PROGRAM INFORMATION:

Program Title:	Supervised Overnight Stay-SOS	**Provider:**	WestCare California, Inc.
Program Description:	An overnight stay program for adult/older adult mental health clients discharged from local hospital emergency departments and 5150 designated facilities. The program provides overnight stay, clinical response, peer support, and discharge services. Transportation to programs is a key component in successful linkages.	**MHP Work Plan:**	1–Behavioral Health Integrated Access
Age Group Served 1:	ADULT	**Dates Of Operation:**	July 22, 2012-Present
Age Group Served 2:	OLDER ADULT	**Reporting Period:**	July 1, 2015 - June 30, 2016
Funding Source 1:	Innovations (MHSA)	**Funding Source 3:**	Choose an item.
Funding Source 2:	Choose an item.	**Other Funding:**	Click here to enter text.

FISCAL INFORMATION:

Program Budget Amount:	$819,090	**Program Actual Amount:**	$768,267.41
Number of Unique Clients Served During Time Period:	687		
Number of Services Rendered During Time Period:	6,263		
Actual Cost Per Client:	$1,118.29		

SOS provided a total of 6263 activities for consumers. Activities are displayed in two categories. Category One (3358 services) includes intake activities performed by Personal Service Coordinators and Peer Support Specialists. Category Two (2905 services) includes various support activities provided by case managers in efforts to get consumers linked to appropriate mental health services.

Contact attempts involve field visits and outreach efforts, coordination with other mental health providers, Fresno County Jail inmate locater and extended family contact when that information is known. These numbers are lower than expected because of identified data training and input errors that resulted from staff turnover and other system issues. Outcomes were not affected by these issues and remain relatively stable overall from previous reporting periods.

CONTRACT INFORMATION:

Program Type: Contract-Operated
Contract Term: July 1, 2012-June 30, 2017

Type of Program: Other, please specify below
For Other: Case Management
Renewal Date: July 1, 2017

Level of Care Information Age 18 & Over: Choose an item.

Level of Care Information Age 0- 17: Choose an item.

The Overnight Stay Facility Provides after hours overnight stay services, clinical response services, peer support services, discharge services, transportation and linkage to appropriate mental health programs to adults and older adults who are deemed appropriate for the Overnight Stay Facility pursuant to discharge from designated hospital emergency departments/designated 5150 facilities.

TARGET POPULATION INFORMATION:

Target Population: Adult and older adult consumers receiving services from Fresno County local hospital emergency departments (ED)/designated 5150 facilities who are discharged to the Overnight Stay Facility upon the ED/designated 5150 facility determination that a higher level of care is not necessary, and linkage to outpatient and related services are required.

MHSA CORE CONCEPTS:

Please select MHSA core concepts embedded in services/ program:
(May select more than one)

Integrated Service Experience

Client/Family Driven Program

Community Collaboration

Choose an item.

Please describe how the selected concept (s) embedded :

Case management services endeavor to link consumers to needed mental-health services as well as other resources needed to stabilize them; case managers look at whole person and attempt to integrate all services necessary to support client, keeping in mind the consumer's strengths, needs and preferences in linkage activities. Key to these efforts is strong collaboration with mental health treatment agencies to get consumers connected to ongoing support.

PROGRAM OUTCOME GOALS:

I.Track response time to emergency departments
II. Track time to place consumers at SOS
III. Monitor recidivism to emergency department/5150/Psychiatric facilities
IV. Track linkage successes and challenges
V. Track follow up and case-management contacts with consumers
VI. Track clinical outcomes by discharge status
VII. Survey customer satisfaction
VIII. Identify services provided to consumers

PROGRAM OUTCOME DATA/INDICATORS:

I. FY 2015-16 average response time from SOS facility to emergency department is *16.2 minutes* well below the expected goal of 30 minutes

II. FY 2015-16 average time from arrival at ED/5150 facility to departure to SOS facility was *16.4 minutes*; consistent with the time it take to secure consent from the client to be transported as well as discharge information from hospital staff.

III. Data show 723 discharges for FY 2015-16. Consumers are tracked from intake forward 90 days for revisits to the emergency room and/or subsequent hospitalizations. Data presented here are limited to information available in Avatar and does not, as a result, include repeat visits to CRMC. Data presented is data for revisits to Exodus only and/or other facilities when consumers subsequently returned to SOS for another overnight stay.

As reported in Avatar, 298 unique persons or 43.4% had no identifiable return visits to Exodus during the time of involvement in the SOS Program. 172 persons (23.8 %) had one recorded return visit. And 57 (8.3%) had two visits to Exodus. This suggests that 76% of persons who were served by SOS did not have excessive repeat visits to the 5150 evaluation facility. Thirty-seven (37) of 687 consumers or 5.4%, had five or more visits return visits and less than one (0.89) percent of consumers had 10 or more return visits to the ED. Of course, this data is to be interpreted cautiously as there is no information available for those consumers presenting at CRMC, St. Agnes and other area emergency departments. It should be noted that this data is consistent with CY2014 data in all regards and neither shows an increase or a decrease of any significance.

IV. Successes: Thirty-eight percent of individuals were successfully linked with one or more mental health services and more than 28% of persons discharged were actively participating in a mental health service at time of discharge. While the percentage of persons linked to services remained static overall, those who were successfully linked and known to be active at time of discharge increased by three percentage points.

Challenges: Because at least 75% of consumers served by SOS are homeless, follow-up contact is very difficult and many consumers get lost until the next visit to the ED or 5150 facility. Keeping consumers engaged in services is also a challenge, and once linkages have been made contact with SOS is less intensive as responsibility for engagement shifts to the mental health provider.
Three hundred fifty-eight (358) recorded linkages were made for consumers during FY 2015-16. This number is consistent with data from CY 2014 in which 384 linkages were recorded. These linkages represent ONLY mental health linkages. The SOS case managers also routinely link consumers to housing, SSI, DSS, physical health providers, payee services, DMV and the like. These additional

linkages are necessary to obtaining other necessary services that may help promote mental health stabilization. The table below identifies mental health linkages, but cannot capture much of the anecdotal stories of consumers with multiple ED contacts who by virtue of SOS persistence in case management demonstrate a reduction in ED visits and successful transitions into ongoing mental health care despite a history of treatment failure.

V. Data for YTD 2015 show that only 2210 activities were logged by case managers in efforts to get consumers linked to on-going mental health services after initial orientation and intake. This number is likely impacted (lower than expected) due to data training and input errors resulting from case manager turnover and other system challenges. These have been identified and are being addressed internally.

VI. Clinical Outcome 1: Thirty eight percent (277) of consumers were linked to services

Clinical Outcome 2: Those consumers *successfully linked and active at discharge* (205) exhibit the following characteristics: they are linked to an identifiably appropriate mental health service; they are able to take an active role in their services, hospitalizations are minimized and returns to the ED are minimal; homeless consumers have been able to take advantage of housing opportunities.

Clinical Outcome 3: Consumers *linked but not active at discharge* (72) exhibit the following clinical outcomes; they are linked to an appropriate individual mental health service, they are familiarized with the range of options available to them; when stabilized homeless consumers can take advantage of housing opportunities and they are offered further supportive services should linkages fail.

Clinical Outcome 4: Consumers who *declined further services* (192) exhibit the following characteristics: they do not consider themselves to be mentally ill or in need of services; they exhibit a high level of denial and poor insight and many have co-occurring substance use disorders they are unwilling to address. They tend to recidivate to area ED/5150 facilities when experiencing a transient crisis.

Clinical Outcome 5: Consumers who cannot be contacted (185) represent 26% of all consumers and exhibit the following characteristics: high levels of denial and poor insight, mostly homeless, are in a constant state of transition and avoid services, except when in a transient crisis; these consumers are more likely to recidivate to are ED/5150 facilities.

Clinical Outcome 6: Those consumers who are identified as *primary substance abusers* in need of linkage to residential and/or outpatient substance use services (30) represent only 4.2% of consumers served at SOS, though co-occurring mental health disorders are highly prevalent across the board for SOS consumers (about 80%). During FY 2015-16, a total of 28 persons with substance abuse disorders were linked directly to substance abuse services, primarily residential. In many cases consumers were also linked to Full Service Partnerships and provided care coordination services to effectively bridge the two service systems.

VII. After revision of intake and completion surveys and approval from DBH, survey collection commenced. One hundred thirteen

(113) and ninety (90) completion surveys were completed by consumers. More robust collection was impeded at intake by overall consumer distress and impairment and at discharge when consumers refuse services and/or are lost to follow-up. Still, for those who completed services, satisfaction with SOS is very high and comments suggest that consumers experience the program staff as hospitable, compassionate and sensitive to their needs. In excess of 90% of surveys are highly positive about the services that were provided. The summary of intake and completion survey data is attached to this report.

VIII. Six hundred and eighty-seven unique (687) persons received services for FY 2015-16, an increase of seventy-one (71) consumers from FY 2014-15. This is consistent with expectations for higher program utilization when program became staffed on a 24 hour basis in January 2015.

One hundred eight-six persons (186) had return visits to SOS during their service episode. This represents 28% of unique consumers served. A revisit occurs when a consumer open to SOS case management returns to Exodus or an ED and is referred for another overnight stay. Most of those who returned to SOS (55%) only had one revisit while receiving SOS services, 23% had 32-3 revisits, and 19% had between 4 and 10 revisits. Six individuals, however, came back to SOS after visiting Exodus, the EDs and/or a hospitalization 10 more times. These six persons (3% of total unique consumers) represent 41% of the revisits (77). Most are homeless and co-occurring, refuse further services or have poor follow through after being linked to a mental health service.

In January 2016 SOS began tracking consumers who were showing in Avatar as linked to a mental health program already when presenting to SOS at intake. Since that date 105 (26%) of 409 referrals to SOS involve consumers who are presumably linked at intake. Forty-seven (47) percent were reportedly linked to an FSP; MHS Impact, TP Vista or TP TAY) and 31% were reportedly linked to Fresno County services (Metro, UCWC or Older Adult). Case managers often discovered that these consumers were linked in Avatar only, weren't actively participating, and were "lost" to the provider and/or homeless. This was especially true in the FSPs. Many of the Metro consumers were receiving "medication only" services and no other type of service.

DEPARTMENT RECOMMENDATION(S):

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