*INVESTMENT IN MENTAL HEALTH WELLNESS ACT OF 2013*

*TRIAGE PERSONNEL GRANT*

# Grantee Evaluation of Program Effectiveness

Ventura County Behavioral Health
July 31, 2018

# Executive Summary

Introduction

Ventura County was awarded grant funds to provide intensive outreach & engagement, assessment, crisis intervention, and case management services to address an array of needs of clients who traditionally have not been successfully engaged and treated by existing programs. A new unit called Rapid Integrated Support and Engagement (RISE) (See attached brochures) was created to operationalize these services. The existing Mobile Crisis Team was also supplemented with additional staff to expand its capacity.

Major Findings

The RISE team has established a strong reputation in Ventura County and has built necessary collaborations with County and community stakeholders including law enforcement, inpatient hospital, Emergency Departments, advocacy groups etc. Ongoing engagement efforts continued throughout the 4 years to ensure the development of collaborations to meet the needs of this hard to reach population. Due to the positive collaborations and impact on the community, Ventura County Behavioral Health has sustained the original RISE program. As our reports submitted to the MHSOAC have demonstrated over the last 4 years, thousands of services have been provided to those clients within our community. In terms of specific outcomes goals outlined in the grant application, some were met or nearly met including:

- Satisfaction and Hopefulness Measures
- Successful Linkage to Outpatient Care
- Reduction in unnecessary initial hospitalizations
- Rapid Response Assessment Teams Target
- Regional Engager Teams Outreach Target

Limitations

Limitations of the data is the critical aspect of the evaluation report. Almost all the data both positive and negative were confounded to a degree by one factor or another. Early on the long hiring delays clearly impacted the ability of the teams to meet client engagement targets. Although almost fully staffed by mid-2016, staff turnover continued, which had an impact on outcomes throughout the duration of the grant period.

Recommendations:

Given that time has passed, and efforts have matured, programs should be allowed to modify the target areas, outcomes, and measures to reflect the knowledge and experience obtained during the grant period. Otherwise, they will have to wait until the end of the grant to better direct resources.

# Program Overview

| Table 1: Overview | | | | |
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| **Team** | **Staff** | **Team Role** | **Location** | **Need Addressed** |
| Crisis Team Expansion | 5 BH Clinicians | Provide rapid response to high-level crisis situations | 2 staff – Sheriff's Station<br>3 staff - VCBH main office | Faster response times, in-person response, response to lower-level crises, preventive intervention for non-5150 clients, increase clients served, increase collaboration with law enforcement agencies |
| VCMC IPU/A&R | 2 BH Clinicians | Assessment of VCMC patients as needed, connecting with VCBH clinic services at IPU discharge, connecting with crisis residential treatment | VCMC IPU and A&R | IPU patients not accessing needed services after hospitalization, patient not accessing crisis residential services, lack of VCMC medical inpatient mental health crisis services |
| Rapid Response and Assessment | 2 BH Clinicians<br>2 CSCs<br>2 Peer Recovery Coaches | Respond to lower-level (non-5150) crises and provide brief intervention, psychosocial assessment, and referral services | Mobile community-based, 1 East and 1 West County team | More persons being provided crisis triage services, faster response times, in-person response, response to lower-level crises, full services, including psychosocial assessment |
| Engager | 2 CSCs<br>2 Peer Counselors | Provide targeted case management, outreach, and referral to mental health service for clients in the community | Community-based staff access clients in community | Known clients not accessing needed services, insufficient identification of high-risk persons needing mental health services |
| CSC Homeless | 2 CSCs | Provide ongoing case management to connect homeless mental ill persons with VCBH services, and intervene before crises become acute | Oxnard and Ventura VCBH clinics | Repeated hospitalizations and disconnect with needed VCBH clinical services among the homeless population |

# Goals & Objectives

**Expansion of Existing Crisis Team:** Expanding the current crisis team will increase VCBH's ability to provide in-person response and better determination of a client's 5150 status, allowing clinicians to conduct more preventive interventions for persons who do not become involuntarily hospitalized. The expansion will also allow the Crisis Team to serve at least 551 more clients per year via increased referrals due to community outreach. Additional staffing will allow for greater collaboration with law enforcement leading to increased crisis team utilization by law enforcement with the desired effect of reducing law enforcement involvement in mental health crisis events.

**VCMC A&R/ER Team:** Original Goal included staffing VCMC with two BH Clinicians to allow the hospital to close three gaps in services that will aid clients in recovery and reduce hospital recidivism, while reducing the need for law enforcement personnel, as follows: (1) connect with patients prior to discharge from the IPU to assess for the need for mental health services, open a case file, and facilitate connections to outpatient mental health clinics; (2) provide a bridge between the A&R/OPOS and short-term crisis residential services for those eligible patients who were declined IPU admittance; and (3) provide short-term crisis intervention and supervision of ER patients who have been written a 5150 hold who need medical clearance prior to IPU hospitalization to alleviate the need for law enforcement personnel for that purpose. These personnel will also respond to persons coming through the ER who may be experiencing a mental health crisis. Due to RISE staffing challenges and circumstances within VCMC ER, number 3 did not happen as planned. See limitations section.

**Rapid Response and Assessment Teams:** To provide triage personnel for those persons who are at high risk for hospitalization, but do not meet the criteria for involuntary detention, this community-based mobile team will provide a full-range of community-based services, including brief intervention, assessment, case management, and referral. Patients will be identified through community partners and on-site outreach at countywide locations, such as *Turning Point's* "tent city" where many mentally ill homeless persons reside. The teams will conduct formal psychosocial assessments, which are the basis for admission into VCBH clinical services. The teams consist of both clinicians and case managers who follow and support the client until they are successfully connected to services.

**Engager Teams:** Engager Teams will provide community-based targeted case management and outreach to those hard-to-reach persons who have newly opened cases from IPU/CRT to assure that they are accessing needed services. The Engager Teams will assist in getting clients to their initial psychosocial assessment and Individual Service Support Plan (ISSP) appointments, connecting clients with clinics, and helping clients access needed services, such as shelter services, health care, etc. The Engager Teams will also provide outreach to high-risk individuals identified in the community and will facilitate referral services to the RRA Team and/or VCBH clinics to reduce their risk of hospitalization. As needed, Engager Teams will follow patients for approximately 30 days which includes at least 2 consecutive post ISSP appointments in the clinic to ensure that clients are accessing services.

**CSC Homeless Team:** Two CSCs will transition persons connected through the Engager Teams to clinic-based services once the 30-day transition period is complete and ensure they remain connected. Focusing on outreach to the homeless mentally ill population who have high levels of hospital recidivism and create repeat Crisis Team calls, CSCs will be the mental health contact for homeless mentally ill persons in the VCBH system when crisis situations become elevated. CSC will be caring, culturally competent case managers with the goal of ensuring that homeless clients are utilizing services defined in the ISSP and remain out of the IPU. The CSCs will be mobile and based in the Ventura and Oxnard VCBH clinics, the regions with the largest numbers of homeless persons.

# Evaluation Questions & Methods[1]

| Table 2: Questions | | |
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| QUESTIONS | MEASURES | OUTCOMES |
| Are clients who receive triage grant services satisfied by these services at annual or discharge? | VCOS – Satisfaction – at annual follow-up and discharge | The average satisfaction rating by clients served by new personnel rate is 8 or better. |
| Are clients who receive triage grant services hopeful at annual or discharge? Hopefulness is associated with lower suicide risk and overall positive functioning. | VCOS – Hopefulness at annual follow-up and discharge | 80% of clients will report a Hopefulness Scale Score of 13 or lower |
| Do triage grant services reduce the costs associated with hospitalization? | Average cost per year of hospitalization post assessment from Avatar reports – baseline from existing clients in FY 2012-13 | Average cost of hospitalization of existing clients is reduced by at least 45% |
| Do triage grant services reach a sufficient number of clients? | Development of team protocols, staff employment records, Avatar service contact reports | A minimum of 3,000 persons served by VCMC A&R/OPOS staff and a minimum of 800 served by Rapid Response and Assessment Team (RRAT) each year |
| Do triage grant services allow for more crisis (including more sub-acute) crisis responses as compared to baseline? | Unduplicated persons served from Avatar and client intervention logs | At least 230 persons served in first 5 months and a minimum of 551 persons served each year |
| Does having additional triage grant funded crisis staff reduce the response time to crisis events? | Average time from call to response based on Crisis Team Call Log | At least a 5% reduction in response time from baseline |
| Do triage grant services reach a sufficient number of clients? | Unduplicated persons served from Avatar and client intervention logs who were served by Engager Teams | A minimum of 625 persons served in first five months and at least 1,500 persons served each year |
| Do triage grant services reach a sufficient number of clients? | Unduplicated persons served from Avatar and client intervention logs who were served by CSC Homeless staff | A minimum of 177 persons served in first five months and at least 425 persons served each year |
| Do triage grant services lead to clients being successfully linked to outpatient services? | At least two successive treatment appointments kept post ISSP, as determined by Avatar reports and client intervention logs/average number of | A minimum of 70% of clients eligible for mental health services and served by Engager Teams become connected with |

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| | days before first appointment/average days since last appointment (retention) | VCBH or other community-based treatment services |
| Do triage grant services lead to accurate 5150 evaluations? | IPU admissions and discharge reports | Crisis-Team generated 5150 admissions of less than 24 hours will be 15% or less of clients hospitalized |
| Are triage grant clients being offered initial intake assessments quickly? | Avatar report average number of days between request for service and the date offered for initial assessment. (Regional Teams) | Average number of days between request for service and date offered for initial assessment will be 7 days or less |
| Do triage grant services impact how frequently clients are re-hospitalized? | The percent of clients who are re-hospitalized within 30 days | Less than 5% of clients are re-hospitalized within 30 days |
| Do triage grant services reduce the need for subsequent crisis interventions within 30 days? | The percent of clients who receive Crisis Team responses within 30 days | Less than 10 % of clients require Crisis Team interventions within 30 days of a previous intervention |
| Do triage grant services reduce the time law enforcement spends at Ventura County Medical Center ER? | Average law enforcement encounters from DCRS/average time law enforcement spends with client from Avatar and Cerner EHR | Average time spent by law enforcement with clients in VCMC ER is reduced by at least 40% |



[1] See Appendix B for Methodology

# Analysis & Findings

| Table 3: Findings and Analysis | | |
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| OUTCOMES | FINDINGS | ANALYSIS |
| The average satisfaction rating by clients served by new personnel rate is 8 or better | 5.7 annual<br>6.2 discharge<br><br>(Appendix A, p. 1) | Results reflect client satisfaction with services. It should be noted that these measures are completed at the point of annual or discharge with the ongoing county clinic service provider and not solely a reflection of RISE services. A portion of the satisfaction ratings were blank, so the total number scored is less than the total number of measures received. Also, our data analysis team have noted a glitch in the electronic system that is being addressed that may impact this data point. This is being addressed with an effort to resolve as quickly as possible. When repaired, if this results is a different data outcome we will report it. |
| 80% of clients will report a Hopefulness Scale Score of 13 or lower | 85%<br>(Appendix A, p. 1) | Results reflect client hopefulness |
| Average cost of hospitalization of existing clients is reduced by at least 45% | See Limitations<br><br>(Appendix A, p. 2) | Unable to provide meaningful calculation as beginning FY 15 the cost of 1-day hospitalization increased from $2400 to $6,000 per administrative action for reasons unrelated to grant. Hospital fiscal data remained difficult to capture. See limitations section. |
| A minimum of 3,000 persons served by VCMC A&R/OPOS staff | Year 1: 0<br>Year 2: 964<br>Year 3: 1898<br>Year 4: 1598<br>(Appendix A, p. 3) | No A&R staff were hired till September 2015 when one staff started. The second A&R staff was hired in April 2016 and left in February 2017. These results reflect short staffing patterns. In addition, with ongoing lack of bed availability, many clients were sent to IPU's outside of our county which impacted the number of people staff could serve. |
| A minimum of 800 served by Rapid Response and Assessment Team (RRAT) each year | Year 1: 4<br>Year 2: 188<br>Year 3: 1473<br>Year 4: 2396<br>(Appendix A, p. 3) | The RRAT endured unexpected turnover early on. Also, some of their contacts in year 1 and 2 may have been included in the Regional Team stats below. This was fixed in our electronic health record. As staffing levels were met, number of clients served were met and exceeded target. |
| At least 230 persons served in first 5 months and a minimum of 551 persons served in each year over baseline (Crisis Team) | 1st 5 months: 215 over baseline<br>Year 1: 51 over baseline<br>Year 2: 298 over baseline<br>Year 3: 1020 over baseline<br>Year 4: 1294 over baseline | Major limitation is that most grant crisis staff were not hired until FY 16-17. And although the grant positions were filled, the larger crisis team had huge turnover still to this date, which has impacted overall crisis team stats. Ventura County Behavioral Health brought Youth crisis services in house on 7/1/16 (prior to this only adult crisis services were provided). This resulted |

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| | Baseline: 1635 (2013-2014)<br>(Appendix A, p. 4) | in a higher volume of calls which greatly exceeded our projected outcomes for FY 16-17 and 17-18. |
| At least a 5% reduction in response time from baseline. | 86 minutes (average)<br>2016-2018<br>74 minutes (average)<br>2014-2016<br><br>(Appendix A, p. 5) | Although crisis triage staff were all hired it should be noted that the crisis team struggled with high turnover and challenges with hiring over the last 2 years, at 30% below capacity. This staffing shortage has directly impacted response times. |
| A minimum of 625 persons served in first five months and at least 1,500 persons served each year (Regional Teams) | 1st 5 months:187<br>Year 1: 1069 (733 manual)<br>Year 2: 1116<br>Year 3: 1047<br>Year 4: 1754<br>(Appendix A, p. 6) | These figures demonstrate broad outreach efforts are reaching a lot of people who otherwise would not be attended to. As staffing levels continued to fluctuate due to hiring delays and turnover, targets were low, only met year 4. |
| A minimum of 177 persons served in first five months and at least 425 persons served each year (Homeless CSC) | 1st 5 months: 0<br>Year 1: 0<br>Year 2: 92<br>Year 3: 113<br>Year 4: 157<br>(Appendix A, p. 7) | First of two staff was hired late in year 1 and second one early in year 2. However, as indicated in the limitations section below, the target number was ill conceived. |
| A minimum of 70% of clients eligible for mental health services and served by Engager Teams become connected with VCBH or other community-based treatment services | 85%<br><br>(Appendix A, p. 8) | This positive result reflects a great deal of effort to engage clients beyond initial linkage to outpatient services. Staff maintain involvement for approximately 30 days from start of outpatient services and for at least 2 post ISSP appointments in our VCBH clinics to insure an effective handoff. |
| Crisis-Team generated 5150 admissions of less than 24 hours will be 15% or less of clients hospitalized | 10.25%<br><br>(Appendix A, p. 9) | This figure suggests the expanded Crisis Team is placing holds on clients who truly are at risk and are able to divert those not requiring inpatient stays to the appropriate level of care. This number has trended in a positive direction (down from 13% in the last evaluation report). |
| Less than 5% of clients are re-hospitalized within 30 days | 14.98<br><br>(Appendix A, p.10) | This figure includes all clients. It appears the interventions have not resulted in lowered IPU recidivism here. It's possible that more outreach is identifying more clients in crisis as the level of contact with client's increases. |
| Less than 10 % of clients require Crisis Team interventions within 30 days of a previous intervention | 14.7%<br><br>(Appendix A, p. 11) | This figure includes all clients, both adult and youth. It appears the interventions have not resulted in lowered crisis team recidivism here. It's possible that more outreach is identifying more clients in crisis as the level of contact with client's increases. |

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| Average number of days between request for service and date offered for initial assessment will be 7 days or less | 11 days (4-year average) Since MHSOAC granted modification: 10.7 days<br><br>(Appendix A, p. 12) | In August 2015, the MHSOAC permitted the grantee to adjust the language of the original outcome. Since the adjustment, there has been better performance. The annual average has trended in a positive direction each year, reaching in 9 days in FY 16-17. This increased slightly to 10 days in FY 17-18 due to loosing clinical assessment staff in both our RISE and STAR teams. |
| Average time spent by law enforcement with clients in VCMC ER is reduced by at least 40% | See Limitations | The grantee struggled to get baseline as VCMC and LE did not have this data. Then in September 2015 there was a licensing issue at the local IPU unit that led to LE and Crisis Teams having to transport ALL clients to ERs which confounded efforts in this area as any baseline would not be valid. This has been an ongoing concern in Ventura County and has continued to date, therefore due to this systems problem with multiple factors outside of our control. we have not been able to receive data in this area. |

## Limitations

There are 3 significant limiting factors with respect to the data included in this report:

Hiring Delays and turnover

As most of the counties awarded large grants have found, hiring qualified staff in a timely way proved to be an enormous challenge. MHSOAC acknowledged this by extending the early unspent funds to 2017-2018. However, although we were able to fill all the positions in FY 16-17, we encountered additional turnover and therefore were not able to be fully staffed. The grantee has submitted staffing reports regularly so that MHSOAC can track this. In the areas where more staffing was available, the outcomes are stronger.

Outside Factors

Two of the outcome targets could not be measured as there were system developments that confounded the process.

- Hospital costs per day were unilaterally raised in January 2015 dramatically from $2503 to $6,000. This meant that the original baseline would no longer be valid. Hospital fiscal data remained difficult to capture. A summary of RISE client data was analyzed in preparation for our MHSOAC Site visit in September 2017 and is as follows. To be able to better observe RISE outcomes over time, data from FY14/15 and FY15/16 were made the focus of the next portion of the present review. This insured at least 12 months of activity following enrollment via RISE would serve as the basis for pre- and post-RISE admission comparisons. The number of psychiatric inpatient admissions and days spent in the hospital was compared in the 12 and 24 months before and after RISE enrollment. Decreases in the use of emergency services were observed following 12 months of enrollment and correspondingly increases in the rate/length of outpatient enrollment and both locked and unlocked psychiatric placements were noted. Broadening the period under observation to 24 months revealed a similar trend with one notable exception. While the number of psychiatric inpatient stays decreased the actual length of stays increased (i.e., from 5.1 days to 9.8 days). It is hypothesized that this may reflect more considerate inpatient treatment and discharge planning/placement, possibly facilitated by outpatient treatment staff involvement, which may have tended to extend inpatient stays while reducing recidivism.

- Licensing crisis at local IPU led to sudden, unexpected diversion of all adult clients to local ERs which meant long LE and Crisis Team hours at ERs. This and the difficulty in establishing a baseline confounded the ability to address this outcome target. VCMC ER continued to require Law Enforcement supervision within their ER for all Patients on a 5150 hold. A&R also changed to the OPOS (Outpatient Psychiatric Observation Services) in January 2017. This required that all patients receive a Medical Screening Exam at a local ER prior to admission to the OPOS. This crisis in Ventura county continued as all adult mental health patients were required to go to an ER first before their mental health needs could be appropriately addressed at the OPOS and Inpatient unit. As a result, in an effort to clear their ER beds, local ER's also send more patients on a 5150 to out of county inpatient facilities. The brief crisis intervention provided by RISE BH Clinicians took place at A&R/ OPOS not the ER.

<u>Unrealistic Targets</u>

- The target for the Homeless Community Service Coordinator (CSC) teams was poorly conceived in hindsight. Since the staff are assigned to two separate teams and carry ongoing caseloads of homeless clients, it is not realistic to think that they could each see over 200 clients per year. Homeless clients do not get housing quickly and, therefore, would remain on a caseload longer. Also, there are not enough homeless clients making it to outpatient care to approach this target even under the best of circumstances. Initially the CSC's worked under the clinic management staff and were often pulled into traditional clinic roles and tasks which impacted their fidelity to the grant outcomes. Therefore, we reevaluated this structure and put them under the direct supervision of the RISE management team, while maintaining their roles outlined in the grant. As evidenced by the data, once the CSC's were moved under the RISE managements direct supervision, the caseload numbers increased.
- The target for reduction in hospital costs is likely too aggressive. There are multiple factors for hospital costs that are not directly related to triage grant services.

## Recommendations and Next Steps

Recommendations

- Allow counties to revise some of the outcomes, measures, and targets given the lessons learned during the extended implementation phase.

- Allow counties to adjust the original outreach plan to more efficiently utilize resources. For example, if permitted, the grantee would change the deployment of two staff members to work with homeless clients in the two largest outpatient clinics and, instead, redirect them to a front-end homeless effort to maximize the ability to bring more homeless individuals into treatment.

Next Steps

Based on the positive feedback we received from our community partners and stakeholders, VCBH has made efforts to not only sustain our current RISE program, but to expand our collaborations with law enforcement, schools, businesses, nonprofit organizations and other community members. Our current collaboration with our law enforcement partners has had such a positive impact on our community that they were a big part in helping the department decide on sustaining the current RISE program and have agreed to commit a dedicated officer full time to VCBH staff for our new expansion. This isn't limited to

county law enforcement i.e. sheriff, law enforcement agencies in 3 of the incorporated cities in Ventura County have also agreed to dedicate a full time officer. This will allow us to continue to outreach to the most marginalized, and vulnerable populations to reduce inpatient hospitalizations, incarcerations, and connect individuals to treatment to meet their needs. Additionally, RISE will also work closely with our Whole Person Care team to not only help these individuals meet their mental health needs, but also to help them address their physical health needs as they move through their road of recovery.