County of Orange Mental Health Board
2013 Annual Report
Health Care Agency, Behavioral Health Services

MESSAGE FROM THE CHAIR

"...there is a level of commitment and compassion here in Orange County's mental health community that truly inspires me."

This year has been a year of major accomplishments for the Orange County Mental Health Board. We have increased our role in the Mental Health Services Act (MHSA) process, with our active membership on the MHSA Steering Committee and hosting the Public Hearing and approving the MHSA Plan Update Fiscal Year 2013/14. Our strong support of several important mental health issues in the county is ongoing. Notably, Assembly Bill (AB) 1421 also known as "Laura's Law" and Welfare and Institutions Code (WIC) 5270 also known as "30-day Hold." We have continued to host several successful outreach meetings in the county to solicit citizen input into the county mental health planning process. Our Centralized Assessment Team (CAT) Ad Hoc Committee has provided input in efforts of improving the CAT Team's approach to mental health. Finally, we also have significantly strengthened the Mental Health Board's structure through updating and improving our Bylaws, refining our public agenda process, and most importantly aiding in the appointment of four new board members. These new board members certainly bring a new perspective and capabilities to our team.

When I reflect on those with whom I have worked on this over the past year, members of the Mental Health Board and Behavioral Health Services staff, I am highly impressed by the level of commitment and caring that is demonstrated in their work ethic. From the "hands on" mental health counselor providing direct services who enjoys helping those in need to the seasoned administrator who continues to give 110% toward making the world a better place, there is a level of commitment and compassion here in Orange County's mental health community that truly inspires me. It is my pleasure to serve with my colleagues in such a progressive and enlightened environment.

Richard E. McConaughy, Ph.D., Chair
Orange County Mental Health Board

ORANGE COUNTY BOARD OF SUPERVISORS

Shawn Nelson, Chairman
Fourth District Supervisor

Patricia C. Bates, Vice-Chairperson
Fifth District Supervisor

Janet Nguyen
First District Supervisor

John M. W. Moorlach
Second District Supervisor

Todd Spitzer
Third District Supervisor

MESSAGE FROM THE COUNTY BEHAVIORAL HEALTH SERVICES DIRECTOR

Greetings!

As the Behavioral Health Services Director, it is very important to me that we provide our clients, family members, and participants with the highest quality of services. I believe we should all be unwilling to settle for anything short of excellence. Over the past several years, we have discussed a reorganization of Behavioral Health Services (BHS). I am excited to announce that the reorganization was implemented in December 2013.

The reorganization will align operational functions with the overall mission of BHS - to prevent substance use and mental health disorders; when signs are present, intervene early and appropriately; and when assessments indicate that treatment is required, provide the right type of treatment, at the right place, by the right person/program to help individuals achieve and maintain the highest quality of health and wellness.

BHS is now divided into the three function areas: (1) Authority and Quality Improvement; (2) Adult and Older Adult Services; and (3) Children, Youth and Prevention Services. Services are organized by function rather than funding source. Mental health services and alcohol and drug services have been integrated, enhancing BHS' ability to treat those with co-occurring mental health and substance use disorders. Attached please find the new organizational chart.

In other exciting BHS news, the Department of Healthcare Services (DHCS) completed their Triennial Audit of our Mental Health System in October 2013. This audit consisted of two parts: a System Review and a Chart Review. The auditors looked broadly at the system and evaluated things such as access to services, beneficiary protection, fiscal reporting procedures, quality improvement activities, processes with contract agencies, and monitoring procedures to ensure compliance. Of the 343 services reviewed, only 20 of them were recouped by the State, thus placing the error rate at about 5%. One of the reviewers noted that Orange County was one of the best that she has ever reviewed. This is a phenomenal outcome and demonstrates the hard work that occurs at all levels.

As we have seen over the years, Mental Health Services Act (MHSA) funding has allowed BHS to make substantial progress in improving

the lives of people living at risk of developing mental illness. We have also made progress in transforming the public mental health system to improve coordination of care; move toward an electronic health record system; prepare for Health Care reform; and to work collaboratively with our community partners. Particularly, the Mental Health Board (MHB), BHS staff and I worked together on recommendations to the MHSA Steering Committee to expand current programs and implement new programs. In September 2013, the MHSA Steering Committee approved the recommendations to expand the following programs: Program for Assertive Community Treatment (PACT); Children's Crisis Residential; Children's In-Home Stabilization; Orange County Post-Partum Wellness Program (OC PPW); and Socialization Program (Early Intervention). In December 2013, the MHSA Steering Committee also approved the recommendations to fund the following new programs: Wellness Center (South Orange County); Transportation Services; Assisted Outpatient Treatment; Adult/TAY In-Home Stabilization Program; and Behavioral Health Counseling Program.

2013 was a very productive year for the Mental Health Board and Behavioral Health Services. On behalf of Behavioral Health Services, I would like to commend and thank the Orange County Mental Health Board. The members of the board serve voluntarily and work with immense dedication and passion as a driving force for the County mental health community. I wish you and your family good health, happiness, and peace in 2014!

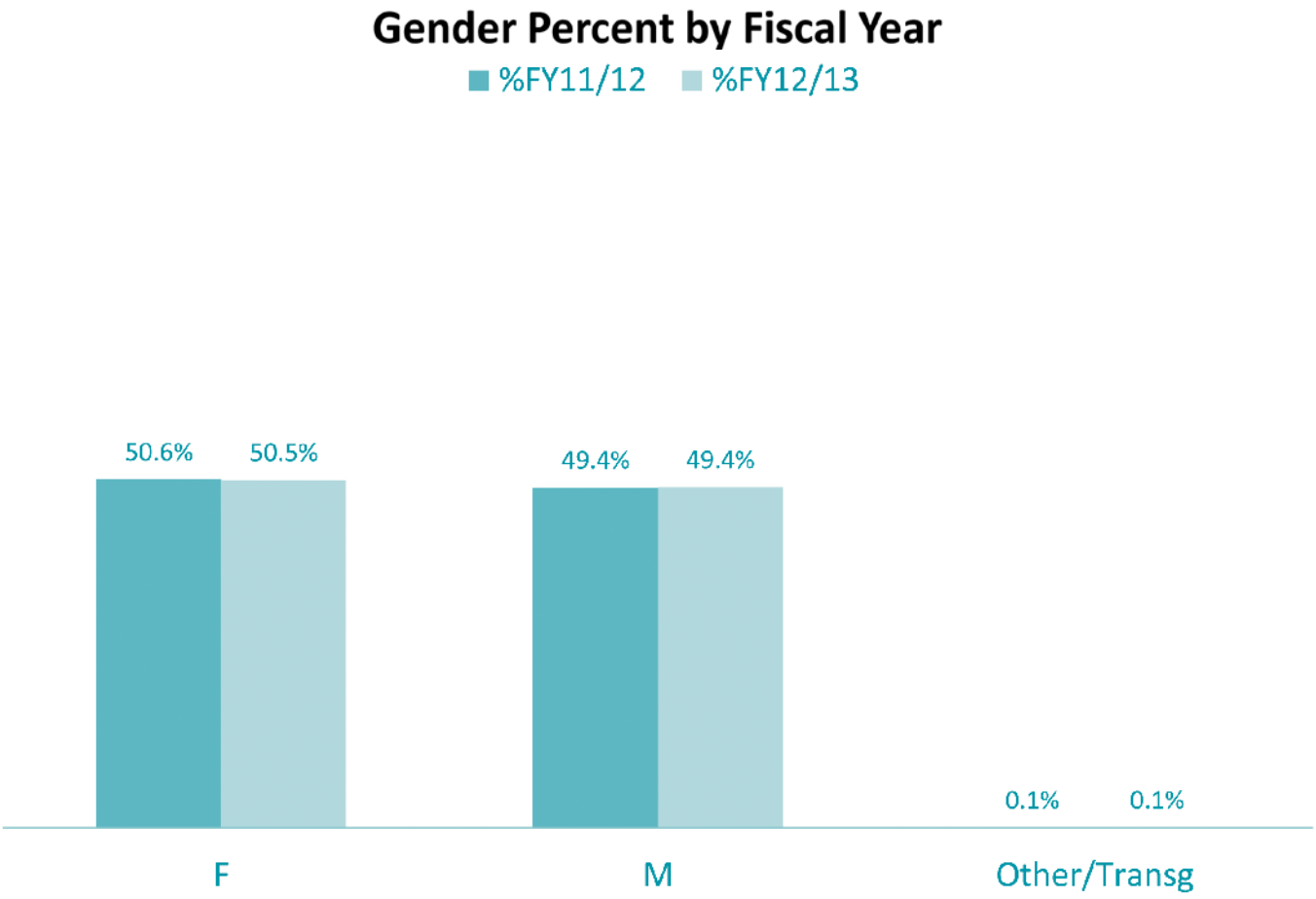
Sincerely,

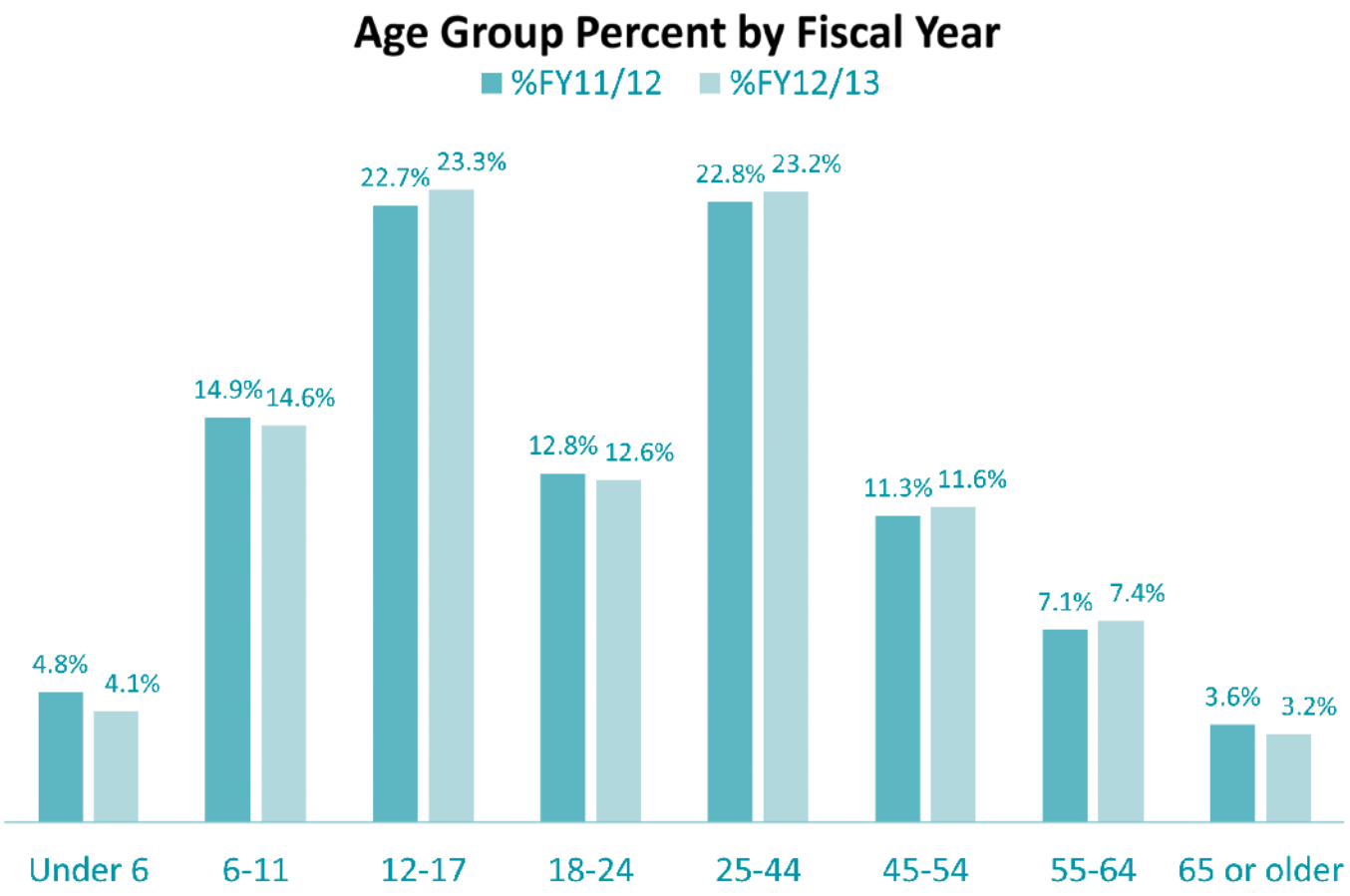
Mary R. Hale, M.S.
Behavioral Health Services Director
Orange County Health Care Agency

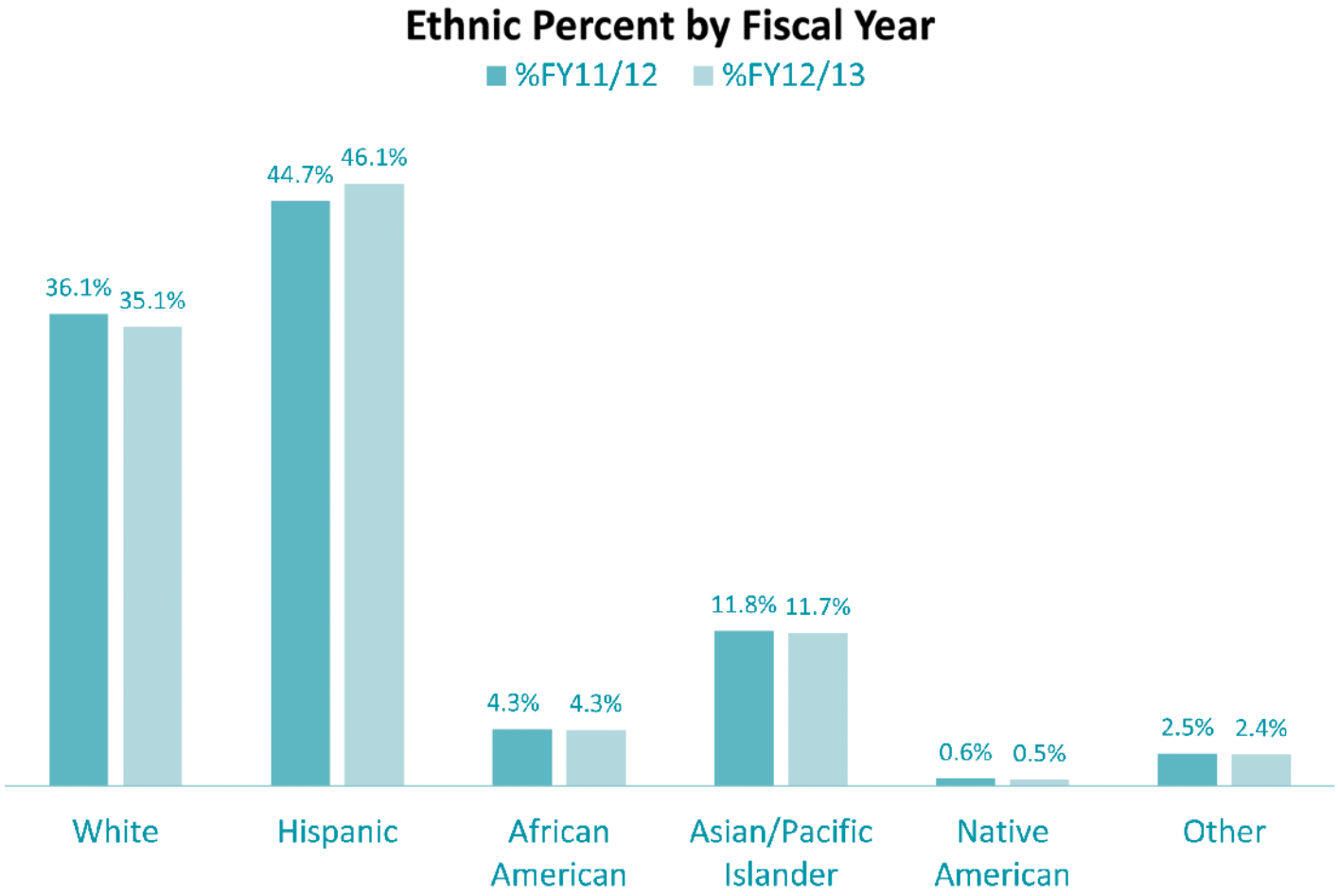
DEMOGRAPHIC CHARACTERISTICS OF CLIENTS SERVED BY ORANGE COUNTY HEALTH CARE AGENCY

Behavioral Health Services (BHS) and its contract providers offer an array of mental health and substance use treatment services to clients in intermediate and long-term care facilities and clients receiving outpatient services.

Total clients served by gender, age and ethnicity.




Age Group Percent by Fiscal Year
%FY11/12
%FY12/13
4.8%
4.1%
14.9%
14.6%
22.7%
23.3%
12.8%
12.6%
22.8%
23.2%
11.3%
11.6%
7.1%
7.4%
3.6%
3.2%
Under 6
6-11
12-17
18-24
25-44
45-54
55-64
65 or older


Ethnic Percent by Fiscal Year
%FY11/12
%FY12/13
36.1%
35.1%
44.7%
46.1%
4.3%
4.3%
11.8%
11.7%
0.6%
0.5%
2.5%
2.4%
White
Hispanic
African American
Asian/Pacific Islander
Native American
Other

ABOUT THE MENTAL HEALTH BOARD

The annual report of the Mental Health Board (MHB) is submitted in accordance with the California Welfare and Institutions Code 5604.2(a). Under state law the Mental Health Board is required to review and evaluate the mental health needs, services, and special projects in the Orange County Community. The Mental Health Board requirements also include advising the Board of Supervisors and Behavioral Health Services Director as to any aspect of the local mental health programs.

The Mental Health Board is comprised of 15 members plus one member of the Board of Supervisors. Each Supervisor makes an individual appointment, and the MHB Nominating Committee also recommends the appointment of new members. The categories of membership include:

- Member of the Board of Supervisors
- Consumer
- Family Member
- Mental Health Professional
- Public Interest

In 2013, the board met regularly twice a month at a Study Committee Planning Meeting and General Meeting. The Mental Health Board serves as a link between the Board of Supervisors and Behavioral Health Services by enhancing public input into the execution of community behavioral health care services.

MEET THE MENTAL HEALTH BOARD

Supervisor Patricia C. Bates
Fifth District
patbates@ocgov.com

Jeffrey Davis
Public Interest
jdavis6761@aol.com

Ehsan Gharadjedaghi, Psy.D.
Direct Consumer
info@mypost.com

April Guajardo, MS
Family Member
aguajardo@sce.edu

Suzi Gulshan, CFA
Direct Consumer
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Brian Jacobs
Consumer/Family Member
bjacobs1@socal.rr.com

Carol Langone, LCSW
Mental Health Professional

Judith Lewis
Family Member
judilewis@aol.com

Nomi Lonky, RN, RNP
Public Interest/Mental Health Professional
nomilonky@gmail.com

Karyn Mendoza, LCSW
Family Member
kmendoza@tallersanjose.org

Richard McConaughy, Ph.D.
Public Interest/Direct Consumer
macmccon_41@yahoo.com

Carolyn Nguyen, M.D.
Public Interest/Mental Health Professional
drcarolyn@drcarolyn.com

Michaell Rose, LCSW
Public Interest
mrose@hoaghospital.org

Gregory Swift, MFT
Public Interest/Direct Consumer
greg.swift@hsala.org

Gregory D. Wright
Family Member
gdwrightla@cs.com

FAREWELL

Richard McConaughy, Suzie Gulshan

Suzie P. Gulshan

Suzie was appointed to the board on November 9, 2010. After one term (3 years) of service, Suzie left the board to pursue her professional goals. Suzie was recognized for her service to the Orange County mental health community and presented with a Certificate of Appreciation at the General Meeting on September 25, 2013.

Richard McConaughy, Carol Langone, Jenny Qian

Carol Langone, LCSW

Carol was appointed to the board on October 30, 2007 and served two complete terms (6 years). During her service on the board, Carol represented the Board of Supervisors, Fifth District Office as their appointee. She chaired the Legislative Committee, Nominations Committee, and served on the Bylaws Committee. Carol was recognized for her dedication and service on the board and presented with a plaque of appreciation at the MHB General Meeting on November 27, 2013.

Gregory D. Wright, 1949 – 2013

The 2013 Mental Health Board Annual Report is dedicated to the memory of Gregory D. Wright, 1949-2013. Gregory was appointed to the Mental Health Board on September 16, 2008. Gregory was a dedicated board member who enjoyed volunteering his time to work toward improving the lives of those individuals living with mental illness. As described by his friends and family, Gregory as a loving father and family member whose passions included photography, advocacy, and service to the mental health community.

WELCOME TO OUR NEWEST MHB MEMBERS!

Please join us in welcoming our newest members to the board. We are thrilled about the level of expertise and knowledge of mental health system they will bring.

- **Ehsan Gharadjedaghi** is a Licensed Clinical Social Worker. He is an active member in the American Psychological Association since 2006 and he is also a faculty member at the University of Phoenix teaching psychology and sociology courses. Mr. Gharadjedaghi fills a Direct Consumer position on the board.

- **April Guajardo** is the Project Director/Coordinator for the Disabled Student Programs and Services/ School of Continuing Education for the North Orange County Community College District. She is an active member of the California Association for Post-Secondary Education and Disability since 2011. She also received her Master of Science in Educational Technology. Ms. Guajardo fills a Consumer/ Family Member slot for the Mental Health Board.

- **Karyn Mendoza** is a Licensed Clinical Social Worker. She is an active member in the National Association of Social Workers and she is also the Director of Programs at Taller San Jose and oversees the enrollment, technical skills training, support services, and education and job placement services. Ms. Mendoza fills a Consumer/Family position on the board.

MAJOR OBJECTIVES

- Increased access to services for clients and family members.

- Community outreach; host a community outreach meeting to solicit the community's involvement with the board and hear their concerns/comments regarding Orange County's mental health system.

- Site Visits; conduct site visits at both county and contract programs in an effort to receive a "hands on" type of learning experiencing on services.

- Centralized Assessment Team (CAT) Ad Hoc Committee; create a work group to review and make recommendations to the county's CAT Program.

MAJOR ACCOMPLISHMENTS

2013 delivered an array of noteworthy accomplishments for the MHB. The board successfully fulfilled its commitment in providing advice and recommendations on program development, budget prioritization, and policy and strategic planning through monthly, community and committee meetings, and site visits.

General Meeting Presentations

The following presentations were provided to the board and community throughout the year:

Children and Youth Services Division Update

- Central Programs – Marcy Garfias, LCSW, Program Manager

- Regional Programs – Kenneth Grebel, Ph.D., Program Manager
- MHSA Programs – James P. Harte, Ph.D. , Program Manager

Office of Consumer and Family Affairs

- Alan Edwards, M.D., Medical Director

County Mental Health Plan Demographic Data Update

- David Horner, Ph.D., Division Manager, Quality Improvement and Program Compliance

Adult Mental Health Services

- Mental Health Court Assessment and Treatment Team – Ian Kemmer, LMFT, Service Chief II
- College Community Services, Opportunity Knocks Program – Jan Gibb, LMFT, Program Director
- Telecare Corporation, Whatever it Takes Program – Lisa Steele, Ph.D., Administrator

The Brown Act/Parliamentary Procedures

- Massoud Shamel, Deputy County Counsel, Office of the County Counsel

Prevention and Intervention Update

- Jason Austin, LMFT, Program Manager

Video Presentation: "Directing Change"

- CalMHSA: Mark Lawrenz, LCSW, Interim Division Manager, Prevention and Intervention

Electronic Health Record Update

- Kathleen Murray, Program Manager

Department of Health Care Services (DHCS) Audit

- David Horner, Ph.D., Quality Improvement and Program Compliance

COMMITTEE REPORTS

Bylaws Committee

Members: Brian Jacobs, Carol Langone, Richard McConaughy

The Bylaws Committee met several times in 2013 to discuss possible revisions which will align with the needs of the MHB and BHS. After much discussion, the committee presented a draft revision of the Bylaws to the MHB. The MHB approved the revised Bylaws and they will be presented to the Board of Supervisor for final approval.

Centralized Assessment Team Ad Hoc Committee*

Members: Brian Jacobs, Judith Lewis, Nomi Lonky, Michaell Rose, Richard McConaughy

The Centralized Assessment Team (CAT) Ad Hoc Committee was formed to address the concerns of families and consumers accessing mental health services and as an opportunity to work toward a better mental health system. The CAT Ad Hoc Committee met several times during the year to discern problems and solutions through data capture and review of policies and procedures. The committee made recommendations for improvements, most of which are being carried out by Orange County Behavioral Health Services.

These recommendations include changing the program goals of CAT from diversion to include intervention, referrals and follow-up. There was no way for the Mental Health Board to find out how widespread the problems might be because information on referrals was recorded only in confidential patient files. Therefore, the committee asked BHS to set up a statistical data capture to track how those not hospitalized connect with mental health services. These changes are being made and results should be available early in 2014.The Committee also suggested that a "big picture" of data is captured to ensure that those not hospitalized are getting community services. This mega-data is not readily accessible or easy to interpret, so the committee recommended that this goal continue to be pursued. The committee recommended expansion of CAT and PERT staff to meet community demands.

The committee recognizes BHS for completing this process in 2013. Further, BHS has various programs with an array of qualifications and services. At times, it can be challenging for a member of the community to determine which program may best fit their needs. Thus, the committee recommended a single point of contact where individuals can receive assistance in navigating through all of BHS programs and services. As a result, BHS implemented a new program – OC LINKS. Moreover, the committee identified several goals that went beyond the scope of the CAT Team Ad Hoc Committee. The committee will further visit these goals and consider the idea of newly formed committees to address them.

California Association of Local Mental Health Boards and Commissions

Members: Richard McConaughy

The California Association of Local Mental Health Boards and Commissions (CALMHB/C) is composed of representatives from mental health boards around the state. The association meets quarterly throughout the state to assist local boards and commissions with their operation and functioning role of improving the mental

health system at the local level. The CALMHB/C's primary goals in 2013 focus on local mental health board trainings, improving communication between the boards across the state, updating the bylaws, and providing a forum for the discussion and dissemination of best practices.

Legislative Committee

Members: Carol Langone, Judith Lewis

The purpose of the Legislative Committee is to stay current on government affairs at the federal, state, and local level. Committee members regularly submitted written reports to the board highlighting policy changes, new laws, and articles published on current policy.

Mental Health Board Community Meeting – Thursday, May 23, 2013

Members: Richard McConaughy, Brian Jacobs, Nomi Lonky, Gregory Swift

In a continued effort to raise awareness and provide information regarding accessing county and contract mental health services, the Mental Health Board hosted its annual Community Outreach Meeting at the Orange County Department of Education. Clients, family members, and professionals in the mental health field attended the event. The event also included resource tables demonstrating detailed information about services. During this meeting, nine public comments were received and the MHB approved the Mental Health Services Act (MHSA) Plan Update for Fiscal Year 2013-14.

Older Adult Services Committee

Members: Michaell Rose

The mission of the Older Adult Services (OAS) Committee is to assist the MHB in performing its function. The committee shall provide information and propose actions and policy positions to the Mental Health Board regarding the mental health needs of older adults. In 2013, the OAS Committee met a total of 6 times with an average attendance of 15 participants. The committee was primarily engaged in the gathering of information on a variety of mental health issues facing older adults. Presentations by both public and private organizations were coordinated in an effort to educate committee members about existing resources and possible gaps in services. One such gap is in the service provision for older adults who have a history of mental illness and then develop an additional diagnosis of Dementia. There is concern on behalf of the committee members about the limited resources and integration of services for this population.

The committee submitted the following recommendations to the Mental Health Board:

- It is recommended that a greater percentage of resources be dedicated to services targeting older adults. These services should be outcomes driven and focused on prevention. Services that encompass and connect the mental and physical health of older adults should be prioritized.

- It is recommended that Behavioral Health Services look to create appropriate emergency placement options for at-risk seniors.

Quality Improvement and Program Compliance Committee

Member: Richard McConaughy

The Quality Improvement and Program Compliance (CQIC) Committee consists of professional and community members and BHS staff. The committee meets every other month and its purpose is to review and discuss the evaluation of BHS programs, including state and federal audits, and compliance reporting. This committee also regularly discusses data retrieved from client satisfaction surveys and medication monitoring reporting.

SITE VISIT

Orange County Post-Partum Wellness Program (OC PPW) & Orange County Center for Resiliency, Wellness, and Recovery (OC CREW)*

792 Town & Country, Building E
Orange, CA 92868
Phone: (714) 480-5160
Hours: Monday – Friday, 8:00 a.m. – 6:00 p.m.

The OC PPW serves new mothers, up to one year postnatal, who are suffering from mild to moderate symptoms of depression, attributable to the recent birth of their child. Services include assessment/screening, early intervention, individual psychotherapy and supportive counseling, psychotherapeutic and psycho-educational groups, family support, coordination and linkage to community resources and community education.

The OC CREW serves young persons ages 14 to 25 who have experienced a first episode of psychosis in the last 12 months because of schizophreniform spectrum disorders. Services are also provided to the families of participants. Services include assessment, individual and/or family therapy, psychiatric services, vocational and educational assistance, Wellness Recovery Action Plans, and other wellness activities. Educational opportunities are also available to the greater community to learn more about psychosis, and how to improve the outcomes of young people who are affected by it.

On September 17, 2013, members of the MHB visited the OC PPW and OC CREW Programs. The MHB is impressed by the staff at these programs. The staff presented well organized information to the MHB and provided an opportunity for the MHB to tour the facility where the services are being provided. Particularly, the MHB appreciates the in depth nature of these programs, the outreach provided to the community, and the multi-cultural capability of the services. The MHB would like to formally commend both the leadership and staff of these programs for their work ethic and the professionalism they provide to the residents of Orange County.

MENTAL HEALTH BOARD SPOTLIGHT!

Assembly Bill 1421 (Laura's Law)

The Mental Health Board is also delighted about Orange County and BHS moving forward with plans to implement its first Assisted Outpatient Treatment (AOT) program. A timeline has been established, and BHS is continuing to work with its constituent partners such as the Public Defender, County Counsel and the Courts to discuss the logistics of the program.

Welfare and Institutions Code (W&I Code) 5270

On November 28, 2012, the MHB voted unanimously to recommend the implementation of W&I Code 5270 in Orange County. This legislation provides an additional period of up to 30 days of intensive inpatient psychiatric treatment beyond the initial 17-day period of intensive treatment. This is meant as an alternative to filing a mental health conservatorship, which can last for up to one year. The MHB is proud to report that on March 19, 2013, the Orange County Board of Supervisor's approved the adoption of W&I Code 5270. Since the adoption of this legislation, HCA has provided training to Orange County designated psychiatric inpatient facilities to assist them with development of Policies and Procedures and data tracking to ensure regulatory compliance. The MHB is confident that this additional tool for the mental health community of Orange County will assist in providing the most effective care available.

Orange County, Behavioral Health Services Information & Referrals

In recent years, the MHB has prioritized access to services for clients, family members and participants. The MHB is ecstatic about BHS' implementation of OC LINKS in 2013. OC LINKS is an information and referral line which provides telephone and online support for anyone seeking information or linkage to any of the Health Care Agency's Behavioral Health Services. The goal of OC Links is to assist callers in the navigation of the County of Orange's Behavioral Health System. Callers can be potential participants, family members, friends or anyone seeking out resources, or providers seeking information about Behavioral Health programs and services. Trained Navigators provide information, referral, and linkage directly to programs that meet the needs of callers. The Mental Health Board is excited about this program and has already received positive feedback about this new service!

Behavioral Health Services (BHS) Update

BHS provides culturally competent services for eligible county residents in need of mental health care and/or treatment for alcohol or other drug abuse. Recovery based services are provided countywide via county-operated and contracted programs. From January 2013 through December 2013, Behavioral Health Services consisted of five divisions, as well as some central services. The five divisions were: Children and Youth Services; Alcohol and Drug Abuse Services; Adult & Older Adult Mental Health Outpatient/Crisis Services; Adult and Older Adult Mental Health Inpatient/Residential Services; and Prevention & Intervention Services.

The BHS infrastructure was expanded with construction of a three building Campus at 401 S. Tustin Street in the City of Orange. This Campus includes a Wellness Center, Education Institute, and Crisis Residential Facility, as well as progress in developing an Electronic Health Record.

The BHS adopted operating budget for fiscal year 2013-2014 is $305 Million. The department has 871 Full Time Employee (FTE) positions and over 100 Personal Service Contractors (PSCs). Further, in fiscal year 2012-2013, approximately 39,475 individuals were served.

*Quality Improvement and Program Compliance (QIPC) Outcome and Metrics

The QIPC department administered the Performance Outcome/Consumer Perception Survey from August 20-2012 through August 24, 2012 for Adults and Older Adults, Children and Youth, and the Family of Children and Youth. A scale of 1-5 was used with "1" representing "Strongly Disagree" and "5" representing "Strongly Agree." Overall, across both Contract and County clinics, mean scores averaged from a low of 3.9 to a high of 4.6. Additionally, most of the questions generated an average response score of "4."

The BHS Consumer Program Survey includes questions related to the adequacy of number, type, and geographic distribution of services. Consumers rate programs on consumer satisfaction with: 1) Hours of operations, 2) Location of service, 3) Accessibility to public transportation, 4) Comfort of waiting area, 5) Reflection of client culture, 6) Availability of written materials in consumers' language, 7) Degree of help given by the program, and 8) Treatment with courtesy and respect. Ratings were scored on a scale of 1 through 7 with 1 = poor and 7 = excellent. The last survey was administered in June of 2011 and concluded in August of 2011. All areas received ratings of "5" or better. Attached please find the detailed QIPC Outcomes and Metrics Report for Fiscal Year 2012-2013.

*Adult Mental Health Services Outcomes and Metrics

Adult Mental Health Services (AMHS) is committed to providing quality care to the clients that are served as well as monitoring our own effectiveness on an ongoing basis. Under the leadership from the AMHS division Manager the Adult and Older Adult Performance Outcomes Department (APOD) collaborates with County and contracted programs to develop, track, and analyze performance outcome related data. It is through the use of this data that proactive changes are implemented with the clients' best interest always in mind. This department also educates staff and stakeholders on the importance of outcomes and metrics so that the collection of data becomes more than just another step in the process but rather the lenses through which programs view their work.

Outcomes are integrated into AMHS contracts so that administration is able to ensure that contractors are providing the best and most appropriate services possible. As part of a larger commitment to outcomes focused programs, multiple AMHS programs volunteered to be part of the Health Care Agency's Balanced Score Card. The Balanced Score Card is part of an effort to break down silos as well as track key performance indicators. Working with the Chief Compliance Officer and other departments has led to a more robust collection and analysis of data in AMHS programs. The agency also takes advantage of collaboration through statewide initiatives such as Care Integration Collaborative (CIC), Transformational Care Planning (TCP), and Advancing Recovery Practices (ARP).

The following outcomes have been collected and analyzed by APOD staff. Each program collects a multitude of data and this report shows only a few main areas of note. Attached please find the detailed AMHS Outcomes and Metrics Report for Fiscal Year 2012-2013.

Behavioral Health Clinic Services

- 98% of adults and 99% of children requesting routine services were offered appointments within 5 days
- For urgent services, 88% of adults and 100% of children were offered appointments within 1 day

Adult Full Service Partnership Programs

- Psychiatric Hospitalization Days: 82% reduction
- Incarceration Days: 80% reduction
- Homeless Days: 55% reduction

Crisis Services

- 53% of Adults and 59% of Children assessed by the Centralized Assessment Teams successfully resolved crisis and avoided hospitalization
- 85% of the children & families serviced by In-Home Crisis Services do not have a hospitalization within sixty days from start of services
- Hospitalizations in the sixty days post intervention is less than 15% for adolescents served in the Crisis Residential Program

Suicide Prevention Hotline

- Fiscal Year 2012-2013, 6,565 calls were received
- Callers reported a significant decrease in suicidal intent by the end of call

Orange County Post-Partum Wellness Program (OC PPW)

- 50% improvement in reduced depression
- 46% improvement in general well-being
- 96% reported overall satisfaction with the program

Orange County Center for Resiliency, Education and Wellness (OC CREW)

- 24% improvement in general well-being
- 34% improvement in overall recovery (MORS)
- 96% reported overall satisfaction with the program

Integrated Community Service: Innovative Program to provide bi-directional services in physical and mental health care

- 60% improvement in total cholesterol level
- 77% improvement in fasting blood sugar
- 43% improvement in body mass index
- Improvement in waist circumference: 40% for female participants and 48% for males
- Participants reported feeling less depression and less anxiety

Alcohol and Drug Abuse Services

- 80% of all clients did not use their primary drug of choice in the past 30 days at the time of discharge

*Department of Health Care Services (DHCS) Triennial Review Preliminary Audit Results

The DHCS has the authority under state regulations and by agreement with the Centers for Medicare and Medicaid Services to provide oversight of the Medi-Cal program, including the Mental Health Plan. They review the system to insure compliance with both state and federal regulations and this review is on a three year cycle. The review primarily looks at the Medi-Cal Mental Health system, however recently began looking at some of the MHSA funding issues. On October 28, 2013 through October 31, 2013, DHCS began their audit of BHS.

The on-site review conducted a Non-Hospital Services – Chart Review as follows:

- 20 Medi-Cal Beneficiaries Randomly Selected
- 10 Children, 10 Adult
- Review period covered January 1, 2013 through March 31, 2013
- 20 Beneficiaries – Totaling 35 Charts and 343 Claims

The areas reviewed were as follows:

- Medical Necessity
- Assessment
- Client Plan
- Progress Notes
- Other chart documentation

In conclusion of the review, 20 of the 343 claims resulted in recoupment at 5.8%, meaning BHS passed the audit. While there are some areas to improve on, the results of this audit were very positive. At the exit conference, the DHCS Review Team had many positive comments about the services in Orange County.

The Mental Health Board appreciates the level of detail and dedication by the employees in BHS. Most importantly, the results of this audit demonstrate the work ethic and sense of teamwork that exist in Behavioral Health Services.

MHB PHOTO GALLERY

Mary Hale, Brian Jacob at the MHB Community Outreach Meeting

Brian Jacobs speaking at the MHB Community Outreach Meeting

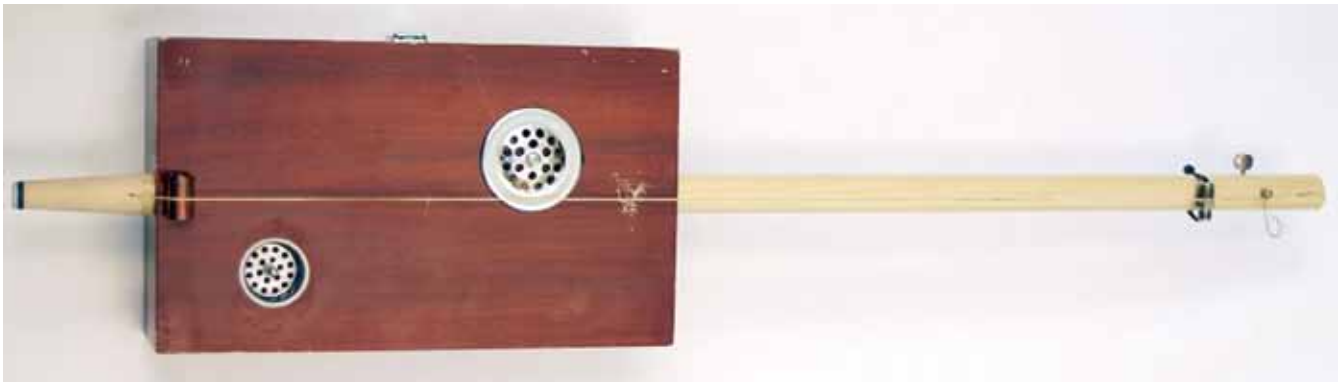
California is taking unprecedented steps to eliminate the barriers of stigma and discrimination so each person knows help is available and feels safe asking for the support they need. At the MHB Community Meeting, information was provided on California's Mental Health Movement "Each Mind Matters" campaign. For more information, visit: http://www.eachmindmatters.org/

Jim Harte, Program Manager, Children and Youth Services, speaking at the MHB Community Outreach Meeting

Pierre Tran and Rosangela Quiroz, BHS Multicultural Development Program staff providing Vietnamese and Spanish Interpreting services at the MHB Community Meeting.

Information on BHS, Children and Youth Services, Centralized Assessment Team was provided at the MHB Community Meeting.

CONSUMER ART GALLERY



Diddly Bobox Guitar
By: Goat

Dragon Trails
By: Vivian DeLeon

Paradise
By: Alania Myhren

Jewelry
By: Cassandra Chatmon

MYTH VS. FACTS ABOUT MENTAL ILLNESS

Myth: Mental health problems don't affect me.

Fact: Mental health problems are actually very common. In 2011, about:

- One in five American adults experienced a mental health issue
- One in 10 young people experienced a period of major depression
- One in 20 Americans lived with a serious mental illness, such as schizophrenia, bipolar disorder, or major depression
- Suicide is the 10th leading cause of death in the United States. It accounts for the loss of more than 38,000 American lives each year, more than double the number of lives lost to homicide.

Myth: Children don't experience mental health problems.

Fact: Even very young children may show early warning signs of mental health concerns. These mental health problems are often clinically diagnosable, and can be a product of the interaction of biological, psychological, and social factors.
Half of all mental health disorders show first signs before a person turns 14 years old, and three quarters of mental health disorders begin before age 24.
Unfortunately, less than 20% of children and adolescents with diagnosable mental health problems receive the treatment they need. Early mental health support can help a child before problems interfere with other developmental needs.

Myth: People with mental health problems are violent and unpredictable.

Fact: The vast majority of people with mental health problems are no more likely to be violent than anyone else. Most people with mental illness are not violent and only 3%-5% of violent acts can be attributed to individuals living with a serious mental illness. In fact, people with severe mental illness are over 10 times more likely to be victims of violent crime than the general population. You probably know someone with a mental health problem and don't even realize it, because many people with mental health problems are highly active and productive members of our communities.

Myth: There is not hope for people with mental health problems. Once a friend or family member develops mental health problems, he or she will never recover.

Fact: Studies show that people with mental health problems get better and many recover completely. Recovery refers to the process in which people are able to live, work, learn, and participate fully in their communities. There are more treatments, services, and community support systems than ever before, and they work.

Myth: Therapy and self-help are a waste of time. Why bother when you can just take a pill?

Fact: Treatment for mental health problems varies depending on the individual and could include medication, therapy, or both. Many individuals work with a support system during the healing and recovery process.

Myth: I can't do anything for a person with a mental health problem.

Fact: Friends and loved ones can make a big difference. Only 38% of adults with diagnosable mental health problems and less than 20% of children and adolescents receive needed treatment. Friends and family can be important influences to help someone get the treatment and services they need by:

- Reaching out and letting them know you are available to help
- Helping them access mental health services
- Learning and sharing the facts about mental health, especially if you hear something that isn't true
- Treating them with respect, just as you would anyone else
- Refusing to define them by their diagnosis or using labels such as "crazy"

Myth: Prevention doesn't work. It is impossible to prevent mental illness.

Fact: Prevention of mental, emotional, and behavioral disorders focuses on addressing known risk factors such as exposure to trauma that can affect the chances that children, youth, and young adults will develop mental health problems. Promoting the social-emotional well-being of children and youth leads to:

- Higher overall productivity
- Better educational outcomes
- Lower crime rates
- Stronger economics
- Lower health care costs
- Improved quality of life
- Increased lifespan
- Improved family life

Source: MentalHealth.gov
http://www.mentalhealth.gov/index.html

BEHAVIORAL HEALTH SERVICES RESOURCES

Behavioral Health Services
http://ochealthinfo.com/bhs/
(714) 834-6023

Mental Health Board
http://ochealthinfo.com/bhs/about/mhb
(714) 834-5481

CRISIS & SUPPORT

OC LINKS: Information and Referral Line
(855) OC-LINKS / (855) 625-4657
TDD Number: (714) 834-2332
http://ochealthinfo.com/oclinks

Centralized Assessment Team (CAT)
(866) 830-6011
*For assessment and evaluation of individuals experiencing psychiatric emergencies including threats to harm self, others, or gravely disabled

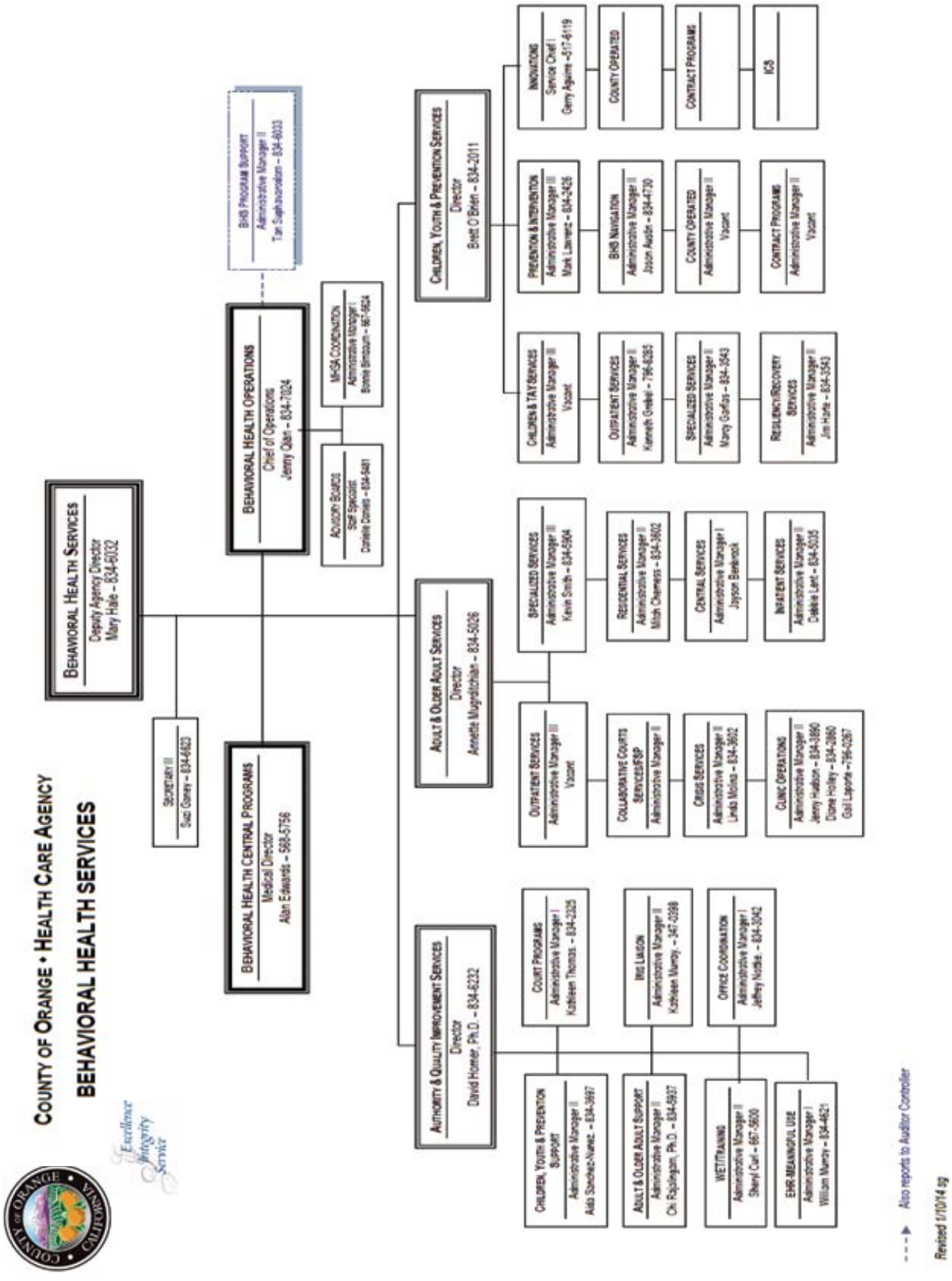
24 Hour Suicide Prevention Line
(877) 7 CRISIS / (877) 727-4747
*Provides 24-hour, immediate, confidential over-the-phone suicide prevention services to anyone who is in crisis or experiencing suicidal thoughts

NAMI WarmLine
(877) 910 WARM / (877) 910-9276
*Provides telephone-based, non-crisis support for anyone struggling with mental health and/or substance abuse issues.

*In compliance with W&I Code 5604 – 5604.5, information provided in these sections specifically meet the MHBs requirement to report on the needs and performance of the county's mental health system.

ATTACHMENTS

I. Behavioral Health Services Organization Chart



II. Quality Improvement and Program Compliance Outcomes and Metrics Annual Report

QIPC ANNUAL REPORT
ON THE STATUS OF THE MHP
QUALITY IMPROVEMENT WORKPLAN
Report Period: July 1, 2012 – June 30, 2013
Report Date: September 9, 2013

A. Monitoring Service Delivery Capacity and Beneficiary Satisfaction

- Performance Outcome Measures

The Performance Outcome/Consumer Perception Survey was reinstated by the State in August 2012. BHS administered the survey between August 20, 2012 – August 24, 2012 for Adults and Older Adults, Children and Youth, and the Family of Children and Youth.

The Consumer Perception Survey includes the MHSIP. The survey was administered and analysis of the data has been completed. A scale of 1 – 5 was used with "1" representing "Strongly Disagree" and "5" representing "Strongly Agree." Overall, across both Contract and County clinics, mean scores averaged from a low of 3.9 to a high of 4.6. Overall, most questions generated an average response score of "4." Please see the full reports for additional information.

Past results are posted on the Intranet in the BHS Resource Center.

- Consumer Program Survey

The BHS Consumer Program includes questions related to the adequacy of number, type, and geographic distribution of services. Consumers rate programs on consumer satisfaction with: 1) Hours of operation, 2) Location of service, 3) Accessibility to public transportation, 4) Comfort of waiting area, 5) Reflection of client culture, 6) Availability of written materials in consumers' language, 7) Degree of help given by the program, and 8) Treatment with courtesy and respect. Ratings were scored on a scale of 1 through 7 with 1 = poor and 7 = excellent.

The last survey was administered in late June 2011 and concluded in mid-August 2011. All areas received ratings of "5" or better. Detailed information can be found in the report prepared by the Office of Quality Management Planning and Research dated September 2011.

- Service Capacity – The Tree House and Telecare and Orange (TAO)

To monitor service capacity, BHS chose to track two programs in particular, the Crisis Residential Program and the Full Service Partnership Program at Telecare. The goal for both programs was to increase the number of clients served from the previous year to the current year.

- Crisis Residential Program – The Tree House

One of the goals of BHS for this fiscal year was to monitor the number of clients served through the Crisis Residential program. The Tree House served 214 clients in 2011-2012 and increased the number of clients served to 276 in fiscal year 2012-2013.

- TAO FSP

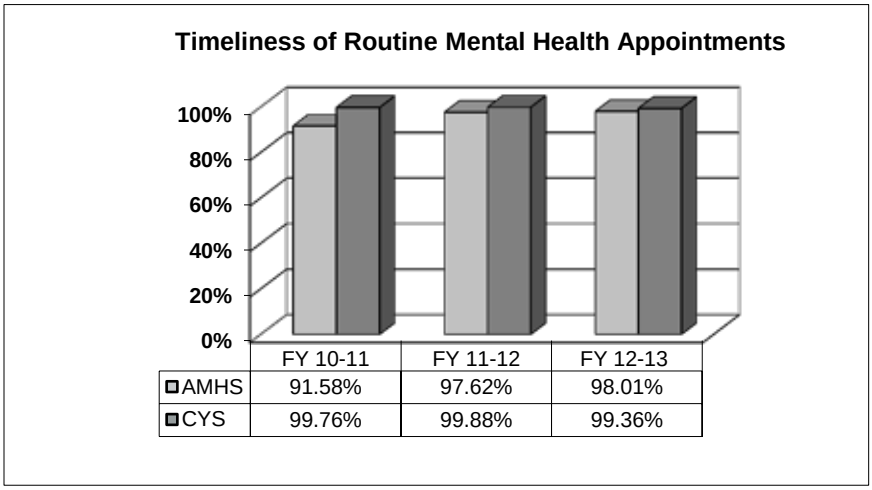
The TAO FSP program for adults had a goal to increase the number of clients served from 281 in FY 2011-2012 to 307 in FY 2012-2013. TAO serves adults ages 18 and over that are homeless or at risk of homelessness. Clients targeted span the entire County and may be unserved with co-occurring mental illness and substance abuse.

In 2012-2013, Telecare was able to add an additional site in Costa Mesa, named Telecare South. Between the two sites, TAO and Telecare South served a total of 384 clients this fiscal year.

B. Monitoring Access to Services

- Timeliness of Routine Mental Health Appointments

BHS's target is to offer 75% of people requesting routine services an appointment within 5 days of the initial call.

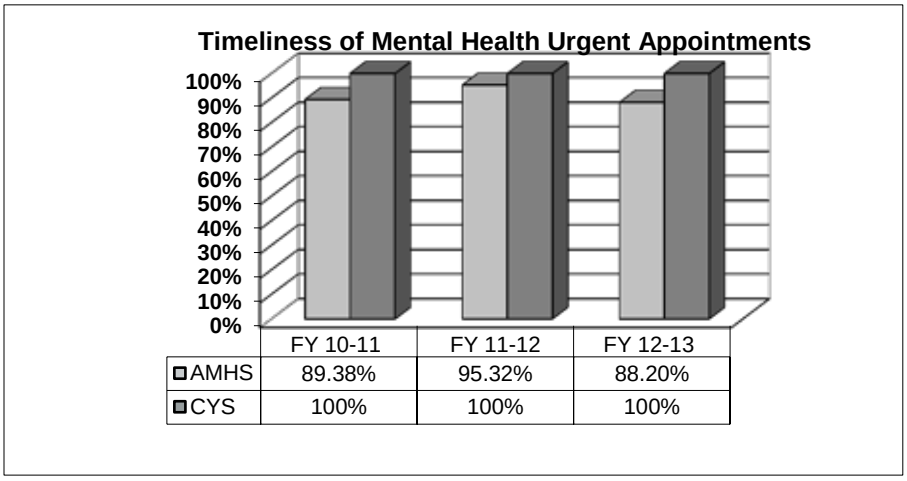


	FY 10-11	FY 11-12	FY 12-13
AMHS	91.58%	97.62%	98.01%
CYS	99.76%	99.88%	99.36%

For routine appointments, both CYS and AMHS met the target. The ability of AMHS to offer a routine appointment within 5 working days of the request has been increasing over the last three years. AMHS' response has improved while CYS' timeliness for offering routine appointments has remained consistent over time.

- Timeliness of Urgent Mental Health Appointments

BHS' target is to offer 90% of all consumers an urgent appointment within 1 day of the initial call.

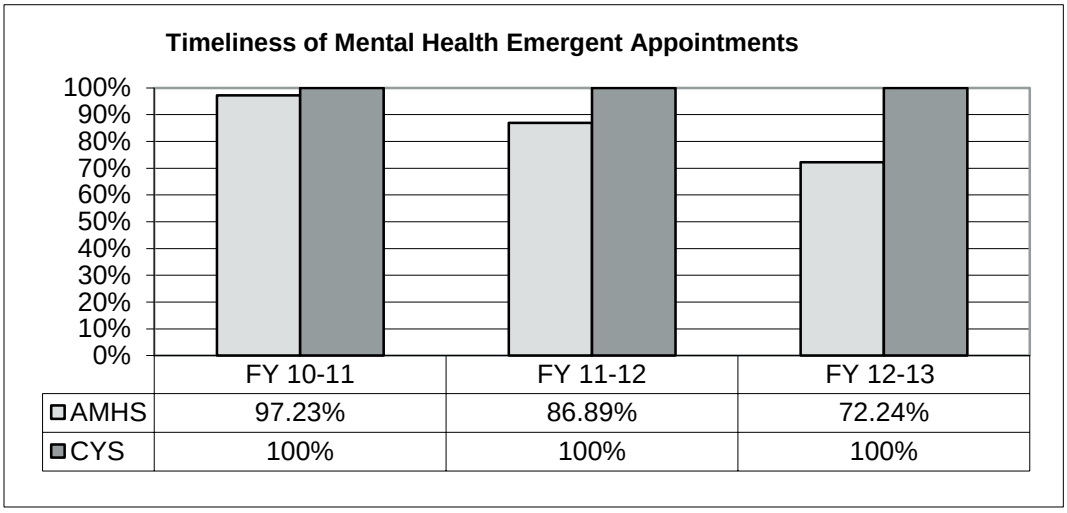


For AMHS, the ability to offer an urgent appointment within a day of the request has decreased significantly this fiscal year.

CYS was able to offer all clients in need of an urgent appointment within one business day. This has been consistent for the last 3 fiscal years.

- Timeliness of Emergent Mental Health Appointment

BHS's target is to offer all callers an emergent appointment within 4 hours of the call.



CYS was able to accomoodate all callers in need of an emergent appointment within 4-hours of the call.

For AMHS, the ability to meet this target has decreased over the last 3 years. AMHS reported increasing CAT staff both in the field and in the clinics as liaisons. The overall numbers of clients served by the Centralized Assessment Team does not seem to have increased this fiscal year. Thus, further analysis should occur to identify the challenge in order to increase response time for emergent appointments.

C. 800 Number Access

The MHP contracts with Cal-Optima/Beacon to provide 24-hour, seven days a week access to the community.

Cal-Optima/Beacon answered a total of 20,558 calls this fiscal year, 91% of which were answered within 30 seconds. Consult with the ASO is advisable in order to determine how long it took to answer the remaining 9 % of calls.

D. Notices of Action

- **TOTAL NOAS**

	FY 09-10	**FY 10-11**	**FY 11-12**	**FY 12-13**
NOA-A	1014*	1,074	1046	862
NOA-B	142*	1	0	1
NOA-C	71	61	76	151
NOA-D	0*	0	0	0
NOA-E	0*	0	0	0
Total	**1,227***	**1,136**	**1125**	**1014**

* There was no data for the 4th Quarter, FY 09-10

Note: NOA-A: Denial of Services Following Assessment
NOA-B: Reduction of Services
NOA-C: Post Service Denial of Payment
NOA-D: Delay in Processing a Beneficiary Grievance or Appeal
NOA-E: Lack of Timely Services

- **AMHS NOAs**

	FY 09-10	**FY 10-11**	**FY 11-12**	**FY 12-13**
NOA-A	132	92	67	107
NOA-B	0	0	0	0
NOA-C	0	0	0	0
NOA-D	0	0	0	0
NOA-E	0	0	0	0
Total	**132**	**92**	**67**	**107**

The total number of NOA-As increased for AMHS this fiscal year compared with to the last two years. Over the last fiscal year, intake counselors have been meeting monthly to review and clarify the clinic intake processes. The goal has been to streamline the processes and to train everyone in the same way. The amount of information being inputted into the Access Log has increased significantly over the past two years, and the intake counselors are inputting information more consistently, which might account for the change.

- **CYS NOAs**

	FY 09-10	FY 10-11	FY 11-12	FY 12-13
NOA-A	770	959	939	704
NOA-B	0	0	0	0
NOA-C	0	0	0	0
NOA-D	0	0	0	0
NOA-E	0	0	0	0
Total	**770**	**959**	**939**	**704**

For CYS, the total number of NOA-As significantly decreased this year compared with previous years.

- **Inpatient NOAs**

	FY 09-10	FY 10-11	FY 11-12	FY 12-13
NOA-A	0	0	0	0
NOA-B	0	0	0	0
NOA-C	71	61	76	151
NOA-D	0	0	0	0
NOA-E	0	0	0	0
Total	**71**	**61**	**76**	**151**

NOAs for Inpatient Services significantly increased this fiscal year compared with previous years.

- **ASO NOAs**

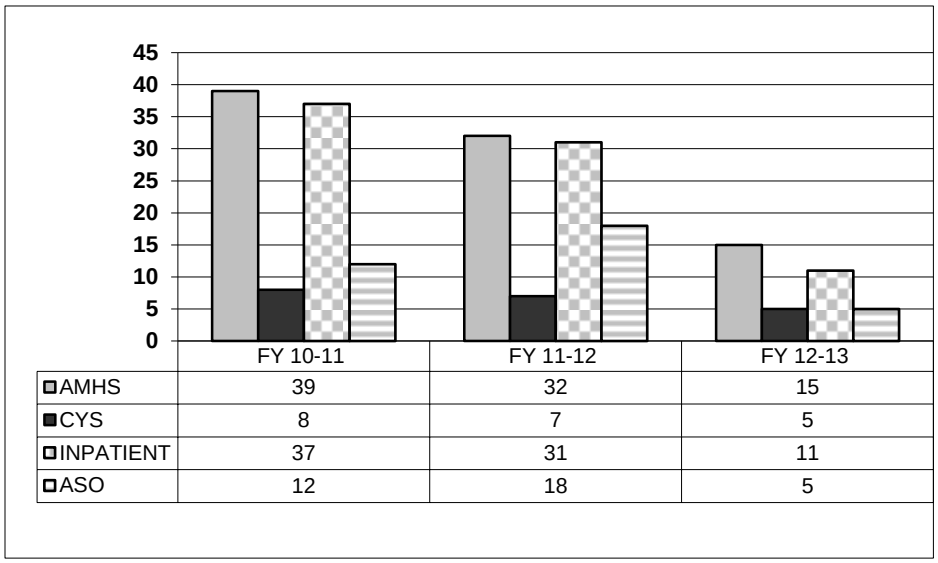
	FY 09-10	FY 10-11	FY 11-12	FY 12-13
NOA-A	112*	23	40	51
NOA-B	142*	1	0	1
NOA-C	0	0	0	0
NOA-D	0	0	0	0
NOA-E	0	0	0	0
Total	**254***	**24**	**40**	**52**

* There was no data for the 4th Quarter, FY 09-10

NOAs for the ASO increased slightly this year compared to the previous year. There was a significant decrease after FY 09-10, but since then, the numbers have been increasing steadily each year.

E. Monitoring Beneficiary Satisfaction

- Medi-Cal Grievances by Fiscal Year



	FY 10-11	FY 11-12	FY 12-13
AMHS	39	32	15
CYS	8	7	5
INPATIENT	37	31	11
ASO	12	18	5

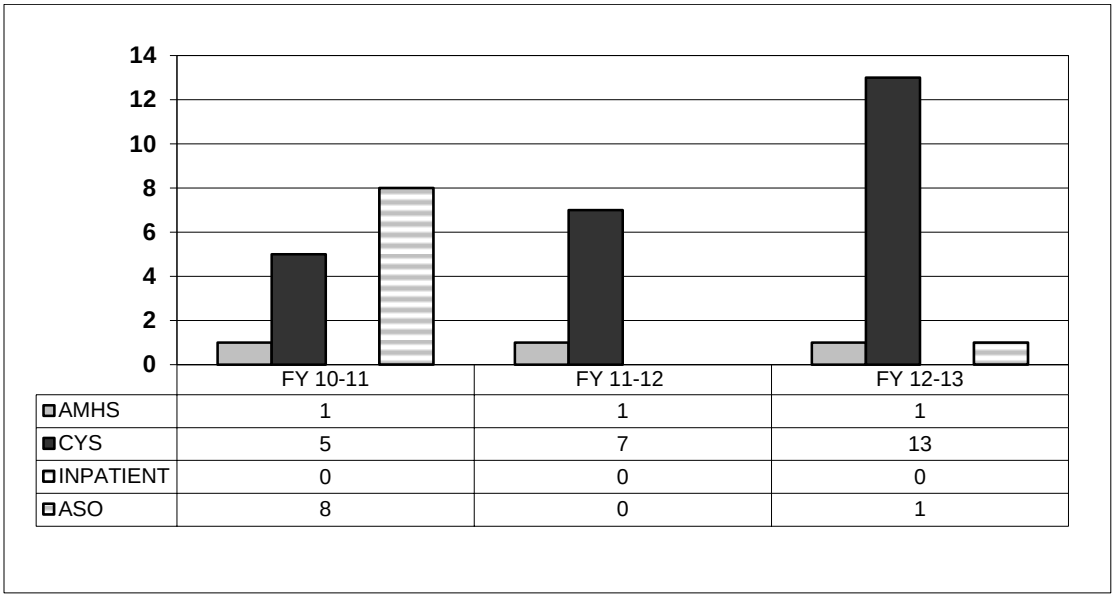
The numbers of grievances received across divisions have decreased this fiscal year. This may be due to several reasons. First, if possible, the staff taking the grievance calls is making an increased effort to encourage callers to first attempt resolution at the clinic level. In many instances, the issue can be resolved by the client having a discussion with the provider and/or the service chief. Second, should the person taking the grievance determine that the issue requires a more urgent response (e.g., before 60 days), these issues are being referred to Patients' Rights for immediate investigation. Calls referred to Patients' Rights are recorded in the logs as non-grievances. Finally, there is a more concerted effort to combine grievances from the same individual, over the same concern, so that the tracking of the same issue is not being duplicated.

- Explanation of Medi-Cal Grievances

		FY 12-13			
		Decision within timelines?		Disposition (resolved by Divisional QRT)?	
		Yes	No	Yes	No
ACCESS	AMHS				
	CYS	6		6	
	INPATIENT				
	ASO				
CHANGE OF PROVIDER	AMHS	4		4	
	CYS				
	INPATIENT				
	ASO				
QUALITY OF CARE	AMHS	10		10	
	CYS	2		2	
	INPATIENT	2		2	
	ASO				
CONFIDENTIALITY	AMHS				
	CYS				
	INPATIENT				
	ASO				
OTHER	AMHS	11		11	
	CYS	1		1	
	INPATIENT	4	1	5	
	ASO	2		2	

All grievances were resolved within the 60 day time-frame with exception of one from Inpatient Services.

- Medi-Cal Appeals by Fiscal Year



	FY 10-11	FY 11-12	FY 12-13
AMHS	1	1	1
CYS	5	7	13
INPATIENT	0	0	0
ASO	8	0	1

Appeals for AMHS remained consistent at one while CYS appeals almost doubled this year as compared to the previous year. ASO appeals increased from zero to one.

- Explanation of Medi-Cal Appeals

		FY 12-13			
		Decision within timelines?		Disposition (resolved by Divisional QRT)?	
		Yes	No	Yes	No
ACCESS	AMHS				
	CYS	13		13	
	INPATIENT				
	ASO				
CHANGE OF PROVIDER	AMHS				
	CYS				
	INPATIENT				
	ASO				
QUALITY OF CARE	AMHS	1		1	
	CYS				
	INPATIENT				
	ASO				
CONFIDENTIALITY	AMHS				
	CYS				
	INPATIENT				
	ASO				
OTHER	AMHS				
	CYS				
	INPATIENT				
	ASO	1		1	

- State Fair Hearings

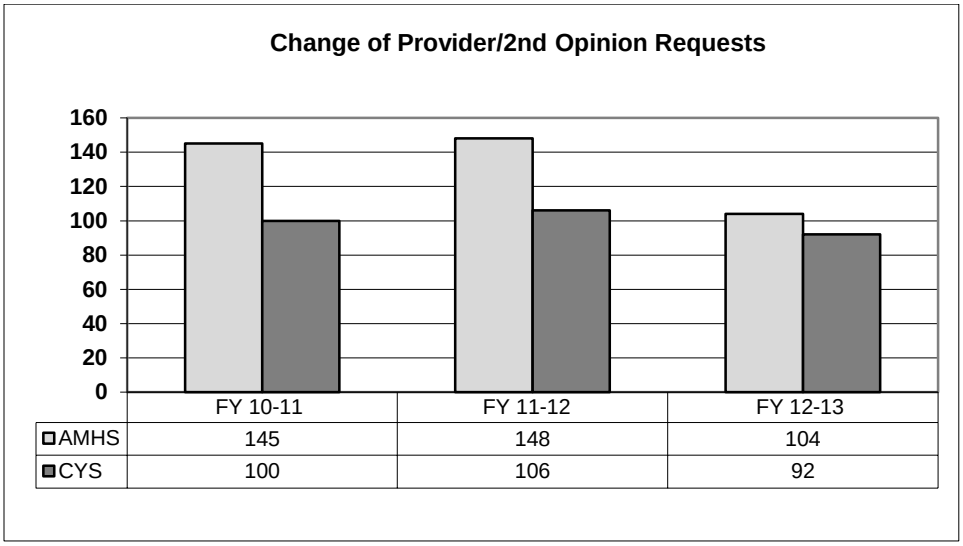
BHS received one request for a State Fair Hearing this year. The request was made in CYS.

- ASO Beneficiary Surveys

The ASO is expected to assess the satisfaction of beneficiaries receiving services at least annually, and report this data and any findings and recommendations to BHS and providers. These surveys will be conducted in the threshold languages, and will assess whether beneficiaries had access to written materials in their primary language.

The ASO conducts beneficiary satisfaction surveys quarterly. Surveys were completed in the threshold languages. The ASO survey measures satisfaction of phone contacts, thus the survey did not readily measure access to written materials in the consumer's primary language.

- **Change of Provider/2nd Opinion Requests**



Requests for a change of provider or 2nd opinion requests have decreased for both AMHS and CYS.

- **Breakdown of AMHS Change of Provider/2nd Opinion**

Reason Cited	FY 09-10	FY 10-11	FY 11-12	FY 12-13
Language/Ethnicity/ Communication	2	7	9	9
Care & Treatment	30	38	51	28
Personality	17	27	27	25
Therapeutic Approach	10	14	4	0
Gender	10	11	8	12
Medication	14	11	7	5
Schedules	5	7	4	1
Clinic Facilities, Location	0	1	0	3
2nd Opinion	6	11	10	3
Other	22	11	7	9
No Reason Given	11	7	21	7
Total	127	145	148	102

The most prominent reason for a change of provider/2nd opinion request for AMHS was "Care and Treatment."

- **Breakdown of CYS Change of Provider/2nd Opinion**

Reason Cited	FY 09-10	FY 10-11	FY 11-12	FY 12-13
Language/Ethnicity/ Communication	20	11	8	10
Care & Treatment	15	13	20	18
Personality	28	13	13	14
Therapeutic Approach	3	2	17	2
Gender	7	16	21	26
Medication	1	4	22	0
Schedules	8	15	6	8
Clinic Facilities, Location	10	3	4	10
2nd Opinion	3	1	1	7
Other	10	9	10	18
No Reason Given	9	13	4	14
Total	114	100	106	127

The most prominent reason for a change of provider/2nd opinion request for CYS was "Gender."

- **Breakdown of Change of Provider/2nd Opinion Across All Divisions**

Reason Cited	FY 09-10	FY 10-11	FY 11-12	FY 12-13
Language/Ethnicity/ Communication	22	18	17	19
Care & Treatment	45	51	71	46
Personality	45	40	40	39
Therapeutic Approach	13	16	21	2
Gender	17	27	29	38
Medication	15	15	29	5
Schedules	13	22	10	9
Clinic Facilities, Location	10	4	4	13
2nd Opinion	9	12	11	10
Other	32	20	17	27
No Reason Given	20	20	25	21
Total	**241**	**245**	**254**	**229**

Across divisions, the most prominent reason for a change of provider/2nd opinion request "Care and Treatment" followed by "Personality" and "Gender."

F. Monitoring the Service Delivery System and Meaningful Clinical Issues

- ***Communication of the Medication Formulary***

The BHS medication formulary and prescribing guidelines manual continue to be updated regularly, and will remain available on the BHS Intranet accessible to all BHS medication prescribers. The formulary and guidelines include medication available to BHS clients.

- ***Medication Monitoring Review***

The BHS Medical Director and Associate Medical Directors oversee a medication monitoring system that includes a peer-review of medication use and prescribing. Results of this monitoring have been provided to the Prescribing Guidelines Committee. The QIPC Division will be represented on the committee that has responsibility for updating the formulary and guidelines and that will continue to meet throughout the year to address medication related issues. The Associate Medical Director for Adult Mental Health Services and for Children and Youth Services last presented the annual report on medication monitoring to the Committee Quality Improvement Committee on January 13, 2013.

G. Monitoring Continuity and Coordination of Care with Physical Health Providers and Other Human Services Agencies

- ***Performance Improvement Project – Linkage to Physical Healthcare***

A continued goal this year was for County clinics to coordinate care with the PCP of each consumer with Medi-Cal coverage. At minimum, the coordination of care was expected to occur through sending of the PCP Communication form.

In October 2012, QIPC surveyed charts at four AMHS clinics. Only 6% of the charts reviewed showed evidence of PCP linkage. This is an ongoing quality improvement project and another check will be completed.

- ***Monitoring the Low Income Health Plan (LIHP)***

In this fiscal year, Behavioral Health Services saw 1,836 LIHP clients. With the implementation of the Affordable Care Act (ACA) in 2014, it is expected that approximately 75% of these clients will transition to regular Short Doyle Medi-Cal, and the remaining 25% of these clients will be insured through the new Covered California (CA's plan to accommodate the Federal ACA).

H. Monitoring Provider Appeals

- Provider Appeals and Inpatient Provider Treatment Authorization Request Appeals

	FY 09-10	**FY 10-11**	**FY 11-12**	**FY 12-13**
Requests for an Appeal Received by the ASO	0	419	0	0
Requests for an Appeal Received by the BHS Inpatient Appeals Office (Also Called 1st level Appeals)	19	22	9	15
# Hospital Days Appealed by Providers	161	216	220	106
# Days Granted by BHS	133 (83%)	81 (37.5%)	19 (8.6%)	81 (76%)
# Days Denied by BHS	28 (17%)	135 (62.5%)	201 (91.4%)	21 (19%)
Requests for an Appeal Received by the Department Mental Health (Also Called 2nd level Appeals)	0	1	0	0
# Denied Hospital Days Appealed By Providers to DMH	N/A	0	0	0
# Days Granted by DMH	N/A	0	0	0
# Days Denied by DMH	N/A	0	0	0

Overall, the number of hospital days appealed by providers has decreased significantly. However, when appealed, BHS is now more likely to grant the days, thus perhaps suggesting that providers are more discriminating in choosing which days to appeal.

III. Adult Mental Health Services Outcomes and Metrics Annual Report

1. Outreach and Engagement

- Children's Outreach & Engagement Program
- Transitional Age Youth Outreach & Engagement Program
- Adult Outreach & Engagement Services

2. Centralized Assessment Team (CAT) and Crisis Residential

- Transitional Age Youth Centralized Assessment Team
- CAT and Psychiatric Emergency Response Team (PERT)
- Adult Crisis Residential Services – Telecare Tree House

3. Adult and Older Adult Full Service Partnerships (FSPs)

- Adult Full Service Partnerships
- Older Adult Support and Intervention System

4. Program of Assertive Community Treatment (PACT)

- Transitional Age Youth PACT
- Program of Assertive Community Treatment (PACT)
- Older Adult PACT

5. Supported Employment Services – Goodwill

6. Adult and Older Adult Recovery Centers

- Adult Recovery Centers
- Expanded Older Adult Mental Health Recovery Program

7. Peer Mentoring

- Adult Peer Mentoring
- Older Adult Peer Mentoring

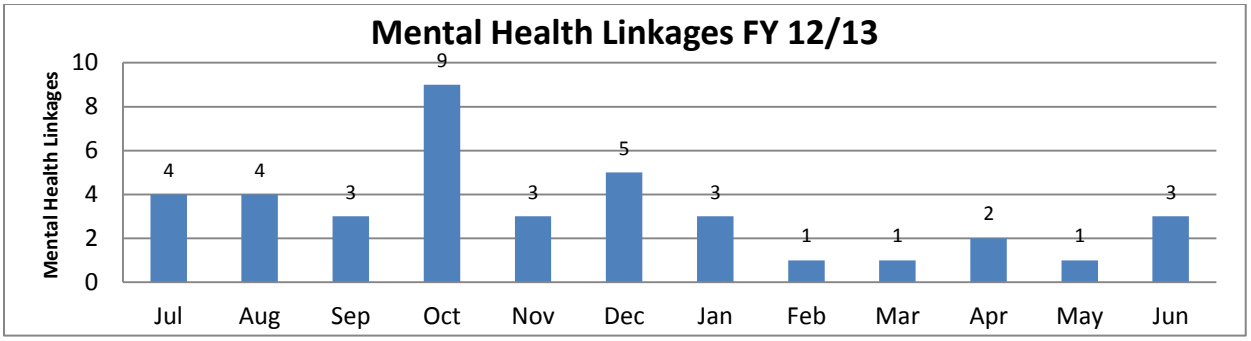
8. Wellness Center

Outreach and Engagement

Children's, Transitional Age Youth, and Adults

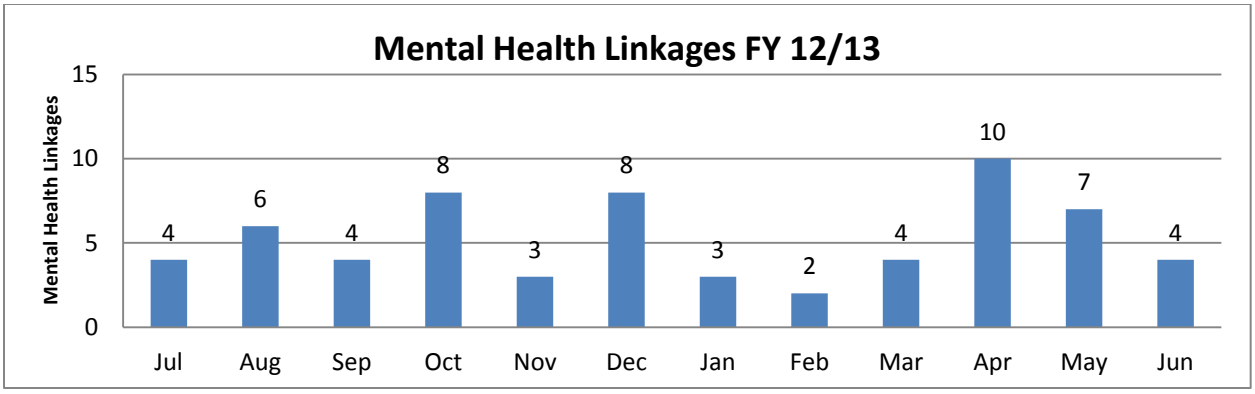
Children's Outreach & Engagement Program

The graph below displays data on the number of successful linkages to mental health services during FY12/13. The number of linkages varies from one to nine per month.



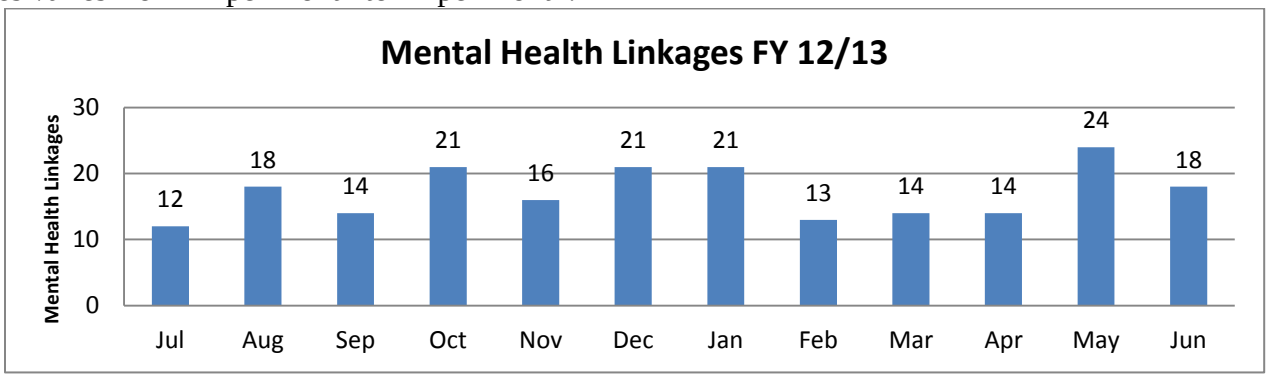
Transitional Age Youth Outreach & Engagement Program

The graph below displays data on the number of successful linkages to service during FY12/13. The number of linkages varies from two to ten per month.



Adult Outreach & Engagement Services

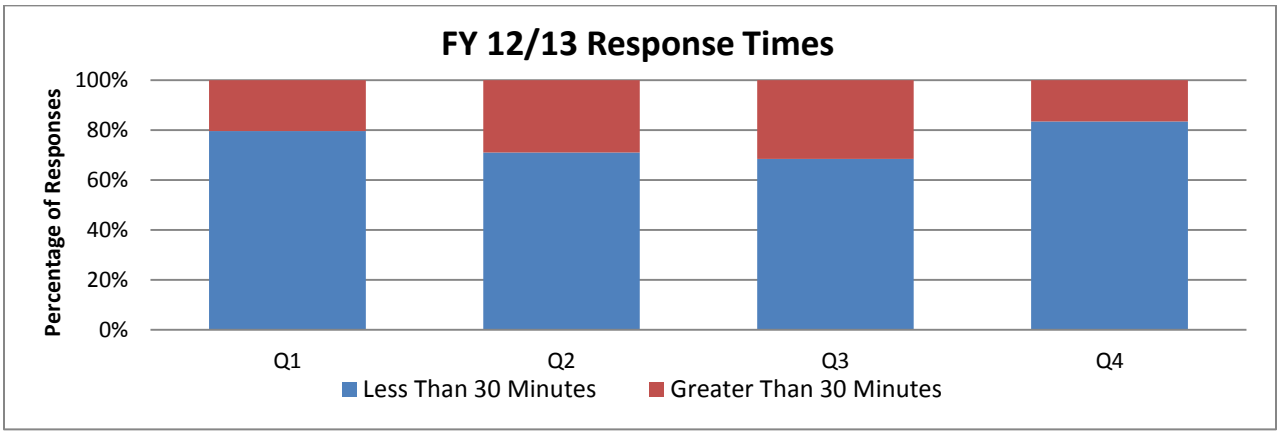
The graph below displays data on the number of successful linkages to service during FY12/13. The number of linkages varies from 12 per month to 24 per month.



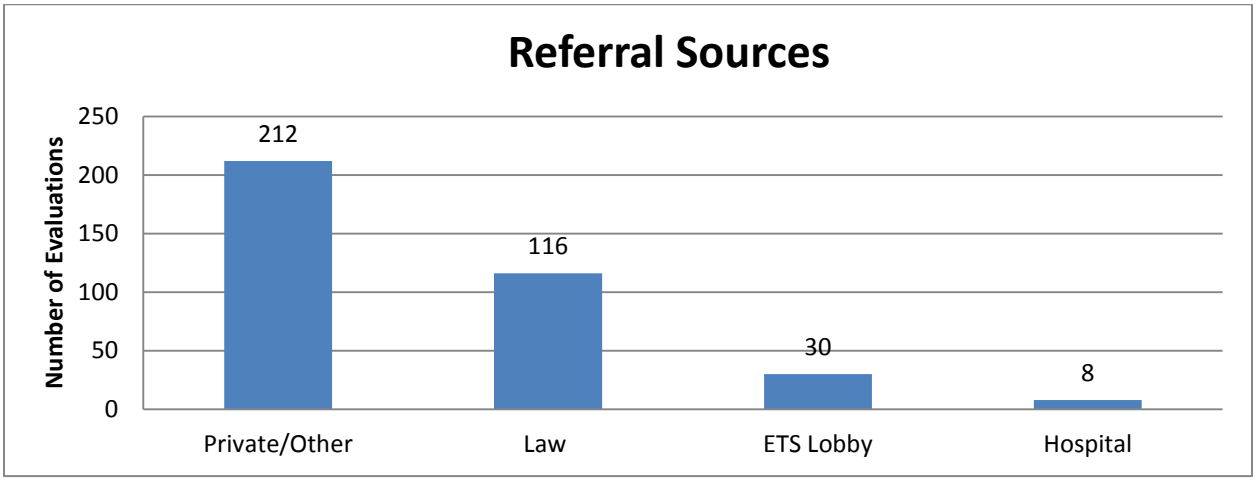
Centralized Assessment Team (CAT) and Crisis Residential

Transitional Age Youth Centralized Assessment Team

Transitional Age Youth CAT served 337 members during FY 12/13. The average response time was just under 20 minutes. On average 77% of the calls were below 30 minutes. The data below is presented quarterly for FY 12/13.

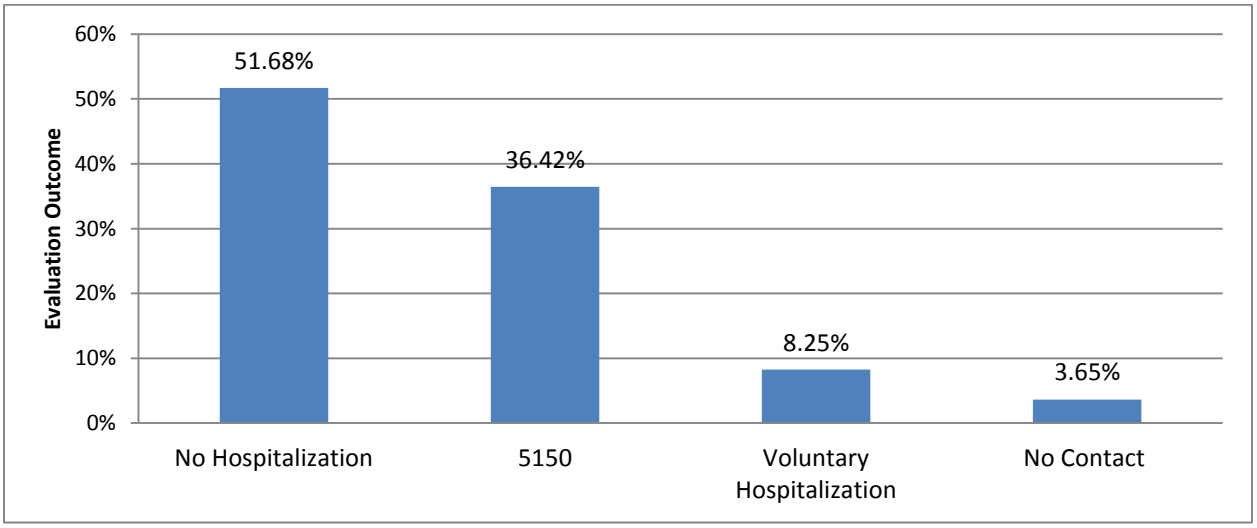


Data on the source of Transitional Age Youth CAT referrals shows that the largest referral source was "Private and Other" at 58% which includes family/significant others, clients, treatment centers, and others. The second largest referral category, 32%, was from law enforcement.

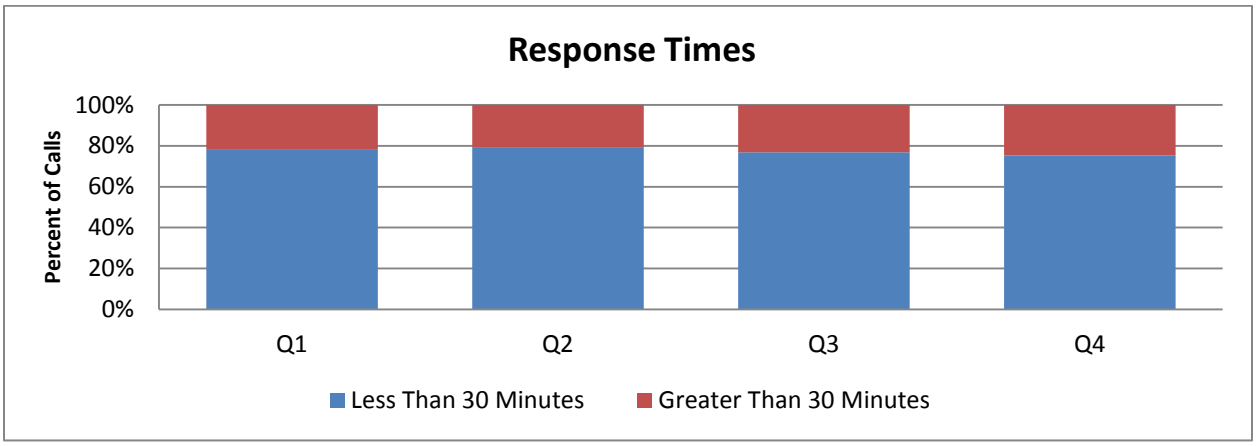


CAT and Psychiatric Emergency Response Team (PERT)

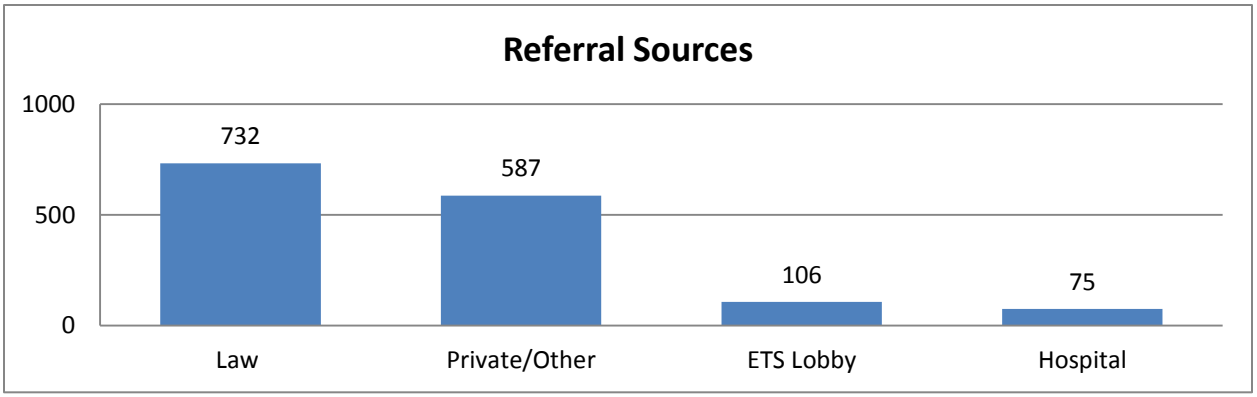
CAT & PERT served 1,528 members during FY 12/13. The performance outcome data reflects the percent of clients assessed who were appropriate or not appropriate for inpatient hospitalization. The percent of total crisis response diverted from hospitalization continues to be monitored regularly.



The average response time was just under 20 minutes. An average of 77% of the calls were below 30 minutes.

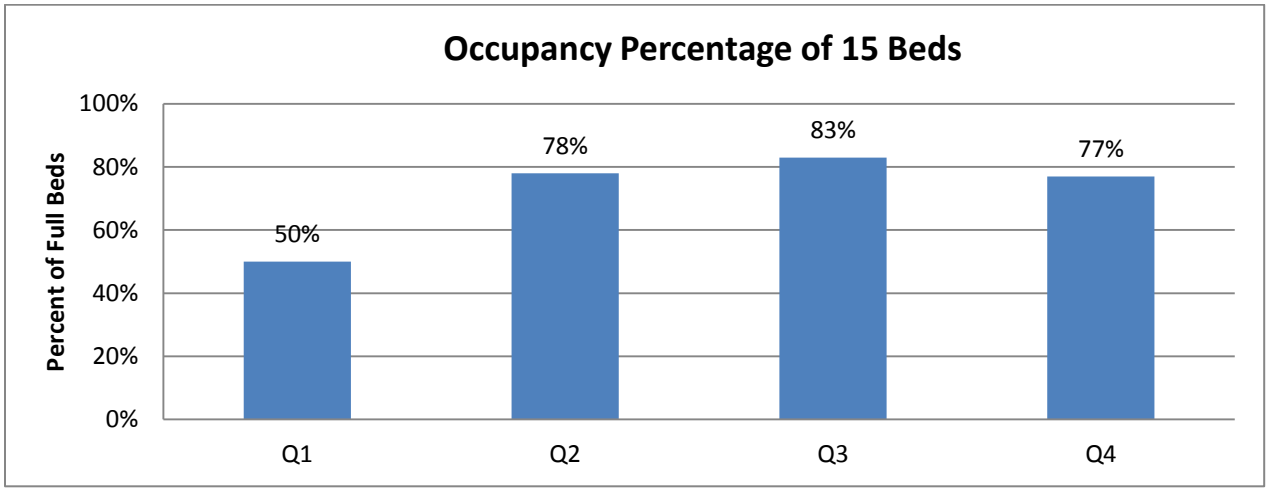


The largest referral source for CAT response was law enforcement, with 49% of the calls. The second largest referral category with 39% was the category of "Private and Other" which includes family/significant others, clients, treatment centers, and others.



Adult Crisis Residential Services – Telecare Tree House

Adult Crisis Residential Services served 276 (unduplicated) members during FY 12/13. Ninety-four percent were discharged to a lower level of care and 97% did not require hospitalization within 48 hours of discharge. From total discharges, 77% of clients were linked to a provider. The occupancy rate for the program was an average of 72% for the fiscal year.



Adult and Older Adult Full Service Partnerships (FSPs)

Adult Full Service Partnerships

The MHSA Adult Full Service Partnership (FSP) programs serve 780+ adults annually in the 18-59 age range, who are diagnosed with a serious and persistent mental illness. The adult programs provide 24 hour a day, seven day a week intensive case management/wrap-around-services, a peer-to-peer line, community based outpatient services, peer mentoring, supported education and employment services, transportation services, housing, benefit acquisition, and co-occurring disorder treatment. These programs are linguistically and culturally competent, and provide services to the underserved cultural populations in Orange County, such as Latinos, Vietnamese, Koreans, Iranians, monolingual non-English speakers, and the Deaf and Hard of Hearing.

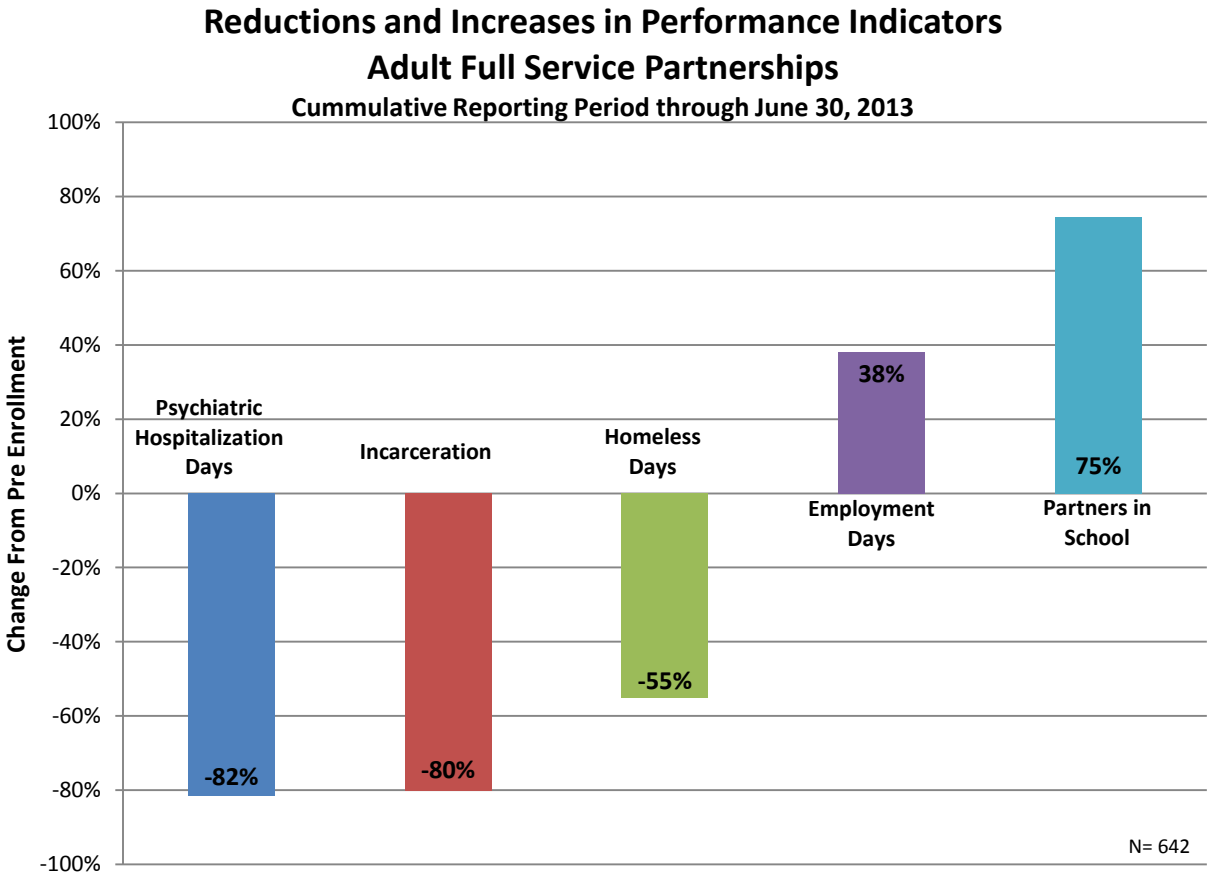
FSP programs in Orange County address those most in need: the homeless mentally ill, those with co-occurring disorders, those being released from jail with no place to go or support to turn to, and those who would be serving long jail sentences for minor crimes related to lifestyle and/or their illness. There is also a focus on underserved communities, including those in Institutes for Mental Disease (IMDs) who could come home if a support system were in place and those in Board and Cares who, given the opportunity, could regain control and independence and achieve enhanced recovery.

All FSPs provide the above services. The Telecare WIT (Whatever It Takes) program is a 100-member Full Service Partnership for persons 18-59 age range diagnosed with serious mental illness that are referred by a specific community court program. The program offers members a final opportunity to receive services in the community rather than in jail, and provides the support to meet requirements set by the court, with the collaborative approach from probation departments, district attorneys and public defenders' offices, as well as mental health professionals and members themselves. "Whatever It Takes" refers to the approach in supporting members in the community to promote wellness and recovery and avoid re-incarceration, hospitalization and homelessness.

The Criminal Justice FSP, known as Opportunity Knocks, serves 155 members, including a specific track for 15 AB 109 members. AB 109 allows some non-violent prisoners to be monitored in their local community instead of state prison, and addresses the immediate behavioral health recovery needs of the AB 109 client being

released from custody. Opportunity Knocks, in addition to providing the wide array of FSP services, utilizes Moral Recognition Therapy (MRT), an evidenced based practice which seeks to decrease recidivism among adult criminal offenders by increasing moral reasoning. MRT takes the form of group and individual counseling using structured group exercises and prescribed homework assignments.

The MHSA Adult FSP programs continue to learn and adopt new models of emerging and evidenced based practices. In addition, improving and expanding the quality and availability of data and data analysis to promote the dissemination of effective, evidenced based interventions and services to advance and identify better health outcomes for individuals, families and communities.



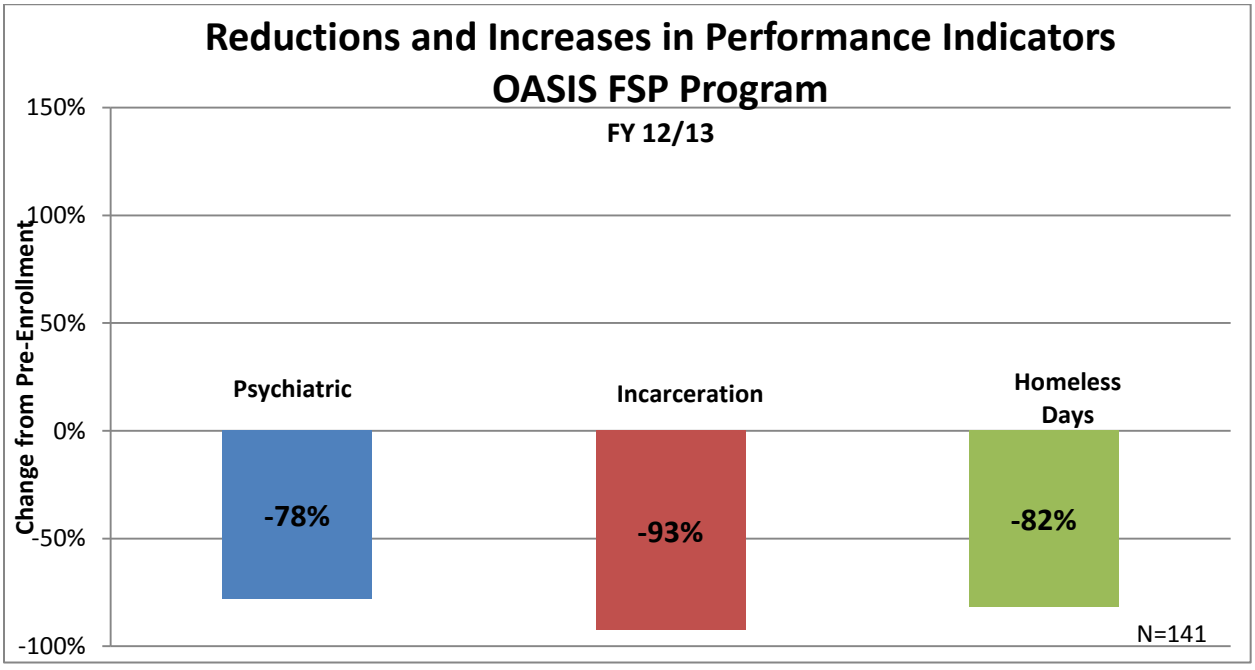
Older Adult Support and Intervention System

The OASIS (Older Adult Support and Intervention System) program is an Older Adult MHSA Full Service Partnership (FSP). OASIS serves 150 older adult members ages 60 and older who are at risk of institutionalization or hospitalization, homeless or at risk of homelessness, who may have recently been discharged from institutions, or who have multiple psychiatric hospitalizations in the recent past, who may have co-occurring substance abuse disorders, and have not been successfully engaged in mental health services.

OASIS provides 24 hour a day, seven day a week intensive case management/wrap-around-services, a peer-to-peer line, community based outpatient services, peer mentoring, supported education/employment services, transportation services, housing, benefit acquisition, and co-occurring disorder treatment. The older adult program uses an evidence and strength based model; with focus on the person rather than the illness. Services follow the Wellness and Recovery Model focusing on consumer strengths, self-identified goals, and objectives. Individuals from all ethnicities and cultures are served with an emphasis on client centered care.

OASIS is comprised of an interdisciplinary staff of peer counselors and life coaches, Personal Services Coordinator (PSC), a therapist, nurses, a nurse practitioner, a gero-psychiatrist, and a pharmacist. All staff members are familiar with the specialized needs of older adults.

The MHSA Adult and Older Adult FSP programs continue to learn and adopt new models of emerging and evidenced based practices. The Program to Encourage Active, Rewarding Lives for Seniors (PEARLS) is an evidenced – based treatment program designed to treat depression in older adults. The model significantly decreases depression and improves functional and emotional well-being. OASIS is certified as a PEARLS provider collecting PEARLS data and outcomes. In addition, improving and expanding the quality and availability of data and data analysis to promote the dissemination of effective, evidenced based interventions and services to advance and identify better health outcomes for individuals, families and communities.



Program of Assertive Community Treatment (PACT)
Transitional Age Youth and Adult

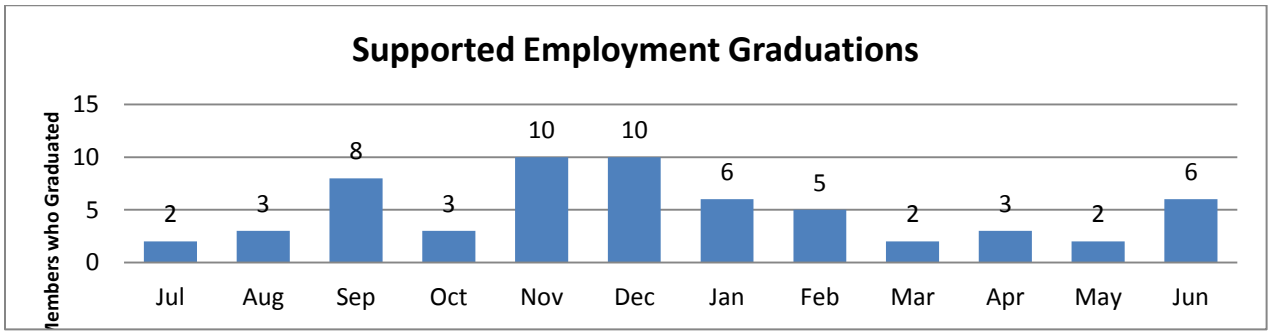
Transitional Age Youth PACT
Transitional Age Youth PACT programs have served 157 clients during FY 2012/2013. The PACT program has outcome data for fiscal years 08/09, 09/10, 10/11, 11/12. There is a gap in data from July 2012 – January 2013 due to the development and implementation of a new and improved database. The outcome measures used for

PACT include reduction of hospitalizations, reduction of incarcerations, reductions in homelessness, and increases in linkage to primary care.

Program of Assertive Community Treatment (PACT)
Adult PACT programs have served 547 clients during fiscal year 12/13. The PACT program has outcome data for fiscal years 08/09, 09/10, 10/11, 11/12. There is a gap in data from July 2012 – January 2013 due to the development and implementation of a new and improved database. The outcome measures used for PACT include reduction of hospitalizations, reduction of incarcerations, reductions in homelessness, and increase in linkage to primary care.

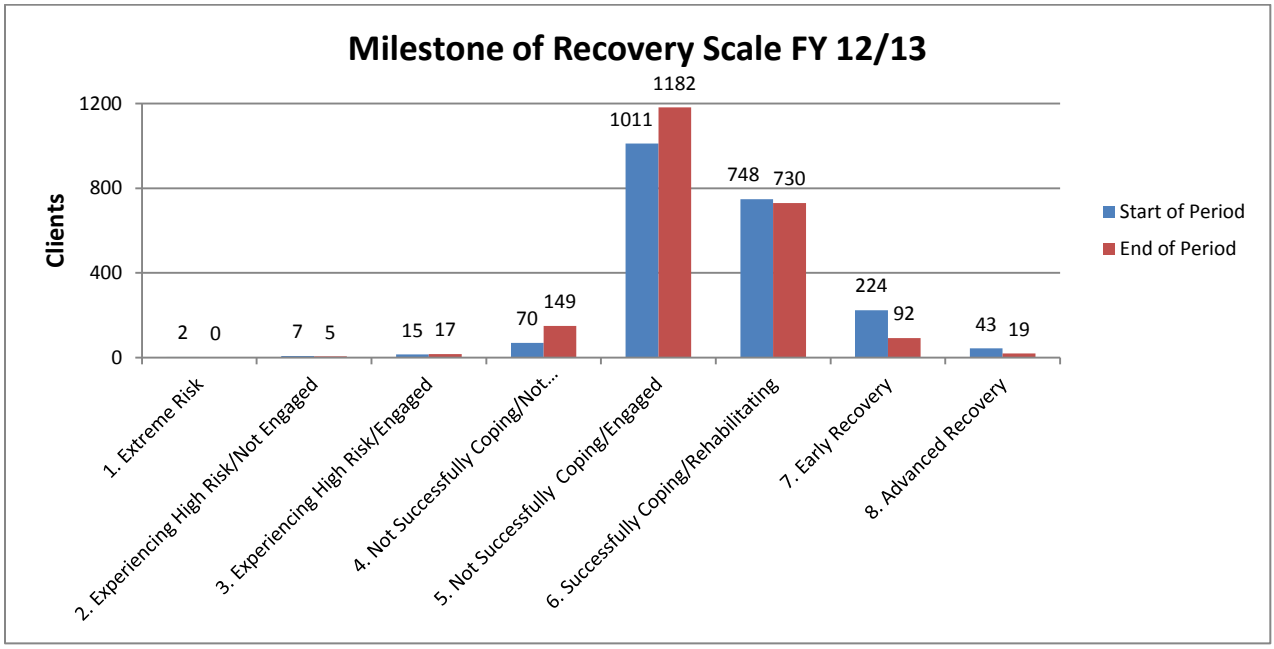
Older Adult PACT
OAS PACT served 70 clients during FY 2012/2013. The PACT program has outcome data for fiscal years 08/09, 09/10, 10/11, 11/12. There is a gap in data from July 2012 – January 2013 due to the development and implementation of a new database. The outcome measures used for PACT include reduction of hospitalizations as well as hospitalization days, reduction of incarcerations and incarceration days, reduction in homelessness, and increase in linkage to primary care.

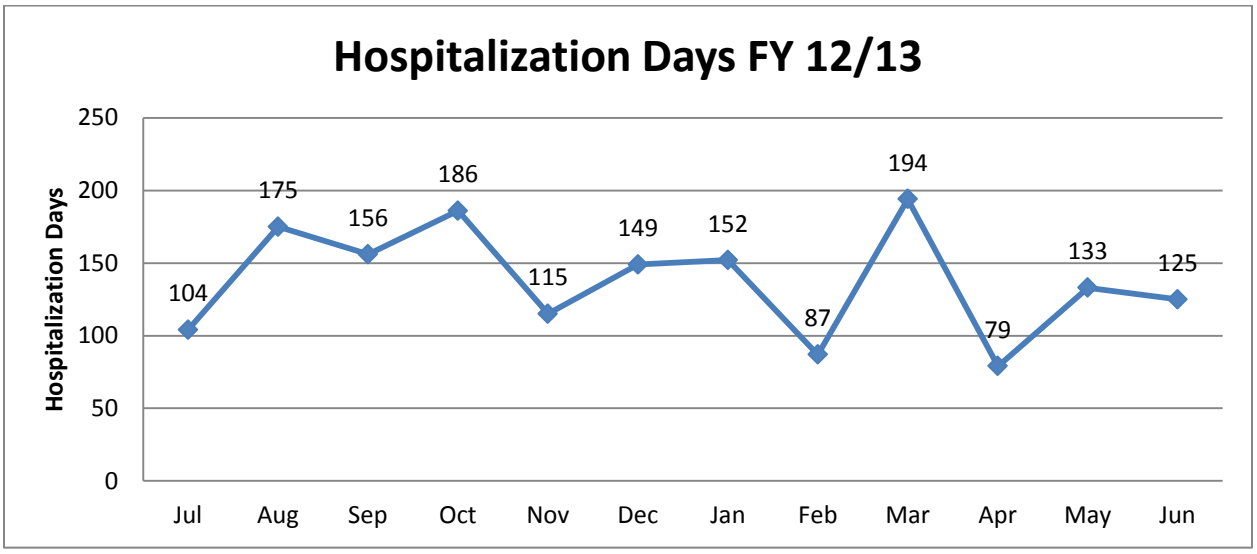
Supported Employment Services – Goodwill
The Supported Employment Program served 296 program participants in FY 12/13, which included 148 new enrollments. During FY 12/13, the program placed 126 program participants in employment. Additionally, 60 program participants graduated successfully from the program after successfully reaching the State of California job retention benchmark which is greater than 90 days in paid employment.



Adult and Older Adult Recovery Centers

Adult Recovery Centers
The Adult Recovery Centers served 3,107 clients during fiscal year 12/13.





Expanded Older Adult Mental Health Recovery Program

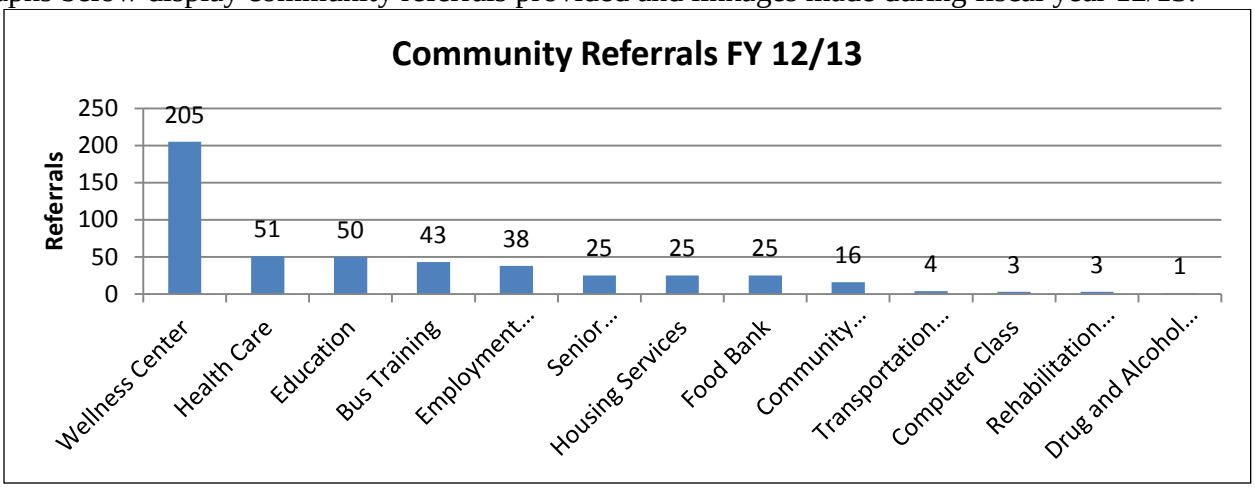
The Older Adult Mental Health Recovery Program served 558 clients during FY 12/13.

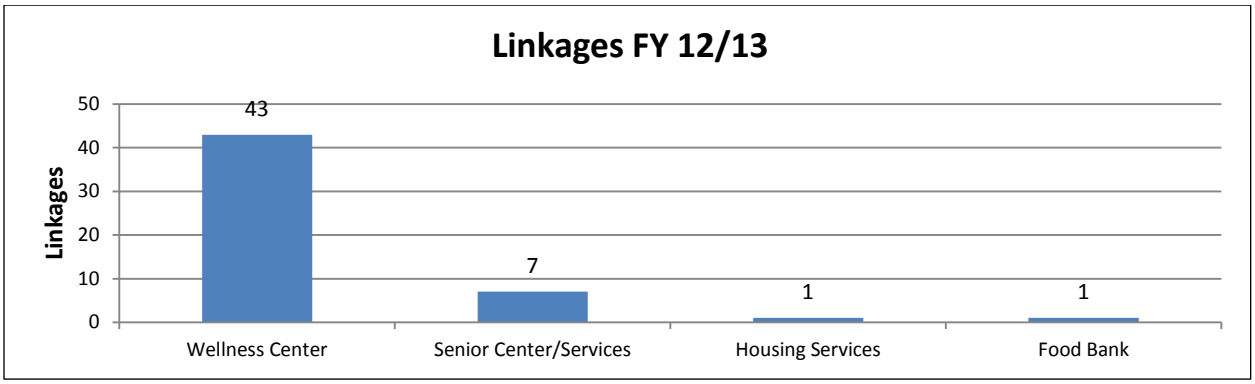
Peer Mentoring

Adult Peer Mentoring

During FY 12/13, Adult Peer Mentoring program served 236 clients.

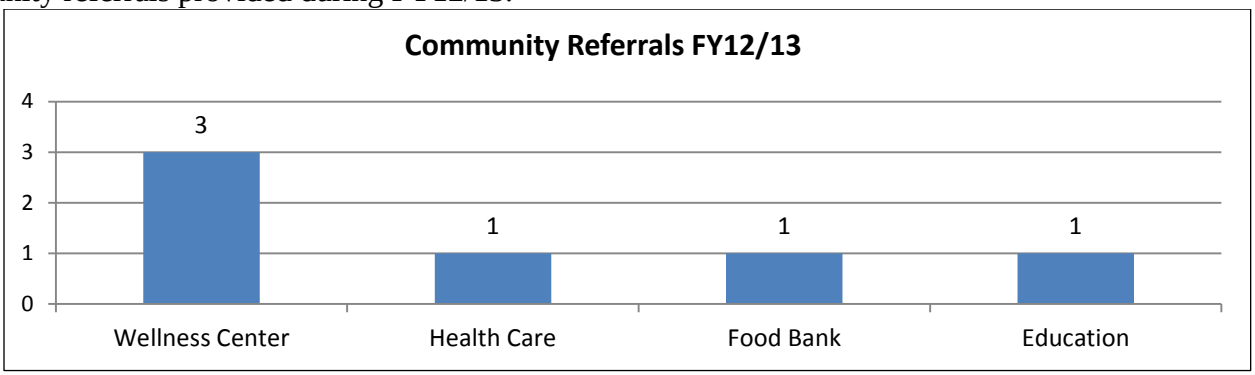
The graphs below display community referrals provided and linkages made during fiscal year 12/13.





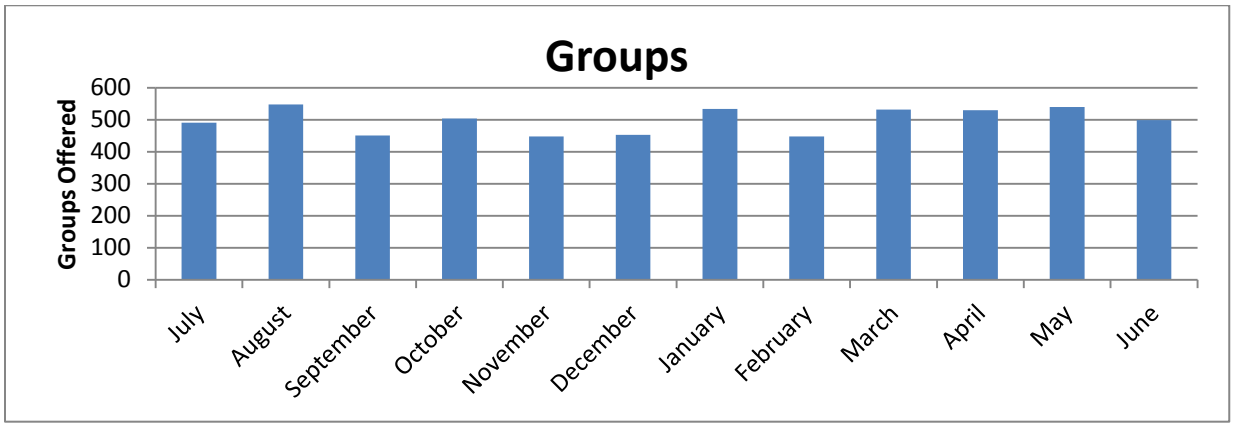
Older Adult Peer Mentoring

The Older Adult Peer Mentoring program served 73 members during FY 12/13. The graph illustrates the community referrals provided during FY12/13.

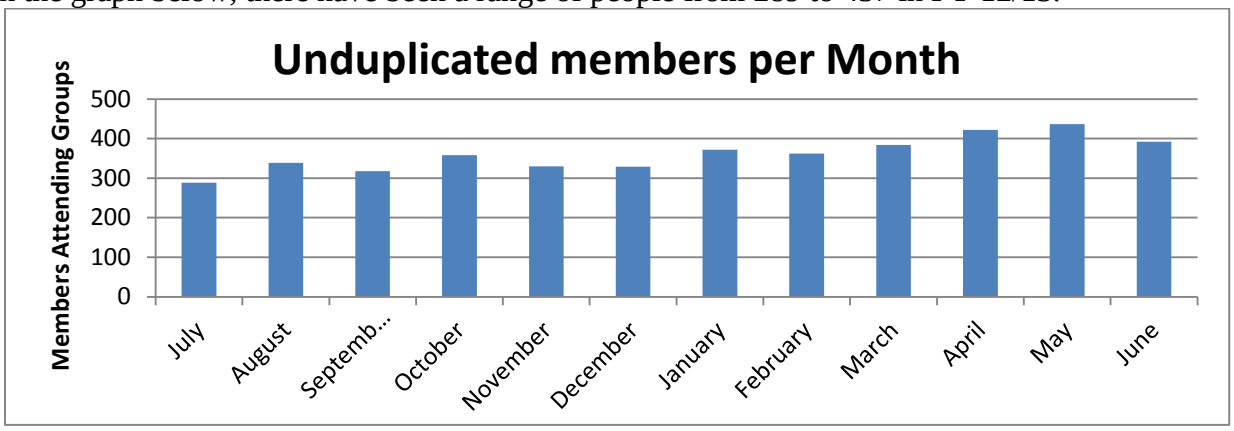


Wellness Center
The Wellness Center had 1,506 members actively participate during fiscal year 12/13.

The Wellness Center offers a variety of Groups, Activities, and Outings, collectively referred to as "groups". Throughout FY 12/13 the number of groups held per month ranged between 450 and 550. This averages out to just fewer than 20 groups a day.



Looking at unduplicated members by month, defined as members who have attended at least one group, is a good metric to assess how many unique individuals are utilizing the Wellness Center in any given month. As shown in the graph below, there have been a range of people from 289 to 437 in FY 12/13.



Excellence
Integrity
Service