
FY 2016-2017

Annual Report



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

300 N. San Antonio Road ♦ Santa Barbara, CA 93110
(805) 681-5220 ♦ Alice Gleghorn, Ph.D., Director

Contents

Letter from the Director, [Page 4](#)

Mission, Vision, Guiding Principles, [Page 5](#)

About Behavioral Wellness, [Page 6](#)

Clinical Operations, [Pages 7-13](#)

Business Operations, [Pages 14-17](#)

Fiscal, [Page 18-22](#)

Annual Data Report [Page 23-37](#)

From the Director

I am very pleased to share the second Annual Report of the Department of Behavioral Wellness.

As the Director of the Behavioral Wellness Department I am proud to share this report as part of our commitment to transparency and accountability - principles that were adopted as part of the Systems Change initiative launched in Fiscal year 2012-2013. The Department has much to be proud of this past year as we have continued to commit ourselves to a process of continual quality improvement and the use of evidence based practices and data to improve care. During this past year, new data reports have been developed that aid our staff in assessing progress towards goals which result in better client care. Across our system of care and recovery, staff have engaged in targeted change projects, and have been successful in identifying, implementing and evaluating program improvement strategies. In adopting a culture of continued quality improvement throughout the department, we have been able to document successful advancements and progress toward achieving Systems Change.

This report focuses on key highlights from our work for Fiscal Year 2016-17. The final section of this report includes new data collection procedures consistent with state requirements and provides more refined and detailed information on essential variables. This report also includes central metrics requested by the Board of Supervisors that are updated every six months. As the Department continues on its path towards transformation, each report provides an opportunity to celebrate our successes and discuss areas for continued attention.

We hope you enjoy our Annual Report!

Sincerely,



Alice Gleghorn, Ph.D.
Director

Mission, Vision and Guiding Principles

Mission

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

Values

- ♦ Quality services for persons of all ages with mental illness and/or substance abuse
- ♦ Integrity in individual and organizational actions
- ♦ Dignity, respect, and compassion for all persons
- ♦ Active involvement of clients and families in treatment, recovery, and policy development
- ♦ Diversity throughout our organization and cultural competency in service delivery
- ♦ A system of care and recovery that is clearly defined and promotes recovery and resiliency
- ♦ Emphasis on prevention and treatment
- ♦ Teamwork among department employees in an atmosphere that is respectful and creative
- ♦ Continuous quality improvement in service delivery and administration
- ♦ Wellness modeled for our clients at all levels; i.e., staff who regularly arrive at the workplace healthy, energetic and resilient
- ♦ Safety for everyone

Guiding Principles

Client- and family-driven system of care: Individuals and families participate in decision making at all levels, empowering clients to drive their own recovery.

Partnership Culture: We develop partnerships with clients, family members, leaders, advocates, agencies, and businesses. We welcome individuals with complex needs, spanning behavioral health, physical health, and substance use disorders, and strive to provide the best possible care.

Peer employment: Client and family employees are trained, valued, and budgeted- for in ever-increasing numbers as part of a well-trained workforce.

Integrated service experiences: Client-driven services are holistic, easily accessible, and provide consistent and seamless communication and coordination across the entire continuum of care delivery providers, agencies and organizations.

Cultural competence, diversity and inclusivity: Our culturally diverse workforce represents this community. We work effectively in cross-cultural situations, consistently adopting behaviors, attitudes and policies that enable staff and providers to communicate with people of all ethnicities, genders, sexual orientations, religious beliefs, and abilities.

Focus on wellness, recovery and resilience: We believe that people with psychiatric and/or substance use disorders are able to recover, live, work, learn and participate fully in their communities.

Strengths-based perspective: Recovery is facilitated by focusing on strengths more than weaknesses, both in ourselves and in our clients.

Fiscal responsibility: We efficiently leverage finite resources to provide the highest quality care to our clients, including those who are indigent.

Transparency and accountability: There are no secrets. We do what we say we will do, or we explain why we can't.

Continuous quality improvement: We reliably collect and consistently use data on outcomes in our system of clients and other pertinent populations (such as incarcerated and homeless), as well as data related to perceptions of families, employees, and community-based organizations, to fuel a continuous quality improvement process.

About Behavioral Wellness



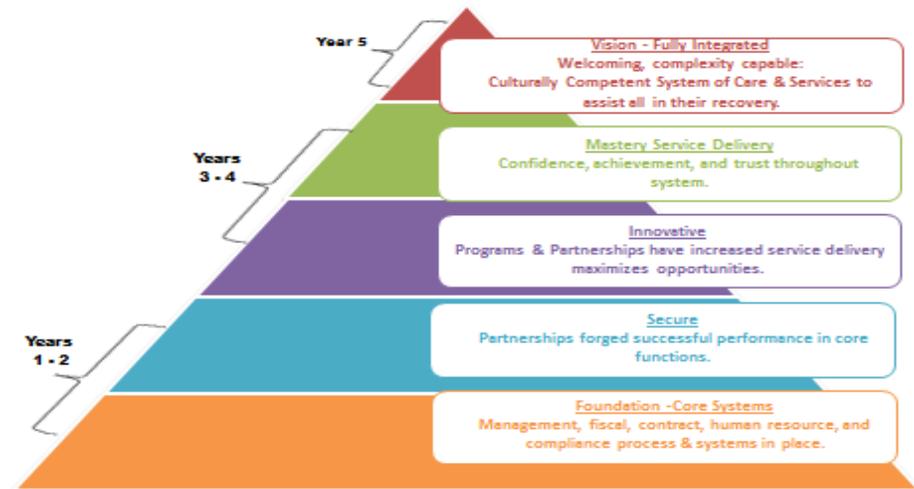
Founded in 1962, the Santa Barbara County Department of Behavioral Wellness promotes the prevention of, and recovery from, addiction and mental illness among individuals, families and communities, by providing effective leadership and delivering state-of-the-art, culturally competent services.

An array of services is provided countywide for adults, children and transition-age youth. Services are provided on an inpatient, outpatient and crisis basis. During FY 2016-17 the Department of Behavioral Wellness served 8,608 mental health clients and 4,453 Alcohol and Drug Program clients.

As of June of 2017, Behavioral Wellness employed 434 persons. Behavioral Wellness also contracts with a number of community-based alcohol, drug and mental health providers, as well as with individual practitioners called "network providers" to offer additional services countywide.

Many systemic improvements and program developments have occurred over the past year, and we are excited to share highlights and our progress toward the broader goal of system change. The Department is currently in the stage of *mastery of service delivery* where the programs and partnerships support system confidence, achievement, and trust throughout the system.

Timeline of Systems Change



This report is organized around the core areas of Clinical, Business and Fiscal Operations of the Department. Each core area will be introduced by a brief definition, followed by key achievements and recent accomplishments.

Clinical operations focus on inpatient and outpatient service delivery systems, the crisis system of care and contracted community-based organization (CBO) services.

Recent Accomplishments

Client and Family Experiences

- ✓ The 24/7 Access line is now centralized and receives calls for connection to routine, urgent or crisis services. Orientation Groups have been expanded throughout all outpatient and CARES clinics and assure timely access to care. The Access line is able to offer immediate access to counseling and medication support through referral to orientation groups, for callers. In addition, people are referred to orientation groups upon their discharge from an acute psychiatric hospitalization to assure immediate access to care.
- ✓ The existing contract which provides certified in-person interpreter services has been expanded. In-person interpretation is now available in multiple languages prevalent in the county, including Spanish, Mixteco and other indigenous Mexican languages, Tagalog and Cantonese. Since the expansion of the service, 82 unique individuals have received in-person interpretation services.
- ✓ Orientation groups and Wellness/Recovery groups are being facilitated by peers system wide at outpatient clinics.

Change Agents and Action Teams

As result of the continuing system change process and through the leadership of system Change Agents, many systemic improvements and program developments have occurred over the past year. Process improvement projects are actively in place in all programs. There has been an increase in leadership participation with Change Agents. All supervisors and regional managers have joined in PDSA training, allowing an increase in knowledge on elements of the change process. Highlights from our system Action Teams, including the Housing Action Team (H.E.A.R.T.), Forensic Action Team, Crisis Action Team, Cultural Competency and Diversity Action Team, Peer Action Team, and the Children's System of Care Action Team are noted throughout this report. Action Teams serve as important venues to encourage communication, planning and coordination throughout the system.

Cultural Competency and Diversity

- ✓ A new Cultural Competency Plan (CCP) was developed and implemented to provide direction on strategies and interventions designed to reduce mental health care disparities for culturally diverse communities. The plan covers Department training, outreach and engagement, and other core activities over a three-year period.
- ✓ The Cultural Competency and Diversity Action Team (CCDAT) made a strong push this year to increase engagement with community partners working with marginalized and disadvantaged communities. Representatives from the United Domestic Worker’s (UDW) Union, Pacific Pride Foundation, Public Health Department, American Indian Health Services (AIHS), NAACP/New Hope Missionary Baptist Church, La Casa de la Raza, and Santa Maria Union High School District participate in CCDAT.
- ✓ In collaboration with community-based organizations and advocacy groups, the Cultural Competency and Diversity Action Team participated in various outreach and engagement events reaching over 1,500 people. Through presentations, workshops and tabling events, community members received information on available services, symptoms and warning signs, and how to access care. Examples of events include Day of the Farmworkers in Santa Maria, Open Streets in Carpinteria, and the Health Fair and Family Fun Day in Santa Barbara.

Investment in Infrastructure and Housing

- ✓ A new building was developed for use by the Resiliency Intervention and Sexual Exploitation (RISE) program.
- ✓ In partnership with the Mental Wellness Center and the City of Santa Barbara Housing Authority, a residence for five homeless women located in Santa Barbara opened and quickly established full tenant occupancy. Current focus of this team collaboration includes planning for the *No Place Like Home* project aimed to develop local housing for those struggling with mental illness.



Words used by girls in the RISE program to express their feelings

Strengthening Community Outreach and Engagement

- ✓ The Behavioral Wellness Assisted Outpatient Treatment (AOT) program began in 2017. During the first 6 months, outreach was provided for 30 individuals. Of those, 26% voluntarily accepted outpatient mental health treatment and the majority of the rest remain engaged with AOT outreach workers. No individual served rose to the level of needing a court petition or court order for mental health services.

30 people met the legal/court criteria for and were referred to the AOT program within the first six months of 2017. On average, the program received 5 referrals per month. Of the first 30 referrals:

- Half were from family members such as parents and children
- 70% were under the age of 45
- 80% had a dual diagnosis
- 57% were homeless

- ✓ Additional support has been provided for outreach programs through the use of AmeriCorps volunteers.
- ✓ Behavioral Wellness and the Behavioral Wellness Response Team continue to provide ongoing community crisis and trauma response. During the 2017 year, the department has been contacted by schools for support of 12 traumatic events, 8 being deaths of students; 9 critical incident debriefings have occurred for local first responders; and support has been provided for additional deaths in the community not related to schools. Behavioral Wellness has also provided consistent support at the Emergency Operations Center (EOC) during activation. Support has been provided to other county departments in the aftermath of a traumatic event among teams, including support for county staff having been present during the shooting in Las Vegas and having returned to Santa Barbara in much need of support.
- ✓ Behavioral Wellness has hosted countless resources tables, offering free screenings when requested, at countless community events at schools and in the community as well as during awareness month focused activities.
- ✓ A variety of presentations on mental health programs and events were hosted throughout the county to assure broad circulation of information among clients. Also, Peers have provided support to many community outreach activities this year including hosting resource tables at events for Suicide Awareness Month, Health Fairs and the Bridges to Resilience Children's Conference.

Serving Children and Teens In The Following Ways:

- ✓ Hired three new employment specialists from the Department of Rehabilitation to work in the transition age youth (TAY) division, one located on each regional team. Through these new positions, clients who are challenged with employment from the symptoms of their mental illness are provided support with job skills and may receive job shadowing to provide coaching and support with their employment.
- ✓ Engaged in active partnership with schools to provide post-intervention support following a traumatic event or death of a student. In addition, through the support of local foundations, Behavioral Wellness has worked with the schools and local partners to develop robust suicide prevention and school mental wellness activities including expanding school based mental health services on campuses, development of a school district protocol for suicide response, initiation of universal screenings in schools, Signs of Suicide curriculum purchased the Santa Barbara Unified School District (SBUSD) to be established for grades 7-12, and Psychological First Aide by training provided for over 125 school personnel and community partners. Additional trainings were provided such as social media training for local youth, gatekeeper training and training on the Chronological Assessment of Suicidal Events (CASE).
- ✓ Resiliency Interventions and Sexual Exploitation (RISE) has provided services and interventions for 100 individuals during the FY16-17. Among many accomplishments, through a contract with an organization called “Runaway Girl,” survivor mentors were paired with RISE clients to ensure best practices of incorporating survivor lead interventions.
- ✓ Countywide trauma informed care trainings were offered in partnership with Child Welfare Services and Probation. Evidence based practice trainings also occurred system wide through sponsorship of the department, Child Welfare Services and organizational providers.
- ✓ Regional partnership meetings are active in each region of the county and promote interdisciplinary coordination of the Children’s System of Care.
- ✓ In collaboration with the Department of Social Services, implementation is underway for the Children’s Care Reform and has launched reorganization of service delivery and administrative functions.
- ✓ The Santa Barbara Children’s clinic change agents identified a challenge in timeliness of documentation entry into the electronic medical records and developed a study and pilot project to improve. As result, corrections were made and the average time between service and documentation dropped from an average of 21 days to 11 days.
- ✓ The Santa Maria Children’s clinic change agents heightened group participation by 49% in a one month period by showing promotional videos in the clinic lobby.

Alcohol and Drug System of Care

- ✓ Restructured and transformed the entire primary prevention system of care, awarding contracts to providers to implement new innovative practices such as the Strengthening Families Program, to align with the DMC-ODS.
- ✓ Our DMC-ODS Implementation Plan was approved by the State of CA Department of Health Care Services (DHCS) in June, 2017.
- ✓ Expanded the Overdose Prevention and Reversal program throughout the county. 450 Naloxone reversal kits were distributed within the community. 150 of these kits were reported to have been used to reverse overdoses within the community.
- ✓ Competitive proposal process is in place to identify providers to be awarded contracts for substance abuse residential treatment including withdrawal management or detoxification services.
- ✓ Led by our Alcohol and Drug team, the Strengthening Families Program (SFP) was successful in the first pilot implementation in bringing multiple families together in Santa Maria to learn better communication and coping skills. Led by skilled family therapists, the program was initiated with six (6) monolingual Spanish speaking families. The program lasted ten (10) weeks, combining communal dinners, separate and combined adolescent and adult group therapies, and incentives as part of the treatment milieu. The SFP will inform family treatment services throughout the Behavioral Wellness system of care.

Forensic Program Development

Enhancements have been made to the Behavioral Wellness Forensic program. For example, a robust forensic team is located in each core region of the county with the hiring of a new clinical psychologist. A current core focus of the collective teams is restoring individuals determined to be incompetent to stand trial, to live within the community rather than locked facilities located out of the county.

Crisis System Improvements

- ✓ Mobile crisis workers report improvement in safety crisis planning efforts and utilization of increased resources for least restrictive settings, with people experiencing a psychiatric crisis. 5150 declarations have been reduced this past year by more than 200.
- ✓ Our mobile Triage program has aimed to reduce hospitalizations and support the individual in the least restrictive setting possible.
- ✓ Relationships have been strengthened with the Sheriff's department Behavioral Sciences Unit (BSU), resulting in increased collaboration between the BSU and the Behavioral Wellness Crisis Triage program. The BSU identifies individuals in the community with frequent law enforcement contact who may be struggling with mental illness. The BSU has also been successful in identification of at risk-missing persons or individuals who are over-utilizing the 911 system and appear to be struggling with mental illness. Crisis triage staff has then been able to provide outreach to these individuals with the aim of engagement with needed services.
- ✓ Two additional beds have been added to the Crisis Residential Facility in Santa Barbara expanding this lesser restrictive option for individuals in crisis.
- ✓ Improved coordination with local hospitals and law enforcement through monthly meetings. Through an initial pilot process, identified cross system high utilizers were collectively discussed and as result, properly redirected to appropriate services to meet individualized levels of need.
- ✓ 502 unique admissions have occurred at the Crisis Stabilization Unit during the FY 16-17. The highest volume of referrals have come from the Emergency Room allowing the most appropriate level and type of treatment to occur for persons experiencing psychiatric crisis.

Access to Care

- ✓ The average wait time to see a Psychiatrist is 28 days (25 days for adults and 31 days for children). This represents a **26% improvement** from last year when the average wait time was 38 days (33 days for adults and 44 days for children).

Making it Happen: A Success Story

A Story of Resilience and Success in a Youth supported by Behavioral Wellness

This story is worth reading. A boy, we will call “M”, originally came to the Lompoc children’s clinic at the age of 14, challenged with symptoms of social anxiety. His symptoms of anxiety were so significant, that therapy needed to occur over the phone, later progressing to therapy through a closed door, to face to face therapy in the community and eventually at the outpatient clinic. This is only the initial example of his drive to improve. Mental illness was present in his family with both parents struggling with mental illness and unable to provide him the support needed. In addition, his family struggled financially resulting in years of homelessness. He lived with his parents in various parking lots, received support services only on occasion and received inconsistent support from his parents.

Throughout his high school years, he and his father lived in a shed which lacked a bathroom or shower. During time on the streets and living in the shed, M struggled with fears of property being stolen, wondering where his next meal would come from, and how long this housing would last. All the while, he remained engaged in his mental health treatment.

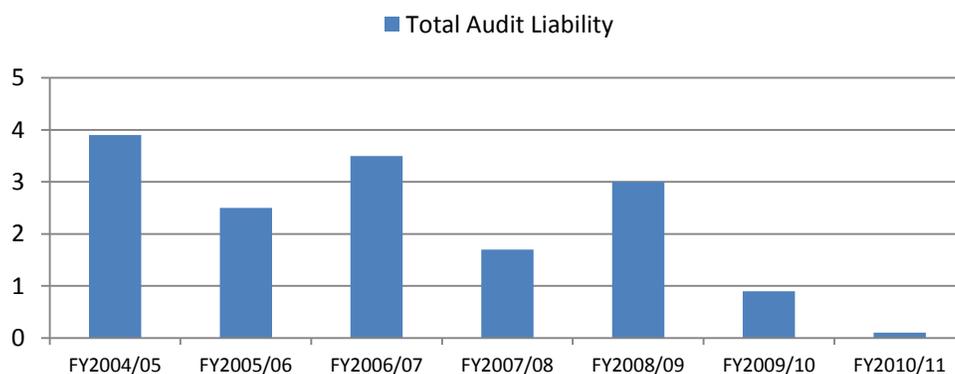
Despite these challenges, M graduated from high school with high academic marks. Though M had been afforded the opportunity of supported housing, he declined in order to be able to provide support for his parents. Through hard work in therapy and work with his Behavioral Wellness Case Manager **Dan Reynolds** and Psychiatrist **Dr. Ruby Agoha** he was able to recognize his worth, value his independent needs and emancipate from his parents. With Behavioral Wellness support, he acquired Cal-Fresh/food stamps, set his own medical appointments, obtained housing, acquired full-time employment, developed his own credit, enrolled at community college, and opened his own checking account all while working through the challenges of living with anxiety, depression, and gender identity issues.

This young man continues to make improvements. He proves that success is possible with drive and self-motivation supported by the right level of individualized treatment.

Significant Reduction in Audit Liabilities

The Department’s cost report is audited annually by State DHCS to evaluate whether costs are allowable and whether federal funding was appropriately disbursed. Audits typically occur 5-7 years in arrears. In prior years, these audits resulted in Behavioral Wellness owing millions of dollars back to the State. Fiscal controls and improvements were implemented beginning in fiscal year 2009/10 and Behavioral Wellness is finally seeing a reduction in audit liabilities. As demonstrated in the below table, cost report audit liabilities have decreased from a high of \$3.9M in fiscal year 2004/05 to a low of \$66K in fiscal year 2010/11, a 98% reduction. The decrease in audit liabilities is a significant change from prior years and we hope that this trend continues into future years.

Behavioral Wellness Audit Liability By Fiscal Year



Improved Triennial DHCS Review Performance

Behavioral Wellness showed outstanding achievement in the Triennial Department of Health Care Services (DHCS) system review, occurring in February, with **92% system compliance**. In addition to the review of system regulatory compliance, medical records and claims were reviewed. A total of 719 claims were reviewed and only 12.8% found to be out of compliance. As result, the fiscal recoupment resulted in only \$5,600, much lower than in years past. As comparison, our 2015 review found our system to be 49% out of compliance. This year’s review is a remarkable success for our system as a whole and for our operation of the Mental Health Plan for Santa Barbara County.

Phase One of Service Now Software Implementation Complete

Behavioral Wellness successfully completed the initial implementation phase for the launch of ServiceNow software within the department. ServiceNow is the new Behavioral Wellness Service Management Portal selected to improve the management of the IT Helpdesk requests and provide data on response efficiency, request type and volume.

Continued Improvements at the Psychiatric Health Facility

- ✓ The PHF Governing Board completed its first year of PHF oversight, adopting more than 75 policies and many facility, service and staffing improvements.
- ✓ Working collaboratively with the Public Defender and the Court, the Psychiatric Health facility achieved a reduction in the number of individuals determined to be Incompetent to Stand Trial at the Psychiatric Health facility, allowing greater capacity for acute psychiatric admissions.
- ✓ Gardening soil was donated which launched a focused upgrade of the patio herb garden. Patients are able to spend much time in the garden while at the PHF. Existing therapy groups exist which revolve around care of the garden following much research on gardens and their potential for healing of trauma, improving depression and reducing stress.



Improved System Business Practices with Cultural Competency and Diversity

- ✓ In November 2016, a Department-wide survey was conducted to assess levels of bilingual staff. 39% of the Behavioral Wellness direct-care workforce was found to be bilingual; 35% of the workforce is Spanish-speaking. Based on existing department data, 7% of clients request and/or require services in Spanish.



Sharing, Listening and Promoting Dialogue

Behavioral Wellness has continued efforts to improve communication within the system, with clients served and among stakeholders. Some examples which occurred during the FY 16-17 are listed below.

- ✓ Monthly CBO Collaborative meeting and regular in person meetings with individual providers.
- ✓ Monthly Directors Report with broad stakeholder distribution.
- ✓ Enhancements to the website including improving access of required forms and policies for providers, new community trauma response section including resources materials for schools, families and the community, new quality care management section to highlight information notices.
- ✓ Regional Partnership meetings take place monthly in each region of the county and our joined by Behavioral Wellness, Public Health, Law Enforcement, Community Based Organizational providers and other local community stakeholders.

Employee Recognition and Appreciation

- ✓ The Behavioral Wellness Employee Engagement and Appreciation Committee has launched a new employee recognition activity which is catching stars and strengthening morale. Each quarter, peers nominate several “stars” to be honored in the quarterly “Salute to a Star” recognition which includes items of reward as well as written biographies published in the quarterly newsletter.
- ✓ Kathleen Mansell and Katarina Zamora were recognized as employees of the year for the County of Santa Barbara.
- ✓ The Behavioral Wellness Consumer Empowerment manager was elected to serve as the Chair of the statewide Mental Health Services Oversight and Accountability Commission which oversees a 2 billion dollar fund for the 58 counties.



A Year of Training

- ✓ On the first day of the '16-17 fiscal year, the Training Division launched a new online learning platform called Relias. The Relias Platform has streamlined enrollment for trainings and offers excellent compliance reporting capabilities. Additionally, the platform hosts a multitude of online trainings available for ongoing learning and development for staff.
- ✓ The department achieved 100% completion of the required HIPAA training by department staff including extra help staff, contracted staff and interns.
- ✓ Mandatory Documentation Training was again a strong focus for the department. As of November 2016, 99.15% of clinical staff completed the 5150 Training, which includes training in suicide risk-assessment and safety planning options. As of March 31, 2017, 100% of clinical staff completed the Clinician's Gateway and Medi-Documentation Training. As of June 30, 2017, 88% of clinical staff completed the Medi-Cal Treatment Planning and Assessment Training.
- ✓ As a priority on the Compliance Committee's risk assessment, Safety trainings also received extra attention this fiscal year. Noteworthy successes include training more than 90% of our clinical staff in de-escalation skills, across the county training at clinics in the emergency response plan and emergency codes, regional active shooter trainings and drills, and most recently, the psychological first aid training for community trauma response. Additionally, five Behavioral Wellness Staff became Red Cross Certified First Aid/CPR/AED Instructors and have begun offering this training to staff at our clinics.
- ✓ 94% staff compliance with the mandatory Code of Conduct, Cultural Diversity and Mental Health Consumer Culture online trainings by the due date and 100% completed within the next 30 days.
- ✓ During the FY 16-17 multiple classroom trainings were offered with a variety of themes such as Documentation, Safety and Disaster Response, Cultural Competency, Peer Training, Staff Development, 3-4-50 Curriculum, multiple Clinical Evidence Based Practice trainings, and more.
- ✓ New training opportunities were coordinated for department and provider staff on topics of cultural competency and diversity and offered online and in-person. In addition to online trainings, several in-person options were offered throughout the county, including a presentation on Mixtec culture by the Mixteco Indigena Community Organizing Project (MICOP), and trainings on sexual orientation and gender identification presented by the Santa Barbara Pacific Pride Foundation.

Fiscal activities focus on capacity and performance in regard to budgeting, the revenue cycle, Medi-Cal cost recovery and broader financial resources management.

Recent Accomplishments

- ✓ Adoption of balanced departmental budget for FY 2017-18 and proposal of five year forecast plan.
- ✓ Developed and adopted the FY 2017-20 Mental Health Services Act (MHSA) three year budget plan.
- ✓ Implementation of fiscal controls has led to a 98% reduction in cost report audit liabilities; a high of \$3.9M in FY 2004-05 to a low of \$66K in the most recent finalized audit for FY 2010-11. State audit findings for FY 2008-09 were also successfully challenged at the informal appeal stage resulting in the County recovering \$758K in funding.
- ✓ In order to provide additional transparency, the Mental Health Service Act Oversight and Accountability Commission has posted a State-wide tool to review Revenue and Expense Reports by county. <http://mhsaac.ca.gov/fiscal-reporting>

Staffing Levels

Behavioral Wellness staffing levels have improved. As can be seen in Table 1, the overall vacancy rate in FY 2015/16 was 11%, compared to 17.4% the previous fiscal year.

Table 1: Behavioral Wellness Staffing, FY 2016-17

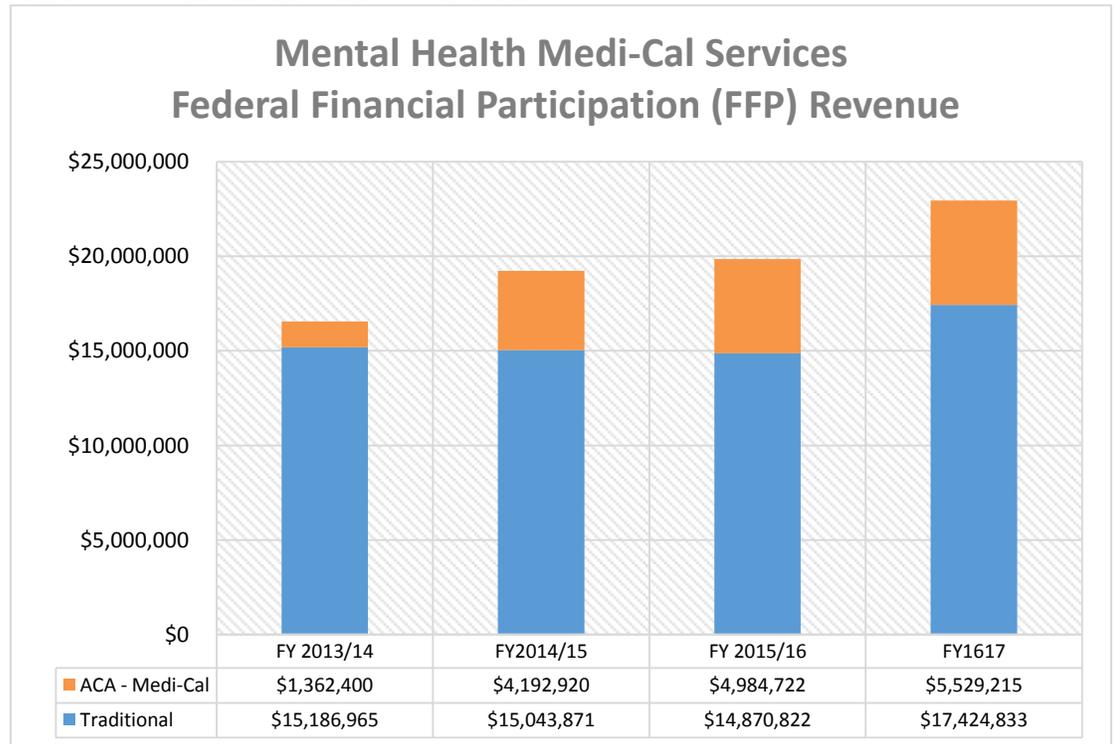
Staff Type	FTE Total	FTE Vacant	FTE Filled	% Vacancy
Regular	367.9	29.24	338.66	8%
Extra Help	61.1	19.38	41.27	32%
Contract	4.3	0.14	4.16	3%
TOTAL	433.3	48.76	384.09	11%



Left-to-Right: Dessi Mladenova, David Simon, Melissa Manzo, Anthony Villa, Rebecca Spears, Susan Goodman, Kimberley Matthews, Christine Foschaar, Keiko Monahan, Tor Hargens, Kathleen Mansell, Diana Johnson, Emma Gomez, Chris Ribeiro, Christie Boyer

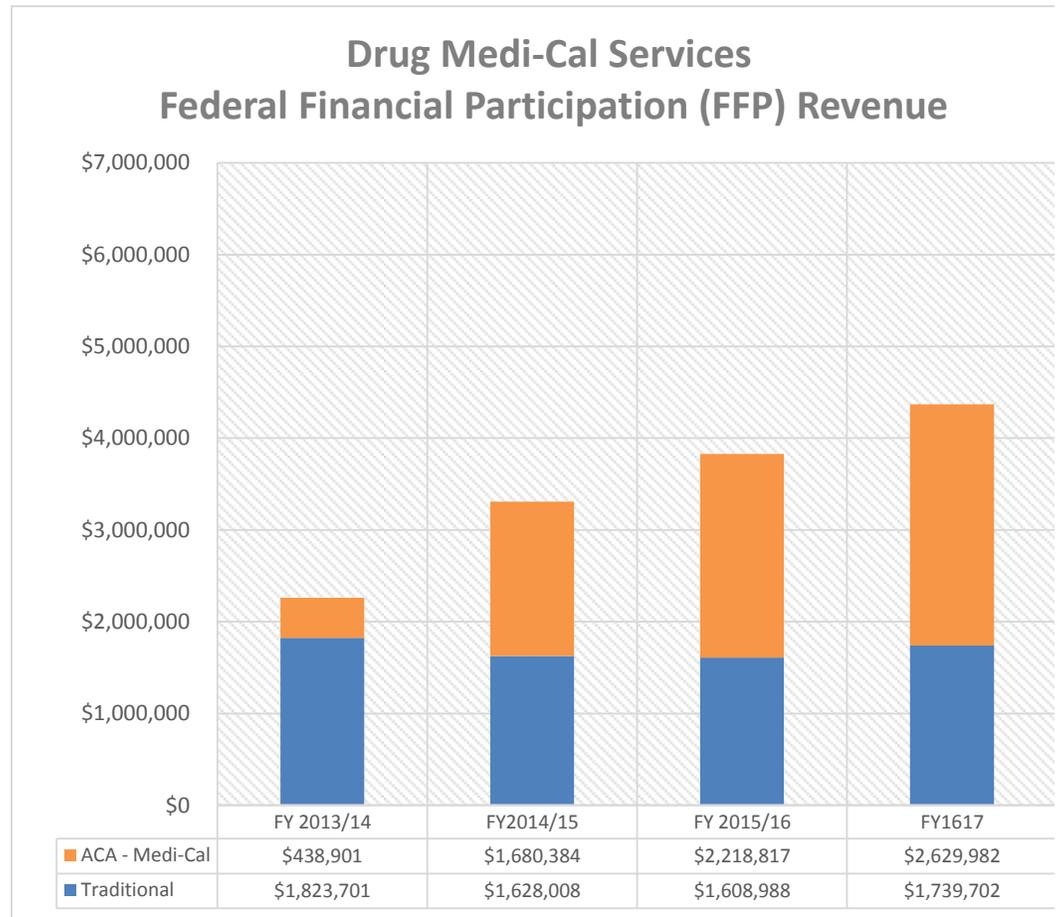
Within Mental Health Medi-Cal-funded programs, the volume of revenues for clients newly enrolled due to the Affordable Care Act (ACA) has increased slightly each year since the inception of this coverage on January 1, 2014. Revenues however from clients covered by Traditional Medi-Cal increased significantly (17.2%) in FY 2016-17 as compared to FY 2015-16. This large year-over-year increase was due primarily to an approximately 30% rate increase for services provided in County operated outpatient clinics. ACA Medi-Cal revenue made up \$5.5M, or 24% of the almost \$23.0M FFP revenue collected in FY 2016-17.

Table 2: MH Medi-Cal Services FFP Revenue



Within Drug Medi-Cal-funded programs for Alcohol and Drug treatment, the volume of revenue for clients newly enrolled due to ACA has increased significantly each year, while revenue from clients covered by Traditional Medi-Cal has remained flat. ACA Medi-Cal revenue made up over \$2.6M, or 60% of the almost \$4.4M FFP revenue collected in FY 2016-17.

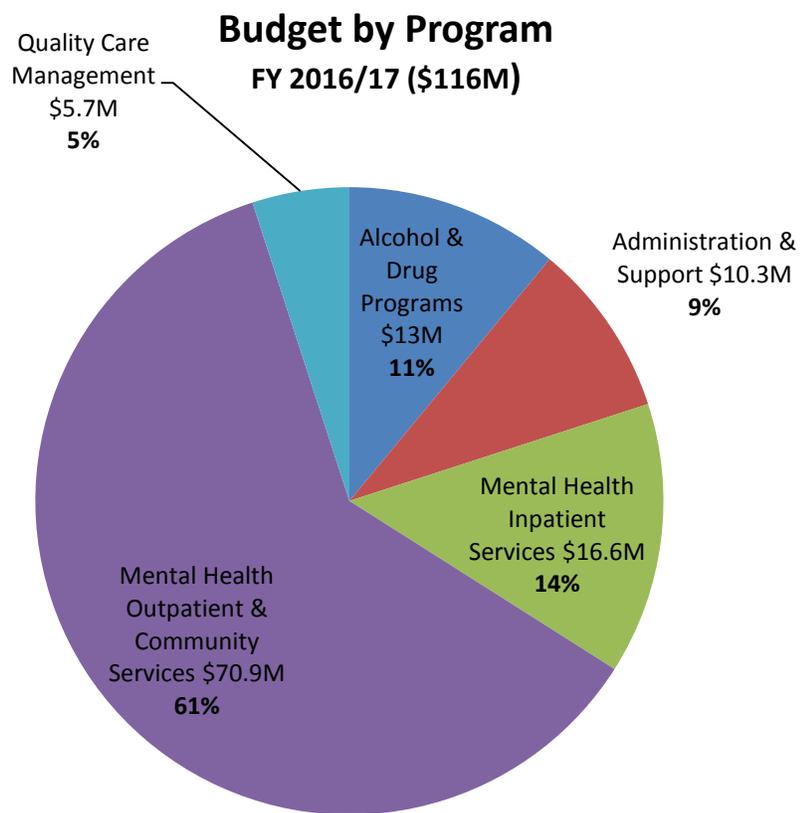
Table 3: Drug Medi-Cal Services FFP Revenue



Current and Future Efforts

- ✓ Implement a fiscal plan for the Organized Delivery System (ODS) that includes rates developed to provide for full cost recovery for all Drug Medi-Cal services.
- ✓ Crisis Triage Teams: Grant funding to be expended by June 2018; development of sustainable model underway, to be implemented with FY 2018-19 Budget.
- ✓ Long Term Institute for Mental Disease (IMD) Costs continue to be an area of significant concern. Expenditures have increased by over 500% in the last five years (thru FY 2016-17) and continue to rise. Exploring alternative service models to leverage additional funding and improve efficiencies to mitigate fiscal impact of continued rising IMD service demands.
- ✓ Forensic MHRC, \$4M (funded in CCP Budget) to provide 15 bed secure MH treatment for justice involved clients (full ongoing operational funding source not yet determined-service to open month 11- 12 of FY 2017-18 with \$750k of annual on-going CCP funds.
- ✓ Exploration of options for locked Mental Health Rehabilitation Center for justice involved clients with funding from the Community Corrections Partnership (CCP).

The total department budget of \$116 million is composed primarily of outpatient services in county run and community based organizations (61%), followed by inpatient services (14%) both in and out of county, alcohol and drug programs (11%), administration (9%), and Quality Care Management (5%). We expect these proportions to change when the expansion of the Drug MediCal Organized Delivery System is launched.



The Santa Barbara County Department of Behavioral Wellness aims to continuously improve programs, practices and policies. We recognize that we cannot improve what we do not measure; it is, therefore, important to thoughtfully collect and analyze data. As a part of our larger system change efforts, we are working to change our culture to be more data-driven, in order to make better decisions (such as adjusting practices or altering resource allocation) and to increase our impact and effectiveness. Efforts to become more data driven, including this report, reflect our commitment to accountable stewardship of public resources, to continuous evaluation and improvement and, most importantly, to delivering on our mission, vision and values.

In February 2016, the Board of Supervisors approved the Semi-Annual Report, which includes a specific but thoughtfully chosen set of measures/metrics. This Annual Report for fiscal year 2016/2017 includes all of those key performance measures, as well as a few others and provides data on: who was served and where; data on our crisis and inpatient services; access to and timeliness of services; child and adult outcomes, including client satisfaction; and, system performance/productivity.

Client Demographics

Alcohol & Drug Programs (ADP)

In FY2016/17, 4,453 **unique clients** were open to ADP – 4,075 (91%) adults and 376 (9%) youth. Because some clients had more than one admission to services during the year, there were more admissions than clients: **6,111 total admissions** – 5,582 (91%) adult and 529 (9%) youth.

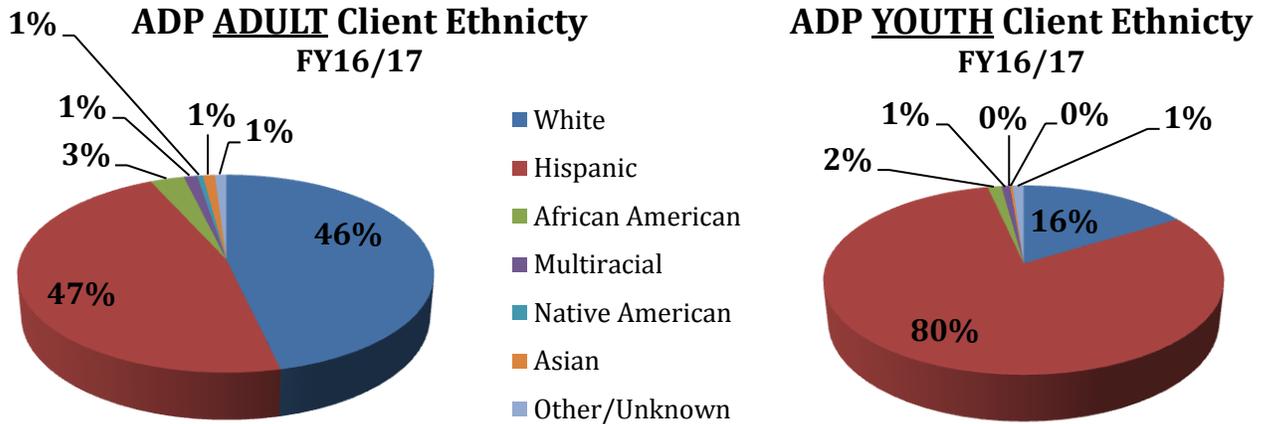
	ALL Adult & Youth		Adult		Youth		Missing DOB
	N	%	N	%	N	%	N
ADP - Unique Clients							
Male	2,894	65%	2,637	65%	257	68%	
Female	1,551	35%	1,432	35%	119	32%	
Missing/Other	7	0%	6	0%	0	0%	
<i>Total</i>	4,453	100%	4,075	100%	376	100%	2
Race/Ethnicity							
White	1,951	44%	1,890	46%	61	16%	
Hispanic	2,210	50%	1,908	47%	302	80%	
African American	128	3%	123	3%	*	1%	
Multiracial	51	1%	48	1%	*	1%	
Native American	21	0%	21	1%	0	0%	
Asian	43	1%	43	1%	*	0%	
Other/Unknown	46	1%	42	1%	**	1%	
<i>Total</i>	4,453		4,075		376		2

*number not included due to small sample size

**note: combined small sample sizes for protection of client privacy

Half (50%) of all APD clients are Hispanic and 44% are White; about two-thirds (66%) of ADP

clients' primary language is English. Among both adults and youth, about two-thirds of ADP clients are male. Whereas ethnicity is more equally divided between Whites (46%) and Hispanics (47%) among adult ADP clients, this is not the case among ADP youth, 80% of whom are Hispanic.



Mental Health System

In FY2016/17, **9,600 unique clients** were open to the Mental Health System – 6,628 (69%) adults and 2,953 (30%) youth. About half (51%) of all Mental Health clients are male, 44% are Hispanic and 40% are White; the vast majority (78%) indicate that English is their primary language.

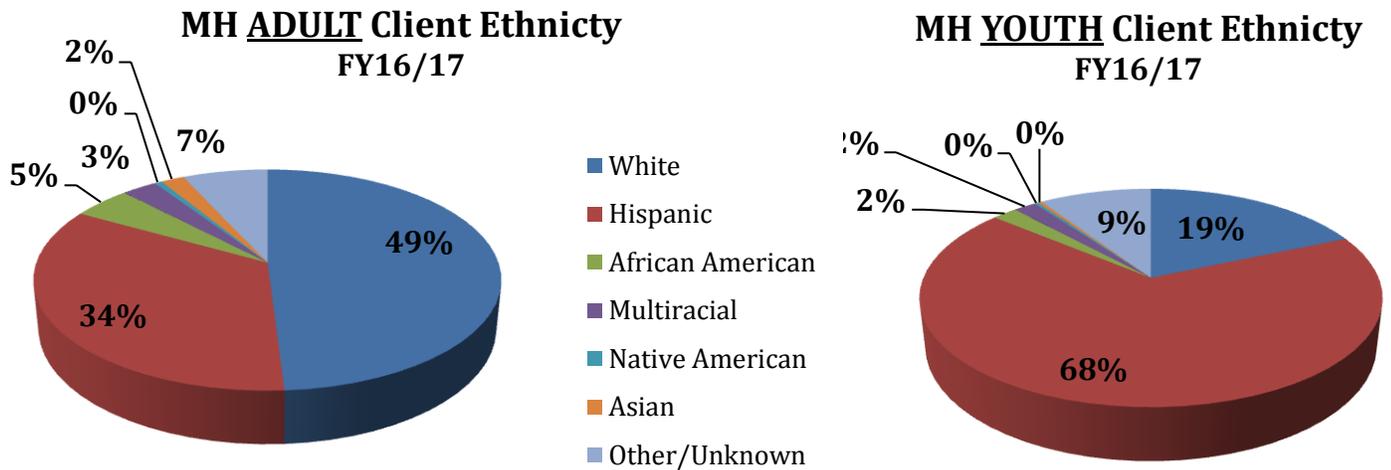
	ALL Adult & Youth		Adult		Youth		Missing DOB
	N	%	N	%	N	%	
Mental Health - Unique Clients							
Male	4,850	51%	3,289	49%	1,555	53%	6
Female	4,651	48%	3,279	50%	1,366	46%	6
Missing/Other	99	1%	60	1%	32	1%	7
Total	9,600		6,628	100%	2,953	100%	19
Race/Ethnicity							
White	3,796	40%	3,249	49%	547	19%	
Hispanic	4,238	44%	2,261	34%	1,977	68%	
African American	373	4%	312	5%	61	2%	
Multiracial	242	3%	189	3%	53	2%	
Native American	46	0%	39	1%	*	0%	
Asian	144	2%	124	2%	*	1%	
Other/Unknown	742	8%	454	7%	**	9%	
Total	9,600		6,628		2,953		19

*number not included due to small sample size

**note: combined small sample sizes for protection of client privacy

Among both adults and youth, nearly half of MH clients served are male. However, the ethnicity of

MH clients differs by age group: adults are 50% White and 33% Hispanic, compared to youth MH clients who are 19% White, and 68% Hispanic. The adult and youth MH systems of care are clearly serving proportionally dissimilar ethnic populations.



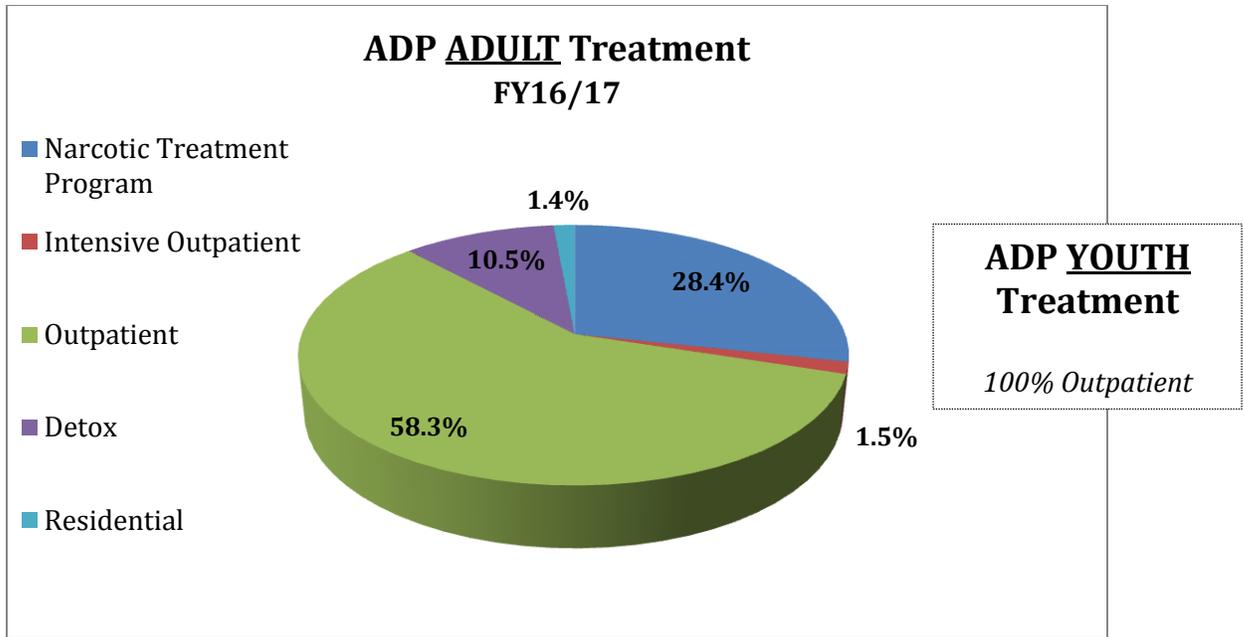
Overall, the Mental Health System is much larger than – nearly twice as large as – ADP, in terms of the number of unique clients served. Both MH and ADP serve more adults, but MH serves a greater proportion of youth (30% in MH, compared to 8% in ADP).

Client Service Settings

Behavioral Wellness and its partner agencies provide a variety of services in both inpatient and outpatient settings. Though most clients receive services in Santa Barbara County, due to limited in-County capacity (in number or kind), some clients are served at inpatient and residential facilities outside of the County. Clients may receive more than one service type during the fiscal year. For example, depending on individual treatment needs, a client may receive services in a Behavioral Wellness clinic and might receive additional services from a crisis team or a partner organization in the community.

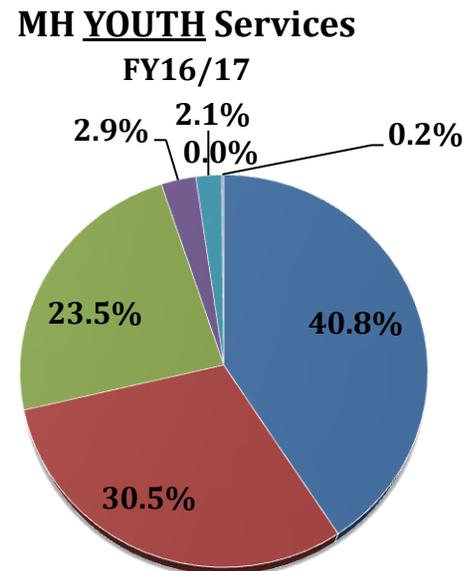
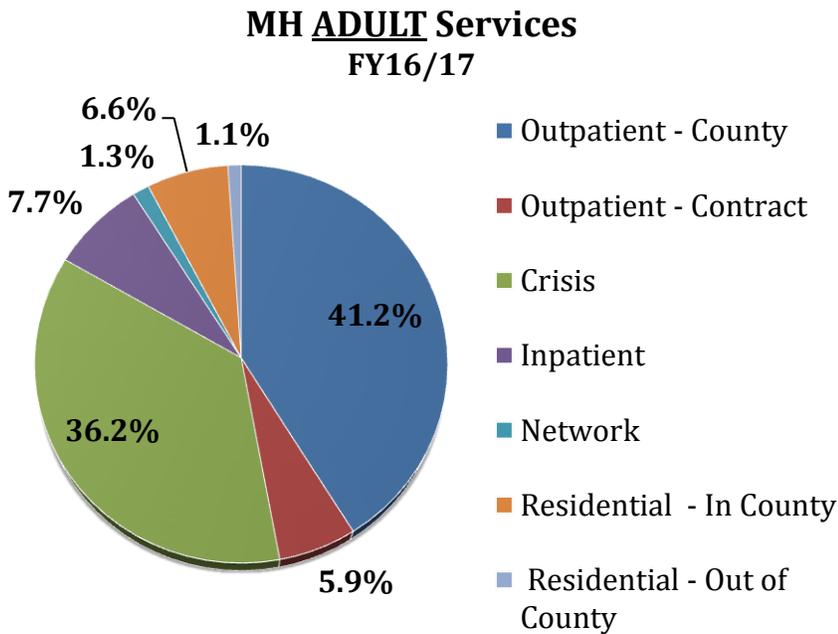
Alcohol & Drug Programs (ADP)

Behavioral Wellness contracts with community based organizations to deliver alcohol and other drug prevention and treatment services. Nearly all adult substance abuse treatment services are provided in outpatient settings, almost a third (28%) of which are outpatient Narcotic Treatment Program (methadone) services. Ten percent (10%) are social model detoxification services. Finally, all youth substance abuse treatment services are provided in outpatient settings.



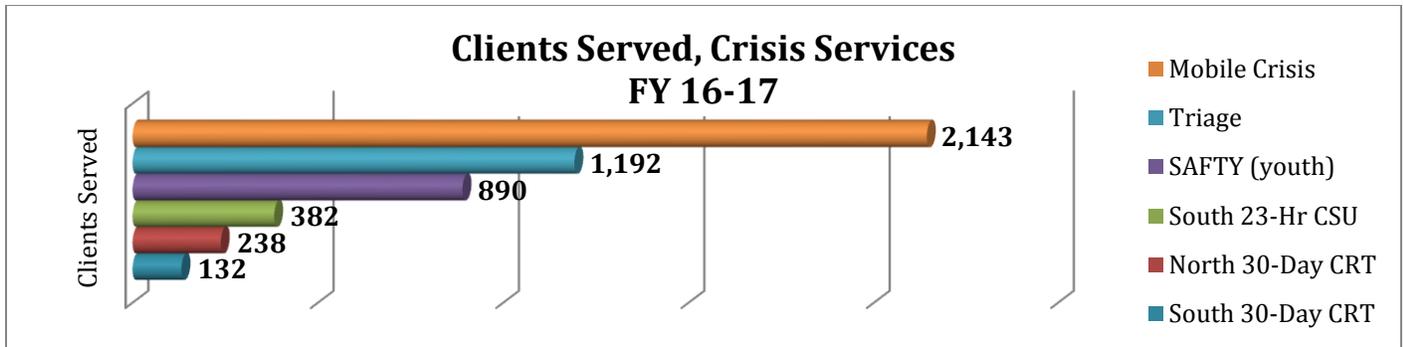
Mental Health System

As can be seen in the pie charts below, 41% of mental health services, for both adults and youth are delivered by the county, in outpatient settings. There are few (6%) contracted outpatient services for adults, while nearly a third (30.5%) of all youth services are provided by contracted outpatient providers. Adults have a greater proportion of community-based crisis care (36.2%) than do youth (23.5%)

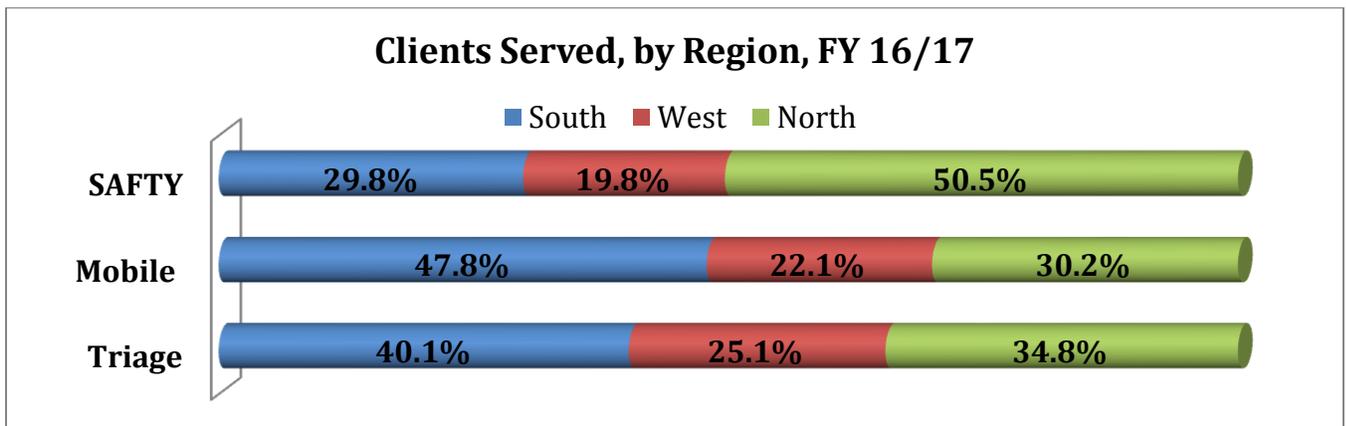


Adult - Clients: 8,569; Admissions: 13,885

Youth - Clients: 3,580; Admissions: 4,491



Crisis Triage and Mobile services are similarly distributed (utilized) throughout the county, while youth SAFTY services are more concentrated (50.5%) in the North.



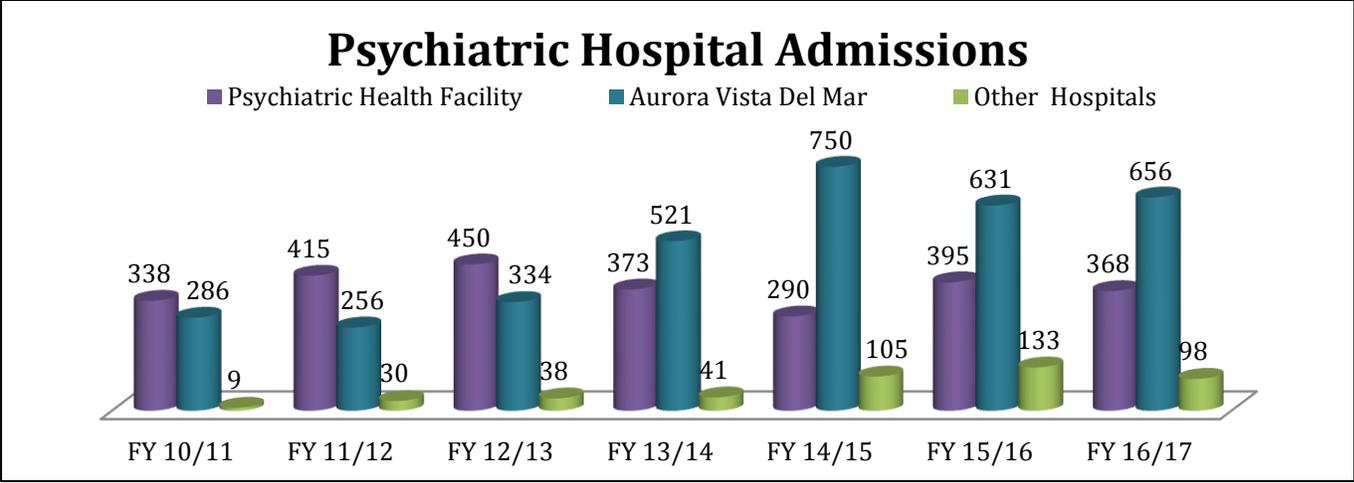
Crisis programs were evaluated by the University of California, Santa Barbara, and the Department of Behavioral Wellness; they were successful in stabilizing clients and preventing hospitalizations:

- ✓ **99%** of clients served by the **Crisis Stabilization Unit** were stabilized - did not need hospitalization - within 24 hours of discharge.
- ✓ **86%** of clients discharged from the **Crisis Stabilization Unit** were stabilized –did not need hospitalization - within 30 days of discharge.
- ✓ **85%** of clients served by the **Crisis Residential** Programs were stabilized - did not need hospitalization -within 30 days of discharge.

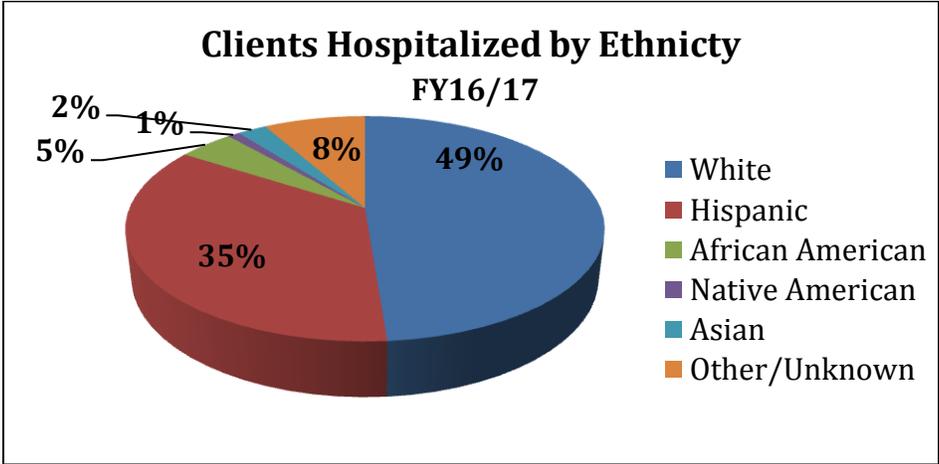
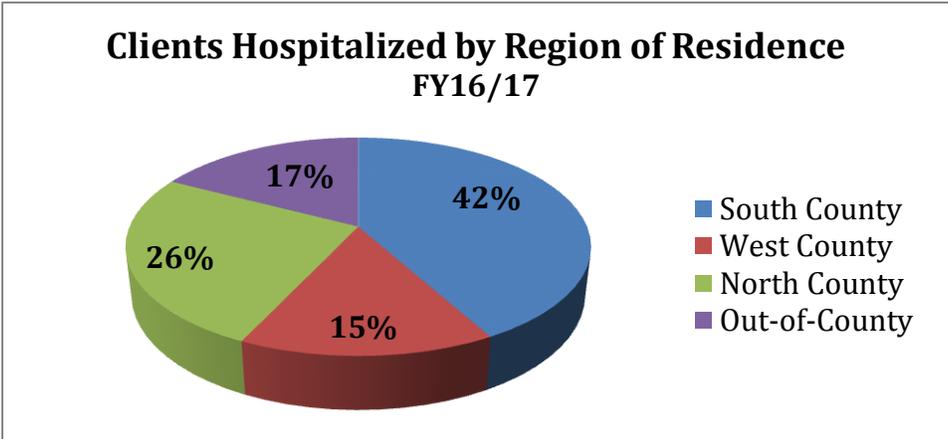
Inpatient Utilization

Behavioral Wellness monitors inpatient services closely in order to assess and address utilization, client care and financial impact. The department routinely tracks: the number of inpatient psychiatric hospital admissions¹ by age group, ethnicity and region of the county. Hospital admission data are available for the County’s Psychiatric Health Facility and all other out-of-county hospitals that report admissions to the department. As is evident below, acute inpatient hospital admissions were steadily increasing for several years, much of which was attributed to increased court-mandated defendants who were declared, “incompetent to stand trial”.

¹ The Department monitors psychiatric hospital admissions for clients open to the department and Medi-Cal beneficiaries that become hospitalized prior to admission to Behavioral Wellness



The largest percentage (42%) of clients hospitalized lived in South County. Most (66.2%) were adults aged 26-64, followed by another 24% that were TAY (16-25); only 10% were under 15 and over 65 years of age. About half (49%) of hospitalized clients were White and a third (35%) were Hispanic.



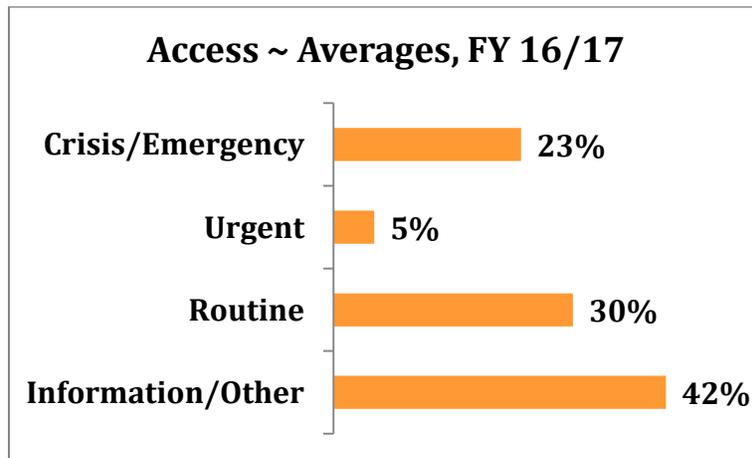
Timeliness of Care

In adherence with regulatory requirements, and to support system improvement efforts, Behavioral Wellness monitors numerous metrics related to timeliness of care. Ensuring that clients discharged from hospitals, for example, are connected to outpatient services, is an important component of continuity of care and reducing hospital readmissions. Likewise, responding in a timely manner to Access Line calls, particularly those designated as *crisis* or *urgent*, can help stabilize clients, meet their mental health needs and aid in avoiding hospitalization.

Access

In FY15/16, the Department recognized the opportunity to improve the functioning of the Access line and the accuracy of data collection. The electronic data collection form was revamped and improved and in October of 2016, Access staffing was centralized within Quality Care Management (QCM). By the fourth quarter of FY 16/17, there was an **average of 736 Access call/entries per month**.

Access calls/entries are categorized as follows: “Crisis” calls/clients are defined as those who are at immediate risk of hospitalization (because they pose a danger to themselves or another) – 23.4% in FY 16/17. “Urgent” calls/clients are defined as those who, without assistance, would likely need inpatient hospitalization within 24 hours – 5.1%. “Routine” calls/clients are defined as those who are neither crisis nor urgent, but rather are seeking outpatient services – 30%. Finally, the largest percentage of calls, 42%, are for “information only” or “other”.



Timeliness, from contact with the 24-hour Access Line to services, serves as a critical set of metrics for the Department. It is important to note that the Access Line structure, staffing and data collection tools recently changed (October 2016), and that the State changed reporting requirements and regulations. Therefore, this year’s data is not comparable to previous years.

The Access data reflect the challenges of implementing system changes, and as we would expect, improved throughout the year, as is evident below. It is expected that these indicators will continue to improve as the Department further refines data collection tools and processes.

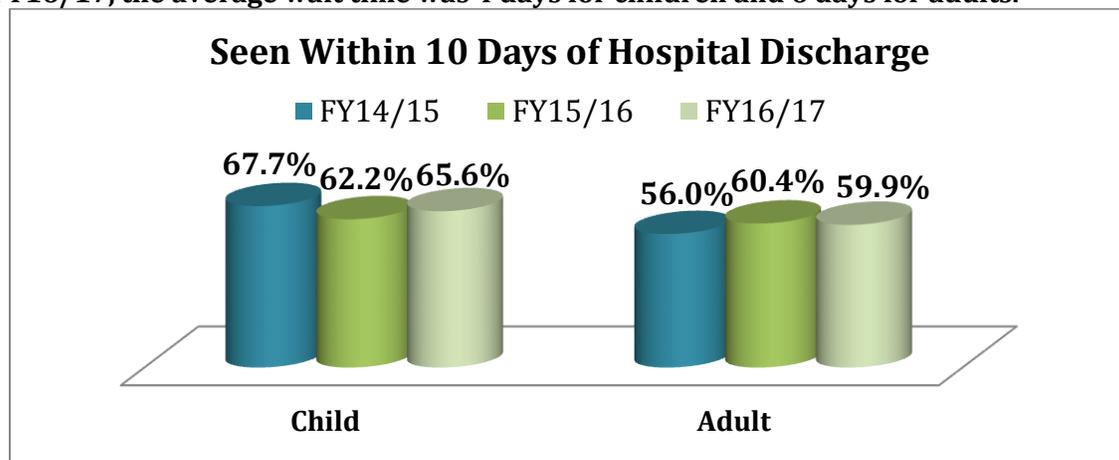
Access: Offered and Attended

		Q2	Q3	Q4
Routine	offered an appointment within 14 days	86.2%	97.7%	98.5%
	<i>had an appointment within 14 days</i>	<i>0.0%</i>	<i>53.4%</i>	<i>79.4%</i>
Urgent	offered an appointment within 24 hours	20.0%	77.8%	85.7%
	<i>had an appointment within 24 hours</i>	<i>0.0%</i>	<i>55.6%</i>	<i>78.6%</i>
Crisis	offered an appointment within 24 hours	0.0%	84.6%	95.7%
	<i>had an appointment within 24 hours</i>	<i>0.0%</i>	<i>69.2%</i>	<i>69.6%</i>

Hospital Discharge - Aftercare

Behavioral Wellness tracks the percent of clients receiving a Specialty Mental Health Service (SMHS) after a psychiatric hospital discharge. As can be seen below, the percentage of clients that have their first SMHS within 10 days, has remained relatively stable. Changes from year to year have been small (under 5%) for both children and adults

In FY16/17, the average wait time was 4 days for children and 6 days for adults.



Psychiatry

Due to limited resources, psychiatric appointments must be prioritized. For example, adults with urgent medication needs are seen more quickly than routine appointments. Similarly, children with urgent needs are scheduled with a psychiatrist after an assessment, whereas other children might have several therapeutic sessions before they are referred to a psychiatrist (and some may never need to see a psychiatrist). From the point of referral to psychiatry:

- On average, **65%** of clients were **offered** an appointment with a **Psychiatrist/MD within 15 days**, 64.8% of adults, and 64.9% of children
- On average, nearly **70%** of clients **attended** their **psychiatric/MD appointment within 15 days**, 63% of adults, and 73% of children
- The **average wait time to Psychiatry/MD is improving**: it was **28 days**, compared to an average wait time of 38 days in 15/16. This represents a **26% improvement**.

Psychiatric Referral to Scheduled Appointment: Q4

	Adult	Child
<i><=15 days</i>	65%	56%
<i>> than 15 days</i>	25%	34%

Children's Outcomes

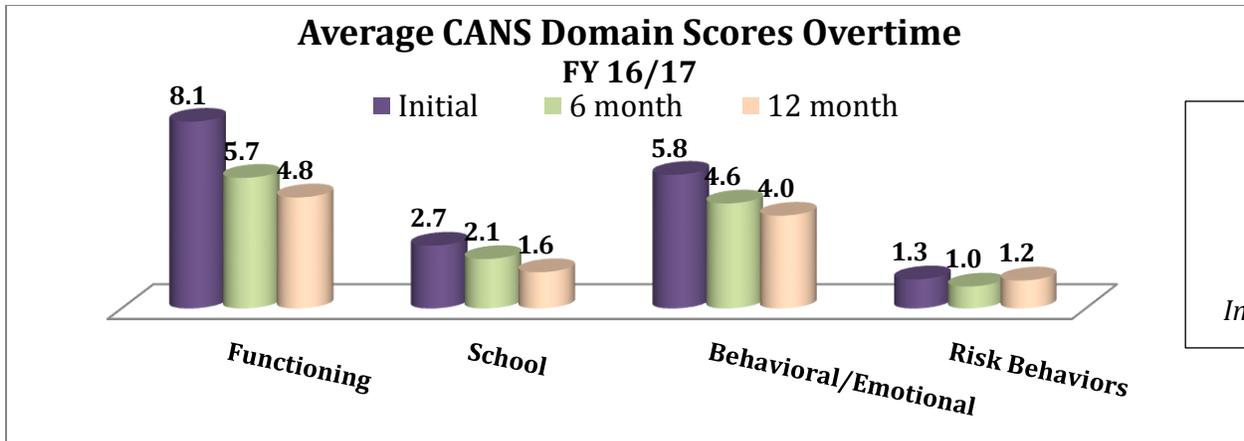
Child and Adolescent Needs and Strengths (CANS)

The CANS is a multi-purpose tool developed for children's service professionals to identify current needs and strengths of the child and family, to support treatment planning, facilitate quality improvement and to monitor outcomes. The CANS is scored from zero (no evidence of a problem/well developed strength) to three (immediate or intensive action needed/no strength identified). Therefore, improvement on the CANS is indicated by a decrease in scores. The CANS is organized into six primary domains: 1) Life Functioning, 2) Risk Behaviors, 3) Child Strengths, 4) School, 5) Behavioral/Emotional Needs, and 6) Caregiver Needs & Strengths.

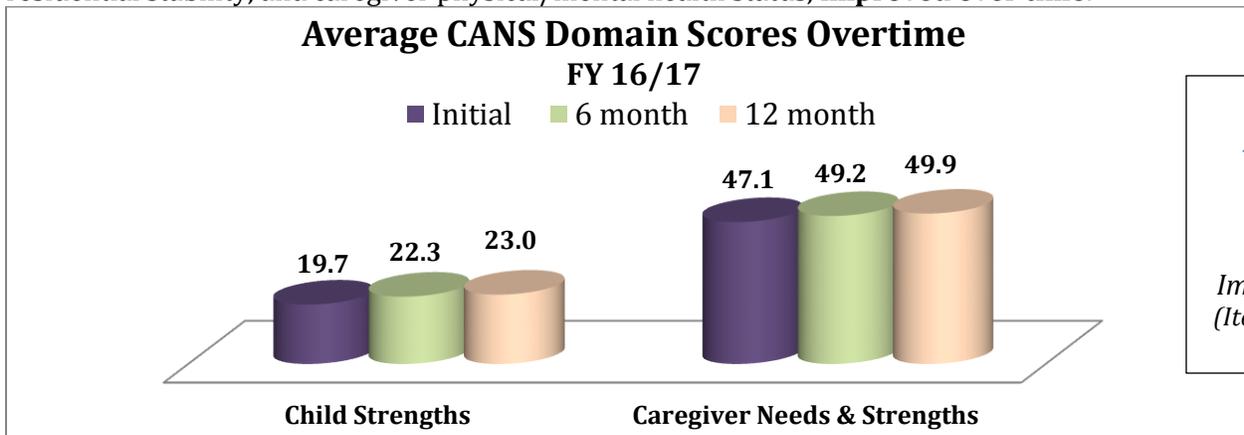
These analyses include only clients who were new, and therefore had their initial CANS in FY 16/17 (N=43) so that we could assess problems and functioning concerns prior to receiving treatment, and changes in these same areas after 6 and 12 month of receiving services. The chart below displays the average CANS scores for clients with an initial, 6-month and 12-month CANS. A reduction in the average scores on the four domains indicates that children have made progress in treatment and reduced the severity of their needs, distress and challenges. The data indicate that **children improve**² between both the initial CANS and 6-month CANS and the subsequent 12-month CANS.

- Behavioral/Emotional Needs were reduced, suggesting that clients had fewer symptoms of depression, anxiety, psychosis and other conditions.
- Children showed improvement in Life Functioning, such as ability to communicate/interact with their families, communication, and social functioning and health status.
- There was a reduction in Child Risk Behaviors, indicating that children are stabilizing and displaying fewer behaviors such as self-injury/suicide, bullying, running away and delinquent behavior.
- School behavior, attendance and grades also improved.

² Children enrolled in services prior to CANS implementation also had the CANS completed over multiple six month periods. This data (n=190) was examined separately from children new to care (n=43) who had a true baseline score, and similar improvement in functioning and strengths was seen over time.



Responses to the items in the Child Strengths and Caregiver Needs & Strengths domains were reverse scored to demonstrate improvement over time. **Child Strengths** such as optimism, relationship permanence, talents/interests, and involvement in treatment, **improved over time**. Likewise, **Caregiver Needs & Strengths** such as child supervision skills, family stress levels, residential stability, and caregiver physical/mental health status, **improved over time**.



Adult Mental Health Outcomes

Milestones of Recovery Scale (MORS)

The MORS is an 8-item tool for identifying stage of recovery. The MORS can be used to assign clients to appropriate levels of care, based on a person-centered assessment of where they are in their recovery process, and can also be used to measure progress towards recovery. Scores of 1-3 indicate extreme risk to high risk; 4-5 indicate poor coping; and, 6-8 indicate coping/rehabilitating and early or advanced recovery.

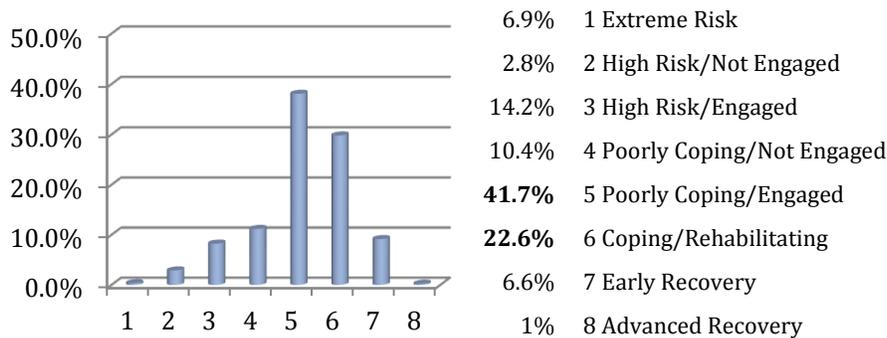
Risk/Need	MORS Scale
Highest	1 Extreme Risk
	2 High Risk / Not Engaged
	3 High Risk / Engaged
Moderate	4 Poorly Coping / Not Engaged
	5 Poorly Coping / Engaged
Least	6 Coping / Rehabilitating
	7 Early Recovery
	8 Advanced Recovery

Improvement on the MORS (higher number) indicates that clients have increased their level of engagement, coping skills and stage of recovery. Decreased scores indicate that clients have not improved and are less engaged (at increased risk). Results of MORS data analyses are reported here, separately, for Transitional Age Youth (TAY) programs, Adult Outpatient and Assertive Community Treatment (ACT). TAY and adult outpatient MORS are administered every 6 months, while adult FP/ACT clients are administered monthly. These analyses include clients with open admissions in FY 2016/17, who had an intake/baseline MORS as well as MORS scores at 6 and 12-months.

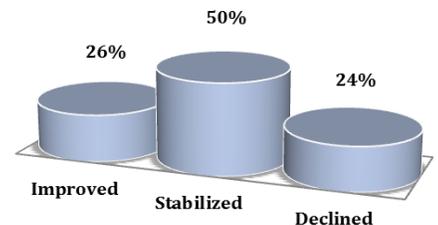
Transitional Age Youth Programs

Of all open TAY clients (N=308), 93.5 % had a baseline MORS score (N=288). Of those, about two-thirds (64%) had a baseline MORS score of five or six – poorly coping and engaged to coping and rehabilitating. About a quarter (26%) of TAY clients improved between MORS assessments – that is, over time - another 50% stabilized (no change in score) and 24% of clients declined over time (N=214). Thus, three-quarters (76%) improved or stabilized.

TAY Baseline MORS



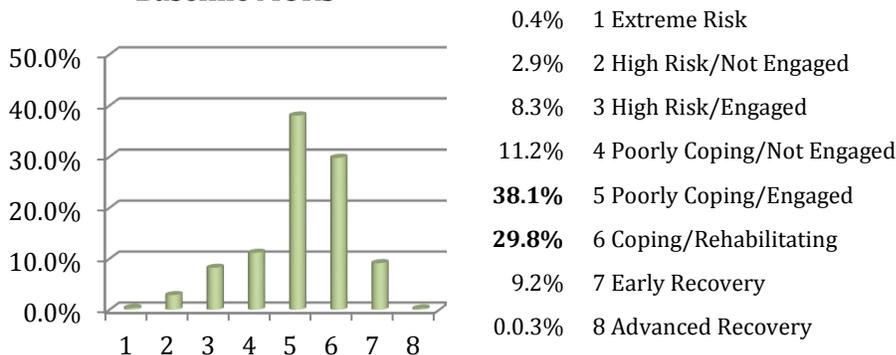
TAY MORS Scores (Baseline, 6 & 12 months)



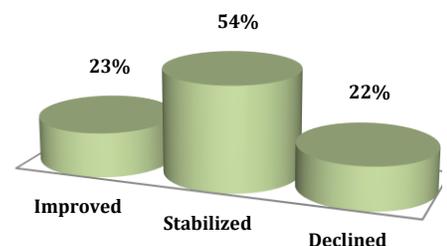
Adult Outpatient Programs

Of all open adult outpatient clients (N=3,042), 65% had a baseline MORS score (N=1,975). Of those, the vast majority (68%) had a baseline MORS score of five or six – poorly coping and engaged to coping and rehabilitating. The graph below displays changes in MORS scores over time; that is, at baseline, 6 and 12 months. About a quarter (23%) of clients improved over time, slightly more than half (54%) stabilized, and 22% declined. Thus, almost 80% of clients improved or stabilized.

Adult Outpatient Baseline MORS

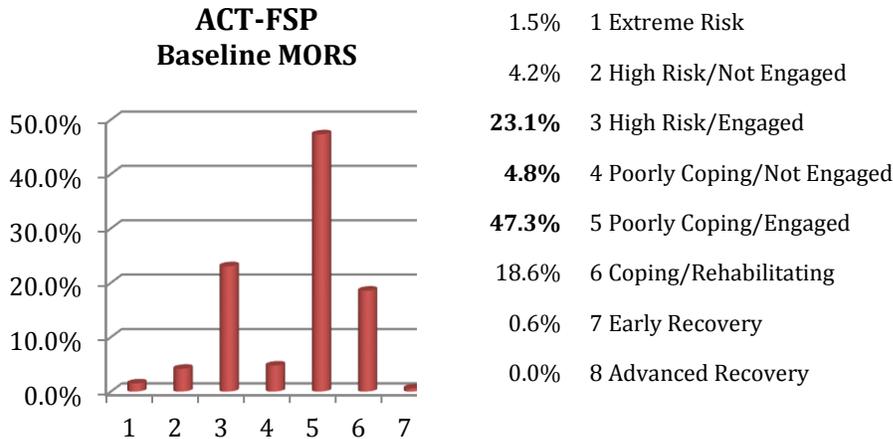


Adult Out-P MORS Scores (Baseline, 6 & 12 months)

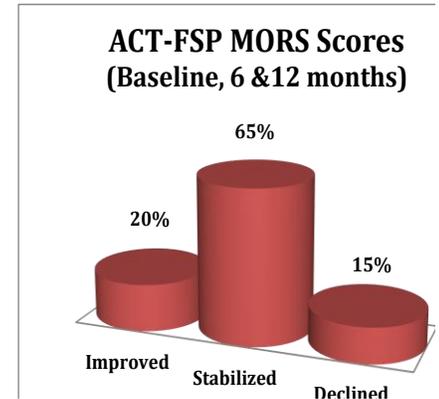


Assertive Community Treatment Programs

Of all open Assertive Community Treatment (ACT) program clients (N=337) 99% had a baseline MORS score (N=334). As we might expect, the vast majority (75%) had a baseline MORS score of three to five. These baseline scores are lower than TAY and other adult outpatient clients, as would be expected. The graph below displays changes in MORS scores over time. Twenty percent (20%) of clients improved over time, and 65% were stabilized and 15% declined. Thus, 85% improved or stabilized.

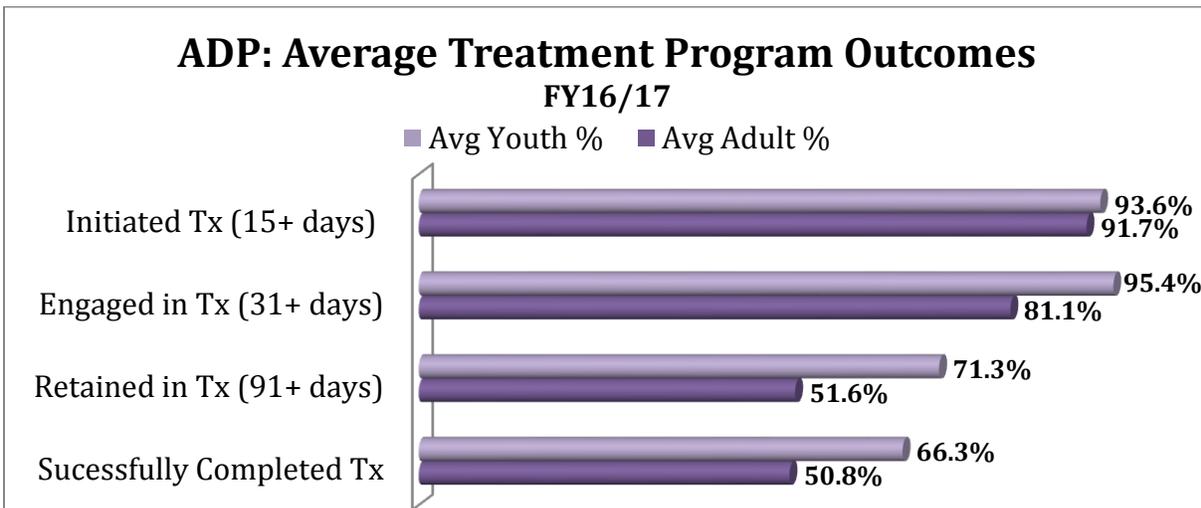


- 1.5% 1 Extreme Risk
- 4.2% 2 High Risk/Not Engaged
- 23.1% 3 High Risk/Engaged
- 4.8% 4 Poorly Coping/Not Engaged
- 47.3% 5 Poorly Coping/Engaged
- 18.6% 6 Coping/Rehabilitating
- 0.6% 7 Early Recovery
- 0.0% 8 Advanced Recovery



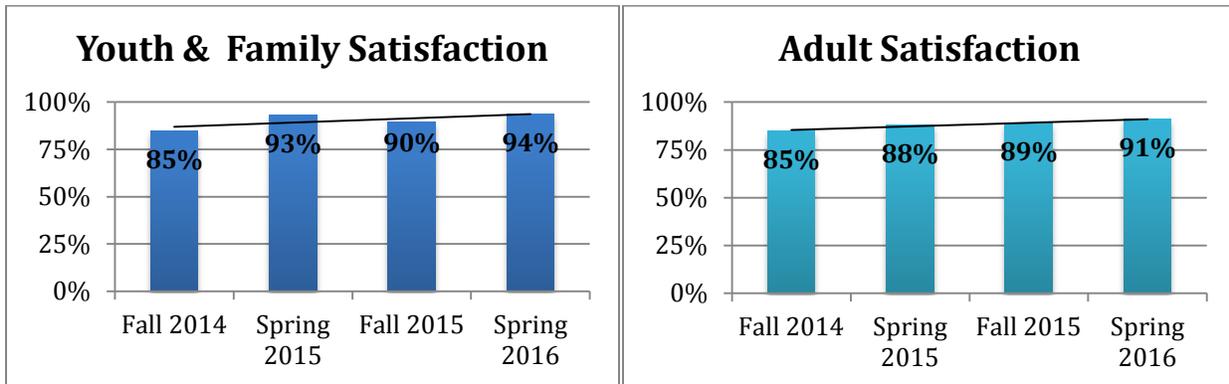
ADP

“Initiation” in treatment includes, of all clients served, those who received more than two weeks of treatment services. “Engagement” in treatment includes, of all clients discharged, those that remained in treatment for more than one month. “Retained” in treatment includes, of all clients discharged, those that remained in treatment for more than three months. “Successful Completion” of treatment includes, of all clients discharged, those who completed treatment, with or without being referred to another program. Successful “completion” can include leaving before treatment completion, if satisfactory progress was being made. Note: all ADP services are delivered by CBOs (not civil service staff).



CPS – Client Satisfaction

The Consumer Perception Survey is administered to a sample of outpatient mental health (not ADP) clients in May and November of every year, including clients served in County operated programs and those served by our community based partners. There are separate, but similar, surveys given to adults, older adults, youth and their parents/guardians. Clients report on their satisfaction with services. The graphs below indicate the percent of clients who **agree to strongly agree** that, “Overall, I am satisfied with the services I received,” or “I like the services that I receive here”.



Productivity

The Department designed a new report for managers and supervisors in order to help them monitor and support higher levels of staff productivity. Data are drawn from employee’s timesheets and the report provides both the number and percentage of hours recorded on different types of activities, such as time spent in trainings, meetings and providing services. The total is the sum of non-billable, billable, training and meeting hours. The total average documented productive time for staff of outpatient clinics was 46%; for Crisis/Triage staff, it was 28%. Note: crisis numbers are expected to be lower since their work is responsive to demand, not scheduled, as in outpatient settings.

Documented Productive Time

	% Meetings & Training	% Billable & Non-Billable Services	% Total
Outpatient Clinics	13%	33%	46%
Crisis/Triage Services:	8%	20%	28%

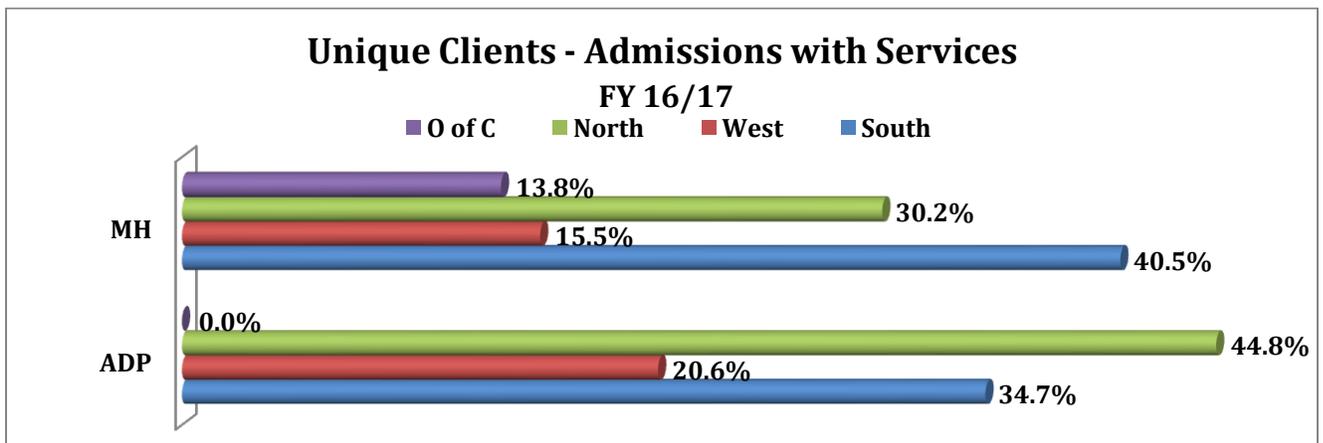
Clients Served

The volume of clients that the Department is able to serve in any given year is an important indicator of productivity and performance. As can be seen in the table below, the Department served nearly fourteen thousand (13,884) unique clients in FY 16/17.

Unique Clients - Admissions with Services

	South	West	North	O of C	Total
ADP	1,210	717	1,562	0	3,489
MH	4,215	1,607	3,142	1,431	10,395
Total	5,425	2,324	4,704	1,431	13,884

While there weren't any ADP services delivered out of county (O of C), almost fourteen percent (13.8%) of Mental Health services were delivered out of county (such as inpatient or mobile crisis services). The largest proportion of mental health services (40.5%) were delivered in South County, while the largest proportion of ADP services (44.8%) were delivered in North County.



Current Treatment Plans

An important indicator of our performance as a system is the extent to which we have current clinical treatment/care plans for clients. As part of Quality Improvement (QI) efforts, reports were developed to monitor this indicator, and staff has been using this data to update and complete treatment plans as required. Since implementing these reports and training staff in their use, completion rates have steadily improved. At the end of the 2016/2017 fiscal year, treatment plans were current for 88% percent of clients and showed improvement from the prior year.

