BEHAVIORAL HEALTH ADVISORY BOARD
EXECUTIVE COMMITTEE (VIRTUAL MEETING VIA ZOOM)
MINUTES ▪ Monday, June 14, 2021

BHAB Officers Present	Ventura County Behavioral Health (VCBH) Staff Present
Jerry Harris, Chair Ratan Bhavnani, 1st Vice Chair Joe S. Ramirez, 2nd Vice Chair Michael Rodriguez, Member-At-Large Janis Gardner, Chair Emeritus	Dr. Sevet Johnson, Director Cynthia Salas, Equity Services Manager – Office of Health Equity & Cultural Diversity Dr. John Schipper, Adult Services Division Chief Vickie Poliquin, Temporary BHAB Assistant
Others Present Gane Brooking, BHAB Jason Canger, County Counsel Vannessa Cortez, Pacific Clinics Cindy Doutt, Telecare Roberta Griego, NAMI Ventura County Maya Lazos, Vista del Mar Hospital Jennifer Morrison, BHAB Chris Ridge, Ventura County Office of Education Carolina Rodriguez, Homeland Language Services Mark Stadler, Crisis Intervention Team Scott Walker, Crisis Intervention Team Liz Warren, Client Network Barry Zimmerman, Health Care Agency	NEXT MEETING: Monday, July 12, 2021, 1:00 – 2:30 p.m. Virtual Meeting Via Zoom

Note: The committee has not yet approved these minutes. There may be additions/deletions or corrections before the minutes are accepted in final form.

	DISCUSSION/CONCLUSIONS	RECOMMENDATIONS/ ACTIONS	RESPONSIBLE
I.	**Call to Order** Chair Harris called the meeting to order at 1:00 PM and explained changes to the way that meeting participants can make public comments noting that all meeting participants, except BHAB members, are muted for the duration of the meeting and are unmuted and recognized when their hands are raised for public comment periods only. Spanish interpreter, Carolina Rodriguez, provided instructions on how to access the Spanish interpretation of the meeting and urged attendees to speak at a moderate pace to assist with her ability to provide simultaneous translation during the meeting.		
II.	**Roll Call – Board Executive Committee Attendees** Chair Harris confirmed that a quorum exists through roll call.		
III.	**Approval of the Agenda** Mr. Harris asked for a motion to approve the agenda. Ms. Gardner moved to approve the agenda as written; Mr. Rodriguez seconded. The motion carried unanimously through roll call.	The agenda was approved as written. **M/S/C**	
IV.	**Approval of the Minutes** Mr. Harris asked for a motion to approve the May 10, 2021, minutes. Mr. Bhavnani moved to approve the minutes; Ms. Gardner seconded. The motion carried unanimously through roll call.	The minutes were approved as written. **M/S/C**	
V.	**Welcome and Introductions** Mr. Harris welcomed everyone from the community, VCBH staff and members of the Executive Committee.		
VI.	**Public Comments** • Liz Warren thanked Chair Harris for sending out information about how to make public comments and asked whether Dr. Johnson is allows to respond to public comments. Mr. Harris provided information about VCBH's current system used to follow-up on public comments and Dr. Johnson provided further clarity of the internal follow-up process noting that responding to public comments could violate HIPAA privacy laws.		

	DISCUSSION/CONCLUSIONS	RECOMMENDATIONS/ ACTIONS	RESPONSIBLE
VII.	**Chair Comments and Announcements** • Mr. Harris noted that he will address items on the Board of Supervisor's June 22 agenda at 1:00 PM related to the BHAB's Annual Report and Lanterman, Petris, Short (LPS) Reform Workgroup Report. • Noted he changed his decision to decline the nomination for Chair Emeritus. • Advised that he was recently contacted by a reporter asking questions about a budget request to increase beds at the Inpatient Psychiatric Unit (IPU).		
VIII.	**Director's Updates** • Dr. Johnson addressed Chair Harris' comments regarding the call her received from the newspaper reporter regarding the budget request information noting that she provided a thorough budget presentation to the Board of Supervisors on June 8 that did not include the expansion of ICU beds or CSU chairs because the items were not approved at that time. Dr. Johnson stated the items will be presented for voting action at the June 22 BOS as a budget amendment and will be voted on at that time. • Dr. Johnson introduced Cynthia Salas, Equity Services Manager for the office of Health Equity and Cultural Diversity who provided a detailed presentation on Logrando Bienestar. • Dr. Johnson stated that clinics have remained open for the duration of the pandemic, clients continue to be served and that Cal/OSHA requirements currently remain unchanged causing VCBH to continue to analyze safe methods to bring groups of people safely into the department. • Noted that Dr. Schipper is leading a campaign called "Knowledge is Power", with the goal of querying vulnerable populations about vaccination information and to aid with challenges that may prevent clients from being vaccinated.		
IX.	**Executive Committee Member Comments and Announcements** No comments or announcements were made.		
X.	**Secretary's Report** Mr. Harris noted that this agenda item has been deferred until July.		
XI.	**Old Business** A. VCBH Response to the Identified Gaps in Service Data Request Update Dr. Johnson confirmed that Data Elements Workgroup member names need to be provided to Dr. Schipper. B. Appoint Chair of the Data Elements Workgroup Mr. Bhavnani moved to approve confirming the appointment of Ms. Morrison as Chair of the Data Elements Workgroup at the June 21 General meeting for action; Mr. Ramirez seconded. The motion carried unanimously through roll call. C. Peer Specialist Workgroup Status/Recommendation Mr. Harris advised that Workgroup meetings were not scheduled as planned and with job specifications currently being developed through Human Resources, suggested disbanding the Workgroup. Ms. Gardner moved to approve the recommendation to disband the Peer Specialist Workgroup at the June 21 General meeting for action; Mr. Bhavnani seconded. The motion carried unanimously through roll call. D. Request to Establish BHAB Budget Details of the proposed budget line items were discussed and members of the Executive Committee provided feedback and direction. Mr. Harris noted that a revised proposed budget will be placed on the General meeting agenda for action. E. Language Interpretation Best Practices Discussion Mr. Harris noted that this item will be placed on the General meeting agenda for action. Mr. Rodriguez asked for clarification whether the Best Practices document would be	Approved appointment of Data Elements Workgroup Chair at June 21 General meeting for action. **M/S/C** Approved recommendation to disband the Peer Specialist Workgroup at the June 21 General meeting for action. **M/S/C**	

	DISCUSSION/CONCLUSIONS	RECOMMENDATIONS/ ACTIONS	RESPONSIBLE
	revised according to the understanding that interpreters would be provided with one 10-minute break, versus the use of two interpreters with no break. Mr. Harris advised that a more thorough discussion will be held at the General meeting. Cynthia Salas asked to contribute to the discussion, noting its importance, and described the nature of the interpreter's work that requires a tremendous amount of mental capacity and focus.		
XII.	**New Business** A. Evaluate May General Board Meeting to Identify Need for Improvement No comments from members of the public or the BHAB. B. New Process for Public Comments Information was previously provided under agenda item I. Mr. Bhavnani restated that BHAB members are unmuted during the meeting proceedings, however if they mute themselves, they are unable to unmute until requested to do so by the meeting host. C. Transition to New Officers – Discussion Mr. Harris noted his desire to ensure that there is a smooth transition for new BHAB officers and offered his and Mr. Bhavnani's assistance to continue with the BHAB's efforts toward its accomplishments. D. Presentation to the Board of Supervisors – June 22 Mr. Harris restated that he will address the BOS on June 22 at 1:00 PM related to the Annual Report and Lanterman, Petris, Short (LPS) Reform Workgroup Report. E. Revision to BHAB Bylaws – Discussion Mr. Harris noted that the Disparities Reduction Workgroup will make a recommendation to become a standing Committee of the BHAB at the June 21 General meeting and stated that this would be a good opportunity to re-review the Bylaws for any additional revisions. F. Alameda County Mental Health Board Recommendations to Reduce Mentally Ill Inmate Population – Discussion Mr. Harris recommended that this item along with agenda item XII.G. be jointly reviewed at the June 21 General meeting. Dr. Johnson provided feedback to Mr. Harris' comments stating that Dr. Schipper has done a great deal of work with his team using County data to estimate what the needs are throughout the crisis continuum and step-downs. Further discussion ensued regarding the need to identify whether identified gaps in service are real or perceived. Mr. Harris advised that Ms. Morrison will provide the names and noted that he is also interested in participating in the discussions. G. San Francisco Behavioral Health Bed Optimization Project – Discussion Discussion points were included in previous agenda item XII.F. H. Presentation Requests • Cynthia Salas – Logrando Bienestar –Achieving Well Being Program regarding a survey conducted by a parent group who expressed concerns regarding connecting to services. I. Recognition Award Recommendations Mr. Harris will present Certificates of Commendation for Mary Haffner and Elizabeth R. Stone at the June 21 General meeting and briefly discussed continuing to provide recognition awards to members of the community and frontline workers who are doing excellent work and deserve the recognition.		

	DISCUSSION/CONCLUSIONS	RECOMMENDATIONS/ ACTIONS	RESPONSIBLE
XIII.	**Develop Agenda for Virtual General Meeting Scheduled for June 21, 2021 at 1:00 PM** Changes were agreed upon as follows: ADD: PRESENTATION: Logrando Bienestar – Achieving Well Being Program (Survey Conducted by Parent Group) – Cynthia Salas, Equity Services Manager – Office of Health Equity and Cultural Diversity (15 min.) REMOVE: NEW BUSINESS 2.a. Transitional Age Youth (TAY) Committee – Joe S. Ramirez, Chair Mr. Rodriguez requested that New Business items 1 and 3 be moved earlier in the agenda due to schedule conflicts that could prevent him from being available for the entire meeting. Mr. Harris asked that he request the change at the General meeting under approval of the agenda and suggested that the items could be placed prior to the two presentations.		
XIV.	**Public Comments** Liz Warren: • Requested a copy of Cynthia Salas' Logrando Bienestar – Achieving Well Being PowerPoint presentation. • Asked Dr. Schipper if clients will be required to wear masks when receiving services. • Advised that the Client Network has some funding within its budget to reimburse peers and consumers for conference fees, workshop registrations and travel. • Asked the BHAB to reconsider its recommendation to disband the Peer Specialist Workgroup.		
XV.	**Adjourn** Mr. Harris expressed his appreciation and thanked the members of the Executive Committee for their work and for providing him with support over the past year as Chair. The meeting was adjourned at 2:27 PM.		

Behavioral Health Advisory Board EXECUTIVE Meeting Attendance 2020-2021

Members 2020-2021	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June
Jerry Harris Chair	X	X	X	X	X	X	X	X	X	X	X	X
Ratan Bhavnani 1st Vice Chair	X	X	X	X	X	X	X	X	X	X	X	X
Joe S. Ramirez 2nd Vice Chair	X	X		e		X	X	X		X	X	X
Mary Haffner Secretary	X	X	X	e	X	X	X	X	X			
Janis Gardner Chair Emeritus	X	X	X	X	X	X	X	X	X	X	X	X
Michael Rodriguez Member-At-Large								X	X	X	X	X

Present = X

District 1: Supervisor LaVere
District 2: Supervisor Parks
District 3: Supervisor Long
District 4: Supervisor Huber
District 5: Supervisor Ramirez

Alameda County
Mental Health Advisory Board

Contact the Mental Health Advisory Board at:

ACBH.MHBCommunications@acgov.org

Date: October 6, 2020

To: Alameda County Board of Supervisors

Re: MHAB Recommendations to Reduce the Mentally Ill Population at Santa Rita Jail

Introduction

The Alameda County Mental Health Advisory Board (MHAB), duly appointed by the Alameda County Board of Supervisors (BOS), provides these recommendations regarding actions the BOS can take to reduce the number of mentally ill individuals at Santa Rita Jail. The MHAB believes that any such actions will only be meaningful and long lasting, however, if they:

- Are based on an analysis of data that is made available to the public in an easily accessible form.[i]
- Include a multi-year timetable with specific, quantifiable goals for each action, including a 50% reduction of the number of people with serious mental illness in Santa Rita Jail within 3 years.
- Are driven by these foundational, well-established principles: 1) incarceration exacerbates mental illness; 2) mental health services are more effective, more humane and more cost-effective than jail; and 3) the current system causes many of our most vulnerable community members to be caught in a vicious cycle of jail and homelessness, without any clear path forward.

The MHAB acknowledges the complexity and multi-faceted nature of this problem and has focused its resources accordingly. MHAB members have participated in each of the Justice Involved Mental Health Taskforce (JIMHT) meetings, the MHAB has dedicated several of its meetings to the topic (including those of the full board, Criminal Justice Committee and Ad Hoc Committee), and sought out and heard the views of the public. We have synthesized everything we have learned into the following specific, prioritized recommendations, each with long-term and short-term action items.

MHAB Priority Recommendations

Recommendation #1: Significantly increase the capacity of residential treatment beds countywide to ensure that effective, humane treatment is available at all levels of need. Alameda County must invest in the expansion of treatment bed capacity to provide a robust continuum of care – from locked beds at an acute crisis facility to treatment at sub-acute facilities, crisis residential facilities and licensed board and cares – each with the capacity to provide the appropriate type and length of treatment. Unless Alameda County aggressively expands residential treatment capacity, Santa Rita Jail will remain the county's primary locked mental health treatment facility.

Long-term action item:

- The building formerly referred to as Glenn Dyer Jail should be repurposed for RESIDENTIAL LOCKED AND UNLOCKED MENTAL HEALTH TREATMENT. The building supplies adequate square footage to allow for a locked portion of the facility as well as unlocked residential capacity. Repurposing this location will reduce the NIMBY response since it was used as a jail in the past.

Short-term action items:

- The County should conduct a feasibility study for retrofitting the building formerly referred to as Glenn Dyer Jail as a locked and unlocked mental health treatment facility.
- The County should identify all vacant or underutilized county-owned buildings and properties to determine which of those could be repurposed or built upon to provide treatment at all levels of need.
- The County should support the creation and retention of licensed Board and Care facilities, including through direct subsidies.

Recommendation #2: **Prioritize the care of "high utilizers"** [ii] **of county mental health and criminal justice services to ensure that they are connected to appropriate treatment and facilities.** The JIMHT, using data supplied by Alameda County Behavioral Health (ACBH), has identified more than 900 "high utilizers" of services. These individuals cycle repeatedly in and out of acute crisis beds, jail or substance use detox facilities. The number of high utilizers has remained constant for at least 2 years.

Long-term action item:

- Create a team of Behavioral Health Care Services employees who are dedicated exclusively to "high utilizers." Rapid turnover in Community Based Organizations (CBOs) leads to a failure in a continuity of care for our most vulnerable community members. Providing a small, dedicated clinical staff modeled after the highly effective and successful Conditional Release Program managed by the Department of State Hospitals would provide the continuity of care and reduction of recidivism badly needed in Alameda County. These employees – not outside contractors or CBOs - would serve as case managers for "high utilizers" to ensure that continuity of care is provided. County employment would increase retention through payment of a living wage as well as benefits.

Short-term action item:

- Identify "high utilizers" and prioritize them for substance use disorder and mental health services within the system of care.

Recommendation #3: **Implement universal mental health and substance use disorder screening and assessment at booking into jail.** One of the most effective ways to facilitate diversion and effectively reduce the population of mentally ill people who are incarcerated at Santa Rita would be to implement a system requiring all people who are incarcerated to receive mental health screening and assessment when they are booked. Currently, people who are incarcerated receive only a health screening by BHCS employees. Universal mental health and substance use screening and assessment, ideally by a team of independent clinical staff, would allow for mentally ill people who are incarcerated to

immediately be diverted to mental health facilities, Behavioral Health and/or treatment/collaborative courts as appropriate.

Long-term action item:

- Direct ACBH to dedicate staff from the newly-funded clinical positions at Santa Rita Jail for universal mental health and substance abuse screening and assessment.

Short-term action item:

- Direct ACBH to identify appropriate screening and assessment tools.

Recommendation #4: Enhance accountability and oversight of Community Based Organizations that are in contract with the County for the provision of mental health and substance use services. The County should ensure the quality and impact of contracted mental health and substance use services by implementing an effective performance accountability system and allocating resources to support the needed infrastructure and capacity to deliver high quality services.

Long-term action item:

- Implement service agreements with CBOs that have at least some of their reimbursement tied to quantifiable performance measures.

Short-term action item:

- Direct ACBH to provide a detailed, publicly available report on the performance of CBOs and their provision of services. This report should include recidivism data after services have been provided.

Other MHAB Recommendations

The Jail:

- Direct ACBH to hire a dedicated staff person for discharge planning and coordination from the jail to outside programs.
- Direct ACBH to expand or create additional programs for the re-entry population.
- Direct ACBH to operate the Safe Landing Project 24/7 and expand its services to ensure that newly-released people who are incarcerated have transportation, particularly if they are released after public transportation has stopped operating.

ACBH:

- Direct ACBH to increase 5150 authorization to licensed social workers, psychiatrists and other mental health professionals in non-volatile situations.
- Direct ACBH to increase the capacity of existing Intensive Outpatient Programs for individuals living with serious mental illness.

The Courts:

- Direct ACBH to increase treatment and assessment capacity within the Behavioral Health Court. This would allow the Court to meet in Oakland more than once a week and also meet in another part of the county.

Conclusion

The MHAB feels that the foregoing recommendations, if implemented, would significantly reduce the number of seriously mentally ill individuals in Santa Rita Jail. We appreciate your consideration.

Sincerely,

Lee Davis

Lee Davis, MHAB Chair

L.D. Louis, MHAB Vice-Chair

[i] The following data is needed, at a minimum:

- the number of seriously mentally ill people who are incarcerated at the Jail
- the number of seriously mentally ill people in the general Alameda County population, with specific data for these people on:
  - their race, age, and gender identity
  - geographic location
  - whether they suffer from anosognosia (impaired ability to perceive one's mental illness)
- for each existing mental health facility (including those with locked and unlocked beds), how many individuals are treated
  - over what period of time,
  - the average length of stay,
  - how many people were turned away,
  - the length of the waiting list, if any, and
  - what happened to those individuals after they left the facility

This data should be compiled and publicly available on the internet on an annual basis.

[ii] In the context of JIMHTF, "high utilizer" refers to a person who has a high level of involvement in the mental health system over a "trailing" 12 month period since the last incidence as defined by: having Justice Involvement (see definition below) and 2 or more CSU i.e., John George episodes and/or having had 2 or more Cherry Hill episodes and/or having had 1 or more Inpatient episodes; or are in conservatorship.
"Justice Involved" means:

- Served by Behavioral Health Court
- Served by a court advocacy program
- Seen by the drug court
- Served by a MH AB109 Program or
- Had arrest or citation at intercept 0.

Napolitano's growing behavioral health treatment law, supported by the Los Angeles County Board of Supervisors

April 20, 2021

press release

WASHINGTON, DC – Today, the Los Angeles County Board of Supervisors moved unanimously to support Rep. Grace F. Napolitano's H.R. 2611, the Increasing Behavioral Health Treatment Act. The bill would repeal the payment ban on Medicaid Mental Illness Institutions (IMDs) and require states to submit a plan to: increase access to outpatient and community-based behavioral health care; increase the availability of crisis stabilization services; and improve data sharing and coordination between physical health, mental health and addiction treatment providers and first responders." Medicaid is the largest payer of mental health services in our country, and the expansion of this critical coverage is long overdue,"
Napolitano said. "Without patient beds, people experiencing mental health crises are often released from emergency departments and forced to deal with their illness without professional care. Tragically too often they end up in prison or on the streets, which not only worsens mental health conditions, but increases the cost of care to the state and the federal government. Providing relief from the IMD payment ban would eventually give California and other states the ability to use federal funds to cover Medicaid-eligible individuals who need behavioral health treatment. I thank the Board of Supervisors for supporting my legislation and recognizing that we must do everything we can to provide life-saving care to any resident in need." Through my motion, passed unanimously today, the Board of Supervisors will send a 5-signature letter in support of H.R. 2611, the Increasing Behavioral Health Treatment Act, introduced by Rep. Grace Napolitano,"
said Supervisor Kathryn Barger, Los Angeles County Board of Supervisors, 5th District. "This is important federal legislation that will help provide adequate inpatient or residential mental health treatment beds for people ages 16 to 64 who need critical services. I thank Representative Napolitano, who shares my commitment and dedication to providing compassionate mental health care, and to ensuring that people receive the most appropriate care in the most appropriate setting. The IMD payment ban is a long-standing policy that

prohibits the federal government from providing Medicaid matching funds to states for services provided to certain Medicaid-eligible individuals, ages 21 to 64, who are patients on IMDs. The term "IMD" is defined as a hospital, nursing facility, or other institution with more than 16 beds, which is primarily dedicated to providing diagnosis, treatment, or care to people with mental illness, including medical care, nursing care, and related services." Repealing the IMD exclusion is not only necessary to address the mental health care needs of people who require and deserve adequate residential services to heal, it is also an important step in resolving both the critical parity gap between physical and mental health care that continues to plague this field from a fiscal perspective, and the social stigma that interferes with access to treatment at the expense of those most affected by brain disease," said

Dr. Jonathan Sherin, Director of the Los Angeles County Department of Mental Health. If you or someone you know needs help, call the National Suicide Prevention Hotline: 1-800-273-TALK (8255).

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SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

Behavioral Health Bed Optimization Project

Analysis and Recommendations for Improving Patient Flow

June 2020

Dr. Anton Nigusse Bland, Director of Mental Health Reform

Lauren Brunner, MPH, Program Coordinator, Mental Health Reform

Executive Summary

The San Francisco Department of Public Health (DPH), like most other health systems in the world, is challenged to consistently match its behavioral health bed supply with the demand for services across the spectrum of care. The advantages of a system with optimized bed capacity are significant; patients get the care they need when they need it, the system benefits when resources are used efficiently, and investments have the greatest impact.

In early 2020, through the financial support of Tipping Point Community, the DPH Mental Health Reform team engaged a simulation modeling vendor, Mosimtec, to answer this most pressing question: *How many beds are needed in each behavioral health bed category to maintain consistent patient flow for adult clients in San Francisco with zero wait time?*

Through an in-depth analysis of patient placements in nearly 1,000 beds in the DPH behavioral health system of care in Fiscal Year 2018-2019, bed simulation modeling offered quantitative recommendations for improving patient flow. Furthermore, the Mental Health Reform team, through discussions with subject matter experts, contemplated additional considerations for behavioral health bed investments.

Summary Recommendations:

1. Invest in **additional bed capacity** in the following categories of care:
    a. Locked Subacute Treatment
    b. Psychiatric Skilled Nursing Facilities
    c. Residential Care Facilities, aka Board and Care
    d. Residential Care Facilities for the Elderly
    e. Mental Health Residential Treatment (12-month programs)
2. Complement all **behavioral health bed investments one-to-one with long-term housing placements** such as Permanent Supportive Housing or Residential Care Facilities, to better serve the high volume of people experiencing homelessness who use the system.
3. **Address the unique needs of specialized populations** who commonly encounter longer wait times, including but not limited to monolingual non-English speakers, people with criminal justice involvement, and patients who are non-ambulatory.
4. Create a **robust wait time and patient placement data-tracking system** to better understand the impact of operational barriers on patient wait time.
5. Invest in facilities with **fixed beds dedicated for use by DPH clients** rather than shared with other health systems. Currently DPH does not have fixed beds set aside for its patients at a number of facilities, challenging its exercise to plan and place patients in a timely manner.
6. **Repeat bed simulation annually** to understand trends and inform long-term planning, mitigate data limitations encountered in this project, and explore other interventions that would improve patient experience.

Background

Managing behavioral health beds – how many a system of care needs to serve its clients – is a consistent challenge for healthcare systems worldwide. A mismatch of bed capacity to demand has significant implications for both client health outcomes and a healthcare system's bottom line. A system with capacity that matches demand is one that provides optimal patient "flow." In an optimized system, patients flow freely between levels of care according to their clinical health needs rather than system constraints. In San Francisco, where the Department of Public Health (DPH) serves nearly 30,000 behavioral health clients per year, highly variable bed demand, persistent bed constraints, and inconsistent data collection prevent DPH from comprehensively understanding bed capacity needs and optimizing patient flow.

In Fiscal Year 2018-2019 (FY1819), DPH provided behavioral health care to people in more than 2,000 beds across a continuum from high acuity (e.g. Acute Inpatient Psychiatry) to low acuity (e.g. Hummingbird Psychiatric Respite).[1] As the behavioral health needs of the population shift with time, the demand for services similarly shifts, further complicating the need to appropriately finance and provide services for clients. Various previous reports evaluating DPH's behavioral health system, including the *BHS Performance Audit* (BLA, 2018) and *Homelessness and Behavioral Health* (JSI-Tipping Point, 2019), have called for improvements in patient wait times, investments in additional beds, and data to quantify and qualify capacity needs.

In early 2020, the Mental Health Reform team identified an innovative solution to its behavioral health bed optimization challenge: bed simulation modeling. Bed simulation modeling has been used internationally as a risk-free strategy for quantifying demand and identifying the impact of novel allocations of treatment beds on patient flow. Recent studies have concluded that using historical, operational data in a simulation model can help identify the appropriate type and number of beds required in public behavioral health systems.[2]

Methods

Through the financial support of Tipping Point Community, DPH engaged an experienced simulation modeling vendor, Mosimtec, to produce a mathematical model that would answer the key question: *How many beds are needed in each behavioral health bed category to maintain consistent patient flow for adult clients in San Francisco with zero wait time?* To answer this question, the model used FY1819 billing data of more than 25,000 admissions to mental health and substance use residential programs (greater than 24-hour stays) and urgent care settings (Psychiatric Emergency Services at Zuckerberg San Francisco General, Psychiatric Urgent Care, and Sobering Center). The data incorporated the demographics of the patients admitted to these care settings, including gender, age, race and ethnicity, and housing status. The analysis also considered the transitions of individuals across the behavioral health care continuum. The analysis

[1]An overview of the bed categories and counts is provided in the Appendix. A subset of 1,000 of these beds was included in the analysis due to data availability.

[2]La et al. "Increasing Access to State Psychiatric Hospital Beds: Exploring Supply-Side Solutions." *Psychiatric Services*, 67:5, May 2016, 523-528. Devapriya et al. "StratBAM: A Discrete-Event Simulation Model to Support Strategic Hospital Bed Capacity Decisions." *J Med Syst,* 39:130, 2015, 130. Yin et al. "Applying Simulation Modeling to Quantify the Impact of Population Health and Capacity Interventions on Hospital Bed Demand" *Proceedings of the 2018 IISE Annual Conference*, 2018.

was not able to calculate "true" demand; that is, people who attempted to receive services but were unsuccessful in doing so. This limitation is considered in more detail in the Discussion section.

To ensure the input data would generate model results that accurately reflect the real-world system, the Mental Health Reform team worked closely with Mosimtec and City subject matter experts to verify that the data provided were complete and that preliminary outputs of the analysis were consistent with operational experience.

Results

The results from the simulation model are presented as "input analysis" – detailed information about how DPH's system of behavioral health beds operated in FY1819 – and "output analysis" showing how the system functions in hypothetical scenarios.

Input Analysis: The input analysis provides critical information about how and by whom the behavioral health system was utilized in FY1819. More than 7,000 individuals accounted for more than 25,000 admissions in the fiscal year at nearly 1,000 different bed placements. *Table 1* provides a summary analysis of the characteristics of the patients who used behavioral health beds in FY1819; people experiencing homelessness represent a significant share. Males experiencing homelessness were the most common patient demographic to admit to the system. A disproportionate share of Black/African Americans utilized the system, representing 24 percent compared to 6 percent of the population of San Francisco. In future reports, DPH will recommend ways to address the equity issues highlighted by this analysis.

Table 1: Characteristics of Patients Admitted to nearly 1,000 DPH Behavioral Health Beds FY1819

Characteristic		**Number of Unique Patients[3]**	**Percent of Total Unique Patients**
Homelessness[4]	Yes	4,140	68%
	No	1,955	32%
Gender	Male	4,032	66%
	Female	1,763	29%
	Other	300	5%
Race/Ethnicity	White	2,015	33%
	Black/African American	1,434	24%
	Latino/a	720	12%
	Asian/Pacific Islander	359	6%
	Other/Not Stated	1,567	26%
Total		**6,095**	**100%**

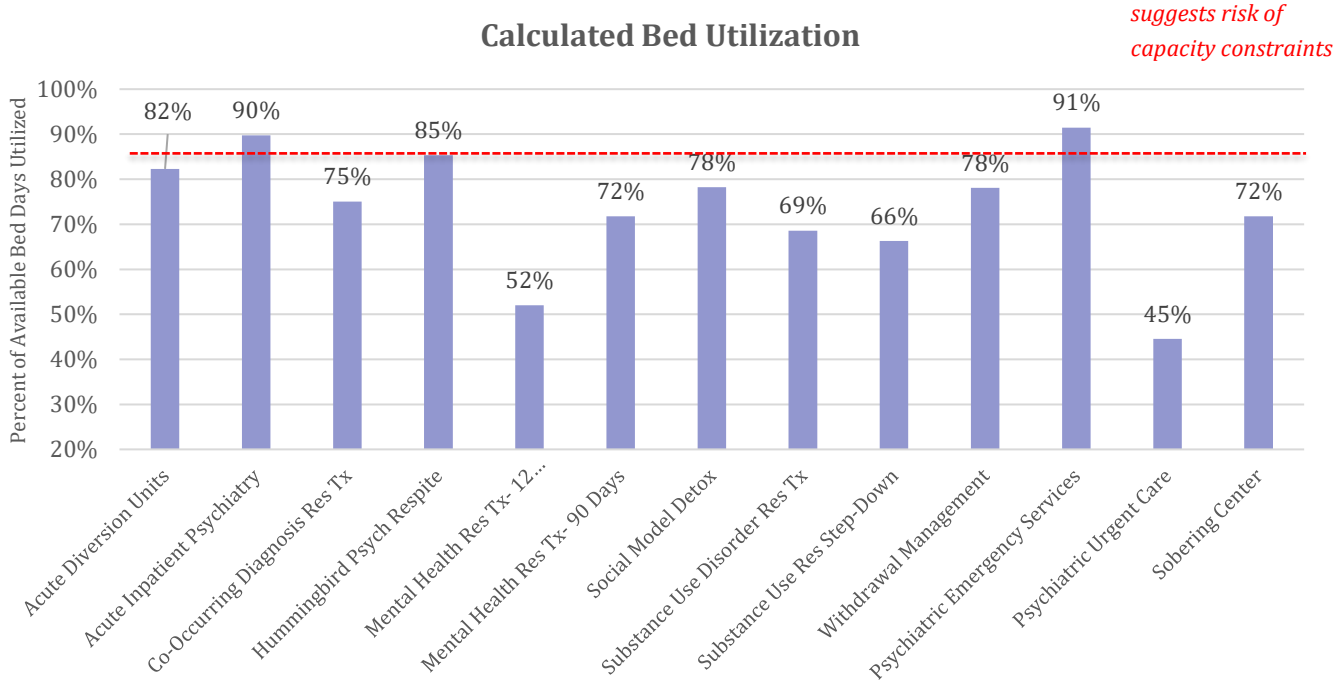
The input analysis also helped visualize where the system is currently overburdened, by revealing the utilization of beds in each category (for programs with fixed bed counts).[5] Utilization is calculated as the ratio of bed days occupied, divided by bed days available.[6] Due to limitations in the input data, utilization

[3] An additional 1,387 identified clients did not have demographic information to include in this analysis.
[4] Homelessness defined by DPH Coordinated Care Management System (CCMS). CCMS defines people as experiencing homelessness in the fiscal year if they either: 1) utilize a City service that indicates housing instability, for example, a City shelter, or 2) self-report homelessness while accessing health care services.
[5] Most of DPH-funded behavioral health beds are contracted annually at a "fixed" bed count. Other beds are purchased individually as needed and as budget and facilities allow.
[6] Bed utilization calculations relied on bed counts provided by the DPH Bed Inventory.

calculations for certain bed categories likely underrepresent the true demand on these services. These categories include Sobering Center, Psychiatric Urgent Care, and Mental Health Residential Treatment 12-month programs. These limitations are detailed, and adjusted as needed, in the Discussion section of this report. Utilization calculations of over 85 percent indicate a care setting that is at risk of being capacity-strained.[7] Using this rule, *Figure 1* demonstrates the categories with potential bed capacity shortages.

Figure 1: Calculated Bed Utilization[8]

**85% utilization suggests risk of capacity constraints*



Output Analysis: The model then created a hypothetical scenario to identify bed capacity adjustments that would improve patient flow by decreasing patient wait times. In general, waiting time experienced by patients in the system can be attributed to limited bed capacity and/or operational processing time (required health screenings, missed appointments, transportation, legal permissions, and other intake protocols). This analysis focused on quantifying wait time that occurs due to capacity constraints. The model considered the system holistically, identifying where patients currently wait prior to admission and then modeling the capacity needed to eliminate the observed wait times. Additionally, as outlined in the Appendix, the model considered a scenario specific to Psychiatric Emergency Services and Acute Inpatient Psychiatry.

The model carefully estimated current utilization in order to identify bed categories with wait times that occur due to capacity constraints. Then, the model simulated expansion scenarios that would reduce wait time to zero.

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[7] Bagust A, Place M, Posnett JW. "Dynamics of bed use in accommodating emergency admissions: stochastic simulation model." *BMJ*. 1999; 319 (7203):155-158

[8] Locked Subacute Treatment, Residential Care Facilities, and Psychiatric Skilled Nursing do not have fixed bed counts and therefore do not have input data Bed-Day Utilization Calculations.

Table 2: Recommended Bed Counts to Decrease Patient Wait Due to Capacity Constraints

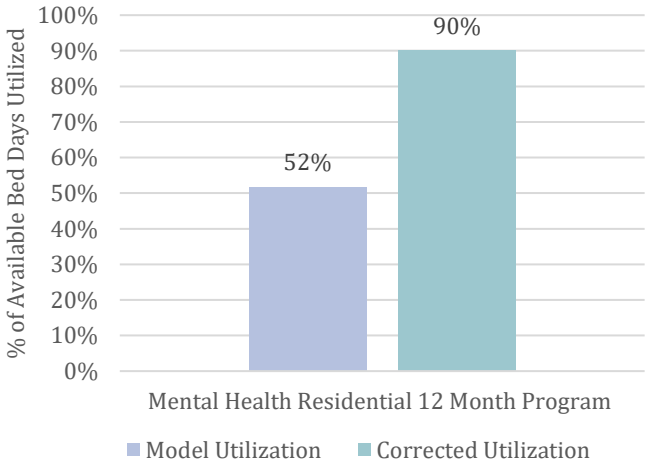
Bed Category	Average Wait Due to Capacity (Days)[9]	Recommended Bed Count Increase For Zero Wait	Bed Count Increase for 50% Wait Time Reduction
Locked Subacute Treatment	62	31	20
Psychiatric Skilled Nursing Facilities	121	13	8
Residential Care Facility aka Board and Care	60	31	13
Residential Care Facility for the Elderly	44	22	9

Table 2 displays the four bed categories the model identified as having wait times greater than one day. For each of these bed categories with wait times, the model then recommended a bed count increase that would reduce wait time to zero in order to create optimal flow. The table also provides an estimate for halving current waits.

Discussion

The model results provide substantial information for improving operations and recommending investments. Because each recommendation to increase capacity in identified bed categories has a different impact on patient flow and budget, the model results must be carefully evaluated in collaboration with DPH's clinical, operational, policy, and financial leadership. Funding priorities must be accompanied by strong policy recommendations. For example, the value of increasing capacity in Locked Subacute Treatment and Psychiatric Skilled Nursing Facilities is only achieved when matched with conservatorship policies that enable efficient patient placements. Furthermore, recommendations must be refined to target populations who historically encounter more challenges in finding appropriate placements, such as people with a history of criminal justice involvement, monolingual non-English speakers, and people who are non-ambulatory.

Figure 2: Adjusted Utilization Using All Billed Days



In reviewing the model results, the Mental Health Reform team found a significant limitation in the utilization calculation for Mental Health Residential Treatment, 12-month programs. Certain bed days were excluded from the input data due to the analysis' inclusion criteria: admissions that occurred within the fiscal year. For Mental Health Residential Treatment, this unintentionally excluded many patients who occupied beds at the start of, and well into, the reporting period. To correct for this limitation, the Mental Health Reform team considered additional billed days that were originally excluded. This had a significant impact on results. The inclusion of the previously excluded data resulted in a report of 90 percent utilization of these beds, as

[9] The model identified wait directly associated with the patient arrivals per day against the bed capacity. The model is not able to account for waiting time associated with processing and other operational barriers that DPH clients often encounter.

demonstrated in *Figure 2*. Because utilization of over 85 percent suggests a need for additional capacity, and due to the recommended increase at the upstream category, Locked Subacute Treatment, an additional investment of 20 Mental Health Residential Treatment 12-month beds is recommended to improve flow.

The Mental Health Reform team recommends that all investments be directed toward facilities where DPH has a fixed number of beds that are dedicated for use by its clients. Currently, many counties share contracted facilities, which often leads to delays in client placement and a lack of transparency about the length of those delays for DPH clients.

The Mental Health Reform team also recommends that, because of the high volume of people experiencing homelessness utilizing the system, each behavioral health treatment investment be paired with a similar expansion of housing options for those clients. The benefits of treatment can quickly diminish if a client is discharged without adequate housing, and waits for housing can impede flow throughout the behavioral health system.

Contextualizing the Recommendations: The DPH Behavioral Health System of Care is represented in Figure 3. Services range from prevention and early intervention for low-acuity patients to intensive treatment, provided in locked facilities, for the most acute patients. This analysis focused on adult residential settings, which are the bottom four categories represented in Figure 3. The results highlight two broad categories that currently bottleneck the system: residential treatment and locked facilities. The specific categories include Mental Health Residential Treatment, Locked Subacute Treatment, Psychiatric Skilled Nursing Facilities, and Residential Care Facilities (for adults and older adults). Detail on these categories and the services provided are listed in *Table 3*. In addition to identifying categories that are overburdened, the model highlighted bed categories with utilization levels and capacity that sufficiently accommodate flow in current operations. These categories include Acute Diversion Units, Substance Use Residential Treatment, and Withdrawal Management programs.

Figure 3: DPH Behavioral Health System of Care

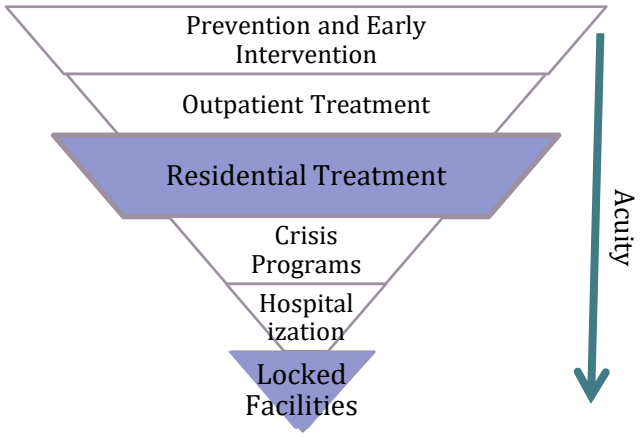


Table 3: Programmatic Detail on Categories with Recommended Capacity Increase

Bed Category	Description	FY1819 Bed Count[10]	Example Facilities
Mental Health Residential Treatment, 12-month	Residential group living program that provides treatment for managing life with mental illness, building life skills and social skills, developing positive coping strategies, pre-vocational/vocational skills, medication adherence and wellness recovery stabilization. Twelve-month programs are commonly used for patients discharging from Locked Subacute Treatment.	30	Progress Foundation Clay Street and Dorine Loso Houses

[10] Bed count based on FY1819 contracts for Mental Health Residential Treatment Programs (12-month) and the patient census as of April 30, 2019 for all other categories.

Bed Category	Description	FY1819 Bed Count[10]	Example Facilities
Locked Subacute Treatment – aka Mental Health Rehabilitation Center (MHRC) and Institute of Mental Disease (IMD)	These facilities are for clients placed on a Lanterman-Petris-Short (LPS) Conservatorship due to grave disability or on a forensic court-ordered hold. These programs provide psychosocial rehabilitation to stabilize mental illness impact on daily functioning, establish medication adherence, improve life and social skills, develop positive coping strategies, and stabilize wellness and recovery.	132	MHRC at SF Behavioral Health Center, Crestwood (SF Healing Center, Canyon Manor, Vallejo)
Psychiatric Skilled Nursing Facility	A licensed health facility, or a distinct part of a hospital, providing 24-hour inpatient care that includes physician, skilled nursing, dietary, and pharmaceutical services, and an activity program. The Psychiatric SNF specializes in treating patients with severe psychiatric disorders who cannot be safely managed in other settings. This setting can be locked or unlocked.	160	Idylwood Care Center, Crestwood (Fremont, Stevenson, Stockton), Medical Hill
Residential Care Facilities (RCF)– also known as Board and Care	RCFs offer group living for people with disabilities (either medical or psychiatric) who need help with meal preparation, medication monitoring, and personal care, but do not need daily acute medical care. Individual RCFs may specialize in certain clinical areas such as mental health rehabilitation and geriatrics.	305	United Family Home Care, South Van Ness Manor, BMB Sunshine Residential Care
Residential Care Facilities for the Elderly (RCFE)	RCFEs generally offer group living for seniors (with either medical or psychiatric needs) who need help with meal preparation, medication monitoring, and personal care, but do not need daily acute medical care. Individual RCFEs may specialize in certain clinical areas such as mental health rehabilitation and geriatrics.	267	Crestwood Hope, Victoria Manor, Country Place Assisted Living

When conducting the cost-benefit analysis of adding beds at different levels of care, it is important to understand how the system functions dynamically as a continuum. Investments at each level of care impact not only that bed category, but also the upstream and downstream bed categories. For example, if DPH follows the recommendation to increase bed capacity in Locked Subacute Treatment, the upstream bed categories Acute Inpatient Psychiatry and Psychiatric Emergency Services will be able to release the patients waiting for that downstream category. Furthermore, choosing to increase capacity only at Locked Subacute Treatment could result in a new bottleneck if housing or step-down programs are not secured for patients discharging from that care level.

Because of the high volume of people experiencing homelessness utilizing the system, all temporary placement investments (e.g. Locked Subacute Treatment) should be complemented one-to-one by investments in permanent placements such as Permanent Supportive Housing or Residential Care Facilities. Without a pathway to reliable housing upon discharge, patients who are experiencing homelessness will struggle to maintain the benefits of treatment.

Cost Analysis: DPH should identify which sequence of investments would have the biggest impact on health outcomes and budget, while maintaining focus on what is operationally feasible. The Mental Health Reform team will work with DPH operational subject matter experts and the Controller's Office, which

completed a flow analysis project for DPH in 2019, to create a decision-making framework for prioritizing investments. Once prioritized and sequenced, these recommendations should be incorporated into San Francisco's budgeting and planning processes, including in the allocation of 2,000 placements that Mayor London Breed has committed to create for people experiencing homelessness and behavioral health issues.

Because the system is financially constrained, the prioritization process must consider the marginal cost benefit of adding a bed to one category versus another. *Table 4* outlines the associated operating costs for the bed increases suggested by the model. An additional cost would be associated with any start-up required, such as building acquisition.

Table 4: Cost of Recommended Bed Investments

Bed Category	Annualized Median Cost Per Bed	Recommended Bed Increase	Annual Cost Recommended Bed Increase
Locked Subacute Treatment	$177,208	31	$5,493,433
Psychiatric Skilled Nursing Facility	$106,580	13	$1,385,540
Residential Care Facilities aka Board and Care	$31,390	31	$973,090
Residential Care Facilities for Elderly	$38,873	22	$855,195
Mental Health Residential Treatment (12-month)	$97,127	20	$1,942,530
Total	**N/A**	**117**	**$10,649,788**

It is important to also consider the anticipated cost savings that result from relieving the bottlenecks occurring in high-cost care settings. For every patient who spends "extra" time – beyond what is clinically necessary – in Acute Inpatient Psychiatry while waiting for a lower level of care, DPH is unable to bill Medi-Cal for the service. These days spent waiting are therefore a burden for both the client's recovery and for the financial health of the organization. By calculating the annual revenue potential lost due to this issue, we can balance the cost of the bed investments against the revenue gained by using Acute Inpatient Psychiatry resources for patients who clinically need the service. *Table 5* demonstrates the potential revenue recovery and net difference from the recommended investment using this model.

Table 5: Potential Revenue Recovery and Net Cost Difference

Bed Category	Admin Days Inpatient Psychiatry	Potential Revenue Recovery*	Annual Cost Recommended Bed Increase	Annual Net Cost Difference
Locked Subacute Treatment	4,131	$4,361,964	$5,493,433	($1,131,469)
Psychiatric Skilled Nursing Facility	1,060	$1,694,060	$1,385,540	$308,520
Residential Care Facilities aka Board and Care	1,351	$2,159,128	$973,090	$1,186,038
Residential Care Facilities for Elderly	289	$461,871	$855,195	($393,324)
Mental Health Residential Treatment (12-month)	531	$858,217	$1,942,530	($1,084,313)

**DPH receives $1,598.17 per day for acute level patients at ZSFG Acute Inpatient Psychiatry. The revenue recovery calculation assumes the non-billable days in FY1819 convert to acute patient bed days. For patients waiting for Locked Subacute Treatment, DPH can bill Medi-Cal for administrative days at $542.26 per day, making the revenue recovery per day $1,055.91. For patients waiting for other bed categories listed, DPH receives no reimbursement from Medi-Cal.*

Limitations: The information used for this analysis is limited by two main factors. First, DPH does not have a centralized data system to capture admissions for all 2,000 of its behavioral health beds. In order to include the full continuum of care in the study, a significant effort was made to unify the data. However, the project was limited by the source data systems and their disparate methods for data management. Second, DPH used only one fiscal year of admissions to these beds. The decision to use one year of data balanced the advantage of relying on recent data and fixed bed counts against the disadvantage of undercounting information related to programs with long lengths of stay (e.g. 12-month Mental Health Residential Treatment, Residential Care Facilities, Psychiatric Skilled Nursing Facilities, Substance Use Residential Step-Down). The Mental Health Reform team worked with the DPH subject matter experts and Mosimtec to mitigate the impact of these limitations on the results of the project. As shown earlier in the discussion section, the limitation affiliated with long-stay programs was corrected in the case of Mental Health Residential Treatment through post-modeling analysis.

Furthermore, while the model can estimate wait times based on input data, this wait-time calculation is limited and not fully representative of reality. For example, in the real system, certain patients may be redirected or choose alternative care settings when wait times are not tolerated by the system or the patient. In this way, it is likely that wait times, and therefore capacity needs, are underrepresented in this exercise. Additionally, the model failed to identify wait times in bed categories where clients are known to wait in practice, for example, Mental Health Residential Treatment. This result is attributable to a few factors; there is no data system concretely tracking wait time, and wait time in the current system could be fully due to processing time and operational barriers rather than capacity shortages. These possibilities and limitations will be fully evaluated by the Mental Health Reform team in collaboration with Behavioral Health Services as a follow-up to this report. Critical to this follow-up is the development of a robust wait time and patient placement data-tracking system. This system will enable a better understanding of the impact of operational barriers on patient wait time.

Conclusion

The Behavioral Health Bed Optimization Project offers new and important insights for expanding the current capacity and improving the flow of behavioral health beds in San Francisco. In addition to recommendations for bed investments, the model illuminates who uses the complex system of care, and how. It also shows the limitations of current data systems. In summary, the final recommendations from this project include:

1. Invest in **additional bed capacity** in the following categories of care:
    a. Locked Subacute Treatment
    b. Psychiatric Skilled Nursing Facilities
    c. Residential Care Facilities, aka Board and Care
    d. Residential Care Facilities for the Elderly
    e. Mental Health Residential Treatment (12-month programs)
2. Complement all **behavioral health bed investments one-to-one with long-term housing placements** such as Permanent Supportive Housing or Residential Care Facilities, to better serve the high volume of people experiencing homelessness who use the system.

3. **Address the unique needs of specialized populations** who commonly encounter longer wait times, including but not limited to monolingual non-English speakers, people with criminal justice involvement, and patients who are non-ambulatory.
4. Create a **robust wait time and patient placement data-tracking system** to better understand the impact of operational barriers on patient wait time.
5. Invest in facilities with **fixed beds dedicated for use by DPH clients** rather than shared with other health systems. Currently DPH does not have fixed beds set aside for its patients at a number of facilities, challenging its exercise to plan and place patients in a timely manner.
6. **Repeat bed simulation annually** to understand trends and inform long term planning, mitigate data limitations encountered in this project, and explore other interventions that would improve patient experience.

Despite the limitations mentioned in this analysis that likely contribute to an underestimation of capacity needs, the Mental Health Reform team is confident that the bed categories identified are consistent with the greatest need. A series of investments that include increasing capacity in high-demand bed categories downstream from Acute Inpatient Psychiatry, coupled with Permanent Supportive Housing units for the high proportion of patients experiencing homelessness, will undoubtedly improve flow and decrease cost and bottlenecks at upstream bed categories. The bed simulation methodology should be replicated to further interrogate the information available, mitigate the data limitations, and explore other interventions that would improve patient experience. Because the health care system and client needs are in constant evolution, the methodology is most effective if used at least annually. The exercise should therefore become a standard operating procedure for DPH to consistently improve health outcomes and reap financial rewards.

Appendix:

SFDPH Behavioral Health Beds FY 2018-19

CRISIS STABILIZATION

Crisis Services are a continuum of services that are provided to individuals experiencing a psychiatric emergency. The primary goal of these services is to stabilize and improve psychological symptoms of distress and to engage individuals in an appropriate treatment.

- Psychiatric Emergency Services
- Acute Diversion Unit
- Psychiatric Urgent Care

74 Beds

ACUTE PSYCHIATRIC

Acute psychiatric services provide high-intensity, acute psychiatric services 24 hours a day for individuals in acute psychiatric distress and experiencing acute psychiatric symptoms and/or at risk of harm to self or others.

- Acute Inpatient Psychiatric Services

44 Beds

WITHDRAWAL MANAGEMENT & RESPITE

These programs provide acute and post-acute medical care for individuals who are too ill or frail to recover from a physical illness or injury on the streets but are not ill enough to be in a hospital. They provide short-term residential care that allows individuals the opportunity to rest in a safe environment while accessing medical care and other supportive services.

- Medical Respite
- Sobering Center
- Withdrawal Management
- Social Detox
- Behavioral Health Respite Navigation Center

171 Beds

LOCKED RESIDENTIAL TREATMENT

These programs are 24-hour locked facilities providing intensive diagnostic evaluation and treatment services for severely impaired residents suffering from a psychiatric illness.

- Locked Subacute
- Psychiatric Skilled Nursing Facility
- State Hospital

338 Beds

OPEN RESIDENTIAL TREATMENT

A residential treatment facility is a live-in health care facility providing therapy for substance abuse, mental illness, or other behavioral problems. Some residential treatment facilities specialize in only one illness, while others treat people with a variety of diagnoses or dual diagnoses of substance abuse and a psychiatric diagnosis.

- Co-Occurring Diagnoses
- Substance Use Disorder
- Mental Health

438 Beds

RESIDENTIAL CARE FACILITIES

Residential care facilities (RCF) offer group living for seniors and/or people with disabilities who need help with meal preparation, medication monitoring, and personal care, but do not need daily acute medical care. Individual RCFs may specialize in clinical areas such as mental health rehabilitation and geriatrics.

- Residential Care Facilities
- Residential Care Facilities for the Elderly

572 Beds

TRANSITIONAL & SUPPORTIVE HOUSING

Transitional and Supportive Housing provides people with significant barriers to housing stability with a place to live and intensive social services while they work toward self-sufficiency and housing stability.

- Residential Step-Down
- Cooperative Living
- Support Hotel
- Stabilization Rooms
- Shelter

598 Beds

Additional Model Results:

***Scenario 2 Results*:** In Scenario 2, the model adjusted historical data using the assumption that all patients who stay more than 24 hours in Psychiatric Emergency Services do so because of a lack of capacity in the "next stop" treatment location, Acute Inpatient Psychiatry, at Zuckerberg San Francisco General (ZSFG). Subsequently, the model calculated the number of beds needed to prevent this wait time. In this scenario, the model identified that in order to prevent bottlenecks at Psychiatric Emergency Services, the bed count at Acute Inpatient Psychiatry would need to be increased significantly (61 percent). However, because investments made in downstream bed categories have been proven to reduce or even eliminate bottlenecks upstream, DPH, in discussion with the experts at Mosimtec, decided against including this result as a final recommendation. This approach will be tested and analyzed when the bed simulation modeling exercise is repeated annually.

Table 6: Scenario 2 Recommended Bed Counts

Bed Category	Baseline Bed Count	Recommended Bed Count	Percent Increase
ZSFG Acute Inpatient Psychiatry	44	71	61%

Validity Reports: The following tables provide detail on the outputs of the model compared with historical input data. These reports support the conclusion that the model reflected reality within a reasonable degree of confidence.

Table 7: Arrivals Per Day

Category	Calculated Input	Scenario 1 Output	% Difference
Acute Diversion Units	2.91	2.92	0%
Acute Inpatient Psychiatric Services	3.42	3.40	(1%)
Co-Occurring Diagnosis Residential Treatment	0.75	0.75	0%
Hummingbird Psychiatric Respite	1.79	1.79	0%
Locked Subacute Treatment	0.54	0.54	0%
Mental Health Residential Treatment	0.88	0.88	0%
Option - St Francis	0.81	0.81	0%
Psychiatric Emergency Services	21.94	21.95	0%
Psychiatric Skilled Nursing Facilities	0.21	0.22	5%
Psychiatric Urgent Care	7.07	7.06	0%
Residential Care Facility aka Board and Care - In County	0.27	0.27	0%
Residential Care Facility aka Board and Care - Out of County	0.12	0.11	(8%)
Residential Care Facility for the Elderly - In County	0.23	0.23	0%

Category	Calculated Input	Scenario 1 Output	% Difference
Residential Care Facility for the Elderly - Out of County	0.16	0.16	0%
Sobering Center	18.03	18.03	0%
Social Model Detox	2.88	2.87	0%
Substance Use Disorder Residential Treatment	3.40	3.40	0%
Substance Use Residential Step-Down	0.65	0.65	0%
Withdrawal Management	2.12	2.12	0%

Table 8: Average Length of Stay (Days)

Category	Calculated Input	Scenario 1 Output	% Difference
Acute Diversion Units	13	12	(8%)
Acute Inpatient Psychiatric Services	12	11	(8%)
Co-Occurring Diagnosis Residential Treatment	52	51	(2%)
Hummingbird Psychiatric Respite	15	14	(7%)
Locked Subacute Treatment	205	203	(1%)
Mental Health Residential Treatment	65	64	(2%)
Option - St Francis	8	8	0%
Psychiatric Emergency Services	1	1	0%
Psychiatric Skilled Nursing Facilities	106	99	(7%)
Psychiatric Urgent Care	1	1	0%
Residential Care Facility aka Board and Care - In County	272	268	(1%)
Residential Care Facility aka Board and Care - Out of County	155	143	(8%)
Residential Care Facility for the Elderly - In County	195	185	(5%)
Residential Care Facility for the Elderly - Out of County	154	142	(8%)
Sobering Center	0	0	0%
Social Model Detox	6	6	0%
Substance Use Disorder Residential Treatment	51	50	(2%)
Substance Use Residential Step-Down	99	97	(2%)
Withdrawal Management	10	10	0%

Table 9: Bed Utilization

Category	Calculated Input	Scenario 1 Output	% Difference
Acute Diversion Units	82%	79%	(4%)
Acute Inpatient Psychiatric Services	90%	83%	(8%)
Co-Occurring Diagnosis Residential Treatment	75%	73%	(3%)
Hummingbird Psychiatric Respite	85%	84%	(1%)
Locked Subacute Treatment	*unknown	79%	NA
Mental Health Residential Treatment	60%	52%	(13%)
Psychiatric Emergency Services	91%	82%	(10%)
Psychiatric Skilled Nursing Facilities	*unknown	86%	NA
Psychiatric Urgent Care	45%	42%	(7%)
Residential Care Facility aka Board and Care - In County	*unknown	74%	NA
Residential Care Facility aka Board and Care - Out of County	*unknown	79%	NA
Residential Care Facility for the Elderly - In County	*unknown	75%	NA
Residential Care Facility for the Elderly - Out of County	*unknown	75%	NA
Sobering Center	72%	36%	(50%)
Social Model Detox	78%	72%	(8%)
Substance Use Disorder Residential Treatment	69%	64%	(7%)
Substance Use Residential Step-Down	66%	54%	(18%)
Withdrawal Management	78%	74%	(5%)

VENTURA COUNTY

BEHAVIORAL HEALTH

A Department of Ventura County Health Care Agency

VENTURA COUNTY
BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

June 14, 2021

LOGRANDO BIENESTAR
ACHIEVING WELL BEING

Program

Cynthia Salas
Equity Services Manager
Office of Health Equity and Cultural Diversity

VENTURA COUNTY
BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

SURVEY CONDUCTED BY PARENT GROUP

”Concerns from community that schools were not connecting to Logrando Bienestar Achieving Wellbeing Program.”

Statements of Concern per Parent Group

- “Program not connecting with schools, and families in need.”

Led to the following surveys questions

- Does your school have the Logrando Bienestar Program (LBP)?
- Do you know what services LBP offers?
- Can you give me the name of the LBP staff assigned to your school?
- Do you have any contact information for the LB person assigned to your school?
- Do you know the referral process?
- How often do you have contact with LBP?

School Clerks for the following school districts were engaged

- Ventura Unified School District – **3 school sites**
- Santa Paula Unified School District- **5 sites**
- Rio School District – **2 sites**
- Oxnard School District- **7 sites**
- Ocean View School District- **2 sites**
- Hueneme School District- **5 sites**
- Fillmore Unified School District –**NO MOU**
  - **But connected with 3 school sites and per school district Sespe is no longer a school.**

Results to clerk responses

- Does your school have the Logrando Bienestar Program (LBP)?
- **8 clerks/YES AND 11 clerks/No**
- Do you know what services LBP offers?
- **1 clerks/YES AND 18 clerks/No**
- Can you give me the name of the LBP staff assigned to your school?
- **2 clerks/YES AND 17 clerks/No**
- Do you have any contact information for the LB person assigned to your school?
- **2 clerks/YES AND 17 clerks/No**
- Do you know the referral process?
- **4 clerks/YES AND 15 clerks/No**
- How often do you have contact with LBP?
- **3- weekly, 1- monthly, 15 never**

19 individuals participated

VENTURA COUNTY BEHAVIORAL HEALTH

Interviewed the following School Districts

- Ventura Unified School District – **Cynthia Frutos**
- Santa Paula Unified School District- **Stephanie Barnes**
- Rio School District – **Oscar Hernandez**
- Oxnard School District- **Jodi Nocero**
- Ocean View School District- **Maria Elena Plaza**
- Hueneme School District- **David Castellano**
- Fillmore Unified School District –**NO MOU**

Responses from School District

- Does your school have the Logrando Bienstar Program (LBP)?
- Do you know what services LBP offers?
- Can you give me the name of the LBP staff assigned to your school?
- Do you have any contact information for the LB person assigned to your school?
- Do you know the referral process?
- How often do you have contact with LBP?
- **School district clerks that responded "no" to several of these questions stated that their office clerks are intentionally not included in this process for confidentiality reasons.**
- **Counselors are the direct line of contact for parents.**
- **Schools would appreciate being connected with parents whose children are part of their school sites to provide them support**

Logrando Bienestar Response

- Teaching Remotely at start of pandemic
- Hybrid teaching still limited the number of staff on campus
- Our staff meets regularly with academic counselors as scheduled between counselors and LB staff.
- Program Administrator has regular scheduled meetings with district leadership/lead administrator
- Schools counselors have all of our staff's information and for schools who have a "parent and counselor" corner (website) our program and staff information is included.
- We have coordinated **93** workshops as of today which has resulted in connecting with **1038** individuals

Logrando Bienestar Response

- LBP has coordinated **93** workshops as of today which has resulted in connecting with **1038** parents
- LBP has coordinated promotional/informational session about our program where we engaged with **3299** individuals.
- LBP has distributed **6376** pieces of information at different events in the community
- LBP has supported **902** individuals through referrals for service of those **446** were connected with VCBH-STAR
- Community providers lower level of care- Non-profit

Logrando Bienestar Efforts

- Age of those served by LBP:
  - 0 to 15: **488**, 16 to 25: **89**, 26 to 59: **203**, 60+: **15**
- **Race**
  - Hispanic-Latinx: **607**
  - White- **52**
  - Other-**13**
  - Decline to answer-**108**
- **Ethnicity**
  - Hispanic-Latinx-**599**
  - Non-Hispanic-**39**
  - Decline to Answer-**143**

La CLAve

- Logrando Bienestar Program last month reached a total of
  - **253 individuals (one month) /419 as of today.**

VENTURA COUNTY BEHAVIORAL HEALTH

Before Expansion

2016-2019

Existed only within two school districts:

- Oxnard School District
- Santa Paula Unified School District

LBP has expanded to the following areas:

Human Services Agency

Probation Agency

Public Defenders Office

District Attorney's Office

Ventura County Public Health

Ventura County Medical Center

After Expansion

Ventura County of Education
Migrant Student Program

School Districts **2020-2021**

- Oxnard School District
- Port Hueneme School District
- El Rio School District
- Briggs School District
- Moorpark Unified School District
- Oxnard School District
- Pleasant Valley School District
- Santa Paula Unified School Districts
- Somis Union School District
- Conejo Valley School District
- Oak Park Unified School District
- Ojai Valley Unified School District
- Ocean View School District

VENTURA COUNTY BEHAVIORAL HEALTH

Ongoing Efforts to Increase services to Latinx and Indigenous community members 2020-2021

County Agencies	Community Institutions /Nonprofits	Faith based Groups
District Attorney's Office Public Defender's Office Probation Sheriff	Oxnard Police Department Ventura Police Department Santa Paula Police Department Port Hueneme Police Department	San Buenaventura Mission Mary Star of the Sea Our Lady of Guadalupe Revive Community Church Evangelistic Center New Life Community Church Family Life Church Total Life Christian Center
Ventura County Public Health Area on Aging Agency Human Services Agency Ventura County Medical Center	Child Development Resources (CDR) Adverse Childhood Experiences Ventura County –Dr. Landon Woman of Honor Men of Substance* The Coalition for Family Harmony-LaClave Mexican Consulate UFWF	**Higher Education Institutions** (Hispanic Serving Institutions) Oxnard College Ventura College East Campus CSUCI CLU

VENTURA COUNTY BEHAVIORAL HEALTH

Conclusion – Logrando Bienestar-Achieving Well Being Program

- CSC are assigned to schools within school districts who act as facilitators and advocates for families
- CSC information is made available to all school counselors
- CSC maintain regular contact with schools as it is structured per school counseling staff
- All schools are educated and informed about LBP
- Has expanded to partner with community groups and other agencies to connect families to mental health services
- Has championed La CLAve to empower parents, families, institutions, and individuals to identify the severe signs of mental illness and how to access services

Thank you, Invitation to Collaborate, and Ask

- Thank you to all parents involved in conducting this survey
- Future surveys be in partnership with the Office of Health Equity and School Districts
- Schools were not aware that their staff was being interviews and didn't understand the benefit of this survey without school partnership
- Several school districts would like to receive the name of parents/students that need support, that is the biggest priority from reading this survey

End of Presentation

Thank you for listening

VENTURA COUNTY
BEHAVIORAL HEALTH