, the jail) to ADMHS.

• There is particularly problematic coordination with schools (and little focused system effort to improve this) and developmental disability service providers.

The shared perspective across nearly every interview we conducted is that referral across services – to clinics, ACT teams, etc. – is similar to referring a person from outside the system and is very burdensome, particularly for people with complex, co-occurring substance use needs and for initial access to psychiatrists (more on this in later findings).

The situation at CARES for adults is particularly problematic at multiple levels:

• For the CARES residential program in North County, there is widespread recognition that the program is underutilized and this has been confirmed through both the HMA Project 1 report and an independent grand jury review.\textsuperscript{39} A review of the program on site and discussions with multiple informants found a consensus that levels of medical staffing are perceived to be inadequate (during the day, medical staff must cover both the CARES outpatient and mobile crisis programs, as well as the residential program). Coordination was seen to be better between the program and the ACT team in the North County. Given the investment of resources in this program, the clear need for co-occurring MH/SUD treatment capacity, and a lack of other 24-hour acute programs in North County, there is a critical need (and opportunity) to revisit this program design and identify near and longer term improvement opportunities.

• For the CARES intake process (both North and South), people routinely stay so long at CARES that they understandably develop a positive connection to the program. This is of concern because the array of available services at CARES is limited compared to ADMHS clinics or specialty teams (e.g., ACT, SH). The length of stay at CARES is routinely too long for many people, and this is compounded by the fact that CARES length of stay is not routinely monitored at the system level and it is up to the individual CARES program to essentially fend for itself in terms of brokering transfers to ADMHS clinics and specialty teams. A systematic redesign of the relationship between CARES services, clinic services, and medical staff.

\textsuperscript{39} Santa Barbara County Grand Jury. (July 2012). CARES Crisis Residential North: An Underutilized Mental Health Asset.
and specialty team services is warranted and should consider integrating the intake and utilization management functions so that the whole array functions more as a single continuum of service with bidirectional flow into the right service intensity and team. This has some similarities to the model currently used (with wide agreement of more success) at the much smaller Lompoc Clinic. While issues of scaling must be addressed in any comparison between Lompoc and the two more populous areas of the county (North and South), the move toward more integration of clinical function generally yields better results in evidence-based applications (see multiple examples in Appendix 2) and should be considered.

• Design issues and central supports must also be addressed for the Mobile Crisis teams. One particular area of concern for these teams, explored in more detail in the Administrative section of this report, is the broad span of control for CARES supervisors. In addition, CARES staff must each manage an independent regional system of call monitoring for both routine and crisis calls. Each CARES program has its own system and protocols for tracking and responding to calls, with no common standards or common supports beyond the shared infrastructure of the Sharecare system and the Clinicians Gateway electronic health record. Although the Electronic Health Record (EHR) is deemed adequate, the internally developed scheduler is quite problematic and contributes to the difficulty of cross-referrals between programs. At CARES South, for example, one supervisor and two full time office staff support 21 FTEs of clinicians and manage five to 10 intakes a week, a range of 200 to 300 routine calls a week, and approximately 100 calls a month requiring mobile response.\(^\text{40}\) Mobile crisis responses are tracked by hand to document response time, and the system response is reportedly 15 to 20 minutes on average for calls to the field and 30 to 35 minutes on average to hospitals, which are excellent response times. Responses times are reportedly longer in North County, which is understandable given the much larger service area. Furthermore, it was reported that very few calls are not responded to in such a rapid fashion, and these are generally due to program-specific clinical and procedural requirements. Reportedly, there are few complaints about initial response from hospitals, but relatively more complaints about the time it takes to resolve placements for people with involuntary treatment needs (i.e., 5,150 cases). For law enforcement, there were reports of complaints that their requests are not always satisfactorily addressed. While on the surface this level of performance seems reasonable, the issue is that it is impossible to verify (our team sought to, then decided against doing so because it would take hours for staff to convert the handwritten logs to electronic form and the logs only track responses to calls, not non-responses). More problematically, because the data are not useable, it is impossible to study trends internally to support improvements, document needs for additional resources, or demonstrate convincingly

\(^{40}\) Based on a summary of current program data provided by the South County Regional Manager on 4/22/2013.
to external stakeholders the degree to which services are responsive. Improved procedures and data analytic supports (both staff and technology) are clearly needed.

• Overall, the ambulatory crisis response capacity for the County is underdeveloped compared to the investment in more routine or long-term service. As a result, intensity of crisis response may be insufficient resulting in higher utilization of more expensive options.

This approach is costing the county too much in high-end service use. According to External Quality Review Organization (EQRO) findings, just 222 high-cost Medi-Cal beneficiaries in FY 2012 drove over $10 million in claims; this is 35.2% of all Medi-Cal claims (well above the statewide rate of 25%).

A very high proportion of the global budget is being spent on very expensive care for a relatively small number of people through the county-run Psychiatric Hospital Facility (PHF), crisis residential program in North County, IMDs, high-cost residential programs and ACT/Supported Housing. For example, in FY 2012, nearly $25 million was spent on high-end services, largely for adults.

The table on the next page provides a comparison of the California External Quality Review Organization (EQRO) reports for calendar year 2010. The EQRO reports show that the Medi-Cal penetration rate (the percent of Medi-Cal beneficiaries that received Specialty Mental Health Services) in Santa Barbara County was both lower than most other counties (with the exception of Monterey), and the claims per beneficiary were slightly higher, meaning SBC provided more Medi-Cal services per member served than the other counties. SBC also had a significantly higher claimed amount per beneficiary for inpatient services relative to the other counties even though they had similar penetration rates. In contrast, the other counties had higher residential claims per beneficiary, implying the other counties might have been able to reduce inpatient services by transferring members served to lower, less costly levels of care. One final statistic demonstrating lack of movement was that more than 50% of the Medi-Cal members served by SBC received 15 or more services during the year while the other four counties ranged from 37 percent to 47 percent. This again indicates that SBC provides more services per member relative to the comparable counties.

42 Same citation. Page 74.
External Quality Review Organization Medi-Cal Specialty Mental Health 2010 Data

<table>
<thead>
<tr>
<th>County</th>
<th>Total Medi-Cal</th>
<th>Medi-Cal Inpatient</th>
<th>Medi-Cal Residential</th>
<th>% of Clients with More than 15 Services / Year</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Penetration Rate</td>
<td>Cost/Member Served</td>
<td>Penetration Rate</td>
<td>Cost/Member Served</td>
</tr>
<tr>
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<td>$6,679</td>
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<tr>
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<td>7.66%</td>
<td>$4,960</td>
<td>0.44%</td>
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<td>Monterey</td>
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<tr>
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Finding CO-2.2: Access to care in general is inadequate and decreasing over time.

Due to the many policy and procedural gaps noted above, access to services at all levels of care is a major challenge. Fewer people are being seen, with Medi-Cal penetration having dropped 22% from FY 2008 to FY 2011.\(^{44}\) It also takes too long to be seen. According to the EQRO report, only 47% of people are seen within the 10 day standard.\(^{45}\) Telephone access is also reportedly unreliable and, as described above in the analysis of the CARES programs, there is inadequate infrastructure to support performance tracking. See the table on the following page for an overview of people served and caseloads by program and staff type within programs.

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\(^{45}\) Same citation. Page 18.
### Program Staff and 2012 Active Cases by Program

<table>
<thead>
<tr>
<th>Program</th>
<th>Total Clinical Staff</th>
<th>Psychiatrists</th>
<th>Other Clinical</th>
<th>Peer Staff</th>
<th>Active Cases</th>
<th>Cases Per MD FTE</th>
<th>Cases Per Non-MD/Peer FTE</th>
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<tbody>
<tr>
<td>Lompoc</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
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<tr>
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<td>121</td>
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</tr>
<tr>
<td>PEI - TAY</td>
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<td>n/a</td>
<td>n/a</td>
<td>13</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>TAY - New Heights</td>
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<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>27</td>
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<tr>
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<tr>
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<td>n/a</td>
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<td>13</td>
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<tr>
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<td></td>
<td></td>
<td></td>
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</tr>
<tr>
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<td>19.0</td>
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<td>339.0</td>
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</tr>
<tr>
<td>SB Children's Services</td>
<td>9.5</td>
<td>1.0</td>
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<tr>
<td>Santa Maria</td>
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<td></td>
<td></td>
<td></td>
<td></td>
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<td>n/a</td>
<td>108</td>
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</tbody>
</table>

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46 Does not include peer staff or peer interns.

47 Includes peer interns.

48 Active cases were calculated as an average of Calendar Year 2012 monthly totals of people seen during the month for overall programs; for individual child and specialty adult programs, cases are a snapshot from September 2012. Since staffing breakouts per child program were not available (n/a) to the TriWest team, detailed FTE analysis for child teams was not completed. Source: ADMHS Summary Table: (1) ADMHS Report SC4040B: “MH: Services Rendered between 01/01/2012 and 12/31/2012.” (2) “Total Census – September, 2012.”
<table>
<thead>
<tr>
<th>Program</th>
<th>Total Clinical Staff</th>
<th>Psychiatrists</th>
<th>Other Clinical Staff</th>
<th>Peer Staff</th>
<th>Active Cases</th>
<th>Cases Per MD FTE</th>
<th>Cases Per Non-MD/Peer FTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>PEI - TAY</td>
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<td>47</td>
<td>n/a</td>
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<td>n/a</td>
<td>11</td>
<td>n/a</td>
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</tr>
</tbody>
</table>

**Specialty**

<table>
<thead>
<tr>
<th>ACT Teams (includes team lead)</th>
<th>Total Staff</th>
<th>Psychiatrists</th>
<th>Other Clinical Staff</th>
<th>Peer Staff</th>
<th>Active Cases</th>
<th>Cases Per MD FTE</th>
<th>Cases Per Non-MD/Peer FTE</th>
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</thead>
<tbody>
<tr>
<td>Santa Barbara</td>
<td>42.3</td>
<td>2.8</td>
<td>39.5</td>
<td>271</td>
<td>96.8</td>
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<td>13.0</td>
<td>96</td>
<td>96.0</td>
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<tr>
<td>Lompoc</td>
<td>14.3</td>
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<td>13.5</td>
<td>91</td>
<td>113.8</td>
<td>6.7</td>
<td></td>
</tr>
</tbody>
</table>

| Supported Housing Teams        | 21.15       | 1.15         | 20.0                 | 223        | 193.9        | 11.2             |                           |
| Santa Barbara                  | 10.5        | 0.5          | 9.0                  | 1.0        | 113          | 226.0            | 12.6                      |
| Santa Maria                    | 10.65       | 0.65         | 9.0                  | 1.0        | 113          | 173.8            | 12.6                      |
While staff report high caseloads and limited capacity to serve more people, only the psychiatrist caseload at CARES North exceeds routine levels reported by other California counties (more on this in the psychiatrist findings below). Discussions at programs and clinics with staff and psychiatrists suggested many opportunities for more flexible, recovery-oriented best practice redesign of the core service teams even within existing resources.

However, one major limitation of the table above is the reliability of the caseload figures. We found a lack of consistency in caseload reporting within programs (estimates varying up to 25% across reports). One component of this finding is that there is no standard metric or reporting to track caseloads at ADMHS. While caseload is only one metric needed to manage performance, the lack of reliable tracking in this area is a major limiting factor for program improvement and overall population management in the system. For example, staff and physicians at CARES North and South reported much higher numbers of people served (anecdotally at over 300/400), whereas the data in the table show levels to be much lower (in the 245 to 339 on average). Furthermore, caseload data are not reliably maintained across time. Comparing the time period of January 2012 through October 2012 with December 2012 (which coincides with the timing of our data requests), reported caseloads dropped 20% to 27%. We interpret this to more likely be an ad hoc effort to clean up caseloads by closing cases no longer seen (and perhaps to some degree some initial efforts to expedite flow between programs) rather than a precipitous drop in people served. In addition, the poor design of the scheduler and its inconsistent use impedes supervisor use of this tool (as is common in other organizations) to assist in balancing caseloads, managing intakes, managing productivity, and identifying problems with show rates. More broadly, programs seem to rely only on productivity tracking reports (more on the limitations of these reports in the Financial section) and have no routine management reporting data on critical variables. An array of potential metrics is listed in the recommendations related to these findings.

Finding CO-2.3: Despite impressive improvements in the number of bilingual Spanish-speaking staff hired and the number of Latino / Hispanic people served each year, significant disparities related to race, ethnicity and culture persist. Santa Barbara County is very diverse. Nearly 53% of its population is non-white/Hispanic and nearly 40% speak a non-English language at home. 49 Both of these percentages are higher for those in poverty, though specific data are not available. Accordingly, ADMHS has a strong Cultural Competency Plan (dated September 2010) that defines culture broadly (including gender and sexual minorities, in addition to race and ethnicity) and also focuses on linguistic competency, including standards for using interpreters. The plan provides clear documentation of various factors associated with provision of services to people in Santa Barbara County,

49 http://www.quickfacts.census.gov/qfd/states/06/06083.html.
whose composition is varied from urban to rural and isolated, and attempts to document variability in available levels of service and community needs based on data and other factors.

The provision of focused training by ADMHS in the area of cultural competency is commendable, as has been its commitment to achieve clinical and non-clinical ADMHS staff composition of 40% Spanish-speaking. The advocacy and support of the Latino Advisory Committee (LAC) is another system strength, and its recent focus group report was an important source of data for the TriWest team.\(^5^0\) MHSA funds have been deployed in creative and targeted ways in support of cultural competency goals, primarily to provide outreach and engagement services in various parts of the county.

There are, however, limited identifiable outcomes in the Cultural Competence Plan and the suggested performance metrics (other than tracking levels of bilingual Spanish-speaking staff) appear not to have been endorsed by the organization nor developed with sufficient collaboration with program managers and the broader ADMHS management team to support their implementation. There also does not appear to be a strategic focus in the Plan on building service capacity within current ADMHS and CBO programs, extending the range of these programs to more community settings, or integrating these MHSA-funded initiatives with the broader system. Instead, the initiatives (while impressive in their focus and design) function essentially as independent, small, standalone projects facing the same challenges as the rest of the community in accessing ADMHS programs. The PEI Promotora efforts in particular are promising, but are small and do not seem to be integrated with broader services, and they are the only culture-specific program efforts we identified for non-Latino populations (e.g., African American, LGTBQ, etc.).

Of even greater concern is that fact that the 2010 Cultural Competence Plan has not been formally adopted and implemented as an ADMHS policy/procedure and is not organizationally visible. For example, the website section on culture refers to training, but does not refer to a plan. Other than the focus on increasing numbers of Spanish-speaking staff at ADMHS and CBOs, key commitments appear unmet (e.g., tracking indicators related to the Oaxaqueno community and tracking provision of/standards for interpretation). Furthermore, even the positive metric of the 40% bilingual Spanish-speaking staffing goal is reportedly limited because it does not take into account regional differences (for example, there are reportedly more Spanish-speaking people in North County than in South County).

\(^5^0\) Santa Barbara County Latino Advisory Committee. 2012. Santa Barbara Latino mental health at the crossroads: Results and recommendations of the Focus Group Project of the Mental Health Services Act Latino Advisory Committee.
ADMHS serves high proportions of people of color (just over 60% for the 93.8% of cases for which such data is reported), people who speak languages other than English (19%), Latino/Hispanic (over 50%) and people who speak primarily Spanish (12%). While over 50% of people served (and even more people in need) are Latino/Hispanic, only 37.2% of clinical staff speak Spanish (and the multiple languages and dialects of the Oaxaca region are not tracked, despite recommendations to do so in the Cultural Competency Plan). In addition, outreach to broader diverse populations is much less developed.

In response to community concerns, resources were added to our study to examine the needs of Latino and Hispanic populations in SBC, and focus groups with Latino leaders, consumers, families, and staff were conducted in North and South County in January 2013, with follow-up meetings with consumers and families in South County to review initial results in April 2013.

Multiple disparities were found. To some degree, Latino and Hispanic informants reported the same challenges that the broader system faces in accessing ADMHS services. They reported:

• It is hard to get an appointment; compounding this, the system is very complex and too often it is not welcoming, especially if one does not speak English;
• Appointments – especially with doctors – take too long to happen;
• People are not aware of services that are available;
• Communities in Santa Maria and Lompoc do not feel as valued and perceive that they have fewer resources;
• Coordination with law enforcement, schools, and other agencies often does not work well;
• Access to housing is a concern;
• Services for people with needs that are less severe (for example, depression as opposed to schizophrenia) are even less available;
• Services in primary health care / medical clinic settings are lacking;
• Services that treat the entire family are lacking; and
• Coordination support for children, families and adults involved with multiple systems is lacking.

However, the interviews, focus groups, and subsequent data analysis found many unique concerns (many also well documented in the LAC report):

• Stigma about mental health is stronger in many Latino communities;
• Despite increases in the number of clinical staff that speak Spanish at ADMHS (31.5% in 2011 to 36.1% in 2013), the clinical services provided are still too often not provided

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52 Source: “Staffing Report for April 9 2013 LAC Meeting.xls.”
by bilingual staff (this was the case in four of the five cases TriWest reviewed, which is too small a sample to generalize; however, the LAC report also highlights this);

- Even more importantly, too often services are provided by staff that, even if bilingual, lack sufficient clinically-relevant bicultural expertise to conduct culture-based differential assessment, formulation of treatment plans, and integration of principles of recovery in ways relevant to SBC’s many different Latino sub-communities; according to the LAC report, only 20% of people of Latino/Hispanic culture receive culturally appropriate care;

- Relatedly, while there are more therapists now that speak Spanish, language is only part of the need; there also needs to be understanding and valuing of culture by developing standards for what constitutes a qualified bicultural staff member and using them to employ more bicultural staff;

- Availability of interpreters is also limited; this was a key finding of the LAC report, which requested additional follow up to examine the underlying causes; in reviewing this further, the TriWest team identified the primary driver as the use of the current productivity tracking tools to encourage staff to provide more direct than indirect service; because of this, staff report that they believe that interpretation is less valued than direct therapy and collaboration and consultation regarding the care of another staff member’s case is discouraged;

- Outreach to and services for people from the Oaxaca region too often fail to recognize the cultural and linguistic differences of the many cultures of that area;

- Law enforcement coordination is complicated by additional lack of coordination with immigration and naturalization services for immigrants;

- There is a need for more community-level education and support in response to community concerns such as suicide, gang involvement, refugee issues, and immigration issues.

Respondents and the LAC report also identified many opportunities for improvement, including:

- Promotion more broadly through multiple methods of welcoming, responsive services by “a person who speaks my language and truly understands my culture” (from the point of initial access to make an appointment through the entire process);

- Expanding employment targets for bilingual staff to languages other than Spanish, development of standards and recruitment targets for bicultural staff, and targeting employment of culturally diverse staff for key positions such as managers and psychiatrists;

- Expansion of support groups such as Nuevo Amanecer, specifically targeting expansion across North County, Lompoc and South County and encouraging ADMHS and CBO staff to form such groups;
• More flexible scheduling at ADMHS clinics and CBOs, including evening times outside of normal working hours and promotion of family-inclusive services;
• Development of SUD prevention, detox, residential, and treatment programs that are culturally and linguistically competent;
• “Providing care where people are” – community settings, family resource centers, cultural centers, churches and faith-based settings, and primary care clinics;
• Utilizing bilingual and bicultural staff and agencies (such as Casa de La Raza) to help “bridge” the gap to care, as well as expanding (and better coordinating with existing services) use of promotores and cultural brokers,\textsuperscript{53} staff willing to serve as interpreters and advocates, and natural supports such as priests, clergy, other human/community service agencies;
• Addressing barriers for individuals concerned about their legal status or documentation, including coordinated efforts with non-profit and faith-based partners;
• Media campaigns in Spanish via Latino/Hispanic media – in partnership with other Latino community partners and leaders – to help combat stigma and increase awareness of available services;
• Promoting Latino heritage by sponsoring events, fairs, and gatherings to reach Latino communities; and
• Partnering with other agencies to support staff recruitment.

The history of the support group El Nuevo Amanecer is instructive. The following “case study” was developed with the help of group leader, Francisco Palencia:

“El Nuevo Amanecer” (translated in English as “The New Dawn”) started as a monthly support group in the fall of 2006. It was initially held at Casa de la Raza and led by an ADMHS bilingual-bicultural counselor. The group began with two people in a small room. Initial efforts to promote the group through pamphlets, presentations at churches and community events were not seen as successful as originally hoped, reportedly because the Latino community lacked trust in the broader system, but the group consistently grew over time. As it grew, the group had to change locations multiple times, until in August 2010 it moved to its present location at CARES South, where the group meets twice a month in the evening. The key factor in the group’s success, as attested to by its leadership, members, and external respondents, was the presence of trust growing out of the mutual support framework. In addition, CARES South is situated in a central location in Santa Barbara accessible by bus, walking and car, and ADMHS provides childcare for the families who attend. Of major importance is the cultural component emphasized consistent, including both celebration of Latino traditions and values as well as support in adapting to a new culture. Engaging family members is also critical.

\textsuperscript{53} See description of these promising practices in Appendix 2.
Finding CO-2.4: Detailed clinical policies are lacking to guide routine clinical service delivery, including uniform standards for initial and continued access to care by level of care, standards to guide transitions between levels of care, and functioning of interdisciplinary teams.

At a more detailed level, there are multiple clinical policy gaps; in fact, a consistently used set of clinical policies and procedures was simply not available to the review team. Nearly every clinical policy requested was either not provided, provided in draft form (often quite good) by a discrete program or individual manager, limited in scope, old, or not currently used. For example:

- Clinics reported different operational policies and displayed no consistency in practice for managing and tracking phone calls; accepting referrals; scheduling; intake, discharge or transfer to another program; case assignment; interdisciplinary team functioning; the use of best practices; and treatment of people with complex needs (more on this in later findings).
- The draft for the co-occurring services policy prepared by the ADP Program Manager is excellent, however, it was not signed nor was it apparent that it had been approved by senior management.
- There was no evidence that the Cultural Competency Plan in any way affects ADMHS or CBO program functioning (other than requirements for bilingual staff recruitment).
- For the clinical policies that do exist (see the ADMHS website for a complete listing), they consistently lack sufficient guidance to form a standard of care. For example, Policy #54 on Medical Services guarantees urgent psychiatrist appointments within 72 hours, but only for county-operated programs and the criteria is “determined by . . . Staff”. Otherwise, Medical Service access is defined with an across-the-board maximum wait time of 60 days, for both children and adults, regardless of level of need or objective indicators of acuity (such as discharge or diversion from PHF, other hospitals, homelessness or other agency; out-of-home settings such as jail, juvenile detention, child welfare facilities, foster care; or others).

As a result of the across-the-board gaps in policies and procedures, collaboration between clinics, CBOs, facilities, and county partners have to be addressed individually by Regional Managers, clinic supervisors and physicians. While informants reported that collaboration is a positive experience in many cases, because of a lack of standardization and policy they also uniformly report too many backups and frustrations.

Clinical policies impede functioning at multiple levels with a significant impact on the ability to use available capacity and expertise to serve people in need. In addition, clinic supervisors have too many direct reports (managing 13 to 25 FTEs each), impinging on both clinic management
and Regional Managers’ time. However, it is also true that multiple managers in central administration do not have current operational responsibilities, so it is not necessarily true that “more managers” is the answer (this is discussed in more detail in the Administrative section). There is also a lack of standards to guide interdisciplinary team functioning at CARES and the ADMHS clinics, and multiple team members report barriers to working together (both because of a lack of procedures and because of a lack of supervisory oversight and support). Relatedly, staff also report limited access to training (and disincentives to attend training because of the emphasis on direct time billed) and a lack of technology supports (for example, requests for mobile solutions to support documentation for staff providing services in the community are seen as not even acknowledged, let alone acted upon).

There is also no systematic approach to EBP use for clinics or CBOs. Implementation varies by provider with no systematic fidelity monitoring. For example, available evidence for ACT teams shows wide divergence from current fidelity requirements. The ACT teams were formed in 2008 and the last training they received was in 2009, nearly five years ago. Furthermore, the standards used at that time were among the best available (the NAMI ACT standards), but development in the field over the last five years have advanced the Tool for Measurement of Assertive Community Treatment (TMACT) Version 1.0 as the leading standard for fidelity. Key advantages of the TMACT model include:

- More specialized requirements for staffing and role functioning for peer and SUD specialists on the team.
- Dynamic caseload modeling that allows caseloads to flex up or down depending on levels of staffing. Given the 13.0 to 13.5 FTE clinical staff on SBC ACT teams currently, caseloads could maintain full fidelity and range as high as 125 for a team with 11.5 non-physician clinical FTE (inclusive of the peer specialist). Given that SBC ACT teams have current non-physician clinical FTE (inclusive of the peer specialist) ranging from 13.0 to 13.5 FTE and only serve 95 to 100 people each currently, if the team were operating with fidelity to the TMACT standards, upwards of 75 more people at any time could be served with 1.5 to 2.0 fewer FTE per team.
- TMACT also puts an emphasis on movement on and off of teams:
  - For a team operating below full capacity (which by even the NAMI standards of at least 100 members at a 10:1 ratio, current SBC teams on average are well below), TMACT Standard OS7 regarding “Active Recruitment” requires that the team “actively recruits new consumers who could benefit from ACT, including assertive

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outreach to referral sites . . . [and] common referral sources and sites outside of usual community mental health settings (e.g., state & community hospitals, ERs, prisons/jails, shelters, street outreach) and “works to fill open slots when they are not at full capacity and/or the consumer-to-staff ratio is well below 10:1 on more mature teams.” The TMACT goes on to succinctly state the rationale for this: “ACT is best suited for consumers who do not effectively use less intensive mental health services. Reliance on passive approaches to consumer recruitment using typical mental health organizational intake systems or internal referrals does not typically ensure that the most suitable persons are served. Teams typically need to actively recruit in community settings outside of a parent agency to ensure that ACT services are offered to persons in their region who are most suited to using them. As ACT is also a scarce resource, it is important for teams to work at full capacity.”

Teams also must work to graduate consumers to lower levels of care. The original 1970s notion of “ACT for life” is no longer the state-of-the-art in a recovery-oriented treatment setting. TMACT Standard OS9 regarding “Transition to Less Intensive Services” requires that the team “conducts regular assessment of need for ACT services [for current team members], “uses explicit criteria or markers for need to transfer to less intensive service option”, engages in “gradual and individualized” transition “with assured continuity of care” and monitoring following transition, with “an option to return to team as needed.”

The rationale for the five year hiatus from monitoring and training/coaching to support fidelity of the ACT teams has been budgetary pressure. However, given that ADMHS spent $6.5 million in FY 2012 to provide ACT services, adding in $15,000 per year for fidelity monitoring by an external expert consultant and coach would be a minor additional expense if it could result in capacity to serve up to 75 additional people at any one time with fewer staff.

However, the TriWest team cautions readers thinking that this would be an easy set of “low hanging fruit” to pursue without more systematic study and planning with stakeholders, including the ACT teams, to consider the track record of ADMHS in implementing EBPs. While most stakeholders we talked with value the current ACT teams, all that were involved at the time described the 2008 implementation process as too rushed, with too little involvement of stakeholders and too little time for transitioning 300 of the hardest to serve cases in the county to these new teams. More recently, respondents we interviewed regarding the implementation of the MHSA-funded Transition Age Youth (TAY) programs cited precipitous, poorly communicated transfers of staff that to some degree undermined start-up of the program. The larger context of a non-collaborative, command and control culture at ADMHS must be kept in mind and any improvements (including improvements to ACT programs that may yield substantial short-term financial savings) must be addressed in that context. If not, simply requiring a new standard for EBP fidelity or assigning additional cases to the ACT teams may
actually result in poorer performance due to unexpected, misunderstood or misdirected efforts stemming from the broader lack of vision and supporting policy framework.

Currently, the ADMHS clinical / medical management function has insufficient capacity to either manage the needs of priority populations or design a broader system effort without re-positioning clinical leadership supports. Simply adding capacity or redesigning services is not the answer, unless embedded in a broader process of organizational culture change to improve data-driven performance improvement capacity.

**Finding CO-2.5: Access to specialized supports for people with complex needs is lacking.**

As noted in Finding CO-1, ADMHS has many strengths, including an outstanding array of peer and recovery supports and many best practices for people with complex needs, including people with co-occurring MH/SUD needs and people involved with the public health, criminal justice, homeless, and child-serving (DSS, juvenile justice) systems. However, because of a lack of integration of these services and supporting management responsibilities and coordinating policies, these discrete, strong programs are too often “pockets of excellence” that are inadequately integrated into the broader clinical system and accessible by people in need. Each area is briefly examined below.

**People in Need of Recovery and Resiliency Supports.** As described above, integration of “clinical” and “recovery/resiliency supports” is lacking. As a result, MHSA Principal Supports, including housing, employment, Recovery Learning Centers, outreach/engagement, co-occurring peer supports, and peer-run programs are seen as “non-medical” (and not covered by Medi-Cal), as opposed to an essential component of contemporary behavioral health practice. There is also a lack of consistency in the roles peer specialists play on treatment teams, as well as a lack of policy and buy-in across programs. A cadre of trained peer specialists does not have jobs, even though CBOs report that they would like to hire them. Multiple barriers exist, including questions about pay ranges and a lack of upward mobility and opportunities for advancement. There has been a lack of training and policy development to support integration of peers into routine clinical practice, and productivity requirements create disincentives to participation in training that is provided.

**People in Need of Co-Occurring MH/SUD Treatment.** There is general recognition that in every service setting there is a high prevalence of individuals (and in children’s services, families) with co-occurring MH/SA conditions. There have also been some notable adverse events related to this population, and there is a vocal and effective advocacy group (Families ACT) that has gone as far as to develop a proposal for addressing this population. However, there is no policy regarding baseline approaches to integrated MH/SA care, no system-wide improvement effort.
directed at this high need, high cost, high volume, poor outcome population, and no consistent practice framework for addressing co-occurring MH/SA needs. Some MH staff prefer to focus only on serious mental illness (SMI), while others questioned whether ADMHS even had responsibility to serve people with SMI and co-occurring substance use conditions. This is a challenge across most systems, but is particularly striking at ADMHS. While there are four direct service ADP-funded staff located across the clinics, the clinics do not generally view integrated treatment of substance use as part of their mission – contractors are perceived as responsible for this.

**People with Complex Health Needs.** Access to physical health services for health conditions is an ongoing challenge, as well as referral to ADMHS from DPH. The newly implemented, cross-referral system is very basic, with no functional data reporting capacity on cross-enrollment. Although there is recognition that primary health/behavioral health integration is an important priority from a customer need perspective, a resource perspective, and an ACA planning perspective, there has been no process or capacity for ADMHS and DPH to initiate a partnership between psychiatric and medical leadership to address this issue in the context of systemic quality improvement.

**People Involved in the Criminal Justice System.** There is a lack of coordination with the criminal justice system. Gaps include perceptions that law enforcement referrals to CARES are not consistently prioritized and concerns that people are discharged from the jail without adequate medication or linkages to treatment. This is despite many strengths (e.g., the Jail Discharge Planner, Forensic Liaison, Justice Alliance Liaisons in each clinic) and seemingly because of a lack of organizational alignment and coordination to better leverage strengths. The bottom line is that there needs to be focused accountability, organization, policy, and ongoing quality improvement for services targeting adults in the criminal justice system.

**People Served by the PHF.** There is also a lack of coordination with the PHF. PHF/outpatient coordination was described as involving “no communication at all” and there is a perception that ACT teams do not prioritize PHF cases or referrals. This lack of coordination is perceived as adding to length of stay, with reportedly four of 16 current cases on the PHF in March 2013 delayed over three weeks because of this. “Length of Stay” meetings were set up to address this, but can only meet every other Friday because of scheduling barriers. The “lack of trust” between PHF and the crisis residential program in Santa Maria (described in more detail above) poses additional barriers.

**People in Need of Employment Supports.** A lack of employment/vocational rehabilitation supports was also identified. There is a possible need for more emphasis on this in MHSA prioritization, given the reduction in Department of Rehabilitation (DOR) service access and the DOR stance that many people served by ADMHS are “not ready” for their supports. More
contemporary supported employment models, such as Individual Placement and Support (IPS), would not result in such barriers. Coordination opportunities abound, including enhanced training and better coordination for ACT vocational leads (and increased collaboration by leads across ACT and broader outpatient teams with ADMHS and CBOs). In addition, informants note the potential use of liaisons to support and coordinate vocational and broader rehabilitation supports, as well as better integration across clinic resources, WET/peers, Partners in Hope, and other county programs (e.g., DSS/CalWorks, etc.) as potential improvement opportunities.

**Homelessness.** Informants reported that while there are some outreach services for homeless individuals, including a case manager assigned to a shelter in Santa Barbara, there are significant gaps in best practice models (such as Supported Housing). Most importantly, there is an essential need to provide MH and SUD or co-occurring treatment where homeless people congregate, rather than in specialty clinics too often remote from these locations. This population often does not have the means or the motivation to drive to a clinic or participate in clinic-based services. Currently, DPH offers health care services to homeless individuals at the Santa Barbara shelter, which was cited by informants as an exemplary model that ADMHS could replicate. Informants recommended assignment of a psychiatrist to each shelter for 10 hours per week, along with one to two case managers to facilitate engagement in treatment, referral to ACT teams or other services when appropriate, and assistance obtaining Medicaid benefits. With the addition of single adults under Medicaid expansion in 2014, coverage of currently uninsured individuals who are homeless is increasingly feasible. ADMHS will need to carefully plan: 1) provision of services that meet people where they are and 2) strategies to maximize Medi-Cal revenues for uninsured people by facilitating their access to benefits.

**Children’s Services (DSS, juvenile justice).** While ADMHS has collaborated with DSS on Katie A. Settlement planning and with juvenile probation on programming, there is an absence of systematic approaches to promote collaboration, braided funding strategies for ADMHS and its child-serving partners, and evidence-based services for children and transition age youth. Many informants reported programmatic success of the MISC as well as the disintegration of collaboration resulting from its termination. We heard variations on “they threw the baby out with the bathwater” from multiple senior system informants across agencies and county departments. Emphasizing a system of care and provision of services where children and families frequent – schools, courts, juvenile probation, faith-based settings, and other community locations – was a strong theme discussed by ADMHS staff, CBOs, DSS, and other county organizations. Schools are the natural setting for children to receive screening, early intervention, treatment and prevention services. Yet, the limited resources assigned to children’s services limits the capacity to affect children while at school. The consistent theme informants expressed of providing services where individuals live and frequent underscores the importance of offering services for children and families in schools and a variety of community locations, in addition to the clinics.
Finding CO-2.6: Collaboration is better for the Alcohol and Drug Program (ADP), but access is lacking in key areas.

In terms of interagency collaboration, reportedly things work better on the ADP side than they do for ADMHS. ADP is reportedly better managed, with fewer bureaucratic barriers, less contradictory information, and more positive reports by informants. However, it is likely that this is due at least in part to ADP being a much smaller program and the much simpler fee-for-service reimbursement model used by ADP for Medi-Cal which does not require compliance with the Medi-Cal cost reporting and EQRO requirements of the at-risk mental health plan. There are essentially no fiscal disallowances reported, and there was strong collaboration reported by probation, sheriff, District Attorney, Public Defenders and CBOs. However, ADP funding was realigned to the counties in 2011, which may result in funding concerns, especially as the county does not currently have the ability to manage ADP services like it does mental health services without a substantial commitment to integration.

Yet, despite the less challenging organizational climate there remain many challenges to access. Sustainability of federal grants is difficult given the relatively low investment of county funds to support SUD services. Further, substance abuse block grant funding is likely to decline, both in the short term due to the federal sequester, and in the longer term due to anticipated changes stemming from ACA. In SBC, there is limited investment in substance abuse treatment, and as a consequence, primary substance use treatment gaps abound: limited physician availability, limited detoxification resources, very limited to non-existent access to newer medication management approaches to controlling addictions, and very limited access to residential treatment compared to other counties. Further, the co-occurring capability development within ADP is compromised in its efficacy by barriers to all non-ADP services within ADMHS (this is part of the broader pattern of disconnects). Finally, there is limited development of partnership between ADP and DPH regarding implementation of key best practices like SBIRT, which extend early intervention for SUD into the primary health arena.

Finding CO-2.7: Access to psychiatry services is lacking.

There is inadequate management of psychiatric capacity and performance. Given the number of psychiatrists available, access to appointments for current and new referrals is very low, compared to other counties. The current EQRO report indicates that the time to the first psychiatrist appointment is 66 days for adults and 73 days for children.

To put these findings in context, the TriWest team conducted a review of information from six comparison counties identified by SBC as comparable/best practice counties. These counties requested that we keep their names confidential in order to give us access to detailed
information on their psychiatric capacity. These comparisons suggest that there is opportunity to provide more psychiatry services with current resources.

There is inadequate management of schedules, visit lengths, evaluation access and lengths, and billing practices. A detailed review of six ADMHS psychiatrist schedules revealed the following:

- ADMHS psychiatrists scheduled fewer intakes (and as a result facilitated less access for new people in need of care) compared to psychiatrists in the other counties:
  - ADMHS intakes for children per psychiatrist were one per week, averaging 80-120 minutes in length; the other California counties ranged from one to three per week, averaging 90-120 minutes per intake.
  - ADMHS intakes for adults per psychiatrist range from two a week to once a month, averaging 70 minutes; the other California counties ranged from two to five a week, averaging 60 minutes per intake.
  - While session lengths were roughly comparable and potentially attributable to understandable variation across providers, ADMHS psychiatrists seem to be scheduling fewer intakes than their peers in other counties.
- The length of routine clinic visits for ADMHS psychiatrists were long compared to other counties:
  - Child outpatient visits for all physicians averaged 60 minutes; the other California counties targeted 45 minutes.
  - Adult outpatient / CARES visits averaged from 30 to 42 to 60 minutes by physician, with no consistency across clinicians; the other California counties all targeted 30 minutes.
- There is no consistency of reporting. All ADMHS psychiatrists reported initial evaluations and medication visits differently, which stymies performance tracking).
- There is a working assumption among CBOs that only ADMHS can provide psychiatry. The other California counties allow contractors to provide psychiatry services. While there is no specific policy prohibition for this, it was apparent that CBOs do not perceive a mechanism for providing their own psychiatry services.

This provides a critical opportunity to initiate a data-driven performance improvement process, in partnership with physician leadership, to improve initial access to psychiatric services system-wide, improve flow through the continuum, make better use of existing capacity, improve consistency from site to site, and improve partnering with community providers. This opportunity needs to be addressed with a sense of priority: Psychiatrists are leaders within the organization and must be engaged as leaders to improve practice. Ultimately, this should result in more consistent routine practice, informed by best practices and information from other counties to address:
• The immediate need to improve flow to bring CARES caseloads down; views vary on whether this can happen within existing resources or whether new psychiatry and case management resources are needed to do so, but our team is convinced improvements can happen immediately by empowering managers, psychiatrists, and staff to develop solutions within a QI framework.

• Longer term and broader efforts to set standards for routine care, while also supporting physician capacity to respond to unique case needs.

• ADMHS could also develop means for contract providers to offer psychiatry to leverage their resources to expand access, particularly to child psychiatry and bicultural/bilingual physicians.

Recommendations in Response to CO-2 Findings

Recommendation CO-2.1: Develop specific work groups as part of the broader quality improvement-driven System Change initiative to guide implementation of short-term changes (one to three months) and longer-term plans (six to 12 months and beyond) to systematically address the Clinical Operations findings.

Findings CO-2.1 to CO-2.7 should be a primary focus of the vision-driven quality improvement process described in Recommendation S-2, and responses to any of the Clinical Operations findings should only be pursued within that framework. To support key areas of change, it is recommended that work groups be considered for formal chartering by the System Change Steering Committee in the following areas:

• ACA implementation and primary care / MH / SUD service integration;
• Katie A. Settlement implementation and child/family systems of care;
• Eliminating health disparities through cultural/linguistic competent systems of care;
• Intake and crisis system redesign, including improved coordination with the PHF and inpatient facilities;
• Improved access to psychiatry;
• Improved movement between levels of care across ADMHS and CBO programs (both MH and SUD contractors);
• Improved coordination between ADMHS and CBOs at an organizational level;
• Expansion and integration of recovery/resiliency-oriented supports and the MHSA Primary Supports within the core clinic and CBO service array;
• Improved treatment for people involved with the criminal justice system;
• Improved treatment of SUD and co-occurring MH/SUD disorders, viewing primary substance use as a priority population, especially where there are treatment gaps in the CBO system;
• Improved treatment and supports for people who are homeless;
• Improved treatment and supports for employment.

The first focus of these work groups should be implementation of “early wins” in the first 90 days of operation. In pursuing these, it will be important to experience some successes, but it will also be instructive to learn from the process of trying to achieve initial targets that prove too complex to change in 90 days. Either way, progress (implementation or learning) occurs.

Potential early wins abound in each of the areas of detailed Clinical Operations findings. Areas that the TriWest team believes will be more amenable to short term change include:

• Moving forward more customer-oriented, vision-driven and inclusive planning and improvement in the areas of recovery-oriented, trauma-informed care, MH/SUD integration, PH/BH integration and ACA implementation more broadly, and Katie A. Settlement implementation for children should be immediate priorities.

• Crisis system restructuring (including an improved crisis residential program) is one of the most ready opportunities for improvement (“low hanging fruit”). Models and standards from other California counties could serve as models to jumpstart the discussion and support rapid progress.

• Progress to standardize referral expectations and facilitate more rapid movement of people between levels of care (including CARES) could be made in 90 days by making plans to restructure the access/intake model and policies to address the limitations of the CARES model, fill gaps in telephone access, and develop routine expectations for all care level transitions (including within clinics across clinicians). It might also be beneficial to consider some movement toward “open” appointment scheduling (an emerging best practice).

• Opportunities to serve people with less intensive needs than ACT/Supported Housing or children’s intensive in-home levels of care, but who could benefit from services and supports in non-clinic settings (places where people of diverse cultures or with other special needs live, work, go to school, or receive care in provider organizations integrated in community settings such as community agencies, homeless shelters/drop in centers, and public health) could be pursued.

• Improving bilingual and bicultural care by involving key internal committees and broader external representation to update and formally adopt the 2010 Cultural Competency Plan, focusing on bicultural standards, improved access to interpreters, cross-system (including ADMHS) performance tracking, and enhanced service in community settings are potential early areas of emphasis and improvement.

• Development and expansion of the peer specialist program: Support for peer specialists is increasing, but strategies for ongoing supervision, assistance with integrating into more “clinical settings,” training and certification, and career ladders are not yet developed. This is a fruitful area for rapid improvement.
• EBP promotion with an initial emphasis on improving the responsiveness and capacity of ACT teams through technical assistance, training, and coaching in the TMACT fidelity model could also be considered.
• MHSA planning for 2013 can be integrated into the broader System Change efforts to support better integration of MHSA supports in the broader systems of care.

Learning from these early change efforts, work groups can also work to develop annual improvement plans by October 2013 to guide longer term redesign efforts. The other advantage of this timing is that it will provide guidance to the FY 2014-15 budget development process which needs to be roughed out in the fall and initially drafted by January 2014.

**Recommendation CO-2.2: Develop improved metrics and routine management reports based on them focused on improving clinical practice and outcomes.**

There are numerous indicators that could be developed to inform efforts to improve clinical practice and outcomes. Over 30 examples of potential metrics are described below, and this is by no means an exhaustive list: it is intended to stimulate efforts by the System Change work groups and ADMHS management to use data to improve practice. While it will not be feasible to immediately implement metrics in all of these areas, the following list offers a range of potential metrics to inform near and medium-term efforts. It is recommended that at least ten meaningful process metrics and two outcome metrics be developed over the next six month for each program type (regardless of whether the program is operated by ADMHS or a CBO). At least five of the ten process metrics should be standardized across all outpatient programs.

Potential metrics include:

1) Telephone access metrics, including average speed of answer and dropped calls, as well as date and time of requests for access and disposition for people referred to other sources;
2) Time from initial call to first appointment of any kind for routine, urgent, and crisis response;
3) Time from initial call to first psychiatrist appointment for routine, urgent, and crisis response;
4) Time for transition between any level of care within ADMHS – CARES to clinic, CARES to ACT or supportive housing, etc. – as well as utilization management data on the percentage of individuals who are appropriately matched to the right level of service intensity in the continuum;
5) Service utilization by program, including trends, outliers, expenditures, and length of stay in each service by level of care using standard measures, such as use/days per 1,000 Members (for Medi-Cal) and penetration rates by level of care and overall (with breakouts by age group, provider, race/ethnicity, language, and county region);
6) Rates of people served with co-occurring mental health and substance use disorders for both children and adults;
7) Rates of people served with co-occurring mental health and developmental disorders for both children and adults;
8) Rates of children and youth served with involvement in the (1) child welfare or (2) juvenile justice system;
9) Seven and 30-day post-discharge (residential and acute care) ambulatory follow-up appointments;
10) Attainment of positive outcomes / service results by program, level of care, and system wide, including clinical and functional outcomes and system-wide outcomes, such as utilization of out-of-home services (e.g., hospitalizations, out-of-home lengths of stay, other restrictive out-of-home care), housing, employment, deaths (including suicide and substance-related deaths);
11) Racial and ethnic disparities (e.g., under-utilization of services by particular racial/ethnic groups) and cultural and linguistic competency using indicators consistent with the National Standards on Culturally and Linguistically Appropriate Services (CLAS).55 ADMHS’s 2010 Cultural Competency Plan (discussed in more detail below) includes some initial ideas for routine indicators. Indicators should be tracked for all major racial and ethnic groups served, for refugees and new immigrants, for any Member speaking a primary language other than English, and for gender (transgender) and sexual (lesbian, gay, bisexual) minorities. Examples of potential indicators include:
   a) Access – Differences in service penetration rates across population groups;
   b) Service Utilization – Differences across population groups in dropout rates, in the amount of community-based versus restrictive care received, and in the chance to receive services in one’s preferred language, including disproportionate use of restrictive settings (e.g., over-utilization of out-of-home [OOH] services by racial/ethnic minorities);
   c) Perceptions of Care – Differences across population groups’ perceptions that services are effective, understandable and respectful (this includes consumer satisfaction);
   d) Outcomes – Differences across population groups in the results of services;
   e) Capacity to Provide Culturally Competent Care – The availability of personnel, programs, and organizations with capacity to deliver culturally competent services, including individual providers expert with each cultural and linguistic subgroup (physicians, other licensed professionals, clinical staff within agencies, certified peers) and agencies / organizations with culture-specific expertise, inclusive of

“mainstream” agencies, culture-specific agencies, and peer/family/youth-operated organizations;

12) Monitoring psychotropic medications for risk groups, including adults on four or more medications, specialized metrics for children ages 12 years and under, use of medication for people with SUD (with a goal of promoting appropriate use);

13) Performance related to grievances and appeals, including types, resolution time frames, and analysis of trends in light of consumer, family and provider satisfaction data (this could include reporting of individual provider appeal rates and outcomes by level of care);

14) The actual number and percentage of Members involuntarily presenting for MH and SUD treatment to 24-hour inpatient settings;

15) Rates of denials and appeals by level of care;

16) For all stakeholders participating in the quality improvement process, regular measurement of participant perceptions of how well they understand material presented, the utility of the process, and the impact of their input on system operations;

17) The recovery competency of both ADMHS and CBO programs (at the program level);

18) The cultural and linguistic competency of both ADMHS and CBO programs (at the program level);

19) Metrics developed with the Department of Public Health related to rates of chronic health conditions (such as diabetes, heart disease, respiratory diseases, asthma, etc.) and other chronic health needs to track performance in addressing co-occurring health and behavioral health conditions;

20) An array of metrics related to crisis response, including:
   a) Metrics developed in collaboration with law enforcement to track responses to and dispositions regarding mobile crisis response;
   b) Metrics developed in collaboration with hospital emergency rooms to track responses to and dispositions regarding mobile crisis response; over time, more complex metrics may be developed, such as the actual number (and percentage of Medi-Cal members) presenting to hospital emergency departments (ED) within thirty (30) days of the discharge date from an acute level of care for any psychiatric or substance abuse diagnosis;
   c) Number of individuals or families who are seen in crisis who have a non-crisis follow up contact within three days, seven days, and then continue to be seen for the following month;
   d) Number of individuals/families in crisis who are treated voluntarily (without a 5150) versus those who are treated involuntarily;
   e) Number of individuals and families who are at risk for crisis who have a voluntary after-hours crisis plan that they know how to use and that will actually work;
f) Numbers of individuals/families in crisis who have crisis resolution and continuing engagement in care without either extended emergency department or inpatient stays;
g) Number of individuals and families who are connected to services as a diversion from a crisis or emergency room stay;

21) Special metrics for child and adolescents served, such as:
   a) The number of children who are involved with multiple county agencies (e.g., ADMHS, DSS, probation, specialized school services, etc.) and the use of the wraparound planning resources of the SPIRIT program by multi-agency involved children and youth;
   b) Use of foster care and other DSS resources by people served by ADMHS;
   c) Use of juvenile justice system resources by people served by ADMHS, including analysis of disproportionate involvement of individuals who are minorities;
   d) Lengths of stay in residential treatment and wait times for residential placement that measure time from initial referral to authorization to actual placement; and
   e) Utilization of ADMHS services by child and adolescent who are in state or county custody;

22) Specialized fidelity metrics for high-cost EBP programs, particularly the ACT program and fidelity-based wraparound SPIRIT program;

23) Number of individuals and families who are connected to peer support (one contact, ongoing contact; acute crisis; routine services; adult MH, adult SUD, child/family);

24) Numbers of people served by ADMHS who are arrested; who are booked; who are incarcerated;

25) Numbers of people served with MH and/or SUD issues who are involved with the criminal justice system and are diverted into community-based MH/SUD services (adults, juveniles; pre-booking, post-booking; post-incarceration; with or without specialty court, etc.);

26) Numbers of people served with MH and/or SUD issues who are involved with the criminal justice system and who leave the justice system (jail, community corrections, juvenile services) without waiting for a subsequent placement;

27) Numbers of people served with MH and/or SUD issues who are involved with the criminal justice system and under community supervision that violate the conditions of their probation;

28) Numbers of people served with SUD and/or MH disorders who are homeless that are connected to any kind of supportive housing or to any kind of continuing treatment support (with or without housing);

29) Diversion of individuals who need longer-term (longer than seven days) inpatient or residential psychiatric care into subacute community residential settings, with reduction in both state hospital utilization and acute inpatient utilization;
30) Diversion of individuals needing competency restoration into community-based settings (including residential settings) in lieu of state hospital or jail;
31) Numbers of people served who present requesting substance abuse treatment who never receive it; reduction of percentage of individuals who receive detox or residential treatment who do not engage in outpatient care; reduction in outpatient care drop-out rate.
Detailed Findings and Recommendations: Financial

Finding F-1: The Medi-Cal cost reporting process is sound.
Analysis of the Medi-Cal cost reporting process by Geiss Consulting has confirmed its soundness. The overall processes and data used to prepare the Medi-Cal Specialty Mental Health Cost Report should result in accurate cost finding consistent with federal and state requirements. Typically, weaknesses in the cost report preparation relate to either inadequate cost finding and/or inaccurate units of service.

ADMHS staff are knowledgeable of allowable and non-allowable costs and correctly document such costs as part of the cost report preparation process. ADMHS’s financial system is structured at a very detailed level that allows for reports to be produced by program. This level of detail facilitates the identification of allowable and non-allowable costs, as well as administrative costs versus direct service costs. Specifically, the County prepared the FY 2010-11 cost report as follows:

- The Expenditure Status financial report from the ADMHS financial system serves as the foundation of the cost report;
- Adjustments to the Expenditure Status financial report are documented and reasonable;
- Costs are allocated to Administration, Utilization Review (UR), and Direct Services directly based on Program Codes;
- Administration and UR costs are apportioned between Medi-Cal and non-Medi-Cal clients based on unduplicated clients;
- Direct Service costs are allocated to modes directly based on Program Codes;
- Mode costs are allocated to service functions based on relative values;
- Relative values use the ADMHS published charge rates as the weighting factor;
- Service function costs are apportioned between Medi-Cal and non-Medi-Cal clients based on units of service claimed to the Medi-Cal program;
- The lower of costs, charges, or Schedule of Maximum Allowances (SMAs) is applied in determining gross Medi-Cal reimbursement;
- The administrative reimbursement limit of 15% is applied to Medi-Cal direct service reimbursement;
- Offsetting revenues are applied against gross Medi-Cal reimbursement to determine net Medi-Cal entitlement.

ADMHS is able to reconcile approved Medi-Cal units of service claims with payments received from the state. Many counties do not have this capability and report an estimate of what they anticipate the approved units to be. With ADMHS being able to conduct this reconciliation, its
approved units of service should reconcile with the state’s units of service thereby minimizing audit settlements.

At the time of this analysis, the only potential cost report weakness was that ADMHS was reliant on a former staff member who no longer resides in California for some of the data compilation and analysis. ADMHS has begun to use more internal staff for this work and should continue to cross train several staff on the completion of the cost report.

**Recommendation F-1: Maintain the current Medi-Cal cost reporting and reconciliation process.**

An additional supporting analysis and recommendation to maintain financial and contract staffing in support of this recommendation can be found in Administrative Finding and Recommendation A-1 in the next section.

**Finding F.2.1: ADMHS has increased overall spending since FY 2009 by 5.9% due to a $8 million increase in MHSA programs at the same time that county-operated MH clinical programs expenditures were cut 2.4%, contract MH outpatient expenditures were cut 4.9%, non-MHSA MH administration expenditures were cut 10.3%, and ADP administration expenditures were cut 20.4%.

As discussed above, the level of expenditure and revenue data in the ADMHS financial system is very detailed. ADMHS assigns revenues to individual programs so that the financial system can be used to generate program budget and expenditure reports that should aid ADMHS staff in the management of programs. One potential downside of such detail is that there is a lot of expenditure data, so the reports can be cumbersome and time consuming to develop. Also, additional resources are sometimes required to maintain such a detailed system.

The table on the next page shows actual program expenditures for the last three fiscal years and the current year adjusted budget compiled from the ADMHS financial system.
### Santa Barbara County Alcohol, Drug and Mental Health Services Department Program

#### Expenditures (Dollars in Millions)

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<thead>
<tr>
<th>Departmental Programs</th>
<th>FY 2009-10</th>
<th>FY 2010-11</th>
<th>FY 2011-12</th>
<th>FY 2012-13 Adjusted Budget</th>
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<td>ACT Programs</td>
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<td>6.24</td>
<td>6.65</td>
<td>6.47</td>
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<tr>
<td>Children's Clinics</td>
<td>4.77</td>
<td>3.15</td>
<td>2.43</td>
<td>2.76</td>
</tr>
<tr>
<td>CARES</td>
<td>4.88</td>
<td>4.35</td>
<td>4.77</td>
<td>4.27</td>
</tr>
<tr>
<td>PHF</td>
<td>5.59</td>
<td>5.74</td>
<td>6.77</td>
<td>6.48</td>
</tr>
<tr>
<td>Other Outpatient (Primarily Contract)</td>
<td>19.69</td>
<td>18.68</td>
<td>17.91</td>
<td>18.73</td>
</tr>
<tr>
<td>Other Inpatient</td>
<td>3.39</td>
<td>2.53</td>
<td>2.51</td>
<td>2.16</td>
</tr>
<tr>
<td>MHSA Admin &amp; Implementation</td>
<td>2.23</td>
<td>2.57</td>
<td>2.49</td>
<td>2.80</td>
</tr>
<tr>
<td>MHSA Capital Facilities &amp; Tech</td>
<td>0.10</td>
<td>1.20</td>
<td>1.15</td>
<td>1.56</td>
</tr>
<tr>
<td>MHSA Prog Eval &amp; Perform Outcomes</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>MHSA Workforce Education &amp; Training</td>
<td>0.22</td>
<td>0.54</td>
<td>0.35</td>
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<td>MHSA Prevention &amp; Early Intervention</td>
<td>0.14</td>
<td>2.77</td>
<td>4.15</td>
<td>4.08</td>
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<tr>
<td>MHSA Innovations</td>
<td>0.02</td>
<td>0.54</td>
<td>1.20</td>
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</tr>
<tr>
<td>ADMHS Administration</td>
<td>3.06</td>
<td>4.49</td>
<td>6.87</td>
<td>1.92</td>
</tr>
<tr>
<td>Fiscal/Acctng/Contracts/Rev Mgmt</td>
<td>2.11</td>
<td>2.03</td>
<td>1.98</td>
<td>2.55</td>
</tr>
<tr>
<td>Management Information Systems</td>
<td>1.40</td>
<td>1.36</td>
<td>0.16</td>
<td>1.43</td>
</tr>
<tr>
<td>County Clinic Oversight/Med Records</td>
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<td>0.62</td>
<td>0.53</td>
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<tr>
<td>Medical Direction</td>
<td>0.19</td>
<td>0.24</td>
<td>0.17</td>
<td>0.18</td>
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<tr>
<td>QA</td>
<td>1.18</td>
<td>1.35</td>
<td>1.38</td>
<td>1.51</td>
</tr>
<tr>
<td>Other Admin</td>
<td>0.50</td>
<td>0.49</td>
<td>0.41</td>
<td>0.48</td>
</tr>
<tr>
<td><strong>Total-Mental Health</strong></td>
<td>$61.48</td>
<td>$64.11</td>
<td>$67.23</td>
<td>$65.67</td>
</tr>
<tr>
<td><strong>Alcohol and Drug Programs</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Program Administration</td>
<td>$1.06</td>
<td>$0.86</td>
<td>$0.84</td>
<td>$0.84</td>
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<tr>
<td>SACPA, Drug Court</td>
<td>1.37</td>
<td>1.48</td>
<td>1.67</td>
<td>1.92</td>
</tr>
<tr>
<td>D/MC, NNA, DUI, Drug Diversion</td>
<td>4.16</td>
<td>4.01</td>
<td>4.30</td>
<td>4.38</td>
</tr>
<tr>
<td>Perinatal</td>
<td>1.20</td>
<td>1.12</td>
<td>0.77</td>
<td>0.65</td>
</tr>
<tr>
<td>CalWORKs, Youth, SDFSC</td>
<td>0.96</td>
<td>0.94</td>
<td>0.94</td>
<td>1.01</td>
</tr>
<tr>
<td>Prevention</td>
<td>0.59</td>
<td>0.36</td>
<td>0.41</td>
<td>0.50</td>
</tr>
<tr>
<td><strong>Total-Alcohol and Drug Programs</strong></td>
<td>$9.34</td>
<td>$8.77</td>
<td>$8.93</td>
<td>$9.30</td>
</tr>
<tr>
<td><strong>Total-ADMHS</strong></td>
<td>$70.82</td>
<td>$72.88</td>
<td>$76.16</td>
<td>$74.97</td>
</tr>
</tbody>
</table>
Finding F-2.2: MH revenue from FY 2012 to FY 2013 is projected by ADMHS to be up 13.2% overall due to growth in all revenue streams, but Geiss Consulting analysis projects MH revenue for FY 2013 to be up 19% ($3.23 million more as a result of more Realignment and MHSA funding than originally projected and slightly less growth in Medi-Cal revenue) and MH revenue for FY 2014 to be flat (down 1.5% from FY 2013); ADP revenue growth is flat.

There are four primary revenue sources for mental health services that fund about 70% of the mental health services in Santa Barbara County. Actual and projected revenue for these four revenue sources are presented in the table below, as well as the other revenue used to fund services in FY 2012 and estimated for FY 2013. For the four primary sources of MH revenue, Geiss Consulting examined the basis of the projections and developed its own independent estimates. Detailed analyses related to the Geiss Consulting results are presented following the table.

### Santa Barbara County Alcohol, Drug and Mental Health Services Department Program Revenues (Dollars in Millions)

<table>
<thead>
<tr>
<th>Revenue Source</th>
<th>FY 2011-12</th>
<th>FY 2012-13 Adjusted Budget</th>
<th>FY 2012-13 Consultant Projections</th>
<th>FY 2013-14 Consultant Projections</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1991 Realignment</td>
<td>$10.25</td>
<td>$11.00</td>
<td>$10.50</td>
<td>$10.50</td>
</tr>
<tr>
<td>2011 Realignment</td>
<td>4.88</td>
<td>5.43</td>
<td>7.00</td>
<td>7.00</td>
</tr>
<tr>
<td>MHSA</td>
<td>11.39</td>
<td>13.88</td>
<td>16.50</td>
<td>14.90</td>
</tr>
<tr>
<td>Medi-Cal FFP</td>
<td>14.99</td>
<td>19.36</td>
<td>18.90</td>
<td>19.50</td>
</tr>
<tr>
<td>Subtotal</td>
<td>$41.51</td>
<td>$49.67</td>
<td>$52.90</td>
<td>$51.90</td>
</tr>
<tr>
<td>Medicare</td>
<td>0.78</td>
<td>1.34</td>
<td></td>
<td></td>
</tr>
<tr>
<td>County General Fund for Operating Costs</td>
<td>2.19</td>
<td>3.14</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prior Year MHSA</td>
<td>8.44</td>
<td>6.59</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>3.36</td>
<td>2.98</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Mental Health</td>
<td>$56.28</td>
<td>$63.73</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol and Drug Programs</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2011 Realignment</td>
<td>$3.70</td>
<td>$3.68</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medi-Cal FFP</td>
<td>1.41</td>
<td>1.63</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Federal Grants</td>
<td>4.11</td>
<td>3.93</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>1.36</td>
<td>1.40</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Alcohol and Drug Programs</td>
<td>$10.58</td>
<td>$10.64</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total-ADMHS</td>
<td>$66.86</td>
<td>$74.37</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Overall, revenues are expected to increase substantially from last year (FY 2012) to the present year (FY 2013), with the largest percentage increase in the proportion of County General Funds for operating costs (43.3% increase), Medi-Cal (29.2% increase per ADMHS estimates; 26.1%
increase per Geiss Consulting estimates), MHSA (21.9% increase per ADMHS estimates; 44.9% increase per Geiss Consulting estimates), and 1991/2011 combined Realignment (8.6% increase per ADMHS estimates; 15.7% increase per Geiss Consulting estimates).

Realignment. The amount of funding for 1991 Realignment is directed by statute as a minimum amount of funding until sales tax and vehicle license fee revenues exceed the amount of funding used by the state for the CalWORKs Maintenance of Effort. It is unlikely that this will occur until no sooner than FY 2013-14, so the amount of 1991 Realignment will most likely remain constant from the monthly amount of $872,843 currently received by ADMHS. ADMHS will also continue to receive $58,752 of vehicle license fee collections annually. The ADMHS FY 2012-13 Adjusted Budget is slightly higher than the actual amount that will be received, probably due to accrued amounts reflected in the ADMHS FY 2012-13 Adjusted Budget.

The 2011 Realignment for mental health services includes funding for the managed care program and the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program. The FY 2012-13 amount is based on the State Department of Health Care Services MHSD Information Notice 12-08 that specifies the amount of 2011 Realignment funding for each county assuming sales tax revenues are sufficient to cover the base amounts. Year to date sales tax revenues are projected to meet that base, so it is anticipated that each county will receive the full amount of funding specified in Information Notice 12-08. One potential area of concern for ADMHS is that the amounts specified in Information Notice 12-08 were based on preliminary estimates of FY 2011-12 EPSDT Certified Public Expenditures (CPE) for EPSDT services. ADMHS overstated preliminary estimates of CPE for FY 2011-12 EPSDT by $2.3 million ($14.0 million estimate versus $11.7 million CPE) as late as April 2012 due to ADMHS reporting their budgeted amount rather than developing an estimate of their EPSDT CPE based on actual expenditures incurred by the County. This resulted in Santa Barbara County receiving a higher distribution of EPSDT funding in FY 2011-12 than they would have otherwise received. This also resulted in an inflated percentage of funding from the 2011 Realignment Behavioral Health Subaccount going to Santa Barbara County in FY 2012-13. It is unknown at this point whether the state will adjust the 2011 Realignment percentages to reflect the final CPE amounts in FY 2012-13, FY 2013-14 or if they will address the final amounts through growth allocations. The consultant projections assume the state will address the final amounts through growth allocations, which is consistent with the recommendation from the California Mental Health Directors’ Association. Should the state adjust the FY 2012-13 percentages or the FY 2013-14 percentages, ADMHS’s 2011 Realignment funding for mental health would most likely decrease by at least $1 million which is consistent with the ADMHS FY 2012-13 Adjusted Budget.

MHSA. The Mental Health Services Act (MHSA) revenues are higher in FY 2012-13 than initial estimates because of the consequences of State Proposition 30, which increased the marginal tax rates on higher income individuals, and the consequences of an effective higher federal tax
rate on capital gains beginning in 2013, which resulted in many individuals recognizing capital gains in 2012 under the lower tax rates. The result is that deposits into the State Mental Health Services Funds through March (which reflect distributions to counties through April 15th) are already almost equal to the budgeted amount. The consultant projections reflect these higher amounts and are based on deposits to the Mental Health Services Funds through the end of June (which reflect distributions to counties through July 15th). ADMHS had budgeted approximately $1.3 million of the prudent reserve in FY 2012-13 that most likely will not have to be used.

**Medi-Cal.** The Medi-Cal Federal Financial Participation (FFP) is difficult to estimate because it ultimately is determined by the actual costs of services and the percentage of Medi-Cal approved services. The consultant projection is slightly lower in FY 2012-13 due to the decrease in overall expenditures in FY 2012-13 versus FY 2011-12 and is based on the expenditures included in the FY 2011-12 Medi-Cal Specialty Mental Health Services cost report. Also, the FY 2012-13 Adjusted Budget may have included anticipated revenues from the Supplemental Payment State Plan Amendment that most likely will not be realized until FY 2013-14 and will carry into FY 2014-15 with the settlement of the FY 2010-11 and FY 2011-12 cost reports. This will equate to approximately $1.3 million in FFP in FY 2014-15 with the settlement of the FY 2010-11 and FY 2011-12 cost reports. Thus, the difference in revenue estimates is due to the timing of receipt of revenues.

The County is required to contribute $644,045 of County General Fund revenues as a condition of receipt of the 1991 Mental Health Realignment funds. Over the last two years, the County has contributed more than the required amount in order to fund unreimbursable costs primarily related to indigent care. These funds are not required to fund the Medi-Cal match because the County receives sufficient 1991 Realignment, 2011 Realignment and MHSA funding to more than cover the 50 percent Medi-Cal match.

**Prior Year MHSA.** ADMHS is currently relying on prior year MHSA revenues to fund current operating costs. For two of the MHSA components (Capital Facilities/Technological Needs and Workforce Education and Training), this is to be expected since the Act does not dedicate funding for these components after FY 2007-08. For the Prevention and Early Intervention and the Innovations components, slow start up requires the use of prior year funds to avoid reversion of funds back to the state. However, for the Community Serviced and Supports (CSS) component, reliance on significant prior year revenue and the prudent reserve will lead to ADMHS having to reduce CSS program levels.
Finding F-2.3: Santa Barbara County is more dependent on Medi-Cal funding for MH than are most California counties.

Medi-Cal funding for specialty mental health services in California is largely a function of the available resources for the county to incur Certified Public Expenditures (CPE) in order to receive the Medi-Cal FFP. The revenues available to all counties to fund CPE (as well as indigent services) are 1991 Realignment, 2011 Realignment and MHSA. A comparison of the per capita funding for each revenue source is provided in the table below.

### Estimated Funding per Capita

<table>
<thead>
<tr>
<th>County</th>
<th>1991 Realignment</th>
<th>2011 Realignment</th>
<th>MHSA</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Santa Barbara</td>
<td>$24.51</td>
<td>$16.59</td>
<td>$39.95</td>
<td>$81.05</td>
</tr>
<tr>
<td>San Luis Obispo</td>
<td>$20.77</td>
<td>$25.40</td>
<td>$36.96</td>
<td>$83.12</td>
</tr>
<tr>
<td>Monterey</td>
<td>$24.36</td>
<td>$17.99</td>
<td>$40.77</td>
<td>$83.12</td>
</tr>
<tr>
<td>San Mateo</td>
<td>$37.12</td>
<td>$8.35</td>
<td>$32.58</td>
<td>$78.04</td>
</tr>
</tbody>
</table>

The 1991 Realignment funding was driven by historical spending which largely benefited counties in the Bay Area. This explains why San Mateo is significantly higher than the other three coastal counties. The 2011 Realignment funding was based on historical allocations for managed care, as well as estimated FY 2011-12 EPSDT CPE. Santa Barbara County has a small managed care allocation relative to other counties because psychiatric inpatient and professional specialty mental health services were already being somewhat “managed” by the County Organized Health System when mental health services were consolidated in the mid to late 1990s, which was not the case in most counties. Santa Barbara County has a relatively large EPSDT allocation because the County overstated their estimated FY2011-12 EPSDT CPE. Since EPSDT accounts for the majority of the 2011 Realignment funding, Santa Barbara County ended up with an allocation consistent with other counties. MHSA funding was largely driven by overall population, but also considered some of the inequities under the 1991 Realignment, and as a result Santa Barbara County again is relatively consistent in its overall funding levels with other counties. Overall, the funding available to Santa Barbara County for Medi-Cal CPE is fairly consistent with funding available to other comparative counties.

With respect to Medi-Cal revenue, Santa Barbara has the highest percentage of their outpatient direct service costs reimbursed with Medi-Cal Federal Financial Participation at 38%, while the other counties ranged from 24% to 37%. This shows Santa Barbara County has a greater focus on Medi-Cal services, or at least is more effective than the other counties at getting services approved and paid by Medi-Cal, even though the comparative counties have similar revenues per capita available to incur CPE. Santa Barbara also primarily uses contractors for Medi-Cal services, with about 75 percent of the contracted services related to Medi-Cal services.
Comparison counties do not place as much of an emphasis with their contractors on Medi-Cal, with the services provided by contractors related to Medi-Cal ranging from 27 to 36 percent. Again, this difference is reflected in the amount of resources used by Santa Barbara County to monitor and manage contracts while, with a lower Medi-Cal percentage, the other counties do not have as many Medi-Cal cost settlement concerns, with a lower level of monitoring contractors.

**Finding F-2.4: ADMHS faces additional risk related to revenue currently and looking forward.**

In the discussion under Finding F-3.1 below, we identify potential future risks of repayment related to potential billing of Medi-Cal in excess of current expenses. Looking forward to 2014, another potential concern involves current financial projections related to expanded service delivery in 2014 following Medicaid expansion and implementation of the ACA. These assumptions were done as part of the budget development process and are understandably only initial estimates. How California intends to implement the ACA is still unknown, although it seems that both the state and the legislature intend to implement both the mandatory Medicaid expansion and the optional Medicaid expansion. The mandatory Medicaid expansion will result in additional Californians who are currently eligible for Medi-Cal enrolling in Medi-Cal. Medi-Cal services provided to these Medi-Cal beneficiaries will generally be funded with 50 percent federal funding and 50 percent local funding, using predominantly Realignment and MHSA funding in Santa Barbara County. The optional expansion will result in newly eligible Medi-Cal beneficiaries in California. Medi-Cal services provided to these beneficiaries will be reimbursed entirely with federal funds for the first several years with a decreasing percentage to 90% federal reimbursement. To the extent that a county is already serving either population, the county would realize additional revenue assuming the state does not “claw back” all of the savings either through reduced realignment revenues or additional state funding obligations passed on to the county. However, with the mandatory expansion, it is highly likely that a new client base will seek voluntary services resulting in an additional cost to the county for the local match.

One of the assumptions applied by ADMHS in their analysis of the impact of the ACA in Santa Barbara County was that ADMHS has a historical practice of serving anyone with a serious mental illness, regardless of their ability to pay, so there was no expectation of “pent up demand” for service translating into increased numbers of people seeking service. This is an assumption that, while perhaps sufficient for initial budget projections, needs to be examined by clinical leadership to determine its validity as part of the ACA preparation activities in 2013. While it was not within the scope of our study to verify this, numerous consumer, advocate, CBO, and county partner informants described perceived limitations in access to ADMHS services for people without insurance; analysis of trends by payer (as described above) show...
that SBC provides a much higher proportion of its services to people with Medi-Cal than do other comparison counties (suggesting lower service levels overall to people without insurance); CBOs for the most part are allowed to serve very few people without Medi-Cal; and ADMHS currently limits the service array to adults without Medi-Cal to a subset of its services (e.g., CARES and crisis/PHF services). To carry out this more informed analysis, ADMHS financial leaders are in need of clinically-informed counterparts.

**Finding F-2.5: A lack of strong, working relationships at the organizational level between ADMHS and other county agencies restricts the ability of the County to leverage MH and SUD funds across departments.**

The lack of partnerships and strong working relationships between ADMHS and other county agencies described in System Finding S-2 above has restricted the ability of Santa Barbara County as a whole to leverage important funding streams utilized by other counties. AB 109 funding to purchase ADMHS services is relatively low at $446,000 in the FY 2012-13 budget (by contrast, in Marin this funding is over $4 million). County departments are (or are considering) contracting with CBOs (or private companies) due to both costs of ADMHS services (e.g., employee costs) and the lack of broader strategic alignment / relationship. There has been no progress on the development of a coverage initiative within the County Health Plan to improve behavioral health access. MHSA-funded integration pilots offer lessons to inform broader planning, both opportunities (e.g., expanded access to bilingual/bicultural prescribers) and challenges to overcome (e.g., administrative burden).

In addition, because of a lack of collaborative planning with CBOs, ADMHS is not able to take into account additional CBO revenue when it projects overall system resources available for MH services. For example, one CBO reports that it routinely has to access more flexible funding streams in order to provide additional MH services not covered by the contract with ADMHS for Medi-Cal recipients. Because of this, it limits its ability to provide services to people not covered by Medi-Cal. By contrast, if Medi-Cal funding was accessed, ADMHS would derive additional FFP revenue and the CBO could collaborate with ADMHS to target its flexible funding sources to fill jointly prioritized service gaps. This is slightly more difficult under the Medi-Cal Certified Public Expenditure requirement in California, but can be done with proper planning and collaboration.

Related to this, ADMHS has not fully implemented systems to collect payment from all third parties who are given access to services. In addition, ADMHS does not consistently collect co-pay and deductibles from Medicare and private insurance clients. ADMHS is in the process of developing a policy to address providing services to private insurance clients. This policy needs to address if (and how) services will be provided to people who obtain insurance through an insurance exchange as part of ACA. ADMHS needs to implement system changes that will allow
it to make reasonable efforts to collect self-pay deductibles and co-pays associated with providing services clients who have third party payers, such as Medicare.

Regarding the need to address co-pay and deductible collections, while only a fraction of current revenue, co-pays and deductibles can add up to be substantial (even if only $100,000 a year). In addition, there is a current fraud alert issued by the OIG that cautions providers that they must require co-pays and deductibles from all Medicare beneficiaries. In particular, not having an adequate system to collect co-pays and deductibles can be problematic.

Finally, if ADMHS is going to continue to accept Medicare only, Medicare/Medi-Cal dual eligibles, and commercial insurances, it must understand that if services are provided by a clinician whose credentials are not recognized by Medicare or commercial insurances, ADMHS will not receive any payments for those services. We recommended that ADMHS develop a very strong front end process to match clinician credentials (from the point of assessment going forward) to the payer requirements so that the third party insurance can be billed with expectation of payment. This currently is not taken into consideration.

Finding F-2.6: Most comparison counties selected for this study spend more County Funds per capita to support MH and ADP services than does Santa Barbara County.

Three benchmark counties were selected for comparison: Monterey, San Luis Obispo, and San Mateo (San Manteo was selected as a best practice county). As in other counties, the Santa Barbara County Board of Supervisors has directed ADMHS to serve people without insurance. It budgeted $3.14 million of County General Funds for MH services in the current fiscal year and no funds for ADP services.

The demand for services for people without insurance keeps rising, and ADMHS has increased its services to this population. From FY 2008 to FY 2012, service delivery to people without insurance has increased 22.4% (from 2,474 to 3,028) while service delivery to Medi-Cal members has dropped 6.2% (from 5,809 to 5,449). Despite the recent 43.3% increase in County General Funds for uninsured people, funding for indigent care is widely perceived across the stakeholders we interviewed as too limited to support demand.

Looking at the comparison counties, the range of county contributions to behavioral health services is quite wide, from $600,000 to $23 million, with San Luis Obispo, a neighboring benchmark county contributing $6.5 million. The per 1,000 population rates below allow for a rough comparison adjusted for population size, which puts Santa Barbara above Monterey but below the other two comparison counties.
Benchmark Counties | Population | County Contribution to Services
---|---|---
Santa Barbara | 426,878 | $3.14 million (approximately $7,356 per 1,000 population)
Monterey | 421,898 | $600,000 (approximately $1,400 per 1,000)\(^{56}\)
San Luis Obispo | 271,969 | $6.5 million (approximately $23,000 per 1,000)
San Mateo (best practice) | 727,209 | $23 million (approximately $31,600 per 1,000)

Finding F-2.7: Most comparison counties maintain reserves for Medi-Cal audit exceptions and variability in MHSA funding.
Santa Barbara County depleted its realignment reserve account used to fund outstanding Medi-Cal liabilities due to the 2008 challenges and has not, as of the time of this analysis, restored it. Benchmark/best practice counties report that it is a prudent business practice to establish and maintain a reserve account to address routine Medi-Cal audit exceptions from prior years due to inconsistent application and promulgation of state billing “rules” by state offices, as well as variability in MHSA revenue (see table below).

Benchmark Counties | Reserve Account Approach
---|---
Marin | Amount based on past “worst” case audit exception from previous years
Monterey | 10% of total budget
San Luis Obispo | Amount routinely calculated based on audit exceptions found each year
San Mateo (best practice) | 2% of total budget

Recommendation F-2: Given continued uncertainties in the current and future expenditure and revenue projections primarily related to the ACA, ADMHS should: 1) continue its robust financial planning functionality, 2) reestablish and maintain its realignment reserve to at least 5% of Medi-Cal FFP, and 3) carry out a clinically-informed planning process to project likely FY 2014 Medi-Cal revenue increases related to the ACA.
As emphasized in Recommendations S-2 and F-1 above and Recommendation A-1 below, the uncertainties in the current and future fiscal environment warrant continued fiscal vigilance, careful planning, and maintenance of current robust financial administrative capacity. However, two key gaps must be addressed.

First, ADMHS should as soon as possible reestablish a reserve for Medi-Cal FFP (e.g., 5-10% of FFP), in addition to a MHSA prudent reserve because of routine volatility in MHSA revenue.

\(^{56}\) Monterey County costs for inpatient psychiatrists, social workers, and a manager are included in this figure. However, substantial additional inpatient costs for operations and nursing staff, while paid for by Monterey County, are managed separately, and therefore were not included in this figure. Thus, the overall Monterey County Contribution to services is substantially higher than the figures cited here.
ADMHS may want to consider funding the realignment reserve with the non-sustainable growth provided to the 1991 Realignment account from 5% growth in the 2011 Realignment supportive services growth account. This growth does not increase the county’s realignment base and so should not be used for on-going programs. Thus, this funding source is ideal for establishing a reserve for Medi-Cal liabilities and uncertainties.

Second, the TriWest team and Geiss Consulting recommend that by October 31, 2013, ADMHS should carry out a financial analysis informed by clinical analysis of post-ACA pent-up demand, increased Medi-Cal service requests, and continued indigent care needs (both people and funds), and integrate this analysis into updated projections of post-ACA Medi-Cal revenue. It is also recommended that ADMHS identify the potential continued gap in funding available for the uninsured (and potentially addressed through additional County General funds, as well as other county revenue such as AB 109, particularly for ADP services) based on a per person basis (to account for future population growth) and develop (1) a sustainable level of ongoing county contribution to care for the uninsured and (2) additional flexibility in the budget process to respond to unanticipated needs. Regarding funding for the uninsured in FY 2014, it is recommended that the County continue and potentially expand funding throughout FY 2014 as a bridge year to Medicaid Expansion under the ACA. While ADMHS is currently not projecting increased service levels for MH and ADP services under the ACA, we believe this analysis to be flawed. We believe that many potential clients who may have sought voluntary outpatient specialty mental health services had they been insured will seek services from the County once enrolled in the Medi-Cal program. Some of these services will require an additional local match because these are clients that are currently eligible for Medi-Cal but haven’t previously enrolled. There are detailed financial models that have been developed by other consulting firms to assist in identifying the potential funding necessary under the ACA.

In addition, the limitations in the ability of ADMHS to correctly identify and bill third party payers (discussed in more detail below), and to require that its subcontractors identify and bill third party payers, will amplify the financial and resource strain on the programs when the ACA is implemented. All providers will be expected to be sophisticated and quite nimble in managing multiple payers and individuals seeking services who move on and off of Medi-Cal depending on their employment and other circumstances. One issue that needs to be handled prior to the onset of the ACA is a clear understanding between the board and the management of ADMHS about who will continue to be eligible for free or discounted care.
Finding F-3.1: Use of the Clinic Model as a productivity enhancement tool has failed to improve rates of direct service provision and led to multiple unintended negative impacts.

Despite the assertive use of the productivity reports of the Clinic Model in recent years to monitor rates of direct service provision, direct provision has dropped continuously for five years (32.7% since FY2008). This has been attributed variously to morale, inconsistent application of sanctions, poor reporting, unclear instructions, and poor training. Of even more concern, there was no agreement among ADMHS managers as to whether or not this was actually true. We had to rely on the EQRO to confirm this trend. This is concerning.

Productivity has both clinical and financial implications. Regarding clinical implications, in the most recent Clinic Model productivity report we reviewed (October), productivity was 40.9% (inclusive of non-billable direct service as well). This is a low number for a primarily clinic-based model. If true, this means that SBC is working significantly below capacity and serving too few people (as also reflected in the data on caseloads presented in the Clinical Operations section). Regarding financial implications, use of the Clinic Model productivity reports by clinical management has been to a large degree misguided. Since the Medi-Cal Specialty Mental Health System is a cost-based reimbursement system, the primary metric that impacts annual Medi-Cal financing (particularly given state-level changes instituted in 2012) is the proportion of billable direct service units for Medi-Cal versus other payers, as this is the primary basis for final cost-apportionment in the Medi-Cal cost reporting system. Whether productivity (that is, billable direct service units) is high or low, if it is the same for Medi-Cal and other payers at the end of the year, then Medi-Cal revenue is driven solely by Medi-Cal penetration. While senior financial managers at ADMHS understand this, there is lack of clarity regarding this on the part of the broader management team and much confusion and misguided consternation on the part of every ADMHS clinician we interviewed about this matter.

This seems to relate to the decision to try to use an elegant and extremely useful tool for revenue and expense modeling, projection and tracking (the Clinic Model) in a secondary role as a productivity enhancement tool. The Clinic Model was developed following the events of FY 2008 for multiple reasons, including:

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57 This is the reduction in Total Approved Claims between FY 2007-8 and FY 2011-12. FY 2006-7 data was not used because it predated the major FY 2007-08 system changes. APS Healthcare. November, 2012. DRAFT California External Quality Review Organization Santa Barbara County MHP: FY 2008-09. Page 28.
• To provide more accurate projections for Medi-Cal related revenues on a real time basis. ADMHS had in prior years consistently missed revenue budgets by millions of dollars and discrepancies were not identified until very late in the fiscal year.
• The clinic model was developed to provide a better basis for budgeting future periods.
• The percentage of Medi-Cal penetration had been declining for several years without reliable information regarding how staff time was being spent.
• Interim monthly claiming was higher than it should have been and resulted in large paybacks to the State after the fiscal year was over, so ADMHS sought to develop a more accurate way to determine an appropriate level of reimbursement.
• There was a significant problem with clinicians not documenting their time. A key goal was to ensure that clinicians were documenting their time.
• There were some productivity reports generated by ShareCare, but they were not viewed as precise or complete. The indication from these reports was that clinics and clinicians performing similar functions had a vastly different percentages of documented and billable services.

The Clinic Model is an effective, dynamic budgeting tool used for both planning and expenditure/revenue monitoring, but the Clinic Model productivity reports should only be one of many factors used by clinic managers when determining the productivity and effectiveness of a clinician. The primary challenge has been that clinical managers use the Clinic Model productivity reports in the absence of a broader set of clinical performance metrics (as described in detail in Clinical Recommendation CO2.2). In addition, as a productivity tool these reports are widely viewed by clinical managers and staff as overly complex, poorly understood, and distracting from broader clinical goals, including the primary need to serve more Medi-Cal members. Its use in this manner by clinical managers is made even more problematic given that it is embedded within the broader, dysfunctional command and control management culture described in the Systemic Findings section.

In addition, the Clinic Model productivity reports are but one example of the inadequacy of using reports primarily designed for financial and contract oversight purposes for clinical management data support. The report is very complex, hard even for a highly skilled clinical manager to understand, and not well documented (for example, when we requested “all major documents” defining it, all we were provided with was a complex spreadsheet and the very detailed reports generated by the model). The reports for managers based on the tool are overly complex and unwieldy. Clinical managers reported to us that they must add in data on employee attendance and recompute the figures in order to use the data in supervision (since low levels of direct service in the report may be a function of vacation or holiday time). A request by clinical managers to adjust the reporting to be more functional made in April 2011 had still not been acted on in December 2012). The reports’ lack of face validity and lack of front-
line clinical input into their design also promotes great skepticism about the accuracy of the productivity reports.

The reactive and negatively focused compliance program at ADMHS described in more detail in the Compliance Section compounds these difficulties. Multiple people report staff listing too many services as non-billable because they are risk-adverse. Also, implementation issues abound. Standards are not tailored to program model differences; there appear to be no consequences for not meeting standards; productivity measured is not reduced if the clinician’s notes are audited and found to be inadequate, if a treatment plan is missing, or if notes are late; and the central scheduler is non-functional in its utility to help promote productivity.

Finding F-3.2: More broadly, management information reporting is seen by clinical managers and staff as unreliable.

Overall, management data reporting is not seen as reliable, and multiple respondents report that most staff (and many managers) simply do not believe the data in currently available reports. At the very least, MIS data is in need of task prioritization to support improved financial and clinical management reporting, with better alignment between the two. Clinical leaders must be empowered to “step up” and help lead in this area by working to help develop effective MIS reporting metrics.

In addition, examples of other poor decision-support resources include the following:

- The central scheduler is generally agreed by clinical managers and staff alike to be a poorly designed product which is being used only by some staff, mostly in the wrong way, and as another dysfunctional component of the command/control culture that results in most staff simply not using it. This is a problem, as a central scheduler is one of the primary tools management has to measure and improve on productivity. The scheduler is being used now in the clinic sites, however it is not clear the extent to which managers use this internal control to determine if all clinic services have been documented and billed. The latter is a very basic financial control that, when not in place, limits the ability of financial and clinical managers to verify the degree to which the “work” of direct service staff has been properly converted into reimbursable services. The lack of this basic connection – scheduled service to billed service – means that unclaimed services are less readily identifiable.

- ADP services do not have an electronic health record (EHR). We were told that this EHR is ready to implement, but that IT resources have not been prioritized. In our view, this seems to relate to the broader culture, as well as crisis-driven and poorly prioritized management oversight of MIS currently (and potentially limited MIS expertise and capacity). This is a major efficiency challenge, both from a provider standpoint and from a compliance and audit standpoint as well.
Ideally, MIS would be an organization-wide function, reporting to the ADMHS Director with capacity to support both financial and clinical management reporting. However, it is not clear if MIS has the expertise and capacity currently to carry out such an expanded role. Given the reduced scope of the TriWest assessment, we were not able to carry out an analysis of the current MIS reporting capacity underlying the multiple functional gaps identified.

Recommendations F-3.1: Financial and clinical managers should collaborate to develop and implement (with necessary training supports) by 7/1/2013 a replacement revenue assurance report that is readily understood by clinical managers and staff and that only tracks metrics relevant to ensure adequate Medi-Cal revenue, such as the proportion of Medi-Cal to non-Medi-Cal direct billable units and the number of uninsured people seen who could potentially qualify for Medi-Cal coverage.

Collaborative re-tooling of productivity management through a cross-functional team of finance, compliance and clinical leadership should be incorporated into the broader quality improvement planning process described in Recommendation S-1 above. In the short term (by 7/1/2013):

- Fiscal, medical and clinical operational management should work together to develop a replacement revenue assurance report. It must be readily understandable, consistently and routinely produced and accurate. It should also clearly focus on metrics essential to ensuring adequate Medi-Cal revenue, such as the proportion of Medi-Cal to non-Medi-Cal direct billable units and the number of uninsured people seen who could potentially qualify for Medi-Cal coverage.
- Fiscal, medical and clinical operational management should also work together to develop and shape supportive policies, set standards, develop necessary training supports, train staff, and be involved in monitoring and management.
- Additional metrics should be developed in accord with Recommendation CO-2.2 above to address client flow for ACT, Supported Housing, clinics, and psychiatrists in particular.

At one level, it might be best to simply suspend productivity measurement via the Clinic Model reports for the two months until the new reporting is developed. Managers could continue to receive the reports, but staff could be reassured that the reports would not be used to monitor and potentially sanction (although we are not aware that this has ever happened) poor performance. However, it is impossible to determine whether there will be unintended negative consequences as a result of such a precipitous and dramatic gesture, so the TriWest team recommends instead an emphasis on the replacement reporting structure without changing the current process until a new report and process is available.
For the longer term (by 10/31/2013), standards need to be set collaboratively between clinical, regulatory compliance, UM, and finance managers, attending to future needs to bill more payers (particularly private payers for people currently uninsured that will have access to private insurance through the new exchange).

More broadly, finance and clinical managers need to work together to establish a wide range of routine financial management reports and collaborate to ensure accuracy of measurement, including agreement on standards and metrics, how they will be measured, who will measure them, and what actions will be taken in response to non-compliance. The standards need to be in writing and both staff and CBOs need to receive collaborative training led by clinical managers.

Recommendation F-3.2: The Tiger Team should employ MIS experts from the County to 1) determine if ADMHS MIS expertise and capacity is sufficient and 2) develop a plan to ensure appropriate oversight of MIS within the developing ADMHS organizational structure.

For the interim, the TriWest team recommends that MIS report to finance as the most critical function supported by its reporting capacity. Given that finance is in the process of hiring a report development analyst, this alignment makes additional sense for the short term.

However, as stated above, MIS should be an organization-wide function, reporting to the ADMHS Director with capacity to support both financial and clinical management both operationally and in tracking and reporting needs. An analysis of the current MIS reporting capacity underlying the multiple functional gaps identified by the TriWest team is necessary, and the Tiger Team should allow access to a wider array of DPH and County resources to carry it out.

Finding F-4: The current ADMHS budgeting and strategic planning does not include meaningful input from clinical managers and MHSA planning efforts.

The budgeting process supports Medi-Cal cost reporting compliance and provides ADMHS with a rigorous and proven capacity to project revenue and expenses. However, its lack of incorporation of input from clinical management and community planning efforts (such as MHSA planning) may be limiting opportunities to manage financial risk and improve clinical operations functioning.

- The budget process is very detailed and careful, largely in response to the past problems SBC has had with recoupments based on compliance and California’s retrospective reconciliation process. The methodology for managing subcontractor budgets is similarly rigorous. This provides a firm foundation for incorporating a broader array of input.
But the key gap is the lack of effective/empowered clinical leadership and a process that begins with community needs, assesses those needs in light of a mission/vision and available resources, and develops community-driven priorities to drive the budget.

Planning regarding service supply and clinical demand is carried out using solely historical information and with a primary goal to maintain current programs, rather than a mix of data and prospective modeling. Especially in a time of market change, potential opportunity and unmet needs must be better factored. This is reportedly the plan for the next budget cycle, and it is essential that this occur.

The MHSA plan has not been integrated into broader financial planning. While MHSA funds are used to support core clinical operations, MHSA planning input (and clinical input more broadly) is not routinely used to drive budget planning. MHSA input is essentially “silied” from the broader planning (as is ADP input). There is a need to integrate processes for MHSA input (which may involve altering these processes to some degree) into the broader ADMHS planning and budget development process. Also, MHSA funding does not seem to be strategically linked to a broader county-wide vision.

**Recommendation F-4.1: Align the System Change initiative to incorporate MHSA planning requirements and result in meaningful input by 10/31/2013 to inform the FY 2014-15 budget process.**

The draft FY 2014-15 ADMHS budget will need to be developed in January 2014. As described above, if the System Change initiative findings can be completed by 10/31/2013 with an explicit emphasis on informing the FY 2015 budget development process, that budget will be better able to respond to expected changes related to ACA implementation, Katie A. Settlement implementation, and other broader system changes with potential to affect both revenue and expenses. A separate work group focused on the budget may be needed to support this, but in addition every work group should include development of assumptions for the FY 2014-15 budget as part of its chartered mandate.

**Recommendation F-4.2: Improve budget planning by development of a “Revenue Cycle Committee” (or similar structure).**

A Revenue Cycle Committee involving a cross-functional team of finance, compliance and clinical leadership should be incorporated into the budget development process. A revenue cycle committee is becoming fairly commonplace in behavioral health care settings and in health care more generally. The “revenue cycle” concept refers to the process from the initial call or referral through payment of services. Organizations are recognizing that this process has multiple moving parts and steps that cross departments and must be aligned to ensure appropriate and effective revenue management. If parts of the revenue cycle do not work well,
or do not do their job in handing off their work to the next step in the cycle, revenue is jeopardized at best and at worst, lost altogether. In addition to being accurate and careful, revenue cycles must also be efficient, so time from one step to the next, and of the cycle as a whole, should be measured and attempted to be optimized, without loss of accuracy and completeness. The Revenue Cycle Committee we recommend would be charged with analyzing, cleaning up, and decreasing the time from step one through the collection of payment. It is critical in complex organizations where there are multiple payers. It is also critical in organizations that primarily rely on the development of revenue through service delivery rather than through other means such as grants. Based on this, we recommend the following:

• ADMHS should immediately establish a committee focused solely on the revenue cycle. ADMHS has a strong base to build on in this area. ADMHS established a Billing Issues Group (BIG) in FY 2011-12 consisting of Fiscal and MIS staff that met weekly to address all billing-related issues, including eligibility, third party liability, and the revenue cycle. In FY 2012-13 ADMHS converted this group into the Revenue Management team. ADMHS also has a Programs Implementation Meeting (PIM) Committee that consists of different disciplines within the department (Fiscal, MIS, Contracts, QA and Clinical Programs). The PIM committee is responsible for implementation and changes to programs. The PIM committee could serve as the “Revenue Cycle” Committee referenced in the report, but to do so it would need to also include the compliance manager and focus its efforts solely on the revenue cycle or risk becoming diluted by other concerns. Given the broader current focus of the PIM committee, it may be necessary to reconvene the group separately for the purposes of revenue cycle redesign.

• In the short term (by 7/1/2013), the committee should plot the current revenue cycle and identify areas where interventions can be made to make this cycle more efficient and effective. Based on our findings, we recommend that the initial focus be on the front end of the revenue cycle and then move onto other critical issues. Eligibility, third party liability, and indigent care would all ultimately be addressed by a typical Revenue Cycle Committee, as well as needed supports (such as a functional central scheduler).

• Development of the indigent care policy should be incorporated into this work. In addition, it should incorporate work in other areas regarding capacity at the front end of the revenue cycle to appropriately check on insurance coverage and assign the right clinician to the client from the assessment forward, as well as pursuit of third party payers.

• The committee should also incorporate efforts to improve tools (central scheduler, ADP EMR, etc.) and increase trust in reporting more broadly, as part of the broader QI process.

• The committee would also be able to be a collaborative forum to support budget development, especially as described in this report where the budget increasingly
incorporates opportunity (including the development of demand and its capture), as well as historical performance and capacity maintenance.
Detailed Findings and Recommendations: Administration

Finding A-1: ADMHS financial and contract oversight operations are comparable in scope to other California counties and functioning well.

The analyses associated with Systemic Finding S-2 and Financial Finding F-1 together document the success of ADMHS in establishing a sound financial and contract oversight process. However, one concern voiced by stakeholders was the amount of resources allocated by ADMHS to these functions. In carrying out the administrative analysis, the following benchmark counties were consulted to determine their administrative capacity and models: Marin, Monterey, San Luis Obispo, and San Mateo.

All benchmark and best practice counties are part of their County Health or Health and Human Services agency. Yet, each county has a unique organization developed over time, and it is difficult to compare across county structures due to different organizational approaches to operations in each county. Specifically in the area of financial operations, staff represented in the organizational charts of benchmark and best practice counties range from one (1) to 34.5 FTEs, with varying degrees of other staff assistance from their umbrella health/human services agencies, without a clear relationship to county population.

Based on the most recently filed Medi-Cal Specialty Mental Health cost report data, Marin, Monterey, San Luis Obispo and Santa Barbara counties all spent approximately two-thirds of their total mental health spending on outpatient direct services. The four counties incurred seven to 11% of their total mental health program spending on administration (which includes the costs of being the Medi-Cal Specialty Mental Health Plan and not the costs of clinical administration which is allocated to direct services), with Santa Barbara on the high side at 11%. This is consistent with the resources dedicated to contract monitoring and management in Santa Barbara County as well as the detailed level of financial and contract monitoring. Given its history, the level of resource commitment in SBC to financial and contract oversight is reasonable.

Recommendation A-1: ADMHS should maintain its current robust financial operations and contract oversight capacity and build upon it by moving oversight of contracts to the finance area.

As emphasized in Recommendation S-3, there should be no reduction in resources or priority assigned to fiscal and contract oversight for the foreseeable future. While additional staffing in these areas is not likely necessary in the near term, the TriWest team recommends integrating oversight of contracts in the finance area given the alignment of focus of these two functions.

59 Medi-Cal Specialty Mental Health Cost Reports, various counties
Finding A-2: There are substantial gaps in clinical administration.

Our review of the comparison counties found that most have defined clinical population management positions as part of their administrative function, including positions responsible for oversight of services in the areas of:

- Adult and older adult services;
- Child, youth, TAY, and family services;
- Alcohol and other drug services;
- Culturally and linguistically competent services;
- Dedicated child welfare clinical leader and clinical team; and
- Dedicated homeless, juvenile justice and correctional services clinical leaders and clinical teams.

They also have key dedicated positions to support clinical operations:

- Full-time Medical Director with medical staff “chiefs” for adult, child, geriatric, and addictions to help shape clinical guidelines and care standards;
- Pharmacy Program Manager (pharmacist);
- Quality Management as a distinct functional unit with a focused system-wide quality improvement program;
- A MHSA planner within the quality management structure to report on MHSA services, with oversight of MHSA services integrated under clinical operations;
- A Provider Relations Coordinator to support CBO communications; and
- Clinical operational managers.

ADMHS’s establishment of the Regional Manager positions to oversee systems of care in each of the three distinct geographic regions is a strong model to promote integration of systems of care in each region. Given Santa Barbara County’s large geographic size and the diversity across its communities, this organizational strategy seems essential.

However, ADMHS has many gaps in its supporting operations:

- There is an absence of senior clinical positions to support the work of the regional managers and develop program policy and standards for services for adult/older adult, child/family, and culture-specific populations.
- There is a part-time Medical Director without adequate time for required functions.
- There has been a long-term vacancy for Assistant Director for Mental Health.
- There are incoherent reporting lines among top clinical managers.
- The primary CBO contact is the Contract Manager (financial/compliance focus); this role should be secondary to and supportive of a primary point of contact with CBOs within clinical operations.
• Clinic supervisors have too many direct reports (13 to 25 FTEs each), and their role needs to be better articulated (until recently they had caseloads, too). The lack of adequate clinical supervisor staffing levels to allow them to directly manage staff (for example, to have primary responsibility for employee performance reviews) leads to extensive diversion of Regional Manager system time to support clinic operations rather than system oversight.

• Regional Managers have responsibility but not clearly delineated authority to coordinate at an agency level (versus individual case level), so the structure does not allow them to truly "manage" their regions (instead they mostly "coordinate" care of individual cases). All key decisions have to be reviewed higher up, interfering with real time operational improvement and leading to multiple unofficial workarounds.

• The Quality Manager reports outside of clinical operations; Quality Management (QM) needs to serve the entire organization with an emphasis on clinical operations and should report to either: A full-time Medical Director able to oversee/develop the program (ideal), the Department Director, or the senior manager over clinical operations.

• The Quality Manager has too many responsibilities that dilute the focus on QM. These include: utilization management (UM), compliance support, billing auditor, inpatient triage, and more, all of which limit time for critical QM tasks such as the annual continuous quality improvement plan, monitoring, reporting, and specific improvement projects.

Recommendation A-2.1: To improve management of clinical operations, immediately address critical gaps, including: a) appointing a full-time Medical Director, b) designating Assistant Medical Directors in key outpatient areas, c) repurposing and filling the vacant Assistant Director of Mental Health as an Assistant Director for Clinical Operations over both MH and SUD, and d) reorganizing existing administrative resources to support additional clinical supervisor time sufficient to reduce spans of control to 8 to 12 FTEs (with an average of 10 FTEs).

Filling these critical gaps is crucial in the next 30 to 90 days.

• The full time Medical Director should have at least 0.9 FTE dedicated to administrative leadership and the position should be part of the Executive Management team. The position should report to the ADMHS Director, but should also maintain an ability to provide an independent perspective on ADMHS functioning on a routine basis to the broader county administrative structure (analogous to the role of the independent Compliance Officer described in the following section). If the Medical Director maintains a clinical practice role (which is often a positive addition to their administrative duties), it should involve no more than 0.1 FTE and be relatively contained and predictable in its
scope (for example, routine clinic duties as opposed to duties for a 24/7 team such as an ACT team).

- Four dedicated Assistant Medical Directors should support the Medical Director, and each should have approximately 0.1 FTE of time assigned for their oversight of adult, child/youth, older adult, and SUD service delivery. These duties could be assigned to current physicians as several are already dedicating substantial amounts of time to administrative activities. The primary change would be recognizing this and giving these physicians credit for their service as an official duty.

- ADMHS should also repurpose and immediately undertake a process to fill the vacant Assistant Director of Mental Health as an Assistant Director for Clinical Operations and fill the position with a licensed senior clinician with strong operational experience (both MH and SUD, preferably) and have that position report to the ADMHS Director and supervise the Regional Managers and Division Chiefs. In selecting the new Assistant Director, we recommend that ADMHS and the County engage a cross-functional team inclusive of CBOs and community members to develop the job description and provide input into the selection of candidates for this position.

- ADMHS should also reallocate existing administrative resources to the extent possible, including vacant, held positions and current management positions without direct operational responsibility, to provide additional clinic supervisor staff. The additional staff should be sufficient to reduce spans of control to 8 to 12 FTEs (with an average of 10 FTEs per supervisor).

The Tiger Team should also institute immediately an interim organizational structure that involves the following functions on the senior management team for ADMHS: the MH Adult/Child Division Chief, the ADP Program Manager, the Consumer Empowerment Manager, MHSA Division Chief / Ethnic Services Manager, and the QA Manager. The longer term roles of these managers should be determined in accord with the following recommendation.

**Recommendation A-2.2: Over the longer term (by 10/1/2013), the Tiger Team should determine the appropriate organizational structure for long-term management of ADMHS.**

The System Change initiative should both improve ADMHS operations and expand options for redesigning clinical operations administrative structures. In addition, the short-term changes of Recommendation A-2.1 should begin to address current policy gaps through the work of the Medical Director and Assistance Medical Directors, allow the Regional Managers to be more involved in policy development, and empower Clinic Supervisors to better support clinic staff.

As these changes are implemented, planning should take place to recommend a permanent organizational structure for ADMHS clinical operations. This plan should be completed by
10/1/2013 in order to be incorporated into the budget development process for FY 2014-15 for implementation as soon as possible in FY 2015. To inform these efforts, ADMHS managers (including Dr. Wada in his role as Interim Director) should continue and expand active participation in the California County Mental Health Directors Association (CMHDA) and its key committees so that planning can be informed by practices in other counties and continued developments over the next year at the statewide level.

Finding A-3: Denial rates are comparable to other California counties, but the utilization management system is underdeveloped.

The Medi-Cal denial rate is five percent (5%). This rate is higher than historically and higher than national best practice (2% to 3% rate), but comparable to California counties. The general consensus is that the problem is client eligibility (identifying payers). This affects the third party liability issue, as well as resources for the uninsured. It also is something beyond the control of finance that requires improved clinic-level administrative processes to identify payers at the front end of the revenue cycle.

Related to this, the ADMHS Utilization Management (UM) system is lacking. Quality Management (QM) is responsible for lower levels of care and, for higher levels of care below inpatient, a team of SBC management and subcontractors tracks use; neither is a best practice. It is also concerning that the upper levels of care (e.g., 24 hour care, inpatient) are managed through an old-style “high risk committee,” rather than a data-driven triage system using standardized decision support tools. Utilization management is a key competency for any organization as large as ADMHS and as heavily involved in subcontracting service delivery. UM administratively helps to control both financial risk and quality of care, supports best practice and evidence-based practice implementation, and allows for a uniform approach across the service delivery system.

The lack of strong internal UM systems has contributed to the lack of actionable data regarding wait lists, wait times and unfulfilled demand (e.g., ADMHS was unable to report ACT denials to us and could not even reliably report MD caseloads). Consequently, clinical resources are poorly assigned based on need and both under- and over-utilization seem to be resulting (e.g., under-utilized crisis residential program noted above and over-expenditures on a relatively small number of consumers, as described in the previous section). Decision-support tools (e.g., the CALOCUS and a home-grown tool for adults) were previously used, but foundered as a result of organizational issues.
Recommendation A-3: Make targeted administrative enhancements to improve UM oversight and payer identification.

Collaborative development of an improved utilization management system and payer identification by finance, compliance and medical/clinical leadership should be incorporated into the broader quality improvement planning process described in the section on Systemic Findings and Recommendations.

- In the short term (by 7/1/2013) consider initiating the following activities:
  - Initial analysis of the 222 top utilizers described in the section on Clinical Operations should be carried out to inform UM planning.
  - Wait lists, wait times, and capacity should begin to be routinely monitored and reported to senior management for planning and budgeting purposes.

- By 10/31/2013:
  - A plan to collaboratively develop and implement standardized UM decision support tools should be adopted similar to the CALOCUS and LOCRI tools previously used, but this time developed with more clinical involvement and cross-ADMHS/CBO buy-in. Once developed, the emphasis should be on training clinical staff at the program level to use the tools to carry out their own UM oversight, with published expectations of care including hours of services, types of services and average length of stay, reserving central UM resources to carry out routine and ongoing outlier analysis and more assertively manage inpatient admissions. The plan should include best practices (for example, inter-rater reliability should be regularly tested for both ADMHS and CBO staff) and UM monitoring should be adequately staffed rather than covered part time by the QA manager.
  - There should also be a plan focused on post-ACA implementation to improve payer identification and third party liability billing capacity in order to maximize access to benefits that some uninsured people in need of ADMHS services will receive under the insurance exchanges. Front desk staff need to revamp their intake, check-in and check-out procedures to incorporate identification and confirmation of insurance and/or self-pay status to address current flow, and these issues will be compounded after January 2014.
Detailed Findings and Recommendations: Compliance

Finding C-1.1: Despite focused improvements (such as in EQRO compliance), there are multiple gaps in clinical compliance processes.

As described in System Finding S-1, EQRO compliance has improved and mechanically-sound financial tracking processes have been established for county and contract services. In many ways, no compliance function at all reportedly existed prior to its establishment following the events of 2008. Yet, despite significant advances, many compliance concerns remain.

The Compliance Officer role has operational responsibilities and is not independent. While this practice was common prior to the implementation of the Affordable Care Act, current standard practice for compliance programs at risk for Medicaid revenue is to have in place a full-time Compliance Officer that has no operational responsibilities and no associated conflict of interest in their oversight. The Compliance Officer must be free to assess, without real or perceived bias, the operations of the entirety of the clinical, financial and administrative activities of the organization. While reporting to the ADMHS Director operationally and day to day, the Compliance Officer must also maintain a direct and regular line of communication to the County Executive Office and advisory commissions for MH and SUD.

ADMHS needs to make a concerted effort to reverse the widely held perception that the organization, through its compliance program, does not adequately address concerns, questions, and negative reports. Interviews with staff yielded numerous reports that the compliance culture at ADMHS was adversarial and overly focused on what not to do versus providing clear guidance on compliant practice. Staff reported that, as a result of this focus, there were general concerns related to reporting of compliance issues. This perception is not unusual in organizations such as ADMHS that have gone through a significant payback and where concerns about additional financial audit risk sometimes overwhelm the compliance program. However, adversarial and retaliatory systems often end up doing the opposite of what is intended as staff refrain from actively participating in the organization’s compliance efforts and, potentially most damaging, do not bring out into the open potential problems so that they can be analyzed and mitigated. As discussed elsewhere in this report, staff at ADMHS are very vested in the organization’s success and want to be employed in a culture that demands the highest quality and adherence to standards. Therefore, changing the compliance culture will likely be welcomed by staff.

To address these concerns, ADMHS would need to implement basic changes to the structure and focus of the compliance program through operational independence of the Compliance
Officer and a refocusing of the compliance message to all staff. In the short-term (two to three months), this would involve activities such as:

- Immediately re-training staff on compliance with an emphasis on developing a “culture of compliance,” the responsibility of staff to report all questions or concerns as part of the broader organizational commitment to quality improvement, and assurance that these reports will be valued and used to increase the quality of care. This re-training should incorporate CBOs and other vendors with compliance risk as well.
- Develop an independent Compliance Officer position with no operational responsibilities and ensure there is a method for direct communication with County leadership.

Over the medium term (three to six months), the emphasis should focus on revamping documentation training to highlight how to comply and not solely what not to do or what will get staff in trouble. Again, CBOs should be involved in this process. Over the longer-term, ADMHS should develop and disseminate tools to help staff and CBOs understand the organization’s expectations for compliance, including a provider manual, frequently asked questions postings, etc. These tools should be developed with the participation of direct service staff in ADMHS and at the CBOs.

There is no formal, written annual assessment of compliance risk completed by the Compliance Officer with input/approval of senior managers. As a result, the compliance program lacks focus and fails to systematically assess risk. In response to the initial identification of this finding, additional documentation of compliance planning for FY 2012 and FY 2013 was provided, but our conclusion is unchanged. The current plan reflects multiple basic misunderstandings about how a compliance program should work. While the ADMHS compliance program has completed a gap analysis, it was not a risk-based analysis and did not include any analysis of operational risk. The analysis instead focused on whether or not the basic elements of a compliance program were in place and functioning. It would be expected that, given how long it has been in operation, the compliance program would have the basic infrastructure in place and would now be positioned to look inside the organization to identify best practices, risks, potential problems, etc. The completed gap analysis actually notes that a risk assessment will be completed once baseline compliance is achieved. This misses the point of the risk assessment, which is to identify those places, based on an internally designed prioritization model, where compliance resources need to be directed to reduce, mitigate or eliminate risk. Without this, basic compliance cannot be achieved. The federal Office of the Inspector General (OIG) explicitly states that they expect continuous risk assessment with findings incorporated into current and future planning and actions of the compliance program.
To address this issue, ADMHS would need to conduct a risk assessment and incorporate ongoing assessment of risk into the job description of the Compliance Officer, the charter of the compliance committee, and the responsibilities of all staff, especially management. In the short-term (two to three months), this would involve conducting a baseline compliance risk assessment, either by developing an internal team or hiring an external expert to do so. This would involve identification of new and unknown risks, as well as the verification and quantification of known risks. These should be prioritized and incorporated into the work plan and action time line for the compliance program.

Over the medium term (three to six months), the emphasis should expand to include risk mitigation through an approach developed by a team of compliance, clinical, administrative and finance staff. This approach should include consideration of the following identified risks:

- Institute controls in the Electronic Health Record (EHR) that would not allow a service to be billed if a current and final treatment plan is not in the EHR.
- Develop policies defining the specific activities to be documented as direct versus indirect services (rather than referencing state documents that lack this specificity).
- Institute consistent monitoring approaches for ADMHS clinics and CBOs with individualized risk assessment tailored to team type (e.g., ACT vs. outpatient vs. PHF).
- Immediately prioritize the development of accurate, available and useful management reports. A lack of adequate information impacts all operations and particularly challenges ADMHS’s ability to determine if internal controls are in place and working to reduce compliance risk. See related discussion and recommendations pertinent to this issue in the Administrative, Clinical Operations and Finance sections.
- Decouple compliance monitoring of CBOs from fiscal monitoring in order to improve the integrity of clinical oversight. Both should be maintained and close communication between the two processes continued and expanded, but fiscal monitoring should be carried out separately from clinical monitoring to ensure that each process has integrity and focus. See further discussion and recommendations below on this issue.
- Have the already developed Frequently Asked Questions (FAQ) document reviewed by a compliance expert, revised, approved by the Tiger Team, and then publicized.

The current medical record review and audit activities of the compliance program and the quality management (QM) programs need to be redesigned and basic claims audits introduced. Currently, the ADMHS compliance program has combined quality and claims audits into one process, resulting in an inability of the program to adequately differentiate and assign risk levels to documentation and service delivery problems. Best practice is to separate claims reviews (the most likely type of federal review) from content and service quality reviews so that each area can be separately assessed and interventions to reduce problems can be better targeted. All of these non-routine reviews should take place under the direction of the county.
or ADMHS compliance attorney in order to establish attorney-client privilege. We were told that all current reviews are conducted under attorney-client privilege, but documentation of the reviews did not support this claim.

We were able to verify that the last combined quality/claims review occurred in FY 2011. This is the most basic and necessary form of review, and it should be done at least annually (and more often in response to concerns identified through the on-going risk analysis). The claims/billing review compares documentation to the basic Medi-Cal requirements and tells the organization whether or not Medi-Cal funds are at risk for recoupment because of inadequate documentation. ADMHS instead combines service quality, documentation content quality, and claims requirements into a single review that does not allow the organization to adequately assess risk in any of the areas being addressed. Published results are therefore relatively meaningless and do not provide actionable content for management. Conducted correctly, claims reviews can address as few as 10 and up to 50 claims chosen randomly. These reviews can target programs, individual providers, departments, or whatever level of the organization is relevant to the question at hand. In addition, these types of claims reviews, with samples and sample size adjusted to allow extrapolation, can be used to determine payback amounts where systemic problems have been identified.

This is differentiated from quality reviews, which examine the quality of service documentation or of the actual services delivered. Depending on their content, sample size and sample selection can be adjusted. Quality reviews of documentation content often look at multiple factors in each of the major documents in the medical record: assessment, treatment plan, and progress notes. Review tools need to allow for separate assessment and scoring of each document type. These reviews can be used to assess risk (for example, how measurable are the objectives for clinic treatment plans?) in order to identify implementation of best practices and evidence-based practices. Because these are generally targeted reviews, the tools and sample sizes need to be adjusted for the review type. Inpatient documentation and risk is very different than outpatient or medical services risk. Currently, ADMHS does not have program-specific QA reviews, nor are they routinely carried out. Progress notes are being evaluated (sometimes by the entire compliance committee in meetings) but the combined quality and claims compliance issues are mixed in the tool, so results are confusing.

Quality reviews of service content also need to be considered by compliance. These reviews look at medical necessity by evaluating service intensity, service content, length of stay, and other key indicators. Currently, because of considerable problems with management reporting, ADMHS management and compliance staff do not have access to accurate measurements for many of these indicators and cannot do the requisite data mining that would support robust service content reviews.
Licensure, accreditation, HIPAA liability and other issues can be addressed in ad hoc reviews as needed and as prioritized in the annual risk assessment and compliance plan. However, before conducting these reviews, compliance should first review the internal controls that have been designed and put in place to reduce risk in these areas. If internal controls are in place, reviews should primarily focus on testing these controls. If no internal controls are in place, then a full assessment of risk should be done, followed by the design and implementation of internal controls, before conducting tests of these controls. Each year, there will also likely be specific issues to review based on a program-by-program assessment of risk (for example, are individuals in ACT clearly still clinically eligible for this level of service based on documentation in the record? Are children prescribed anti-psychotic medications being medically followed, internally or externally, by a primary care physician?). These usually arise from staff reports, external audits, data mining or other activities. Issues also arise from external reviews. State and federal reviews provide valuable information about risk. Often, though, it is up to the organization to further explore the extent of the risk, evaluate internal controls and intervene where necessary.

Addressing this will require ADMHS to develop a new medical record audit and review plan that is supported with data mining to identify outliers and potential compliance problems. In the short-term (two to three months), this would involve developing and implementing a claims review protocol and initiating a systematic review of claims risks in all programs. Over the medium term (three to six months), the focus should shift to developing a protocol for evaluating documentation content. The protocol should include the tools, a timeline, and the mitigation activities anticipated. These should be carefully designed to allow for corrective actions and re-review post remedial training. Therefore, they need to be systematic in targeting what are anticipated to be the most problematic programs (usually identified through the claims reviews or staff reports) so that the organization is not overwhelmed. Over the longer-term, ADMHS should develop the data-mining capacity needed to support medical record reviews regarding the medical necessity of service content, including design and implementation of a protocol for review of outliers.

**Key internal controls and management reports are not in place.** Basic, essential management reports (e.g., productivity and treatment plan timeliness) are viewed across management as neither accurate nor useful. Finance is hiring an analyst to improve utility of reporting (which is a positive stop-gap), but the key is effective clinical integration of financial reporting. There is no policy defining what constitutes direct versus indirect services; instead, state documents are cited and inconsistently interpreted. ADMHS needs a specific policy, regularly updated, that defines what should be documented as direct service and what should not. In addition to simply reporting on operations and finance, the report function must be able to mine data that will assist ADMHS management in identifying outliers, potential compliance problems, new areas of financial risk, and other priorities.
The Compliance Committee is inefficiently focused. Too much of the time of the compliance committee is spent in reviewing specific progress notes. These are notes that have already been reviewed and scored by audit staff. This is an inefficient use of time currently, although early on in the program’s establishment it did help to establish inter-rater reliability and program managers’ understanding of the key documentation issues within the programs. The committee also invited line staff to attend meetings, which made the program more transparent. This is laudable, however, the compliance committee must routinely address sensitive and confidential issues and the introduction of new staff at each meeting who are not able to participate in discussions and decisions at this level presents a serious barrier for the committee in completing its work.

To address this, ADMHS would need to refocus the compliance committee on core functions of evaluation and support to the Compliance Officer and compliance program, and away from direct oversight activities such as the review of progress notes or other parts of the medical record. Over the short-term (two to three months), ADMHS should review and modify the charter of the compliance committee to reflect its responsibilities as described in compliance guidance issued by the OIG. Over the medium-term (three to six months), ADMHS should conduct a staff survey about the compliance program and assess staff knowledge and perceptions of its purpose, as well as their evaluation of its usefulness. Over the longer term, ADMHS could review the staff survey results through the compliance committee and design outreach and training activities to address issues raised that limit the compliance program’s effectiveness.

Finding C-1.2: Training in support of compliance and more broadly is inadequate.

Training overall and compliance training in particular is problematic in multiple ways:

- The content of the compliance training did not allow for modifications based on new information or the identification of new risk areas. The current policy needs to be updated to reflect the need for a dynamic program with specific responsibility assigned to individuals for training development and oversight by the Compliance Officer along with the compliance committee.
- The training materials lack clarity and are too focused on avoiding mistakes rather than providing clear guidance to promote compliant practice (e.g., staff and CBOs report that some billable services end up being designated as non-billable to avoid personal risk).
- Training does not focus on newly identified high risk areas by program type in a timely fashion, such as admission and continued stay criteria for inpatient services and completion of treatment plans.
• More broadly, training needs to be prioritized (including best practices like the use of peer support and co-occurring care, as well as basics such as the response to violent / threatening behavior and management/financial training for supervisors).
• Training time must be supported by the productivity tracking system so that staff do not perceive time spent in training as “non-productive,” and training budgets need to be established for both clinical programs and ad hoc needs in response to emerging issues.

More broadly, training programs overall need to be better targeted, tracked, evaluated and modified based on attendee evaluations. In particular, compliance training needs to engage staff in the value of compliance and the relationship between compliance and quality of care.

**Recommendation C-1: Address short term compliance needs by carrying out a written compliance risk assessment over the next three months and develop a plan by 10/1/2013 to address remaining compliance gaps.**

The most immediate need is to develop an annual written compliance risk assessment. In addition, ADMHS should work with the County (separate from the broader System Change initiative) to develop a plan to address the gaps noted in this section and prioritize the short, medium and longer-term activities specified throughout.

**Finding C-2: Despite improvements in financial oversight for CBOs, substantial gaps remain in oversight that impede development of productive working relationships.**

ADMHS has improved the core mechanics of its contracting and contract oversight process: Processes are now standardized and timely, standards have been clarified, and robust electronic linkages have been established. CBOs recognize these improvements and in general expressed support for maintaining them. In addition, ADMHS clinical staff and CBO providers reportedly work well and collaboratively regarding care delivery in most instances. However, at an organizational level the overall climate between ADMHS and its CBOs is one of mutual distrust, undermining the partnership envisioned by the MHSA Full Partnership models. The goal of CBO oversight should be to improve contractor performance, but the perception is that contractors are being systematically deemphasized and downsized (and budget reductions since 2008 correlate with this perception). Provider development as a system goal needs to be more clearly embraced and communicated. Instead, there is a perception among many CBOs that they “do the work without recognition / support;” the implicit requirement that county staff/physicians must oversee every case compounds this.

While there have been improvements in provider contract development and implementation of a monitoring approach, the top-down directives, command/control culture, and crisis-driven style of ADMHS management generally is perceived by providers as perpetuating a climate of
negativity and impaired organizational working relationships. This is a particular problem in a state like California where most counties rely on strong relationships with contract providers to respond collaboratively to the adversity of the Medi-Cal claiming system and volatility in MHSA funding.

As a result, the relationship between the compliance program at ADMHS and CBO operations and compliance programs is too adversarial. The ADMHS compliance program should include a major focus on helping the CBOs build their compliance programs collaboratively with ADMHS. This would reduce risk at both the ADMHS level and the provider level as well. Rather than continuously auditing the CBOs, the focus of the compliance program should be to help the contractors develop their own internally robust compliance programs that systematically report findings to ADMHS, subject to ongoing audit and verification by ADMHS. This reduces risk to the system of care overall by engaging all parties in meaningful compliance monitoring and promotion. Currently, levels of auditing would continue until sound, effective, and externally validated compliance programs are in place. Once a CBO has established such a program, the ADMHS compliance program would focus its efforts for that CBO on evaluating the effectiveness of the CBO compliance program. ADMHS could also require that the contractor’s internal audit findings and audit plan be reported. ADMHS should also be monitoring provider paybacks based on these internal reviews.

Currently, mental health provider communications center primarily on contract management with very little interaction at the organizational level (versus individual case level) by clinical leadership once the contract is executed. Many positive contract processes are therefore seen more negatively. This is not the situation for ADP or MHSA planning, but these activities are not integrated into broader clinical/service planning. Meetings with senior managers prior to September 2012 (and the initiation of this project) were infrequently scheduled (once a month) and often cancelled without advance notice to providers.

As noted above, the Provider Scorecards, while positive and a best practice in concept, are uniformly received by providers as ineffectual in providing useful information to improve care.

- The primary flaw is that original implementation of the Provider Scorecards did not include CBO input, and there has not been a process since to reengage CBOs in fundamentally redesigning them. Typically, report metrics are developed in collaboration with providers and implemented on a trial basis to determine reliability and validity.
- Scorecards can be useful tools if implemented with consistency and appropriate standards developed with provider buy-in. Their promotion at ADMHS was a best practice, but clinical leadership should have driven the process alongside contract and finance leads. The contract/financial functionality underlying the reports cards is sound,
but the failure to embed them in a broader, shared clinical/support vision limits their utility and reinforces negative perceptions of their intent.

- Scorecards are applied only to CBOs, not ADMHS and not ADP contractors; they should be applied across the board and tailored to individual program types.
- Because they are embedded in a compliance/financial function that is not aligned with ADMHS clinical leadership, provider scorecards are perceived as focusing primarily on managing financial risk, not promoting broader clinical compliance or improved clinical care, and are inconsistently addressed. Even though they include clinical factors, their focus is perceived to be primarily financial as that is where the oversight is grounded.
- The current Scorecards are the same for all programs and thereby overlook individualization of risk (e.g., ACT versus outpatient).
- While ADMHS has worked to respond to CBO input to improve the Scorecards, because buy-in for the larger process was never established up-front (for understandable reasons, given the crisis environment at the time), there is a need to step back and restart (rather than just revise). Senior ADMHS, County, and some CBO leaders understandably expressed concern that the current reporting capacity not be lost, and strongly believe that the quarterly rate reviews are an integral element of financial control that needs to be maintained. We agree. We also expect the process of “starting anew” will in fact validate much of the current ADMHS contract reporting capacity. Furthermore, some ADMHS leaders further questioned whether such a process would be an optimal use of resources given investments already made in the process. We believe that the considerable investment ADMHS has already made in development of this reporting capacity cannot yield optimal benefit without an effort to reengage CBOs and start fresh. The current analytic and reporting capacity should be able to be built upon, but the definition of indicators and establishment of buy-in will require a renewed process of dialogue and engagement.

In addition, ADMHS shifts more financial risk to contractors than do most California counties. This is understandable given the County’s history, but needs to be better understood at the community level and balanced by a clear statement of support for contractor capacity and development. Since ADMHS controls referrals, there is risk to providers that referrals may not meet budgets; since budgets are time-driven, there is risk to ADMHS of overpaying. Currently, per report by CBOs, rates are perceived as being only adjusted down, never up. Rates are overall perceived as typically adjusting in favor of ADMHS, despite examples provided by ADMHS definitively showing that they in fact adjust both ways. It is imperative that ADMHS continue to monitor and adjust rates; current practice should continue, and most CBOs told us that they value the quarterly reconciliation process. CBOs should have sufficient controls (cost centers, monthly time cards, etc.) to ensure what is charged to the contract is based on what has been incurred, but some level of review is needed to ensure this. However, communication
needs to improve. Also, because of a quite rigid approach to cost/contract management, there may potentially be substantial compliance risk that providers will manipulate admissions, discharges and lengths of stay in order to meet cost numbers. The report cards do not evaluate this risk.

It is likely that developments during the implementation of the ACA will lead to other reimbursement options (and potential challenges). So, ongoing collaborative review and development of the model by ADMHS clinical, financial, and compliance leadership, with collaborative participation by CBO clinical, financial, and compliance leadership, is essential.

In addition, typically a provider manual outlines billing and documentation requirements and other contract compliance and quality management issues, but no such manual is available.

**Recommendation C-2: Immediately shift participation in the CBO Scorecard process to a voluntary basis and establish a System Change Work Group focused on improving the ADMHS / CBO working relationship over the short and longer term.**

Collaborative re-tooling of the ADMHS / CBO relationship needs to be a central focus of the quality improvement planning process described in Recommendation S-1.

- As a gesture of good faith, ADMHS should immediately shift participation in the CBO Provider Scorecard process to a voluntary basis and also move towards development of a county-wide, ADMHS-facilitated compliance group to provide a forum for the exchange of information and the development of CBO compliance programs. Mandated data reporting would continue, but CBOs would decide whether or not they wanted to continue to receive the monthly Scorecards from ADMHS. We would expect that most, if not all, CBOs would continue to want to receive these reports, but the symbolism of giving CBOs a choice seems valuable. However, if this act is not followed up by immediate efforts to substantially improve these processes, it would be no more than a gesture.

- In the short term (by 7/1/2013), ADMHS should establish an ADMHS-CBO Partnership Work Group involving clinical/program leaders from CBOs and the ADMHS senior clinical team to develop policies to guide clinical collaboration. QM, fiscal, contracting, and compliance staff would attend for agenda-specific items, as would additional “change agents” from CBOs and ADMHS as needed. Key goals would include the following:
  - Emphasize that contract management should function as a “service” to facilitate excellent, collaborative clinical care. Clinical collaboration is the goal.
  - Focus on both clinical and strategic planning priorities.
  - Meet at least monthly for the first several months, with an agenda mutually developed in advance with CBO input, and notes on progress published on the ADMHS website to promote transparency.
- This same model could be used for a county-wide meeting of the compliance officers to support consistent and robust compliance programs within CBOs.

- Building on the initial work group’s success, develop an annual improvement plan and a more formal Provider Advisory Committee (or similar permanent structure to support the ADMHS-CBO relationship ongoing) by 10/1/2013.

In order to reduce system-wide compliance risk, the ADMHS compliance program should also balance its oversight activities with technical assistance, training, and encouragement to CBOs to develop their own effective compliance programs. Over the short-term, ADMHS should develop a county-wide compliance group facilitated by the ADMHS Compliance Officer and attended by CBO compliance officers. This would be a forum for sharing information, training, informing, asking questions, and other support activities. Its purpose would be focused on technical assistance and it would primarily be used initially as a forum for introducing the ADMHS compliance program as a benefit for providers. Efforts over the medium term should focus on developing a self-assessment tool for CBOs to evaluate their compliance programs that would inform development of a technical assistance plan (as a part of the overall ADMHS compliance plan) to assist in compliance program development. Over the longer term, ADMHS would need to develop a policy for shared responsibility for compliance with CBO compliance programs, including development of a review protocol for testing compliance program effectiveness at the CBOs.
## Appendix 1: Members of CEO Advisory Committee on Behavioral Health

<table>
<thead>
<tr>
<th>Member Name</th>
<th>Committee Role</th>
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<tbody>
<tr>
<td>Tom Alvarez, CPA</td>
<td>Budget/Finance Representative</td>
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<tr>
<td>Celeste Andersen, JD</td>
<td>Legal Advisor</td>
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<tr>
<td>Ole Behrendtsen, MD</td>
<td>ADMHS Medical Director</td>
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<tr>
<td>Patti Bliss</td>
<td>CBO Representative – Adult</td>
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<tr>
<td>Michelle Brenner</td>
<td>Mental Health Commission Representative (Vice Chair)</td>
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<tr>
<td>Ann Marie Cameron</td>
<td>Provider Representative</td>
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<tr>
<td>Manuel Casas, PhD</td>
<td>Mental Health Commission Representative</td>
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<tr>
<td>Ann Eldridge</td>
<td>NAMI Representative</td>
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<tr>
<td>Heather Fletcher, CPA</td>
<td>Auditor Controller Representative</td>
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<tr>
<td>Mark Kofler, MD</td>
<td>Labor Representative – Physicians</td>
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<tr>
<td>Terri Nisich, Assistant CEO</td>
<td>Staff Lead</td>
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<tr>
<td>Don Patterson</td>
<td>Sheriff Representative</td>
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<tr>
<td>Cecilia Rodriguez</td>
<td>CBO Representative – Children</td>
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<tr>
<td>Cuco Rodriguez</td>
<td>ADMHS, MHSA Program Representative</td>
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<tr>
<td>Sara Scofield</td>
<td>Labor Representative – Clinicians</td>
</tr>
<tr>
<td>Mike Vellekamp</td>
<td>Consumer Representative</td>
</tr>
<tr>
<td>Takashi Wada, MD</td>
<td>Public Health Director/Interim ADMHS Director</td>
</tr>
<tr>
<td>Tina Wooten</td>
<td>ADMHS, Consumer Peer Outreach Representative</td>
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</table>
Appendix 2: Highlighted Evidence-Based Practices for Public Systems

There are hundreds of evidence-based practices available for mental health (MH) and substance use disorder (SUD) treatment, and the most definitive listing of these practices is provided by the federal Substance Abuse and Mental Health Services Administration (SAMHSA) through the National Registry for Evidence-based Programs and Practices (NREPP). The NREPP includes MH and SUD treatment approaches ranging from prevention through treatment. While the NREPP is, in its own description, “not exhaustive,” it is the most complete source on evidence-based practices of which we are aware. The NREPP refers to all practices in the registry as “evidence-based,” using the following definition: “Approaches to prevention or treatment that are based in theory and have undergone scientific evaluation.” The NREPP then rates each program and practice on a multi-point scale across multiple domains to characterize the quality of the evidence underlying the intervention. Thus, many approaches formerly termed “promising” are now included in the NREPP, albeit with lower scores in some domains.

As noted in the main body of this report, successful evidence-based practice (EBP) promotion begins with an understanding of the real world limitations of each specific best practice and addresses a range of those limitations. The EBPs described in this appendix for children and families and adults with serious mental illness are offered in the context that they are only likely to be effective if implemented in the context of an organization-wide quality improvement structure.

Also note that this section focuses on clinical practice. It does not attempt to determine if any particular EBP listed can be paid for by a specific funding stream available to ADMHS, particularly Medi-Cal. It includes prevention-oriented EBPs that are not generally reimbursable in a medical benefit. However, the range of Medi-Cal, MHSA, local partner, and local county funding available to ADMHS should be able to support delivery of priority EBPs if appropriate attention is paid to relevant regulatory and fiscal standards.

Major EBPs for Children and Families

In this section we describe EBPs at three levels – prevention approaches, office and community-based interventions, and out-of-home treatment options. We also try to differentiate approaches by age group, where applicable.

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60 The NREPP’s searchable database can be found at: http://www.nrepp.samhsa.gov/.
Prevention

Many EBPs are available to increase parenting skills, with an emphasis on early childhood (on up to age 12). These include:

- **The Incredible Years**\(^{61}\): The Incredible Years program focuses on preventing conduct problems from developing and intervening early in the onset of these behaviors in children, targeting infancy to school-age children. This is accomplished through an interaction of three programs aimed at improving the skills of the child (in the areas of academic and social achievement), parent (to increase communication and nurturing approaches), and teacher (promoting effective classroom management and teaching of social skills). This curriculum particularly targets risk factors for conduct disorder, and promotes a positive environment for the child both in the home and at school.

- **Positive Parenting Program (Triple-P)**\(^{62}\): This program is aimed at teaching parents strategies to prevent emotional, behavioral, and developmental problems. It includes five levels of varying intensity (from the dissemination of printed materials, to 8-10 session parenting programs and more enhanced interventions for families experiencing higher levels of relational stress). Using social learning, cognitive-behavioral, and developmental theory, in combination with studies of risk and protective factors for these problems, Triple-P aims to increase the knowledge and confidence of parents in dealing with their children’s behavioral issues.

Prevention efforts shift as children enter school (ages 6 – 12) to increase positive social interactions, decrease aggression and bullying, and increase academic motivation. School-wide initiatives such as Positive Behavioral Interventions and Supports (PBIS) have significantly decreased aggressive incidents among students and increased the comfort and confidence of school staff within the school environment. PBIS is a school-based application of a behaviorally-based systems approach to enhance the capacity of schools, families, and communities to design effective environments that improve the link between research-validated practices and the environments in which teaching and learning occurs. The model includes primary (school-wide), secondary (classroom), and tertiary (individual) systems of support that improve functioning and outcomes (personal, health, social, family, work, and recreation) for all children and youth by making problem behavior less effective, efficient, and relevant, and desired

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behavior more functional. PBIS has three primary features: (1) functional (behavioral) assessment, (2) comprehensive intervention, and (3) lifestyle enhancement. 63

The value of school-wide PBIS integrated with mental health, according to the Bazelon Center, lies in its three-tiered approach. Eighty percent of students fall into the first tier. For them, school-wide PBIS creates “a social environment that reinforces positive behavior and discourages unacceptable behaviors.” 64 A second tier of students benefits from some additional services, often provided in coordination with the mental health system. This, the report notes, makes it “easier to identify students who require early intervention to keep problem behaviors from becoming habitual” and to provide that intervention. Finally, tier-three students, who have the most severe behavioral-support needs, can be provided intensive services through partnerships between the school, the mental health system, other child-serving agencies, and the child’s family.

Office and Community-Based Interventions

There is growing evidence that, in most situations, children can be effectively served in their homes and communities and that community-based treatment programs are often superior to institution-based programs. Studies show that, with the exception of youth with highly complex needs or dangerous behaviors, such as fire setting or repeated sexual offenses, programs in community settings are more effective than those in institutional settings, with intensive, community-based and family-centered interventions the most promising. Even children and adolescents with SEDs and longstanding difficulties can make and sustain larger gains in functioning when treatment is provided in a family-focused and youth-centered manner within their communities.

The development and dissemination of evidence-based psychosocial interventions for children and adolescents has rapidly developed in recent years. The ideal system would have treatment protocols offered in clinics, schools or homes with the objective of: 1) decreasing problematic symptoms and behaviors, 2) increasing youth’s and parents’ skills and coping and/or 3) preventing out-of-home placement. Core components of some of these interventions should


also be used as part of an individualized treatment plan for a child of any age who is receiving intensive intervention in a day treatment program. The following examples of evidence-based and other best practice treatments are offered as examples of the types of services needed in the ideal system and are not intended to be an exhaustive inventory of potential community-based interventions and EBPs.

**During the preschool years**, parent/caregiver participation in treatment is an essential part of success. An ideal service array should include interventions, such as the following:

- **Parent-Child Interaction Therapy (PCIT)** has strong support as an intervention for use with children ages three to six who are experiencing oppositional disorders or other problems.\(^{65}\) PCIT works by improving the parent-child attachment through coaching parents in behavior management. It uses play and communication skills to help parents implement constructive discipline and limit setting. In order to improve the parent-child attachment through behavior management, the PCIT program uses structural play and specific communication skills to teach parents and children constructive discipline and limit setting. PCIT teaches parents how to assess their child's immediate behavior and give feedback while the interaction is occurring. In addition, parents learn how to give their child direction towards positive behavior. The therapist guides parents through education and skill building sessions and oversees practicing sessions with the child. PCIT has been adapted for use with Hispanic and Native American families.

- **Early Childhood Mental Health Consultation** in early childhood settings, such as child care centers, emphasizes problem-solving and capacity-building intervention within a collaborative relationship between a professional consultant with mental health expertise and one or more individuals, primarily child care center staff, with other areas of expertise.\(^{66}\) Early childhood mental health consultation aims to build the capacity

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(improve the ability) of staff, families, programs, and systems to prevent, identify, treat, and reduce the impact of mental health problems among children from birth to age six, and their families. Two types of early childhood mental health consultation are generally discussed, program level and child/family level. The goals of program level mental health consultation seek to improve a program’s overall quality and address problems that affect more than one child, family or staff member. Consultants may assist the setting in creating an overall approach to enhance the social and emotional development of all children. Child/family-centered consultation seeks to address a specific child or family’s difficulties in the setting. The consultant provides assistance to the staff in developing a plan to address the child’s needs, and may participate in observation, meet with the parents of the child, and in some cases refer the child and family for mental health services.

- **Applied Behavior Analysis (ABA)** has good support for the treatment of autism in young children in particular. ABA can be used in a school or clinic setting and is typically delivered between two and five days per week for two weeks to 11 months. ABA is one of the most widely used approaches with this population. The ABA approach teaches social, motor, and verbal behaviors, as well as reasoning skills. ABA teaches skills through use of behavioral observation and positive reinforcement or prompting to teach each step of a behavior. Generally, ABA involves intensive training of the therapists, extensive time spent in ABA therapy (20-40 hours per week), and weekly supervision by experienced clinical supervisors known as certified behavior analysts. It is preferred that a parent or other caregiver be the source for the generalization of skills outside of school. In the ABA approach, developing and maintaining a structured working relationship between parents and professionals is essential to ensure consistency of training and maximum benefit.

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• **Preschool Post-Traumatic Stress Disorder Treatment** is an approach adapted from trauma-focused cognitive behavioral therapy (TF-CBT – see below) and trauma-focused coping to help young children recover from traumatic events with support from their parents throughout the treatment process.

**For latency-aged children**, individual cognitive behavioral techniques are effective, parent work is still important and some group therapy can begin. Examples include:

- **Behavior Therapy** has support for the treatment of attention and hyperactivity disorders; substance abuse; depression; and conduct problems. Typically, behavior therapy features behavior management techniques taught to teachers / parents to aid the child in replacing negative behaviors with more positive ones.\(^{68}\)

- **Brief Strategic Family Therapy (BSFT)** is a problem-focused, family-based approach to the elimination of substance abuse risk factors. It targets problem behaviors in children and adolescents six to 17 years of age, and strengthens their families. BSFT provides families with tools to decrease individual and family risk factors through focused interventions that improve problematic family relations and skill building strategies that strengthen families. It targets conduct problems, associations with anti-social peers, early substance use and problematic family relations.\(^{69}\)

- **Cognitive Behavior Therapy (CBT)** is widely accepted as an evidence-based, cost-effective psychotherapy for many disorders.\(^{70}\) It is sometimes applied in group as well as individual settings. CBT can be seen as an umbrella term for many different therapies that share some common elements. For children and youth, CBT is often used to treat depression, anxiety disorders, and symptoms related to trauma and Post Traumatic Stress Disorder. CBT can be used for anxious and avoidant disorders, depression, substance abuse, disruptive behavior, and ADHD. It can be used with family intervention. Specific pediatric examples include Coping Cat and the Friends Program.

CBT works with the individual to understand their behaviors in the context of their environment, thoughts and feelings. The premise is that a person can change the way

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they feel/act despite the environmental context. CBT programs can include a number of components including psychoeducation, social skills, social competency, problem solving, self-control, decision making, relaxation, coping strategies, modeling, and self-monitoring.

- **Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)** has strong support for efficacy with children and youth aged three to 18 years old, and their parents.\(^7\)\(^1\) It can be provided in individual, family, and group sessions in outpatient settings. TF-CBT addresses anxiety, self esteem and other symptoms related to traumatic experiences. TF-CBT is a treatment intervention designed to help children, youth, and their parents overcome the negative effects of traumatic life events such as child sexual or physical abuse; traumatic loss of a loved one; domestic, school, or community violence; or exposure to disasters, terrorist attacks, or war trauma. It integrates cognitive and behavioral interventions with traditional child abuse therapies, in order to focus on enhancing children’s interpersonal trust and re-empowerment. TF-CBT has been applied to an array of anxiety symptoms as well as: intrusive thoughts of the traumatic event; avoidance of reminders of the trauma; emotional numbing; excessive physical arousal/activity; irritability; and trouble sleeping or concentrating. It also addresses issues commonly experienced by traumatized children, such as poor self-esteem, difficulty trusting others, mood instability, and self-injurious behavior, including substance use. TF-CBT has been adapted for Hispanic/Latino children and some of its assessment instruments are available in Spanish.

**For adolescents**, the same EBPs as above should be available in outpatient and school-based clinics, as should the following programs for teens with severe difficulties, including those that may be at risk for out-of-home placement:

- **Wraparound Service Coordination** (based on the standards of the National Wraparound Initiative) is an integrated care coordination approach delivered by professionals, alongside youth and family partners, for children involved with multiple systems and at risk of placement in institutional or congregate living settings. It helps children and families access the appropriate services and supports and can be adapted to meet the needs of various populations.

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the highest risk for out-of-home placement. \textsuperscript{72} Wraparound is not a treatment per se. Instead, wraparound facilitation is a care coordination approach that fundamentally changes the way in which individualized care is planned and managed across systems. The wraparound process aims to achieve positive outcomes by providing a structured, creative and individualized team planning process that, compared to traditional treatment planning, results in plans that are more effective and more relevant to the child and family. Additionally, wraparound plans are more holistic than traditional care plans in that they address the needs of the youth within the context of the broader family unit and are also designed to address a range of life areas. Through the team-based planning and implementation process, wraparound also aims to develop the problem-solving skills, coping skills and self-efficacy of the young people and family members. Finally, there is an emphasis on integrating the youth into the community and building the family’s social support network. The wraparound process also centers on intensive care coordination by a child and family team (CFT) coordinated by a wraparound facilitator. The family, the youth, and the family support network comprise the core of the CFT members, joined by parent and youth support staff, providers involved in the care of the family, representatives of agencies with which the family is involved, and natural supports chosen by the family. The CFT is the primary point of responsibility for coordinating the many services and supports involved, with the family and youth ultimately driving the process. The wraparound process involves multiple phases over which responsibility for care coordination increasingly shifts from the wraparound facilitator and the CFT to the family (for additional information on the phases of the wraparound process, see information at http://www.nwi.pdx.edu/NWI-book/Chapters/Walker-4a.1-(phases-and-activities).pdf).

- **Dialectical Behavior Therapy (DBT) Approaches for Adolescents** is well supported for adults, but also has moderate support for helping youth to develop new skills to deal with emotional reaction and to use what they learn in their daily lives. \textsuperscript{73} DBT for youth


often includes parents or other caregivers in the skills-training group so that they can coach the adolescent in skills and so they can improve their own skills when interacting with the youth. Therapy sessions usually occur twice per week. There are four primary sets of DBT strategies, each set including both acceptance-oriented and more change-oriented strategies. Core strategies in DBT are validation (acceptance) and problem-solving (change). Dialectical behavior therapy proposes that comprehensive treatment needs to address four functions. It needs to help consumers develop new skills, address motivational obstacles to skill use, generalize what they learn to their daily lives, and keep therapists motivated and skilled. In standard outpatient DBT, these four functions are addressed primarily through four different modes of treatment: group skills training, individual psychotherapy, telephone coaching between sessions when needed, and a therapist consultation team meeting, respectively. Skills are taught in four modules: mindfulness, distress tolerance, emotion regulation, and interpersonal effectiveness.

- **Functional Family Therapy (FFT)** is a well-established EBP with proven outcomes and cost benefits when implemented with fidelity for targeted populations. FFT is a research-based family program for at risk adolescents and their families, targeting youth between the ages of 11 and 18. It has been shown to be effective for the following range of adolescent problems: violence, drug abuse/use, conduct disorder, and family conflict. FFT targets multiple areas of family functioning and ecology for change, and features well developed protocols for training, implementation (i.e., service delivery, supervision, and organizational support), and quality assurance and improvement. FFT focuses on family alliance and involvement in treatment. The initial focus is to motivate the family and prevent dropout. The treatment model is deliberately respectful of individual differences, cultures, and ethnicities, and aims for obtainable change with specific and individualized intervention that focuses on both risk and protective factors. Intervention incorporates community resources for maintaining, generalizing and supporting family change.

- **Multidimensional Family Therapy (MDFT)** is a family-based program designed to treat substance abusing and delinquent youth. MDFT has good support for Caucasian, African American and Hispanic/Latino youth between the ages of 11 and 18 in urban, suburban

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Treatments usually last between four to six months and can be used alone or with other interventions. MDFT is a multi-component and multilevel intervention system that assesses and intervenes at three levels including: adolescent and parents individually, family as an interacting system, and individuals in the family, relative to their interactions with influential social systems (e.g., school, juvenile justice) that impact the adolescent’s development. MDFT interventions are solution-focused and emphasize immediate and practical outcomes in important functional domains of the youth’s everyday life. MDFT can operate as a stand-alone outpatient intervention in any community-based clinical or prevention facility. It also has been successfully incorporated into existing community-based drug treatment programs, including hospital-based day treatment programs.

- **Multisystemic Therapy (MST)** is a well-established EBP with proven outcomes and cost benefits when implemented with fidelity for youth living at home with more severe behavioral problems related to willful misconduct and delinquency. In addition, the developers are currently working to develop specialized supplements to meet the needs of specific sub-groups of youth. MST is an intensive home-based service model provided to families in their natural environment at times convenient to the family. MST is intensive and comprehensive with low caseloads and varying frequency, duration, and intensity levels. MST is based on social-ecological theory that views behavior as best understood in its naturally occurring context. MST was developed to address major limitations in serving juvenile offenders and focuses on changing the determinants of youth anti-social behavior. At its core, MST assumes that problems are multi-determined and that, in order to be effective, treatment needs to impact multiple systems, such as a youth’s family and peer group. Accordingly, MST is designed to

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increase family functioning through improved parental monitoring of children, reduction of familial conflict, improved communication, and related factors. Additionally, MST interventions focus on increasing the youth’s interaction with “prosocial” peers and a reduction in association with “deviant” peers, primarily through parental mediation. MST-Psychiatric (MST-P) is an approach similar to MST, but adapted for teens with serious emotional disorders.

• **Assertive Community Treatment for Transition-Age Youth** uses a recovery/resilience orientation, which offers community-based intensive case management and skills-building in various life domains, as well medication management and substance abuse services for youth ages 18 – 21, with severe and persistent mental illness. More broadly, ACT is an integrated, self-contained service approach in which a range of treatment, rehabilitation, and support services are directly provided by a multidisciplinary team composed of psychiatrists, nurses, vocational specialists, substance abuse specialists, peer specialists, mental health professionals, and other clinical staff in the fields of psychology, social work, rehabilitation, counseling, and occupational therapy. Given the breadth of expertise represented on the multidisciplinary team, ACT provides a range of services to meet individual consumer needs, including (but not limited to) service coordination, crisis intervention, symptom and medication management, psychotherapy, co-occurring disorders treatment, employment services, skills training, peer support, and wellness recovery services. The majority of ACT services are delivered to the consumer within his or her home and community, rather than provided in hospital or outpatient clinic settings, and services are available around the clock. Each team member is familiar with each consumer served by the team and is available when needed for consultation or to provide assistance. The most recent conceptualizations of ACT include peer specialists as integral team members. ACT is intended to serve individuals with severe and persistent mental illness, significant functional impairments (such as difficulty with maintaining housing or employment), and continuous high service needs (such as long-term or multiple acute inpatient admissions or frequent use of crisis services).^80,81

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Out-of-Home Intervention Options

Treatment of youth in residential facilities is no longer thought to be the most beneficial way to treat those with significant difficulties. The 1999 Surgeon Generals’ Report on Mental Health states: “Residential treatment centers (RTCs) are the second most restrictive form of care (next to inpatient hospitalization) for children with severe mental disorders. In the past, admission to an RTC was justified on the basis of community protection, child protection and benefits of residential treatment. However, none of these justifications have stood up to research scrutiny. In particular, youth who display seriously violent and aggressive behavior do not appear to improve in such settings, according to limited evidence.”

Residential treatment represents a necessary component of the continuum of care for children and adolescent youth whose behavior is not managed effectively in a less restrictive setting. However, residential treatment is among the most restrictive mental health services provided to children and youth and, as such, should be reserved for situations when less restrictive placements are ruled out. For example, specialized residential treatment services are supported for youth with highly complex needs or dangerous behaviors, such as fire setting, that may not respond to intensive, nonresidential service approaches (Stroul, 2007). Yet, on a national basis children and youth are too often placed in residential treatment because more appropriate community-based services are not available.

Nevertheless, youth do sometimes need to be placed outside of their homes for their own safety and/or the safety of others. Safety should be the primary determinant in selecting out-of-home treatment as an option, as the evidence-based community interventions described above allow for even the most intensive treatment services to be delivered in community settings. Whether the situation is temporary, due to a crisis or for longer term care, the ideal service system should include an array of safe places for children and youth.

A family-driven, youth-guided, community-based plan should follow the child or youth across all levels of care (including out-of-home placements, as applicable) and help him/her return to home as quickly as possible, knitting together an individualized mix from among the following array of services.

A full continuum of crisis response, with mobile supports and short- to intermediate-term, local out-of-home options, including respite, psychosocial and behavioral health interventions for youth and their families should include:

- A mobile crisis team for children and families, with the capacity to provide limited ongoing in-home supports, case management and direct access to out-of-home crisis
supports (for a national example, Wraparound Milwaukee’s Mobile Urgent Treatment Team / MUTT\(^\text{82}\) is offered).

- A bio-psychosocial assessment, supported by protocols to communicate assessment results across professionals and to determine the appropriate level of services.
- An array of crisis supports tailored to the needs and resources of the local system of care, including an array of options such as:
  - Crisis foster care (a few days up to 30 days),
  - Crisis group home (up to 14 days),
  - Crisis respite (up to three days),
  - Crisis runaway shelter (15 days),
  - Crisis stabilization (30 – 90 days) with capacity for 1:1 MH crisis intervention,
  - Crisis supervision (30 – 90 days) to maintain safety in the community,
  - Placement stabilization center, providing out-of-home respite,
  - Acute inpatient care,
  - Consultation, and
  - Linkages to a full continuum of empirically supported practices.

**A residential continuum of placement types**, grounded in continued connections and accountability to the home community, with a focus on specialized programming, including treatment foster care (Multidimensional Treatment Foster Care is a well-established EBP that has demonstrated outcomes and cost savings when implemented with fidelity and with research support for its efficacy with Caucasian, African American and American Indian youth and families\(^\text{83}\)), gender-responsive services that go beyond just a willingness to serve female youth and that include a continuum of out-of-home treatment options for young women with behavioral health needs (including histories of sexual maltreatment) and specialized residential programming for youth with gender-identity issues, and residential placement options that vary by intensity of service provided, primary clinical needs addressed, and targeted length of stay, emphasizing , acute-oriented programs to serve as an inpatient alternative, in which children

\(^{82}\) For more information, see: http://county.milwaukee.gov/MobileUrgentTreatmen10109.htm. While the MUTT model has not been demonstrated at the level of an EBP, it is widely cited as a best practice and has been the basis of EPSDT settlements in Massachusetts (Rosie D.) and many other positive systems reforms for children’s systems of care nationally.


and youth can have behaviors that require longer than a typical acute inpatient stay to be stabilized, complex needs evaluated, and treatment begun while transition planning back to a more natural environment takes place.

When residential treatment is provided, there should be extensive involvement of the family. Residential (and community-based) services and supports must be thoroughly integrated and coordinated, and residential treatment and support interventions must work to maintain, restore, repair or establish youths’ relationships with family and community.

Family involvement is essential throughout the course of residential treatment, especially at admission, in the development of the treatment plan, when milestones are reached, and in discharge planning.

**Best Practices for Adults and Older Adults**

Best practices for adults and older adults with severe needs are emphasized, differentiating between interventions that are well established and those that are promising:

a) **Well established** interventions may be characterized by their support from randomized controlled studies, as well as evidence from real-world care settings. Further, well established interventions are sufficiently documented to allow tracking of fidelity to established standards.

b) **Promising interventions** are supported by methodologically sound studies in either controlled or routine care settings and are sufficiently documented to allow at least limited fidelity tracking.

**Well Established Practices for Adults and Older Adults**

**Assertive Community Treatment (ACT).** ACT is an integrated, self-contained service approach in which a range of treatment, rehabilitation, and support services are directly provided by a multidisciplinary team composed of psychiatrists, nurses, vocational specialists, substance abuse specialists, peer specialists, mental health professionals, and other clinical staff in the fields of psychology, social work, rehabilitation, counseling, and occupational therapy. Given the breadth of expertise represented on the multidisciplinary team, ACT provides a range of services to meet individual consumer needs, including (but not limited to) service coordination, crisis intervention, symptom and medication management, psychotherapy, co-occurring disorders treatment, employment services, skills training, peer support, and wellness recovery services. The majority of ACT services are delivered to the consumer within his or her home and community, rather than provided in hospital or outpatient clinic settings, and services are available round the clock. Each team member is familiar with each consumer served by the
team and is available when needed for consultation or to provide assistance. The most recent conceptualizations of ACT include peer specialists as integral team members. ACT is intended to serve individuals with severe and persistent mental illness, significant functional impairments (such as difficulty with maintaining housing or employment), and continuous high service needs (such as long-term or multiple acute inpatient admissions or frequent use of crisis services).  

The Substance Abuse and Mental Health Services Administration (SAMHSA) also developed an ACT Implementation Kit (often referred to as a “toolkit”) to provide guidance for program implementation. More recent ACT promotion efforts seeking to systematically promote consistent outcomes across programs over time in the states of Washington, Indiana, North Carolina, and elsewhere have focused on supporting ACT service development through a comprehensive process of interactive, qualitative fidelity monitoring of clinical services using best practice measures such as the Tool for Measurement of Assertive Community Treatment (TMACT). This is the current standard in the field and represents the best currently known way to broadly develop high quality teams system wide building on the lessons of best practice implementation science. Such an approach is particularl critical because high fidelity implementation of programs like ACT is a predictor of good outcomes and of system wide cost savings. Rigorous fidelity assessment also provides a basis for needed service delivery enhancements within a continuous quality improvement (CQI) process. In effect, qualitative clinical services monitoring will help ensure fidelity to the ACT model, evaluate whether settlement stipulations are being met, and contribute to a continuous quality improvement process.

ACT is one of the most well-studied service approaches for persons with SPMI, with over 50 published studies demonstrating its success, 25 of which are randomized clinical trials.

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(RCTs).\textsuperscript{90} Research studies indicate that when compared to treatment as usual (typically standard case management), ACT substantially reduces inpatient psychiatric hospital use and increases housing stability, while moderately improving psychiatric symptoms and subjective quality of life for people with serious mental illnesses.\textsuperscript{91} Studies also show that consumers and their family members find ACT more satisfactory than comparable interventions and that ACT promotes continuity.

This intervention is most appropriate and cost-effective for people who experience the most serious symptoms of mental illness, have the greatest impairments in functioning, and have not benefited from traditional approaches to treatment. It is often used as an alternative to restrictive placements in inpatient or correctional settings.

**Cognitive Behavior Therapy (CBT).** CBT is widely accepted as an evidence-based, cost-effective psychotherapy for many disorders.\textsuperscript{92} It is sometimes applied in group as well as individual settings. CBT can be seen as an umbrella term for many different therapies that share some common elements. For adults and older adults, CBT is often used to treat depression, anxiety disorders, and symptoms related to trauma and Post Traumatic Stress Disorder.

CBT can also be used for Substance Abuse, Eating Disorders, and ADHD. It can be used with family intervention. The premise is that a person can change the way they feel/act despite the environmental context. CBT programs can include a number of components including psychoeducational, social skills, social competency, problem solving, self-control, decision making, relaxation, coping strategies, modeling, and self-monitoring.

**Collaborative Care.** Collaborative Care is a model of integrating mental health and primary care services in primary care settings in order to: (1) treat the individual where he or she is most comfortable; (2) build on the established relationship of trust between a doctor and consumer; (3) better coordinate mental health and medical care; and (4) reduce the stigma associated with receiving mental health services.\textsuperscript{93}


Two key principles form the basis of the Collaborative Care model:

1. Mental health professionals or allied health professionals with mental health expertise are integrated into primary care settings to help educate consumers, monitor adherence and outcomes, and provide brief behavioral treatments according to evidence-based structured protocols; and
2. Psychiatric and psychological consultation and supervision of care managers is available to provide additional mental health expertise where needed.

Key components of the Collaborative Care model include screening, consumer education and self-management support, stepped up care (including mental health specialty referrals as needed for severe illness or high diagnostic complexity), and linkages with other community services such as senior centers, day programs or Meals on Wheels.94

Several randomized studies have documented the effectiveness of collaborative care models to treat anxiety and panic disorders,95 depression in adults,96 and depression in older adults.97 For example, a study of IMPACT (Improving Mood: Providing Access to Collaborative Treatment for Late Life Depression) – a multi-state Collaborative Care program with study sites in multiple states – led to higher satisfaction with depression treatment, reduced prevalence and severity of symptoms, or complete remission as compared to usual primary care. The 2003 Final Report of the President’s New Freedom Commission on Mental Health suggested that collaborative care models should be widely implemented in primary health care settings and reimbursed by public and private insurers.

Dialectical Behavior Therapy (DBT). Dialectical Behavior Therapy (DBT) is a modification of cognitive behavioral therapy in which an ongoing focus on behavioral change is balanced with acceptance, compassion, and validation of the consumer.98 Services are delivered through individual therapy, skills group sessions, and telephonic coaching.

Randomized studies have shown that DBT reduces severe dysfunctional behaviors that are targeted for intervention, increases treatment retention, and reduces psychiatric hospitalization. Although published follow-up data are limited, the available data indicate that

improvements may remain up to one year after treatment.\textsuperscript{99} DBT is specifically designed to address the particular needs of people who have borderline personality disorder and/or self-harming behaviors.

**Family Psychoeducation.** Family psychoeducation is a method of working in partnership with families to provide current information about mental illness and to help families develop increasingly sophisticated coping skills for handling problems posed by mental illness in one member of the family.\textsuperscript{100} They last from nine months to five years, are usually diagnosis specific, and focus primarily on consumer outcomes, although the well-being of the family is an essential intermediate outcome.\textsuperscript{101} Under this approach, the practitioner, consumer, and family work together to support recovery, incorporating individual, family, and cultural realities and perspectives.

Family psychoeducation can be used in a single family or multi-family group format and can vary in terms of the duration of treatment, consumer participation, and treatment setting, depending on the consumers and family’s wishes, as well as empirical indications. Although several treatment models exist, the following are essential elements of any evidence-based program:\textsuperscript{102}

1. The intervention should span at least nine months.
2. The intervention should include education about mental illness, family support, crisis intervention, and problem solving.
3. Families should participate in education and support programs.
4. Family members should be engaged in the treatment and rehabilitation of consumers who are mentally ill.
5. The information should be accompanied by skills training, ongoing guidance about management of mental illness, and emotional support for family members.
6. Optimal medication management should be provided.


Extensive research demonstrates that family psychoeducation significantly reduces rates of relapse and re-hospitalization. When compared to consumers who received standard individual services, differences ranged from 20-50% over two years. Recent studies have shown employment rate gains of two to four times baseline levels, especially when combined with supported employment, another EBP. Families report a decrease in feeling confused, stressed, and isolated and also experience reduced medical care costs. In addition, studies consistently indicate a very favorable cost-benefit ratio, especially in savings from reduced hospital admissions, reduction in hospital days, and in crisis intervention contacts.

The SAMHSA/CMHS Family Psychoeducation Resource Kit suggests that family psychoeducation is most beneficial for people with the most severe mental illnesses and their families. Although most research involves consumers with schizophrenia, improved outcomes have been found with other psychiatric disorders, including bipolar disorder, major depression, obsessive-compulsive disorder, anorexia nervosa, and borderline personality disorder.

**Gatekeeper Program.** The Gatekeeper Program engages and trains a range of community members who have frequent contact with older adults – such as utility, cable telephone, bank, housing, and postal workers – as well as emergency medical technicians, firefighters, police officers, and other first responders to identify older adults who may need mental health services and report them to a central information and referral office.¹⁰³

After referral, a clinical case manager and nurse visit the individual at his or her home, making repeat visits as needed to overcome the individual’s suspicion and promote engagement. An interdisciplinary team, usually including a psychiatrist and physician, develop a plan of care and, if appropriate, meets with the individual’s family with a goal of providing community-based rather than institutional services.

Research suggests that the Gatekeeper Program is effective in reaching older adults with mental illnesses who are more likely to be economically and socially isolated than older adults referred by a medical provider or other traditional referral source.¹⁰⁴ Some studies found that Gatekeeper referrals were no more likely to be placed out-of-home than those referred by other sources.¹⁰⁵ Although there is limited data regarding specific clinical outcomes associated with the Gatekeeper Program, a recent literature review suggests that multidisciplinary

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¹⁰⁴ Van Citters, A.D. and Bartels, S.J. (2004). A Systematic Review of the Effectiveness of Community-Based Mental Health Outreach Services for Older Adults. Psychiatric Services, 55,1237-1249.

approaches to serving older adults in their homes may be effective in reducing symptom severity.

The Gatekeeper program is designed to identify older adults with any level of mental health needs. MHD had collaborated with Area Agencies of Aging in the mid-1990s to implement Gatekeeper programs using federal block grant funds. However, many of these programs have been modified at the local level outside of MHD oversight over time and many no longer have fidelity to the Gatekeeper model.

**Illness Management and Recovery.** Illness Management and Recovery (IMR) is a set of specific evidence-based practices for teaching people with severe mental illness how to manage their disorder in collaboration with professionals and significant others in order to achieve personal recovery goals. These practices include: (1) psychoeducation; (2) behavioral tailoring to improve medication adherence; (3) relapse prevention training; (4) increasing coping skills; and (5) social skills training. IMR involves a series of weekly sessions in which specially trained professionals use these practices to help people who have experienced psychiatric symptoms in developing personal strategies for coping with mental illness and moving forward in their lives.\(^\text{106}\)

Practitioners educate consumers on nine topic areas, ranging from recovery strategies and illness information, to coping with stress and finding help in the mental health system. IMR practitioners combine motivational, educational, and cognitive-behavioral strategies aimed at helping consumers make progress towards personal recovery goals. The program can be provided in an individual or group format and generally lasts between three and six months.

Research has demonstrated that IMR can increase an individual’s knowledge about mental illness, reduce relapses and hospitalizations, help consumers cope more effectively, reduce distress from symptoms, and assist consumers in using medications more effectively.\(^\text{107}\) In addition, when using IMR practitioners often report a high rate of job satisfaction as consumers learn to reduce relapses, avoid hospitalization, and make steady progress toward personalized recovery goals.

This intervention is most appropriate for people who have experienced symptoms of schizophrenia, bipolar disorder, or depression at various stages of the recovery process.

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Emerging research suggests that this intervention may also be effective for people with serious mental illnesses in the criminal justice system.\textsuperscript{108}

**Integrated Dual Disorder Treatment (IDDT) for Co-Occurring Mental Illness and Substance Use Disorders.** Integrated Dual Disorder Treatment (IDDT) provides mental health and substance abuse services through one practitioner or treatment team and co-locates all services in a single agency (or team) so that the consumer is not excluded from or confused by multiple programs.\textsuperscript{109} IDDT encompasses 14 components, each of which is evidence-based, including but not limited to: (1) screening and assessments that emphasize a “no wrong door” approach; (2) “blended” treatment to ensure compatibility in treatment approaches; (3) stage-wise treatment that recognizes that different services are helpful at different stages of the recovery process; and (4) motivational interviewing and treatment, using specific listening and counseling skills to develop consumer awareness, hopefulness, and motivation for recovery. Combined mental health and substance abuse treatment is effective at engaging people with both diagnoses in outpatient services, maintaining continuity and consistency of care, reducing hospitalization, and decreasing substance abuse, while at the same time improving social functioning.\textsuperscript{110} Integrated treatment also reduces symptoms of mental disorders and overall treatment costs.\textsuperscript{111} Fidelity to the components of IDDT is clearly tied to better clinical outcomes.\textsuperscript{112}

This intervention is appropriate for individuals with co-occurring mental illness and substance use disorders. A “conceptual framework” developed jointly by the National Association of State Mental Health Directors (NASMHPD) and the National Association of State Alcohol and Drug


Abuse Directors (NASADAD) suggests that mental health and substance abuse treatment should be provided along a continuum of coordination, collaboration, and integration among service systems, depending on the severity of the mental illness and substance abuse disorder. Motivational Interviewing. People with substance use disorders or co-occurring mental illness and substance use often are not ready to attempt to make changes in their use of substances. Clinical leaders and researchers argue that if people have not moved beyond the stage of preparing for or becoming determined to make changes in their behavior, then the focus needs to be not on changing behavior but on increasing motivation so that the person is ready to take action toward making these changes.

Motivational Interviewing (MI) is an evidence-based practice (EBP) that was developed to help increase motivation to reduce use of substances and to recover from substance use disorders. Motivational Interviewing combines principles of empathic responding with elements of behavioral analysis, including careful identification of the unique set of rewards and punishments that influence a given person's behavior. The clinician helps the person clarify his or her most important goals and the advantages and disadvantages associated with achieving those goals. Clinicians adopt an objective, nonjudgmental stance in their work with consumers. Reviews of studies generally find MI to be an effective substance abuse intervention, with some indication that it is particularly effective in ethnic minority study samples. Although the evidence base for MI with adolescents may not yet be quite as strong as for adults, MI is widely used in the juvenile justice system as a behavior change intervention.

In a review of studies, Apodaca and Longabaugh (2009) found that certain aspects of MI were associated with better outcomes and that when therapists' behavior was inconsistent with MI principles outcomes were worse. Core principles of MI include the following (Corrigan et al., 2005):


• **Express Empathy** – Use reflective listening to help consumers clarify the advantages and disadvantages associated with behavior change. It promotes honest discussion of the person's reluctance and concerns about reducing use.

• **Develop Discrepancy** – Clinicians help clarify, in a non-confrontational manner, the ways in which not changing substance use and other behaviors associated with it are interfering with the attainment of consumers' most important goals.

• **Avoid Argumentation** – Clinicians avoid direct confrontation of the person and slipping into an argumentative style of relating.

• **Roll with Resistance** – Motivational Interviewing clinicians view clients' resistance as an indication that they (the clinicians) are not addressing issues the consumer believes are important or relevant; they use resistance as a way to try to help the person focus on actual barriers to change.

• **Support Self-Efficacy** – The Motivational Interviewing approach assumes that consumers are responsible for change. Clinicians attempt to convey confidence in the consumers—that she or he will decide to change and begin to reduce substance use when they are ready to do so.

**Supported Employment.** Supported Employment promotes rehabilitation and a return to mainstream employment for persons with serious mental illnesses and co-occurring disorders. Supported Employment programs integrate employment specialists with other members of the treatment team to ensure that employment is an integral part of the treatment plan. Employment specialists are responsible for carrying out vocational services while all members of the treatment team understand and promote employment. All Supported Employment programs are based on the following principles:

1. Eligibility is based on consumer choice. Individuals interested in employment are not screened for job readiness.
2. Supported employment is integrated with treatment. Employment specialists coordinate plans with the treatment team, including the case manager, therapist, psychiatrist, and others.
3. Competitive employment is the goal. The focus is on community jobs in integrated settings that anyone can apply for that pay at least minimum wage, including both part-time and full-time work.
4. Job search starts soon after a consumer expresses interest in working. There are no requirements for completing extensive pre-employment assessment and training, or intermediate work experiences (like transitional employment or sheltered workshops). Follow-along supports are continuous.
5. Individualized supports to maintain employment continue as long as consumers want the assistance.
6. Consumer preferences are important.
7. Vocational Specialists collaborate with the person’s natural support networks and with employers (when the consumer wants his or her status as a mental health consumer disclosed to the employer).

A considerable body of research indicates that Supported Employment models, such as Independent Placement and Support (IPS), are successful in increasing competitive employment among consumers.\(^{119}\) A seven-state, multi-site study supported by the federal Substance Abuse and Mental Health Services Administration (SAMHSA) found that Supported Employment participants were significantly more likely (55%) than comparison participants (34%) to achieve competitive employment.\(^{120}\) A review of three randomized controlled trials found that, in general, 60-80% of people served by a Supported Employment model obtain at least one competitive job.\(^{121}\)

In addition, the research consistently shows that specific consumer factors such as diagnosis, age, gender, disability status, prior hospitalization, co-occurring substance abuse disorder, and education are not strong or consistent predictors of an individual’s work outcomes.\(^{122}\) Supported employment remains more effective than traditional vocational services for consumers with both good and poor work histories. This intervention should be offered to all individuals with mental illnesses and/or co-occurring disorders who want to work, regardless of prior work history, housing status, or other population characteristics.\(^{123}\)

**Promising Practices for Adults and Older Adults**


\(^{120}\) Cook, J. Executive Summary of Findings from the Employment Intervention Demonstration Program. Retrieved at www.psych.uic.edu/eidp/EIDPexecsum.pdf.


**Case Management.** The primary purpose of case management is to coordinate service delivery and to ensure continuity and integration of services.\(^{124}\) There are many models of case management for people with mental illnesses. Clinical case management and targeted case management generally include at least five integrated functions: (1) assessing consumers’ needs; (2) planning service strategies to respond to identified needs; (3) linking consumers to appropriate services, including non-mental health specialty services such as housing, employment supports, or other social services; (4) monitoring consumers’ progress to detect changing needs; and (5) providing follow up and ongoing evaluation.\(^{125}\) Some models may also include limited skills building techniques.

In addition, intensive case management may also involve the actual delivery of service. ACT is sometimes thought of as a model of intensive case management, although many distinguish intensive case management as usually relying less on a team approach to service delivery, likely involving more brokering than delivery of services, and focusing more on facilitating participation by consumers in treatment decisions.

Considerable research suggests the effectiveness of intensive case management models, including ACT, in reducing inpatient use among high-risk consumers. Several studies also suggest improvements in clinical and social outcomes over conventional case management approaches.\(^ {126}\) However, at least one recent study has suggested that intensive case management programs are effective only in community settings where there is an ample supply of treatment and support services.\(^ {127}\)

There is less of a research base to support more traditional clinical and targeted case management approaches. One review of the research found that clinical case management was as effective as ACT in reducing symptoms of illness, improving social functioning, and increasing consumer and family satisfaction with services. However, that review also found that clinical case management increased hospitalizations and the proportion of consumers hospitalized.\(^ {128}\)

Comprehensive Crisis Services. In general, crisis services involve short-term, round-the-clock help provided in a non-hospital setting during a crisis with the purposes of stabilizing the individual, avoiding hospitalization or other high-cost services, and helping individuals return to pre-crisis functioning as quickly as possible. Crisis services can also help assure that emergency room, ambulance, law officer, and jail resources are not inappropriately utilized for behavioral health crises.\(^\text{129}\)

Best practice components of comprehensive crisis services include but are not limited to:

1. A 24-hour telephone response system staffed by qualified mental health professionals with immediate capacity for face-to-face assessment and on-call consultation with a psychiatrist.
2. Mobile services capacity with transportation to assist individuals in getting to stabilization facilities.
3. Access to short-term intensive residential treatment resources for stabilization and hospital diversion.
4. Cultural and linguistic competency to facilitate assessment.
5. Access to appropriate linkages with other healthcare resources.

Research suggests that when crisis services are provided in non-hospital settings, the likelihood of inpatient admission is reduced.\(^\text{130}\) At least one study has found that, for individuals with serious mental illness in need of hospital level care and willing to accept voluntary treatment, residential crisis centers provided the same outcomes as inpatient hospitals for significantly less cost.\(^\text{131}\)

Comprehensive crisis services are appropriate for individuals with an acute mental illness experiencing a crisis that puts them at risk of hospitalization or other high-cost care.

Peer Support. Peer Support is a service through which consumers can: (1) direct their own recovery and advocacy process and (2) teach and support each other in the acquisition and exercise of skills needed for management of symptoms and for utilization of natural resources within the community.\(^\text{132}\) This service typically provides structured, scheduled activities that promote socialization, recovery, self-advocacy, development of natural supports, and maintenance of community living skills, often under the direct supervision of a mental health professional.


professional. Peer Support can also encompass a range of supports delivered by consumers, including informal services or as part of a consumer-operated service.

An innovative Georgia model, which receives Medicaid reimbursement for peer support and which has been replicated in several states, emphasizes the role of Certified Peer Specialists, who provide direct services to assist consumers in developing the perspective and skills to facilitate recovery and who also model the possibility of recovery through their own experiences as consumers engaged in self-directed recovery. A job description defines specific support activities, including helping consumers create a wellness recovery action plan and supporting vocational choices.

The Georgia certification process includes two required weeklong trainings followed by a written and oral examination, as well as periodic continuing education seminars and workshops. Certified Peer Specialists are paid employees of public and private providers and operate as part of a clinical team, which can be integrated into a range of emergency, outpatient (including ACT), or inpatient settings. A Georgia-model Peer Support service reimbursable under Medicaid must be operated at least 12 hours a week, at least four hours per day for at least three days per week.

Emerging evidence suggests that integrating peer specialists into a range of treatment approaches may lead to better outcomes for consumers. For example, one controlled study found that individuals served by case management teams that included consumers as peer specialists had experienced increases in several areas of quality of life and reductions in major life problems, as compared to two comparison groups of individuals served by case management teams that did not include peer specialists.\(^{133}\)

Under the Medicaid-reimbursable model implemented in Georgia, peer support services are geared toward consumers with severe and persistent mental illness. These consumers may have co-occurring mental retardation or substance abuse disorders.\(^{134}\)

**Respite Care.** Respite care is designed to provide community-based, planned or emergency short-term relief to family caregivers, alleviating the pressures of ongoing care and enabling individuals with disabilities to remain in their homes and communities.\(^{135}\)


frequently is provided in the family home. Without respite care, many family caregivers experience significant stress, loss of employment, financial burdens, and marital difficulties.

Little existing research is available regarding the effectiveness of this intervention either for family caregivers or mental health consumers. The majority of family caregiving studies identify a need for greater quality, quantity, variety, and flexibility in respite provision.  

**Standardized Screening for Substance Abuse Disorders.** Effective treatment for co-occurring disorders begins with accurate screening and assessment in settings where individuals present for treatment. Failure to detect substance abuse disorders can result in a misdiagnosis of mental disorders, sub-optimal pharmacological treatments, neglect of appropriate substance abuse interventions, and inappropriate treatment planning and referral. In addition, since use of even limited amounts of alcohol or other drugs can be associated with negative outcomes among people with mental illnesses, routine screening is an important component of mental health prevention and treatment.

The clinical screening process enables a service provider to assess if an individual demonstrates signs of substance abuse or is at risk of substance abuse. Screening is a formal process that is typically brief and occurs soon after the consumer presents for services. The purpose is not to establish the presence or specific type of such a disorder, but to establish the need for an in-depth assessment.

A broad range of effective screening tools exist for specific populations. Many are brief self-report screens that can be completed as part of an initial intake interview for an individual with a severe mental illness. For example, Washington State is currently using the Global Appraisal of Individual Needs – Short Screener (GAIN-SS), a shortened version of a leading tool for a broad range of substance use. In addition, the Michigan Alcoholism Screening Test (MAST) is

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considered reliable and valid as a screening tool for persons with primary alcoholism, but includes items that are irrelevant or confusing for people with severe mental illness. Research suggests that the Dartmouth Assessment of Life Style Instrument (DALI) is effective for individuals with acute mental illness.

Prevention and both early identification and intervention of substance abuse disorders are appropriate for individuals of all ages, but are especially critical for young people and individuals whose substance use problems have not risen to the level of seriousness to require treatment.

**Supportive Housing.** Supportive housing (sometimes called supported housing) is a term used to describe a wide range of approaches and implementation strategies to effectively meet the housing needs of people with disabilities, including people with mental illnesses. Supportive housing may include supervised apartment programs, scattered site rental assistance, and other residential options. NASMHPD has identified supportive housing as a best practice in the field, and SAMHSA’s Center for Mental Health Services is in the process of developing an Evidence-Based Practice Implementation Resource Kit for this approach.

The overall goal of supportive housing is to help consumers find permanent housing that is integrated socially, reflects their personal preferences, and encourages empowerment and skills development. Program staff provide an individualized, flexible, and responsive array of services, supports, and linkages to community resources, which may include such services as employment support, educational opportunities, integrated treatment for co-occurring disorders, recovery planning, and assistance in building living skills. The level of support is expected to fluctuate over time.

Numerous studies of consumer preferences agree that mental health consumers generally prefer normal housing and supports over congregate residential living. Furthermore, people tend to want to live alone or with another person of their choice, rather than with groups of people who have psychiatric disabilities. Residential stability and life satisfaction are

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144 Housing for persons with psychiatric disabilities: Best practices for a changing environment. Alexandria, VA: National Technical Assistance Center for State Mental Health Planning.


increased when consumers perceive they have choices and when their housing and support preferences are honored.\textsuperscript{148}

All supportive housing models should maximize, to the extent possible, the following components of an ideal model of supportive housing: (1) choice of housing; (2) separation of housing and services; (3) decent, safe, and affordable housing; (4) housing integration; (5) access to housing; and (6) flexible, voluntary services.\textsuperscript{149}

A significant body of research demonstrates that people in supportive housing experience reduced homelessness, increased residential stability, reduced recidivism to hospitalization and shorter lengths of stay, and reduced time spent incarcerated.\textsuperscript{150} A few studies relate supported housing to reductions in psychiatric symptoms, increased social functioning, and improved quality of life.\textsuperscript{151}

Supportive housing program models have been successfully adapted and implemented to meet the needs of people with serious mental illnesses and co-occurring substance abuse and developmental disabilities, including those with special needs such as veterans, people who are homeless, families with children, transition-age youth, people who have histories of trauma, people with HIV/AIDS, and offenders leaving prisons or jails.

**Telepsychiatry.** Telepsychiatry is a method of providing expert psychiatric treatment to consumers at a distance from the source of care. Its use has been suggested for the treatment of consumers in remote locations or in areas where psychiatric expertise is scarce.\textsuperscript{152} Telepsychiatry sometimes includes educational initiatives for providers and other non-clinical uses.

Psychiatric interviews conducted by telepsychiatry appear to be generally reliable, and consumers and clinicians generally report high levels of satisfaction with telepsychiatry.\textsuperscript{153} Current technologies make telepsychiatry feasible, increases access to care, and enables


\textsuperscript{149} Fidelity Scale for Ideal Permanent Supportive Housing (2007). Draft in progress for inclusion in SAMHSA Supportive Housing Implementation Resource Kit.


specialty consultation.\textsuperscript{154} There is little evidence to date regarding clinical outcomes or cost-effectiveness of telepsychiatry as compared to in-person treatment. However, at least one randomized, controlled study has found that remote treatment of depression by means of telepsychiatry and in-person treatment of depression have comparable outcomes and equivalent levels of consumer adherence and satisfaction.\textsuperscript{155} In that study, telepsychiatry was found to be more expensive per treatment session, but this difference disappeared if the costs of psychiatrists’ travel to remote clinics more than 22 miles away from the medical center were considered.

**Wellness Recovery Action Plan (WRAP).** The Wellness Recovery Action Plan (WRAP) approach is a self-management and recovery system designed to help consumers identify internal and external resources and then use these tools to create their own, individualized plans for recovery. Under the WRAP model developed and disseminated by Mary Ellen Copeland,\textsuperscript{156} WRAP services are provided by facilitators who have developed and used their own WRAP and who are trained and certified through participation in a five-day seminar.

A WRAP includes the following six main components: (1) developing a Daily Maintenance Plan, including a description of oneself when well and tools needed on a daily basis to maintain wellness such as maintaining a healthy diet, exercise, or stable sleep patterns; (2) identifying triggers to illness; (3) identifying early warning signs of symptom exacerbation or crisis; (4) identifying signs that symptoms are more severe; (5) developing a crisis plan or advance directive; and (6) developing a post-crisis plan.

The WRAP model includes a pre-test/post-test tool to measure the impact of the intervention. At least one study using this tool found significant increases in consumers’ self-reported knowledge of early warning signs of psychosis; use of wellness tools in daily routines; ability to create crisis plans; comfort in asking questions and obtaining information about community services; and hope for recovery.\textsuperscript{157} Another widely-cited study found increases in consumers’ self-reporting that they have a support system in place; manage their medications well; have a list of things to do every day to remain well; are aware of symptom triggers and early warning signs of psychosis; have a crisis plan; and have a lifestyle that promoted recovery.\textsuperscript{158}

\textsuperscript{155} Ruskin, P.E., et al. (2004).
The WRAP model has been integrated into MHD’s current peer counseling training curriculum, and federal block grant funds have been used to support training in the last fiscal year.

**Cultural Brokers.** To supplement the lack of diversity in the health care workforce, standards have also been developed regarding the strategy of employing cultural brokers. The potential utility of cultural brokers in mental health settings has been described, and the National Center for Cultural Competence (NCCC) at the Georgetown University School of Medicine has developed a guide to promote the development of cultural broker programs. The NCCC guidelines take a broad view of culture, including factors related to sexual orientation, age, disabilities, social economic status, religion, political beliefs, and education. The guide defines a cultural broker broadly as an advocate between groups of differing cultural backgrounds; it defines the role more specifically for health care settings as a particular intervention to engage a range of individuals with diverse backgrounds to help span the boundaries between the culture of health care delivery and the cultures of the people served. These individuals range in their roles within the health care delivery system from consumers to providers to leaders. Singh and his colleagues (1999) describe the broker as acculturated in the mainstream health care delivery culture and one or more minority cultures. The NCCC guidelines note that, while cultural brokers generally achieve acculturation in a particular minority culture through their own experience as a member of that culture, membership is neither a sufficient nor a necessary requirement. The guidelines instead center on the person’s

> . . . history and experience with cultural groups for which they serve as a broker including the trust and respect of the community; knowledge of values, beliefs, and health practices of cultural groups; an understanding of traditional and indigenous wellness and healing networks within diverse communities; and experience navigating health care delivery and supportive systems within communities. (page 5)

The NCCC guidelines focus on the development of programs within health care organizations to expand the availability of cultural brokers for the specific communities served by those organizations. The guidelines include the following:

1. “Cultural brokering honors and respects cultural differences within communities,” recognizing that diversity within specific communities is as important a factor as diversity across communities.

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2. “Cultural brokering is community driven,” building on the principle that community engagement and respect for the need for communities to determine their own needs is essential.

3. “Cultural brokering is provided in a safe, non-judgmental, and confidential manner,” underscoring the professional responsibilities of the cultural broker to provide the service responsibly.

4. “Cultural brokering involves delivering services in settings that are accessible and tailored to the unique needs of the communities served,” emphasizing the importance of flexibility in the implementation of cultural brokering programs.

5. “Cultural brokering acknowledges the reciprocity and transfer of assets between the community and health care settings,” acknowledging that skills and knowledge must be built both within the health care organization and the broader community being served.

It should be noted that, while membership in a specific cultural group is not necessary to serve as a cultural broker, a high level of acculturation is necessary. In order for a person to bridge two cultures, a level of acculturation in both cultures is needed. While a successful cultural brokering program can also promote awareness and skills that build cross-cultural competence (related to CLAS Standard 1, emphasizing the cultural competence of the entire health care workforce), the specific mechanism of the cultural broker focuses on their ability to bridge cultures they know well (related to CLAS Standard 2, emphasizing the match between the diversity of the health care workforce and the communities served).

A cultural broker does not have knowledge of how to work with “all cultures” or even “all members of a specific culture,” as such a standard is simply not attainable. They instead have sufficient knowledge and skill to be viewed as credible by a sufficient number of the members of the specific communities being served to function as a bridge. This poses challenges to regulations and systematic efforts to require cultural competence, as will be seen below. While mental health specialists are regulated in terms of a minimum level of competence, the broader array of potential cultural brokers are not. In addition, cultural brokers typically are paraprofessionals, whose skills are vital but do not include the level of mental health expertise to deliver services or consult independently.

The tradeoff between ensuring a minimum level of competency and access to a broader array of skills is one that the health care workforce is continually seeking to balance, whether it be between prescribers and prescriber extenders, licensed mental health professionals and unlicensed mental health workers, or professional and peer support. While regulation can ensure that a set of minimum defined standards are met, it can be problematic when misconstrued as an endorsement of high quality or expert status or as a barrier to a broader array of resources.
Promotores de Salud. Promotores de salud (health promoters) provide culturally competent assistance to people in accessing and utilizing a range of health and/or mental health services in the community, including prevention and early intervention services. While the physical health system historically has made wider use of promotores, in California promotores have begun to play a key role in helping Latino individuals and families navigate the mental health system. Promotores are from the communities they serve, they speak the primary languages of the communities they serve, and they understand the culture. They also know the service systems that they help people navigate. Because of their unique knowledge of culture and systems, and because of their credibility within the communities they serve, promotores are especially well positioned to enhance access to and optimize utilization of services. Promotores assist people by providing health (and/or mental health) education to community members and they assist both community members and providers in identifying and overcoming barriers to services, such as language, stigma, mistrust, transportation, and others.¹⁶¹

¹⁶¹ Summary was based on a description of the role of Promotores de Salud found on the California Institute for Mental Health Website. See http://www.cimh.org/LinkClick.aspx?fileticket=Qw5mqcEahTl%3d&tabid=568 for the CiMH report.
Appendix 3: On Site Interview Protocol

On Site Interview Protocol

Key Informant: ____________________________  Organization: ____________________________

Position: ________________________________  Date: ____________________________

Interviewer: ____________________________

Introduction
Hello. We appreciate the opportunity to meet with you today. We represent TriWest Group and would like to discuss your views of the strengths and challenges present in Santa Barbara’s behavioral health system. The information we discuss today will be shared as part of our overall findings and recommendations. However, we will not identify any comments with specific individuals.

<table>
<thead>
<tr>
<th>Question</th>
<th>Response</th>
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<tbody>
<tr>
<td>1. First, could you tell us a little about your role with Santa Barbara’s behavioral health program and how long you have been involved with the system of care?</td>
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<td>2. Are there specific strengths of the system you would like to be preserved?</td>
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<td>3. Can you provide an overview of the challenges you have observed?</td>
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<td>4. What are the top three things you think need improvement? Others?</td>
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<td>5. Can you suggest any reports or information that we should collect as part of our work?</td>
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<td>6. Are there specific staff, providers, consumers or family members, or other individuals you believe we should speak to?</td>
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<td>7. When TriWest has completed our assignment, how will you decide our work has helped Santa Barbara County?</td>
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<td>8. Is there anything else you would like to mention that we haven’t discussed?</td>
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<td>9. Do you have any questions for use before we conclude?</td>
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Thank you for your help today. We look forward to ongoing communications and work with you.
Appendix 4: Initial Data Request – October 15, 2012

The following is a data request to support the initial desk review for the Alcohol, Drug and Mental Health Services Department review by TriWest Group (TriWest). Questions not answered during the desk review will be addressed and desk review findings will be validated during the onsite review scheduled for the week of December 10, 2012.

Please submit one electronic copy of the documents listed below by October 31, 2012.

TriWest has set up an electronic fileshare folder online for these documents. This folder is accessible only by secure login and password, so people submitting documents will need to set up permissions to access the folder. Bill Wilson from TriWest will be the point person and can help people get their logins and passwords set up. His contact information is:

Bill Wilson, MSW, TriWest Group  
Telephone: 231.348.7902  
bwilson@triwestgroup.net

The folder also includes a subfolder with special protections Protected Health Information (PHI) subject to the protections of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and/or 42 CFR Part II. If any of the documents requested include PHI, please make arrangements with Bill prior to uploading the information to ensure adequate protections.

If you have any questions about the document request, please contact Bill Wilson at 231.348.7902, Email: Bwilson@triwestgroup.net; or Kathy Sternbach at 650.312.1344, Email: Kathy.sternbach@att.net.

Also, if any of the files or documents requested below create an inordinate workload demand or if there are other documents you would like us to consider as alternatives to what we are requesting, please discuss that with us. Our goal is for the data request to entail as minimal a burden on ongoing county and ADMHS operations as possible.

The table that follows can be used as a checklist for responding to the data request. Please be sure to let us know the name of the document responding to each request when you upload it. You can use this table and simply check if you are including it in your response. We expect that documents will be uploaded in multiple batches, so please be sure to communicate to us each time a single document or batch of documents is added and let us know which documents were added and their filenames. It may also be that some requested documents are not available. If so, please let us know.
Finally, since this is an iterative process, our review may identify other document needs; additional will be coordinated with the County and adequate time allowed for response.

Thank you in advance for your assistance.

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<th>Document Request</th>
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<tbody>
<tr>
<td><strong>Administrative/Financial</strong></td>
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<td>Table of organization for the county, showing ADMHS,</td>
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<td>and for all personnel employed by ADMHS.</td>
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<td>Mission statement and annual goals since FY 2006-07</td>
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<td>A timeline summarizing major events since the beginning</td>
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<td>of FY2006-07 through present related to the self-disclosure and Multi-Interdisciplinary System of Care (MISC)</td>
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<td>Current liability schedule related to outstanding cost</td>
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<td>reports</td>
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<td>Historical liability schedules going back to FY 2002-03</td>
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<td>including schedules prepared by the Auditor Controller</td>
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<td>showing liabilities at the end of each year</td>
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<td>Copies of any major presentations made since FY 2006-07</td>
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<td>to the following groups to summarize the financial /</td>
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<td>compliance difficulties related to the self-disclosure</td>
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<td>and/or the MISC:</td>
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<td>• Other county agencies (e.g., DSS, Probation, etc.)</td>
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<td>• Public presentations CBO/external providers/other</td>
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<td>• Other entities that ADMHS believes our team should</td>
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<td>Financial summary reports on revenue and expenditures for the current fiscal year (year to date, through the most recent reportable month) and the past five fiscal years (back to FY2006-07) showing breakouts, as possible:</td>
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<td>• By fund (core MH, MHSA, ADP) – to the extent possible, please provide additional detail by MHSA funding source</td>
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<td>• By each of the seven divisions</td>
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<td>• To the extent possible, by clinic and external CBO/provider (including inpatient) (at least for the current and most recent past fiscal year)</td>
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<td>• Any additional reporting necessary to determine Medi-Cal revenue as a subset of the broader revenue reports (our understanding is that these reports can be overlaid by clinic to identify the subset of revenue in each period derived from Medi-Cal)</td>
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<td>MHSA plan and annual updates that include spending by MHS service category</td>
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<td>Summaries of claims data by clinic and level of care for the current fiscal year (year to date, through the most recent reportable month) and the past five fiscal years (back to FY2006-07)</td>
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<td>Copies of all audit reports and major documents (internal and external) related to the 2007 self-disclosure</td>
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<td>Copies of all audit reports and major documents (internal and external) related to MISC/CEC program</td>
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<td>Example of documents from a quarterly rate review with one major adult external provider and one major child external provider</td>
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<tr>
<td>Major documents defining the financial “clinic models” for adult, child and CARES clinics – documentation should be sufficiently detailed to allow our team to understand all variables defining the model and how changes in them affect model outputs and targets</td>
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<tr>
<td>Documentation available as of present regarding the “clinic model” for MHSA currently under development</td>
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<td>Document Request</td>
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<td>If not included above, provide current productivity expectations by clinic and staff type (e.g., MD, RN, MFP, psych tech, etc. – whatever staff categories are routinely used in the “clinic model” – please also include a history going back to the origination of the clinic models of any variability in these expectations (e.g., did they used to be higher or lower and, if so, when and how much)</td>
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<tr>
<td>Sample “Clinic Model Service Reports” from the most recent period (e.g., reports generated for each clinic tracking “clinic model” revenue, documented minute, type of service, and all other targets) – include aggregate clinic and individual staff target vs. actual variance reports and any other reports used by managers and individual staff; include an overview to help us understand what reports are included and how they are used by managers</td>
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<tr>
<td>A summary for the most recent available 12 month period summarizing performance for the “clinic model” by: • Clinic • Categories of individual staff member (e.g., physician, RN, psych tech, MFP, etc. – whatever type of staff credential is used to aggregate), and • Individual staff member</td>
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<tr>
<td>A summary for the most recent available 12 month period and the prior two fiscal years summarizing performance for each CBO and provider regarding: • Score card metrics • Services delivered by level of care • Amount of contract by funding source • Amount earned by funding source</td>
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<tr>
<td><strong>Performance Tracking</strong></td>
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<td>Sample reports from the last monthly internal management meeting to review inpatient performance and metrics for both the PHF and external inpatient providers</td>
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<td>The most recent 4 quarterly score cards for all CBOs under contract; please also provide copies of any written responses from CBOs to these reports, including correction plans or other responses required by ADMHS and any other written appeals, inquiries or other documentation from the CBOs – if any of these would entail a very large number of documents, please discuss with our team before providing to clarify the minimum necessary scope of response</td>
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<tr>
<td>Copies of the current financial settlement proposals for the three largest providers that have been found by ADMHS to owe money to the county (whether just proposed or accepted)</td>
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<tr>
<td><strong>Clinical</strong></td>
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<tr>
<td>Current Quality Management Plan</td>
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<td>Current Utilization Management Plan</td>
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<td>Quality management studies/reports for FY 2009-10 and FY2010-11 and, if any are available, FY 2011-12</td>
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<tr>
<td>Samples of significant root cause analyses for FY2010-11 and, if any are available, FY 2011-12. Prioritize cases that illustrate significant system issues regarding access to and retention in care</td>
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<tr>
<td>Minutes of Quality Management or similar committee meetings for FY 2010-11 and FY 2011-12</td>
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<tr>
<td>Minutes of provider advisory committee or other regular provider/CBO meetings for FY 2011-12, or agendas if no minutes available for FY 2011-12</td>
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<tr>
<td>Minutes of Medical Directors, Medical Practice Committee, and other regular physician / psychiatrist meetings, or agendas if no minutes available for FY 2011-2012</td>
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<td>Service eligibility policies/procedures or description of criteria for determining eligible individuals (Medi-Cal and uninsured)</td>
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<tr>
<td>An overview describing the levels of care and major providers of the <em>adult</em> mental health system of care</td>
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<tr>
<th>Document Name</th>
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<tbody>
<tr>
<td>An overview describing the levels of care and major providers of the children’s mental health system of care</td>
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<tr>
<td>An overview describing the service types and major providers ADP-funded <strong>treatment services</strong></td>
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<tr>
<td>An overview describing the service types and major providers ADP-funded <strong>prevention services</strong></td>
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<tr>
<td>List of any services specifically <strong>excluded</strong> from Medi-Cal billing by Santa Barbara County, e.g., EBPs for children, adults, substance use conditions</td>
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<tr>
<td>Current caseload sizes for clinic staff by position type (if there is variation within position type – e.g., across psychiatrists at different clinics – please describe the full range of the variation)</td>
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<tr>
<td>Staffing pattern (including position type detail) for CARES by shift by CARES clinic site</td>
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<tr>
<td>Staffing pattern for ACT and caseload size by team; include any recent quality or outcome measures (including scorecards for contract teams)</td>
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<tr>
<td>Staffing pattern for Supported Housing (SH) teams and caseload size by team; include any recent fidelity analyses or other quality or outcome measures (including scorecards for contract teams)</td>
<td></td>
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<tr>
<td>Fidelity assessment summaries for ACT, SH or other EBPs; include children’s services (for example, Wraparound team fidelity scores); please include the most recent two analyses, going as far back as necessary to find two (up to 10 years); if not available, please let us know</td>
<td></td>
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<tr>
<td>Clinical policies and procedures that describe access and engagement in care for individuals who present in an emergency, for individuals who present in crisis requiring urgent intervention, and for individuals who present with routine requests for service. The policies should address adults, children, TAY, older adults, ethnic / racial / cultural / linguistic minorities (including LGTBQ), and both Medi-Cal and Non-Medi-Cal populations.</td>
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<tr>
<td>Clinical policies and procedures that describe flow through access, screening, assessment and ongoing care for individuals who present in outpatient clinic or other outpatient settings. Case examples of successful and unsuccessful flow would also be helpful. Additional chart reviews addressing this may be done on site in December.</td>
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<tr>
<td>Clinical policies regarding screening, assessment, and recovery planning</td>
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<td>Policies regarding utilization of peer support specialists (training, HR policies, reimbursement)</td>
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<tr>
<td>Any policies or protocols related to integrated or collaborative services for individuals or families with co-occurring MH and SUD conditions; same for co-occurring MH/DD; same for co-occurring BH/physical health. Include the referral policies between ADMHS and DPH.</td>
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<tr>
<td>Any policies or protocols related to trauma informed care; recovery oriented care; child/family centered resiliency oriented care; wraparound</td>
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<tr>
<td>Any policies protocols, planning documents, and data related to individuals with both behavioral health and criminal or juvenile justice needs (jail based screening and intervention; application of sequential intercept mapping; transition planning for clients with criminal justice involvement; efforts at jail diversion, etc.)</td>
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<tr>
<td>Any policies, protocols, planning documents, and data related to individuals and families who are homeless, as well as planning for a continuum of housing services for individuals with psychiatric and co-occurring disabilities</td>
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</tbody>
</table>
Standard summary reports on clients served for the current fiscal year (year to date, through the most recent reportable month) and the past five fiscal years (back to FY2006-07) summarizing the following variables (unduplicated preferably, unless this will delay receipt of the data unduly – if so, please discuss this with our team so we can figure out what accommodations may be acceptable):

- All people served (both MH and ADP)
- People served by clinic by age (child and adult at least – if possible, it would be good to break out TAY and geriatric)
- People served by clinic
- People served by clinic by funding source
- People served by clinic by race/ethnicity
- People served by funding source by race/ethnicity
- People served by age by race/ethnicity
- People served by level of care by race/ethnicity
- People served by clinic by language spoken (at least English / non-English, if available)
- People served by funding source by language spoken (at least English / non-English, if available)
- People served by age by language spoken (at least English / non-English, if available)
- People served by level of care by language spoken (at least English / non-English, if available)
- People served with co-occurring MH/SA
- People served with co-occurring MH/DD
- People with BH needs and CJ/JJ involvement
- People who are homeless who have behavioral health needs
- Other special populations or analyses recommended by ADMHS to help us understand clinical populations and needs

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<th>Document Request</th>
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<tr>
<td>Standard summary reports on clients served for the current fiscal year (year to date, through the most recent reportable month) and the past five fiscal years (back to FY2006-07) summarizing the following variables (unduplicated preferably, unless this will delay receipt of the data unduly – if so, please discuss this with our team so we can figure out what accommodations may be acceptable):</td>
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Compliance
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<th>Document Request</th>
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<tr>
<td>Compliance Plan</td>
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<td>Compliance Policies</td>
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<tr>
<td>Code of Conduct</td>
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<tr>
<td>Contact information compliance officer, privacy officer, security officer</td>
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<tr>
<td>Compliance Committee Meeting Minutes for FY 2011-12, FY2010-11, FY2009-101</td>
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<tr>
<td>Meeting minutes of any provider network compliance meetings for FY 2011-12, FY2010-11, FY2009-101</td>
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<tr>
<td>Board Meeting Minutes where Compliance Officer Reported on Compliance Program</td>
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<tr>
<td>Boilerplate contract provisions on provider responsibilities re: compliance</td>
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<tr>
<td>Most recent written risk assessment or risk profile</td>
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<tr>
<td>Audit plan for county provided services and for network providers for FY2011-12</td>
<td></td>
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<tr>
<td>Audit reports: Most recent three completed on internal providers, most recent three completed external providers</td>
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<tr>
<td>Claims audit tool</td>
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<td>Medical records audit tool</td>
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<td>Country HR process for checking for excluded providers</td>
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<td>Training materials used for new employees, including HIPAA / 42 CFR Part II and compliance</td>
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<tr>
<td>Training materials used for training board members, including HIPAA / 42 CFR Part II and compliance</td>
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<tr>
<td>Training schedule or training materials on Medi-Cal requirements, billing, coding, documentation – for both county staff and providers</td>
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<tr>
<td>Strategic Planning</td>
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<td>Document Request</td>
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<tr>
<td><strong>Overall county and ADMHS:</strong> Current and recent past (dating back up to 12 months) planning documents and an overview of the strategic planning process at the county and ADMHS level related to behavioral health</td>
<td></td>
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<tr>
<td><strong>Katie A:</strong> Current and recent past (dating back up to 12 months) planning documents and an overview of the strategic planning process (including involvement and roles of other child-serving agencies) related to Katie A planning</td>
<td></td>
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<tr>
<td><strong>2011 Realignment:</strong> Current and recent past (dating back up to 12 months) planning documents and an overview of the strategic planning process (including involvement and roles of other child-serving agencies) related to implementation of the 2011 Realignment</td>
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<tr>
<td><strong>Affordable Care Act / 1115 Waiver / LIP:</strong> Current and recent past (dating back up to 12 months) planning documents and an overview of the strategic planning process (including involvement and roles of other agencies) related implementation of the Affordable Care Act and activities related to health care reform; include planning and (if available) implementation documents concerning implementation of the County health plan, as well as any Medi-Cal waiver or coverage initiative in Santa Barbara re: the County Health Plan, and how that waiver or Plan covers behavioral health needs</td>
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<tr>
<td>The two most recent analyses (going back up to 10 years) of provider system / network adequacy</td>
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<tr>
<td>The two most recent analyses (going back up to 10 years) of local behavioral health needs / needs assessment</td>
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<tr>
<td>Any other county or ADMHS or county agency (DPH, DSS, probation, etc.) planning materials in the last two fiscal years that may be pertinent to BH planning</td>
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<tr>
<td>Any other state-level planning materials in the last two fiscal years that may be pertinent to BH planning</td>
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Appendix 5: Follow-Up Data Request – January 15, 2013

The following is a data request in follow up to the initial desk review TriWest Group (TriWest) conducted for the Alcohol, Drug and Mental Health Services Department during the fall of 2012.

Please submit one electronic copy of the documents listed below by as soon as reasonably possible.

TriWest has once again set up an electronic fileshare folder online for collecting these documents. This folder is accessible only by secure login and password, so people submitting documents will need to set up permissions to access the folder. Bill Wilson from TriWest will be the point person and can help people get their logins and passwords set up. His contact information is:

Bill Wilson, MSW, TriWest Group; Telephone: 231.348.7902; email: bwilson@triwestgroup.net

The folder also includes a subfolder with special protections for Protected Health Information (PHI), subject to the protections of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and/or 42 CFR Part II. If any of the documents requested include PHI, please make arrangements with Bill prior to uploading the information to ensure adequate protections.

If you have any questions about the document request, please contact Bill Wilson at 231.348.7902; email: bwilson@triwestgroup.net.

Also, if any of the files or documents requested below create an inordinate workload demand or if there are other documents you would like us to consider as alternatives to what we are requesting, please discuss that with us. Our goal is for the data request to entail as minimal a burden on ongoing county and ADMHS operations as possible.

The table that follows can be used as a checklist for responding to the data request. Please be sure to let us know the name of the document responding to each request when you upload it. You can use this table and simply check if you are including it in your response. We expect that documents will be uploaded in multiple batches, so please be sure to communicate to us each time a single document or batch of documents is added and let us know which documents were added and their filenames. It may also be that some requested documents are not available. If so, please let us know.

One caveat about this request:
Some of what we are asking for here may not be readily doable in the format we have requested. If that is true, rather than have people submit a document that is different from
what we are requesting, but "close", we would request that they contact Andy Keller directly and discuss the issues with him so they can decide which alternative approaches will serve our needs and which will just waste the time of both county staff and us.

Thank you in advance for your assistance.

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<tr>
<td>1</td>
<td>Copies of EQRO reports for the past five most recent fiscal years for which they are available.</td>
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<tr>
<td>2</td>
<td>Contacts at the Health Plan so we can interview them about their interface with ADMHS (this was discussed with Terri and Dr. Wada at lunch Thursday); also, what is the current behavioral health benefit covered by the County Health Plan.</td>
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<td>3</td>
<td>Detailed organizational charts with break out under the regional managers and staff reporting to executive managers. If there are org charts for the clinics and CARES programs with number of FTEs listed, that would be wonderful as well, as available.</td>
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<td>4</td>
<td>List of current annual personnel costs (salary, benefits) for each current county staff member – by FTE and staff member, listing the staff members’ credentials and job title.</td>
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<td>5</td>
<td>List of all current county staff who are able to provide services or interpretation in language other than English – please also list the non-English language(s) spoken by each person (including sign languages).</td>
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<td>6</td>
<td>List of current annual contract amounts and requirements for persons served for each CBO contract program (by program for CBOs with multiple programs).</td>
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<td>7</td>
<td>List of caseloads for each individual MD at two points in time:</td>
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<tr>
<td></td>
<td>a. The most recent available point in time (ideally no further back than November 2012)</td>
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<td></td>
<td>b. A year prior to that point in time (more or</td>
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| 8     | Examples of a recent month (preferably the most recent available full month that is complete) of the appointment schedule for a full time adult psychiatrist and, if applicable, full time child psychiatrist from each of the three outpatient clinics and each of the two CARES sites.  
  o A PDF of a print-out of the monthly schedule could have PHI blanked out or we can also set up the on line secure folder to allow for it to include PHI.                                                                 |               |                             |
| 9     | List of all positions with vacancies over the last 12 months, current status (filled or open), and length of vacancy (date the position left, date position filled and the person reports for duty).                                                                                                                                  |               |                             |
| 10    | Summary of any union grievances filed in the last 12 months, including date, position grieving, summary of issue involved, and resolution.                                                                                                                                                                                                 |               |                             |
| 11    | Average direct service hours per person served (face to face time with the person only – do not include telephone time, travel time [with or without the person present], or time with collaterals) for the most recent four week period for which data are complete; we need the time reported by person for each of the following teams (that is, a complete distribution of the data by person served for each team – if there are 100 people on the team, we should receive 100 four-week totals of face-to-face hours served); this time should also be broken down by time in the community versus time in a clinic for each person:  
  a. ACT team (both county and contract)  
  b. Supported Housing team  
  c. New Heights – TAY  
  d. PEI – TAY  
  e. SPIRIT  
  f. AB 3632 |               |                             |
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<tr>
<td>g.</td>
<td>Intensive In-home</td>
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<td>h.</td>
<td>AB 109</td>
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<tr>
<td>i.</td>
<td>CARES North</td>
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<td>j.</td>
<td>CARES South</td>
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<td>k.</td>
<td>Calle Real Adult OP</td>
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<td>l.</td>
<td>Calle Real C/A OP</td>
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<td>m.</td>
<td>Santa Maria Adult OP</td>
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<td>n.</td>
<td>Santa Maria C/A OP</td>
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<td>o.</td>
<td>Lompoc Adult OP</td>
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<td>p.</td>
<td>Lompoc C/A OP</td>
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<td>12</td>
<td>For each of the same teams in the last question, plus TBS services, the following data points for each of the past 12 months for which complete data is available (for example, Nov 2011 through Oct 2012); data points should include:</td>
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<td>a.</td>
<td>Unique persons served by the team/program that month</td>
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<td>b.</td>
<td>Referrals to the team/program</td>
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<td>c.</td>
<td>Referrals accepted (admits to team/program)</td>
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<td>d.</td>
<td>Referrals denied</td>
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<td>e.</td>
<td>Discharges from the team/program</td>
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<td>13</td>
<td>List of any trauma-specific treatment modalities (TF-CBT, EMDT, etc.) and related EBPs (DBT, PCIT, etc.) used and the clinic/CBO using them.</td>
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<td>14</td>
<td>Policies related to how the following interactions with the client are (1) documented and (2) reimbursed:</td>
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<td>a.</td>
<td>Travel time without the person present</td>
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<td>b.</td>
<td>Travel time with the person present</td>
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<tr>
<td>c.</td>
<td>Documentation time without the person present</td>
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<tr>
<td>d.</td>
<td>Documentation time with the person present</td>
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<td>15</td>
<td>By clinic and program for county-run programs only, (1) what percent of current caseloads have current data for their Primary Care Practitioner available in the data base and (2) what percent are also served currently by the county health clinics?</td>
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