Monterey County
Behavioral Health Review

Prepared for:
Monterey County Health Department

January 2015

Ezequiel Vega, MBA, CGFM, Lead Consultant
Kyle Titus, Ph.D., Clinical Consultant

Monterey County Health Department
Behavioral Health Division

January 31, 2015

Mr. Ray Bullick
Health Director
1270 Natividad Road
Salinas, CA 93906

I am pleased to present this report on our Assessment Review of Monterey County's Health Department Behavioral Health Bureau. The report contains 21 findings and corresponding recommendations in six areas pertaining to the Bureau's delivery of services to Monterey County residents and its overall management and service environment. This report would not have been possible without the timely and professional help from Behavioral Health staff and management.

Thank you for providing me the opportunity to conduct this review and make valuable resources available such as Kyle Titus, Ph.D in order to complete the assessment. I am available to respond to any questions about this report.

Sincerely,

Ezequiel Vega
Lead Consultant

Table of Contents

Executive Summary 4

Discussion 7

- Provision of services in the Adult System of Care Access Program 7
- Policies governing intake, assessment, length of time in service, and discharge from services 11
- Expectations of staff by supervisors 12
- Service Levels and language and cultural capability 12
- Workload Analysis 13
- Workplace culture 15

Conclusion 17

Executive Summary

Ezequiel Vega and Kyle Titus Ph.D. were engaged as lead consultant and clinical consultant, respectively, to conduct this review. The objectives of the review were:

1) Assess the risk of the existence of disparate services being provided in the adult system of care access program
2) Determine the existence of consistent policies governing intake, assessment, length of time in service, and discharge from services
3) Asses the existence or non-existence of disparate expectations of staff by different supervisors
4) Review the communication methodologies by management/supervisors to staff
5) Review if service levels to clients vary based on language and cultural capability
6) Review if disparate workload and/or excessive workload exists
7) Workplace Culture

The results of this review are presented in six sections, each containing findings, conclusions, and recommendations. Altogether, there are 21 findings in this report. A summary of findings and recommendations from each report section are as follows:

1. **Provision of services in the Adult System of Care Access Program (System Wide Access)**

Summary of Findings

a) Like most organizations, the insufficiency of resources is hindering the regional offices ability to provide services to all consumers seeking services (adults and children) creating a gap in services which is reflected in long waiting lists. However, by optimizing resources this service gap can be improved. There is a volume and capacity issue.
b) Waiting lists are being managed differently at each of the clinics, with Salinas not having a formal list and South County and Coastal offices having long waiting lists. The average length of stay in the waiting list from January 1, 2013 to January 28, 2015 was 86 days.
c) There is a system in place to track referrals to Behavioral Health services but not all clinics are following it consistently.
d) The access website is not easily accessible or easily followed. Access of services via phone is also challenging and setting up appointments for services takes up to 7-8 weeks.

Options to address these findings include:

a) Review the current allocation of resources by region to determine the optimal allocation of staff for each region in order to better meet the needs of each region. This could be done by reviewing the service demand for each region and redeploy resources accordingly.
    - Establish one position to manage Access to services across the Bureau (the position could be a services manager level or deputy director level)
    - Incentivize contract providers to provide mental health services in the South County Area or other regions, and
    - Work with Beacon Services to ensure they provide services in all areas in accordance with their State contract, or
    - ***Integrate access services with primary are clinics County wide***. This will enable better service for clients by enabling care for physical and mental health. In addition, it would help better serve the mild to moderate mental health clients as primary care clinics currently have a contract to provide services for Beacon clients and obtain reimbursement for services through primary care

b) Establish a standard to manage waiting lists to include:
    - Establish clear protocols for referring clients to other organizations including primary care
    - Determine which clients currently in the system could be seen primarily in primary care with psychiatric consultation available for those clients
    - Add psychiatry medication management services to access, specifically for people who have recently needed medication refills from recent hospitalizations

c) Ensure the existing system to track referrals to and from Behavioral Health is consistently followed to ensure collaboration with other sources can be better coordinated.

d) Website needs to be simplified for ease of access to information on how to get services. Examples could be found in other Bay Area websites; i.e. Santa Cruz County. Access to services via phone needs to also be revamped by having a clinician answer the phone and triage for mental health services.

2. **Policies governing intake, assessment, length of time in service, and discharge from services**

Summary of Findings

a) Policies for the intake, assessment, and discharge from services are clearly delineated in the medical documentation manual. Specifically, policy 319 delineates standard documentation which must be completed during intake, while policy 219 outlines the general documentation guidelines for diagnosis and intakes. Specific policies for length of time in service and discharge of service were not evident during the review.

b) There is no standard screening tool which is being consistently used for intake of clients. Managers indicated the cross-cutting screening tool in the back of DSM-5 is being used in some instances for walk-in clients and staff will also get trained on the PHQ-9 as a possible standard for all clinics. During the review, it was apparent that Behavioral Health staff had already identified this as an issue and began testing potential assessment tools to be used system wide. The system is not prepared to appropriately screen and asses mild-to moderate clients requesting services.

Options to address these findings include:

a) Behavioral Health should establish a standard policy and procedure to review individuals receiving services and how to transition them to primary care or other service providers for ongoing treatment if appropriate.
    - This policy should include the review of mental illness severity on an annual basis and the appropriate level of care needed for each client

b) A standard screening tool should be implemented as soon as practicable. Behavioral Health Staff has begun testing the COJAC tool and based on meeting with staff it will be implemented system wide effective second week of July until 2nd week of August 2014. Any new screening tool which is implemented will require extensive and consistent clinical training in order to be successful. This tool should be integrated with the Medi-Cal records system to minimize the duplication of work. Using and app or medical records functionality for this task should be evaluated.

3. **Expectations and Communications from Managers to supervisors and staff**

Summary of Findings

a) Expectations of staff by supervisors are communicated during supervisory meetings will respective staff. The communication varied from writing of formal agendas with bullet points, summary communication, to verbal communication of expectations. The communication of these expectations varied depending on the preference of the supervisor.

b) Ongoing communication of policies, procedures, and other administrative directives are formally communicated through the quality improvement (QI) division of Behavioral Health. The Deputy Director of Children and Adult Services also communicates with all managers when new policies, procedures, or administrative directives are provided. These changes are written on a formal agenda. Behavioral Health Services Managers in turn communicate these changes to supervisors, who communicate to line staff. However, most of these changes are not new to staff as many of these changes are communicated system wide via the QI newsletter or website. Other ongoing operational changes are communicated by supervisors directly to staff.

Options to address these findings include:

a) Establish a consistent communication methodology for all supervisors and managers. Ensure all communication from managers is in writing or at least in outline mode. When there is a change in policy concerning to treatment, adequate training must be planned to implement the change in policy.

4. **Service Levels and language and cultural capability**

Summary of Findings

a) The system focuses on service accessibility and availability in a manner which is reflective of cultural competence principles and practices as indicated in the EQRO report.
b) Resources are not optimized for better distribution of services to better match the cultural and linguistic mix of the clients being served

Options to address these findings include:

a) The system needs to continue to focus on accessibility with a keen focus on providing culturally competent services in the community
b) Focus on optimizing current resources in the delivery of services to match the cultural and linguistic mix of the clients being served

5. **Workload Analysis**

Summary of Findings

a) Caseloads among ASOC clinicians are 35.9 on average, with the Salinas region having the greatest average at 39.3 cases and the South County region having the lowest caseload at 29.4 cases. Although the caseload numbers appear reasonable when reviewing in aggregate form, there are at least three clinician caseloads which are almost double the average clinician's caseload. These caseloads must be looked at immediately and rebalance workload among staff.
b) In general, caseloads between bilingual and non-bilingual staff vary by approximately half a case (35.1 and 34.5 respectively) for the entire system but cases for particular staff could be as high as 66 or as low as seven.
c) Medical Records Documentation and productivity for all staff is tracked in Avatar and data for each staff is summarized monthly by the Deputy Director's secretary who shares the report with all Behavioral Health Service Managers. Managers also use this report to communicate with supervisors and line staff.
    - Timely medical records documentation varied from a low of 70% to a high of 95%
    - Staff productivity varied from a low of 11% to a high of 68%
d) Doctor's productivity (system wide, excluding inpatient doctors) varied from a low of 13% to a high of 82%.
e) Doctor's caseload varied from a low of 9 to a high of 92. The number of cases was derived from the case coordinator report provided by quality improvement.

f) There is a tendency for experience clinicians to move from the Adult System of Care to other areas in the system. Newly hired staff have lower caseloads putting a strain on people with more experience.

Options to address these findings include:

a) Caseloads must be reviewed monthly to ensure the supervisors can divide cases more evenly among clinicians. The clinician caseload report can be used to accomplish this. In addition, when taking into new cases, this same report can be used to assign the new cases to clinicians with lower caseloads.
b) through e) Productivity for all staff including doctors needs to be reviewed at least monthly with quarterly trends to be discussed one on one with each staff/doctor and prepare a corrective action plan to include analysis of no shows and scheduling practices. Additionally, special productivity reports for all doctors, especially inpatient doctors, should be generated. These new reports should indicate the number of patients' visits per day, number of new clients seen per day, per week, month, quarter, etc.
e) Establish good communication between different components of the system to ensure staff talent is retained in the areas the system needs them the most while allowing for professional growth of staff and prioritizing the clients needs.

6. **Workplace Culture**

Summary of Findings

a) There are several workplace culture issues which are affecting the system's efficiency to deliver services to the community

Options to address these findings include:

a) Develop a system to enable staff to constructively provide feedback to managers. An annual anonymous survey could be a great vehicle for obtaining this feedback. Management should review the results of the survey and implement changes to improve staff morale.

Discussion

Provision of services in the Adult System of Care Access Program

Clients seeking Behavioral Health Services encounter several volume and capacity issues in order to receive services. According to the data provided by Behavioral Health Quality Improvement, during the period of January 1, 2013 to January 28, 2015; there were 2,527 clients which were placed on waiting list with the average client waiting on such a list for a period of 86 days. This information was corroborated by our site visits to the clinics where Behavioral Health Service Managers indicated the waiting list had grown significantly over the last couple of years due to increasing demand for services and inadequacy of resources to meet this demand.

Even though the number is alarmingly high, it is also important to mention that when resources are allocated to provide services, this waiting list number can be reduced. An example of this can be found in the Coastal region numbers. According to information provided by the regional manager in that office, the waiting list was as high as 79 at one point, but as seen in the report below, there are only 7 people in the waiting list as of 01/28/2015.

Program	Clients placed on waitlist	Age 0 to 25	Total Unassigned	Unassigned 0 to25
Not Assigned	112	63	60	22
Access CALWORKS	30	9	18	5
Access CALWORKS Coastal	4	0	1	0
Access School Based Services	1	0	1	0
Access To Treatment Coastal Region	615	213	5	2
Access to Treatment Gap Services Salinas	1	0	0	0
Access to Treatment King City	217	132	24	8
Access to Treatment Salinas	3	1	0	0
Access to Treatment Soledad	147	83	47	26
Access to Treatment Soledad Calworks	1	1	0	0
AS Creating New Choices-INACTIVE	1	0	1	0
AS King City Outpatient Clinic	2	0	1	0
AS Monterey Med Support	1	0	1	0
AS Monterey Outpatient	14	0	12	0
AS Path to Wellness	1	0	0	0
AS Salinas Outpatient	31	0	25	0
AS Soledad Outpatient Clinic	1	0	0	0
Bienestar Grant	229	16	11	0
CS Education IEP Coastal	48	48	29	29
CS Education IEP Salinas	47	47	10	10
CS Family Partnership	1	1	1	1
CS Family Preservation	15	15	6	6
CS Family Reunification FSP	145	19	27	6
CS FAST Dependency Unit	300	204	11	9
CS JJ SAMHSA MHSA	271	271	16	16
CS MCSTART	78	78	8	8
CS MHSA TIP Avanza SYSDEV	6	6	6	6
CS Monterey OP Clinic 26.5	64	64	0	0
CS Salinas Outpatient Clinic 26.5	123	123	0	0
ER Crisis NMC	1	1	0	0
Interim Sunflower Garden	1	0	1	0
Pre-Admission Program	13	6	6	3
Pre-Admission Program NoS	1	1	1	1
YWCA Soledad Outpatient Clinic	2	2	2	2
Total	2,527	1,404	331	160
		56%	**13%**	**48%**

The improvement could be attributed to the hiring of a social worker III in that office over the last nine months and the proactive response by the Service Manager in that office to reduce the waitlist significantly.

This example speaks to issues of capacity and volume. The system received requests for service from at least 2,527 of which 56% were children (ages 0-25) and 44% were adults. In 2014, it is estimated there were 1622 individuals admitted in ACCESS in 2013 (2014 will have increase). This number represents 31 clients a week seeking services, of this number, about 38% of individuals seek treatment services come through Walk in Wednesday. This contrasts with the staffing levels the three regional offices, 2 Psychiatric Social Workers (PSW) in Marina, 4 total PSW in Salinas, and approximately 2.5 PSW in South County. There are more clients than can be seen so the average wait for first appointment is currently 86 days.

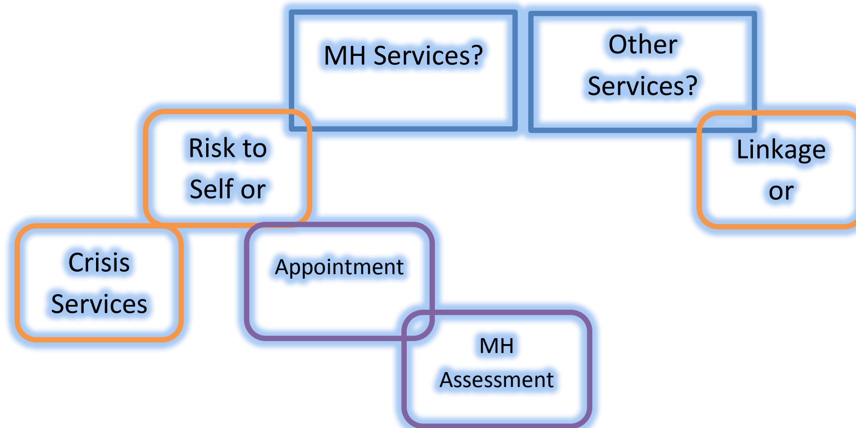
The issue is exacerbated since referrals keep coming from various sources. As an example, there are about 50-60 individuals referred monthly from Primary Care to Behavioral Health Access; there are also 20- to 40 Medi-Cal eligible individuals referred from inpatient discharge from NMC and CHOMP per month. Additionally, referrals from Cal Works, Promontories, DSES, crisis team, other community service providers are also adding to the issues of the system to serve the clients seeking services through Access. Access is overwhelmed not only in providing Assessments in a timely manner; they also lack treatment resources for the individuals who complete the assessment phase. Although clinic managers have made every effort to address this issue, an imbalance between the number of clients seeking services and resources available has not allowed this gap to be closed.

This issue is not specific to Monterey County. During our research, we found that the County of San Benito has similar issues with waiting lists. However, the process for providing clients with access to services is slightly different. San Benito and other bay area counties (Santa Clara, San Benito, Santa Cruz, and Santa Barbara) offer different community resources they can contract with to help with the volume of service. Generally, all Counties used the same system for access, which included:

- Calls come into an ACCESS call center (800 number)
- Call is answered by a clinical person who assesses for safety/risk

- The clinical person gathers presenting problem issues- (in a warm engaging way) and begins a log of data in the EMR.
- Checks the payment/insurance source, triage if necessary for crisis or other services.

If the individual is seeking non emergent services, the clinician has access to intake/assessment appointments in their system and schedules one either with a County clinician or a contractor who will provide service (most take about 2 weeks to 2 months to get appointment). This model is similar to the one recommended by Dr. Sandoval in her access report. A flow chart of this model is shown above. A model like this one is beginning to be designed at the management level in behavioral health. A



conceptual framework of how this model would be as follows.

The existing 800 number will be the main avenue for clients seeking services to contact behavioral health; the website will be redesigned to be more users friendly and will follow designs of other bay area counties. New clients seeking services at the clinics will be given an appointment or will be asked to call the 800 number or faster service.

- A clinical staff (triage clinician) will answer the phone. There will be a backup to the triage clinician in case he/she is out on a certain date. The trial clinician will be rotated among a pool of staff so that different individuals located at any of the offices in the County can perform this role at any given time.
    - If the person seeking services is new to the the triage clinician will ask for basic questions to register the client (if appropriate) or refer to other relevant services in the community
        - Scheduling of an appointment will occur within 7-14 days with clinician or doctor, if an emergency, the clinician will coordinate services with the crisis team or emergency services at the hospital as appropriate
            - The appointment will be scheduled with either:
                - Short term treatment staff dedicated to provide services to new clients needing short term treatment
                    - The modality of treatment will be either group or individual treatment
                        - Training required for Evidence Based Practices for treatment in groups or individual
                - Staff providing services in the children System of Care (specialists in school based services, adult system of care, TAY, etc.)
                - Referrals to community services or BH Contractors

            - If the person seeking services is already a client and the need is not emergent the triage clinician will schedule an appointment with the clinician handling the case; if clinician out a referral to supervisor, and if supervisor out then officer of the day will talk to the client.

This plan will require that certain resources are identified. These resources include:

- Location of clinicians, linguistic capabilities of new hires to meet the demand,
- Need dedicated staff for short term treatment
- System to track referrals in and out of the system
- Maintain caseloads for existing staff between 30-40 active ongoing clients depending on acuity of clients

Before moving in this direction, Behavioral Health will have to consider the following:

- The current number of client calls per day by region and linguistic preferences per week, month, and year. Need to identify a redundancy system to backups
- Refine how walk in clients will be better served (every day, and eliminate walk in Wednesdays)
- Determine the need for telecommunication devices in the lobby to access other resources in the system, including telemedicine equipment to reach psychiatrists if needed.
- Exploring the inclusion of technology such as iPad, computer kiosks, or other technology to have the clients enter basic information for pre-admission status and facilitate expediency in serving clients.
- An initial startup budget will have to be developed
    - A ballpark cost and staffing is shown below

Item	Cost
Deputy Director	$ 200,000
2 psychiatrists	$ 600,000
10 clinicians	$1,200,000
One time equipment costs	$ 400,000
6 System navigators (SW III or MA, or BHA)$	$ 480,000
Supervisor (existing position)	$ 150,000
Admin costs	$ 150,000
Totals	$2,980,000

Primary Care and Behavioral Health collaboration

With Mental Health Parity and the Affordable Care Act (ACA) more individuals than ever are now eligible for mental health services. Historically, the public mental Health System has focused on the seriously and persistently mentally ill. With the increase in individuals eligible for services including individuals with mild to moderate mental health issues coupled with the limited capacity of current services there is a greater need for collaboration between primary health care and behavioral health services. In this recent review it was found that there are between 50 and 70 monthly new referrals from health care providers to behavioral health.

As Monterey County Behavioral Health works to reorganize its access and short term treatment services it needs to develop a closer more integrated relationship with primary care. This collaborative, evolving care model offers an approach that could help bridge the gap for increased and unmet needs of community residents. An Integrated primary care and behavioral health setting offers an efficient way of ensuring service while minimizing stigma and discrimination. It is well documented in the literature that there are challenges in developing an integrated services. They include: current fragmented service delivery systems, difficulty in sharing information across systems, and differing reimbursement

requirements. Given these larger system challenges it is recommended that the Behavioral Health Access and short term treatment be reorganized so that integration of behavioral health services can be coordinated between primary care and behavioral health.

Policies governing intake, assessment, length of time in service, and discharge from services

During our interviews it was evident that Behavioral Health has strived to develop many good policies to provide direction to staff regarding the provision of services to clients, how to stay productive, use the Electronic Medical Records (EMR) system, and meet the documentation requirements of various funding sources. However, policies which delineate the ongoing review of services and parameters to determine if individuals can be discharged or referred to lower levels of service was not evident. It was also evident that the partnership with primary health clinics needs to be further developed. If this partnership is developed, there is a greater possibility of clients overall mental and physical health needs being met.

The documentation manual is a great document to be used for reference by clinicians throughout the system. In addition, the policies for discharge from services are clearly delineated in the medical documentation manual. Specifically, policy 319 delineates standard documentation which must be completed during intake, while policy 219 outlines the general documentation guidelines for diagnosis and intakes. Specific policies for length of time in service and discharge of service were not evident during the review. Even though the aforementioned policies clearly delineate the steps to perform these functions and how to document them, there is no standard that requires cases to be reviewed for potential discharge or handoff to other partners in the community such as primary care clinics.

The same applies to a standard for screening clients seeking services. This need was identified in Doctor Sandoval's report where she recommended the review and piloting of standard screening tools in access such as the COJAC. Based on the information obtained during the review, Behavioral health piloted this tool in the Salinas office from July until the second week of August of 2014. Results of the implementation of this tool were mixed. Some clinicians believed this tool was helpful or could have been helpful; however, systematic and in depth training for the utilization of such a tool was not sufficient to fully evaluate the effectiveness of such a tool. Accordingly, this tool has not been implemented system wide. In fact, managers indicated their clinics are currently utilizing the cross-cutting screening tool in the back of DSM-5 is being used in some instances for walk-in clients and staff will also get trained on the PHQ-9 as a possible standard for all clinics. During the review, it was apparent that Behavioral Health staff had already identified this as an issue and began testing potential assessment tools to be used system wide. The system is not prepared to appropriately screen and asses mid-to moderate clients requesting services at this point. Additional training, staffing, and other resources would be required for the system to better serve the clients seeking services.

Table 6.1 Summary of Caseloads and Bilingual Capabilities

Clinic	Title	Sum of Caseload	FTE	Average
Coastal	PSW I	189.00	5.00	37.8
	PSW I	46.00	1.00	46.0
	PSW II	100.00	3.00	33.3
	PSW II	44.00	1.00	44.0
Coastal Total		**379.00**	**10.00**	**37.9**
Salinas	PSW I	294.00	8.00	36.8
	PSW II	301.00	7.00	43.0
	PSW Trainee	33.00	1.00	33.0
Salinas Total		**628.00**	**16.00**	**39.3**
South County	PSW I	75.00	2.00	37.5
	PSW I	120.00	4.00	30.0
	PSW II	128.00	5.00	25.6
South County Total		**323.00**	**11.00**	**29.4**
Grand Total		**1,330.00**	**37.00**	**35.9**

This lack of consistent policies has aided the growth of caseloads for clinicians the adult system of care and access.

As seen in table 6.1, aggregate caseloads for each regional office are within the targeted goal of 30-40 cases per clinician; however, there are some positions which exceed this targeted goal. This caseload imbalance could be helped by identifying clients which are currently being served in these clinics which could be transitioned to be served in the primary care setting with the availability of behavioral health services clinicians and psychiatrists. The feasibility of this type of model could be better assessed after reviewing the data presented by the study to be performed by Dr. Lewis, a consultant engaged by the health department to evaluate this scenario by looking at a sample of clients in both systems (behavioral health and primary care).

Table 3.1

Average of Percentage of notes written within 72 business hours Team	Total
ASOC, Salinas Valley Team 2	70.18
ASOC, Salinas Valley Team 1	72.11
ASOC, South County Team	72.72
NMC MHU	74.19
ASOC, Salinas Access Team	80.85
Acute	85.98
ASOC, Coastal Region	86.70
NMC Crisis Team	87.19
ASOC, CALWORKS	90.51
ASOC, Coastal Access Team	92.30
AOD	93.38
ASOC, Coastal Region 2	94.55

Expectations of staff by supervisors

As the executive summary to this report explains, expectations of staff by supervisors are communicated in different manners in accordance to the management style of each supervisor. In some instances, communication of expectations is communicated during supervisory meetings with respective staff. Some supervisors communicated these expectations and documented them in the performance evaluations of the employees while others did not. The communication to employees varied from writing of formal agendas with bullet points, summary communication, to verbal communication of expectations.

Evidence of the varied style of communications and corresponding results could be traced to the compliance with a couple of important policies in the organization. One of these policies refers to the compliance with documentation of services provided. As seen on table 3.1; there is a large variation with compliance with this policy in the adult system of care with the lowest level at 70.18 percent of then notes being entered within 72 hours and 94.55% of the time at the highest level. Although the data shown above reflects numbers In order to alleviate this level of variance, it is recommended that supervisors communicate systematically in writing how the policies will be implemented, provide ample system wide training for supervisors and staff about the expectations of complying with system wide policies.

Service Levels and language and cultural capability

In accordance with the FY 2013-14 California External Quality Review Organization (CAEQRO) report for the period of August 2013; Monterey County Behavioral Health (MCBH) services accessibility and availability are reflective of cultural competence principles and practices. This Same report also indicates that MCBH "tracks and trends service provision and need by region with consistent focus on identifying service disparities to the regions that ae home to the highest concentrations of Latinos" and plans on expanding resources in the areas where these services are needed. This was apparent the by opening of the second clinic in South County (Soledad). However, the same report also indicates that the services to the Latino population remain well below the statewide average. Additionally, this same report also points out that the percentage of Latinos receiving three of fewer services exceeds the percentage of those receiving more than three services. This indicates that more work is still needed to retain the Latino population so they can receive services which can help improve their mental health.

Table 6.2b Summary of Caseload and Bilingual Capability			
Title	(Multiple Items)		
Bilingual?	**'Caseload**	**FTE**	**Average**
Yes	636.00	18.00	35.3
No	694.00	19.00	36.5
Grand Total	**1,330.00**	**37.00**	35.9

In addition, MCBH own report (Monterey County Behavioral Health Quality Improvement 1Q 2013), indicates of the total number of clients being served in the County, the largest majority is Latino (56%), followed by White (25%). However, the total services provided to the Latino clients amounts to only 49% of total services, creating a 7% gap between the service population and services provided for this ethnic group. (how long does it take to bilingual people to get service vs. other people)

Correspondingly, our analysis of data showed that in the Adult System of Care, the staffing which providers services in this program has about equal number of bilingual and non-bilingual staff and the average caseloads for each group of staff is about the same. As seen in table 6.2b; the total number of licensed staff providing services is 37, with 48.6% of the possessing bilingual skills. The caseload for bilingual and non-bilingual staff averaged 35.3 and 36.5 respectively, while the average system wide was 35.9 cases. Even though the analysis shows that general terms there is parity in caseloads between bilingual and non-bilingual staff; it is important for management to dig deeper into the analysis as some individual staff has higher levels of cases that others. More details about workloads will be analyzed in the following section of the report.

Workload Analysis

Our caseload analysis looked at point time and realizes that caseload numbers could fluctuate over the course of the year. Information presented in the report attempts to summarize data for management in an effort to provide a tool to review data in an ongoing basis.

Table 6.1 Summary of Caseloads and Bilingual Capabilities				
Clinic	**Title**	**Sum of Caseload**	**FTE**	**Average**
Coastal	PSW I	189.00	5.00	37.8
	PSW I	46.00	1.00	46.0
	PSW II	100.00	3.00	33.3
	PSW II	44.00	1.00	44.0
Coastal Total		**379.00**	**10.00**	**37.9**
Salinas	PSW I	294.00	8.00	36.8
	PSW II	301.00	7.00	43.0
	PSW Trainee	33.00	1.00	33.0
Salinas Total		**628.00**	**16.00**	**39.3**
South County	PSW I	75.00	2.00	37.5
	PSW I	120.00	4.00	30.0
	PSW II	128.00	5.00	25.6
South County Total		**323.00**	**11.00**	**29.4**
Grand Total		**1,330.00**	**37.00**	**35.9**

In general, ASOC wide workload based on caseloads is 35.9 on average. The Salinas region has the greatest number of cases at 39.3 cases per clinician and the South County region having the lowest number of cases per clinician at 29.4cases. As indicated previously in the report, this number is within the Bureau's targeted goal of 30-40 cases per clinician. However; deeper review of data shows that some clinicians have grater caseloads than others. For example, some individual clinicians had caseloads of up to 66 cases while one clinician had a caseload of only seven. The gap between these types of numbers needs to be reviewed for appropriateness as some clients might need more intensive services than others and the numbers on their own do not necessarily reflect the true workload of the clinician.

Similarly, caseloads between bilingual and non-bilingual staff vary by approximately half a case (35.1 and 34.5 respectively) for the entire system but cases for particular staff could be as high as 66 or as low as seven.

Table 6.2 Summary of Caseload and Bilingual Capability				
Bilingual?	**Title**	**'Caseload**	**FTE**	**Average**
Yes	PSW I	75.00	2.00	37.5
	PSW I	275.00	8.00	34.4
	PSW I	46.00	1.00	46.0
	PSW II	240.00	7.00	34.3
Yes Total		**636.00**	**18.00**	35.3
No	PSW I	328.00	9.00	36.4
	PSW II	289.00	8.00	36.1
	PSW II	44.00	1.00	44.0
	PSW Trainee	33.00	1.00	33.0
No Total		**694.00**	**19.00**	36.5
Grand Total		**1,330.00**	**37.00**	35.9

Although the medical records documentation and productivity for all staff is tracked in Avatar and data for each staff is summarized monthly by the Deputy Director's secretary who shares the report with all Behavioral Health Service Managers; and managers also use this report to communicate with supervisors and line staff; data analysis shows a wide range of compliance with the policy. Medical records documentation varied from a low of 70% to a high of 95% and staff productivity varied from a low of 23.1% to a high of 63.6% for an overall average of 51.2%. If the children's programs productivity is removed from this equation, the ASOC productivity has an average of 51.9%, slightly higher than the overall system productivity.

Doctor's productivity (system wide, excluding inpatient doctors) varied from a low of 13.4% to a high of 88.5%. Doctor's caseload varied from a low of 9 to a high of 92. The number of cases was derived from the case coordinator report provided by quality improvement. Some of the options to address these findings include the review of productivity reports monthly to ensure the supervisors can divide cases more evenly among clinicians. The clinician caseload report can be used to accomplish this. In addition, when taking into new cases, this same report can be used to assign the new cases to clinicians with lower caseloads. Similarly, productivity for doctors needs to be reviewed at least monthly with quarterly trends to be discussed one on one with each doctor and prepare a corrective action plan to include analysis of no shows and scheduling practices. Additionally, special productivity reports for all doctors, especially inpatient doctors, should be generated. These new reports should indicate the number of patients' visits per day, number of new clients seen per day, per week, month, quarter, etc.

P1: Management Team Producti

Avg Productivity Row Labels	Grand Total
ASOC Acute MHU Crisis	23.1%
MD	34.7%
ASOC AOD and Forensic	37.4%
South County Team - King City	46.4%
CSOC Education Team	46.5%
CSOC Placement Team	49.0%
ASOC Salinas Regional Team	51.8%
South County Team - Soledad	52.9%
CSOC DSES/FAST Team	58.5%
CSOC TAY and Early Interventio	59.3%
ASOC Coastal Regional Team	61.4%
CSOC Juvenile Justice Team	63.6%
Grand Total	**51.2%**

P1: Management Team Productivity

Avg Productivity Row Labels	Grand Total
ASOC Acute MHU Crisis	23.1%
ASOC AOD and Forensic	37.4%
South County Team - King City	46.4%
ASOC Salinas Regional Team	51.8%
South County Team - Soledad	52.9%
CSOC DSES/FAST Team	58.5%
ASOC Coastal Regional Team	61.4%
Grand Total	**51.9%**

All these productivity numbers in conjunction with the caseload numbers indicate that resources are not optimally allocated to serve clients throughout the County and this optimization should be re-evaluated.

In order to optimize these resources, the Adult System of Care would benefit from a Level of Care assessment tool that would allow clinicians to use the rating from the scale to assist in the

determination of what level of treatment service an individual may benefit from, and assist in helping to target the level of service an individual may benefit from over the next service period.
There are several instruments available for consideration. The State of California, as well as, several other States piloted a tool called the LOCUS (Level of Care Utilization Scale). Additionally, some managed care program such as, Aetna, have developed tools to help determine the appropriate level or type of care an individual would most benefit from. Under such models, the level of care an individual requires would be measured annually at the time of the individual service update. The clinician, in collaboration with the individual client, would review the individual's current clinical status and life events over the past year. This review of events and current clinical status would determine the level of care needed during the coming year.

Most Levels of Care Assessment tools have four levels of service needs that can be identified as follows:

- **Level One:** An individual who has had many unplanned MH services including hospitalizations, or has co-occurring life stresses that impact the stability of the individual's mental health. This level may require a Full Service Partnership (FSP) or Assertive Community treatment. Under this level of care a clinician's caseload size maybe much smaller with a limit of up to 12 individuals
- **Level Two:** An individual who is an active change process in their life, or attempting to move to a lower level of care, and may require some intensive level of service to assist with the facilitation of these changes or to maintain their living in the community without moving to a higher level of care. Under this level of care a clinician's caseload size maybe up to 25
- **Level Three:** An individual has been stable based on a consistent level of MH support that would include case management and medication management services. These individuals might be living in a residential facility. This level of outpatient mental health treatment with some case management, and medication stabilization could be managed in a caseload size of up to 40.
- **Level Four:** Medication only services. Individuals in this level of care have achieved stable community living and has managed with medication support. They may be in the process of some medication change-- or adjustment. These individuals could potentially be moved transitioned into services provided in primary care settings.

In accordance with these levels, it is recommended that the ASOC review the measurement tools available and select a tool that would assist in identifying the level of care and level of treatment required to remain in the community and look at assessing caseloads to develop specific clinical treatment teams to service individuals within the various service levels. This would include development of intensive Assertive Community Treatment Teams in reach regional office for service individuals who are high users of sometimes unplanned mental health services. This could reduce the number of hospitalizations or re-admissions.

Workplace culture

This aspect of the review could be better summarized by reviewing the feedback received from employees via the employee survey. Overall, a large number of staff responded to the employee survey. Additionally, staff took time to write thoughtful suggestions. This report attempts to highlight themes that came from the written responses.

Generally, responses fell into 6 categories.

Category	Percent
Management issues	38%
Direct Supervisors	14%
Workload/Caseload Concerns	20%
Clinical Focus Training	18%
QI/HER	5%
Work Environment Safety	3%
Other	2%

Quantitative and Qualitative Analysis of the written response:

The largest number of written responses was in the area of general management issues, 38%. Additionally, two smaller management areas of concern included: Supervisors, 14% and QI- electronic health record 5%. If you add these three management areas together it represents 57%, or the majority of staff written concerns. Other areas frequently mentioned by the ASOC staff were high caseload/workload, 20%; with training, clinical focus and job advancement representing 18% of comments. Workplace safety emerged 3% of the time. The remainder of the comments were personal comments regarding an individual pay, or concern about this survey.

These numbers are interesting because it reflects the staff interest in providing good services to the individuals they serve. (20% + 18%=38%) while feeling unsupported, not included in communication and mistrusting of management. (38%+14%+5%=57%)

Themes that emerged in each category are presented below:

Management Issues:

- Better decision making practices in setting priorities
- Diversify the power structure
- Review patterns of administrative actions
- Greater transparency for management decisions
- Create a culture that is willing to receive input, ideas
- There needs to be a way to seek change without fear of retribution
- Lack of diversity among top management
- Elimination of favoritism practices

Supervisors:

- Rotate supervisors and provide them with managerial mentoring
- Value team members input
- Remove areas in policies that state "supervisor's discretion"
- Encourage better communication
- Improve workplace ethic's
- Re schedule supervision if it's canceled

QI /EHR:

- Better balance between QI requests and the realities of staff and workload
- Require more reasonable QI goals

- Provide more EHR training especially for supervisors

Workload Caseload concerns:
- Reasonable workload/caseloads
- Better Clarify SWIII and PSW roles
- Consistent accountability for productivity between staff in same job classification
- Review reasons for high turn over-and transfers from ASOC to CSOC
- Need senior PSW positions in ASOC to mentor and retain staff
- Heavy workload-- and unfair hiring practices

Clinical focus/ training
- More ACT case management (Assertive Community Treatment)
- Provide more opportunity for case consultation/ peer to peer opportunities
- Mentoring
- More innovative approaches to client care
- More training and support around Evidence based practices
- Pressure Beacon to provide more services for mild to moderate individuals
- More clinical training opportunities provided in house

Work environment/ safety issues:
- Improve clinic security
- Create safer workplace-emergency communications

Conclusion

Overall there are 21 findings which resulted from this review. There are many dedicated staff and managers who are currently providing good service to the community; and with the implementation of the recommended changes, service delivery, optimization of resources, and job satisfaction could be improved.