San Mateo County
Mental Health Services Division
Strategic Plan
# Table of Contents

SAN MATEO COUNTY MENTAL HEALTH ................................................................. 3  

OVERVIEW ........................................................................................................... 3  
MISSION AND VALUES ....................................................................................... 3  
PRINCIPLES ......................................................................................................... 4  
SYSTEM-WIDE GOALS ....................................................................................... 4  

SERVICES FOR CHILDREN AND ADOLESCENTS ........................................... 8  

OVERVIEW ........................................................................................................... 8  
PRINCIPLES FOR THE MENTAL HEALTH SERVICE DELIVERY SYSTEM ........ 8  
SYSTEM DEVELOPMENT PRIORITIES .............................................................. 10  
ARRAY OF SERVICES – CHILDREN AND ADOLESCENTS AND THEIR FAMILIES ... 11  
PROCESS OF CARE FLOW ............................................................................. 18  
GLOSSARY ............................................................................................................ 31  

SERVICES FOR ADULTS AND OLDER ADULTS ............................................. 32  

OVERVIEW ........................................................................................................... 32  
PRINCIPLES FOR THE MENTAL HEALTH SERVICE DELIVERY SYSTEM ........ 32  
SYSTEM DEVELOPMENT PRIORITIES .............................................................. 34  
ARRAY OF SERVICES – ADULTS AND OLDER ADULTS .................................. 35  
PROCESS OF CARE FLOW ............................................................................. 41  
GLOSSARY ............................................................................................................ 53  

INFORMATION TECHNOLOGY ......................................................................... 54  

OVERVIEW ........................................................................................................... 54  
COMPUTER-BASED PATIENT RECORD (CPR) SYSTEM .................................... 54  
DECISION SUPPORT SYSTEM (DSS) ................................................................. 58  
EDUCATION AND COMMUNITY RESOURCE DATABASE ................................. 59  
APPLICATION SUPPORT STAFFING RESOURCES .......................................... 60  

BUSINESS SERVICES ......................................................................................... 62  

OVERVIEW ........................................................................................................... 62  
CLIENT AND THIRD PARTY REVENUE GENERATION .................................... 62  
DECENTRALIZED BUDGETING SYSTEM ............................................................ 63
San Mateo County Mental Health

Overview

The San Mateo County Mental Health Services Division initiated this strategic planning process in the fall of 2001. The intent of the process as articulated in the Request for Qualifications is that:

- Mental health services delivered by the County or contracted through community-based organizations will be:
  - Accessible and culturally appropriate, predictable and perceived as being allocated fairly on the basis of client need.
  - Cost effective, financially viable and less reliant on County General Fund support.
  - In compliance with State and Federal managed care and other regulations.
  - Focused on quality and “best practices.”
  - Accountable through ongoing use of performance indicators and client outcomes.

This strategic plan builds on the success of San Mateo’s current mental health program, which is recognized at both the state and national level for its innovation, quality service, and commitment to early intervention activities. The plan identifies further innovation and improvement and is intended to provide vision and direction for the period of the existing Federal/State Waiver, which was renewed for fiscal years (FY) 1/02 and 02/03, and to provide the basis for renegotiation and implementation of the Waiver in the future—implementation of the plan is projected through the end of FY 04/05.

Mission and Values

VISION

To set the standard for excellence in mental health services.

MISSION

To promote wellness and provide public mental health services that support San Mateo County residents to achieve their potential in meaningful life activities, and to live as contributing and successful members of their families and communities.

VALUES

- Partnership with clients and their families to promote recovery while respecting strengths and choices.
- Commitment to honor diversity and to ensure culturally and linguistically competent services.
• Partnerships with county and community based agencies and organizations to address the psychological, spiritual, health, social, and daily needs of people with serious emotional disturbances/mental illness.

• Commitment to advocacy and public education to eliminate stigma and to promote understanding, acceptance and support for people with mental illness.

• Commitment to prevention and early intervention services to promote well-being and to reduce avoidable costs of disability on individuals and on our communities.

• Commitment to function as a learning organization dedicated to ongoing training, development and support of staff, providers, consumers and family members; recognizing the essential role of these stakeholders in our organization’s effectiveness.

• Commitment to clinical and service excellence.

• Commitment to accountability for wise and cost effective use of resources with measurable results.

**OUR CORE SERVICE MANDATES**

Our mandate as San Mateo County’s public Mental Health Plan is to assure access to necessary services to children and youth with serious emotional disturbances, to adults and older adults with serious mental illness/psychiatric disability and to Medi-Cal beneficiaries. We partner with other County and community agencies to provide crisis intervention and a mental health response to critical community incidents and disasters.

**Principles**

Principles have been articulated for the system of care serving children and adolescents and the system of care serving adults and older adults. These can be found in the age specific chapters of the plan.

**System-wide Goals**

The goals that follow are listed in an order derived from the system process of care flow charts that appear in the body of the strategic plan—one for children and youth and one for adults and older adults. A separate action plan document suggests the sequencing of action plan tasks. There are significant relationships among the action plan items that are taken into consideration in sequencing and prioritization (these relationships are cross referenced in the action plans). Thus, the numbered order of the goals is not a statement about priority or time sequence.

1. Strengthen collaboration with system partners [Community Based Organizations (CBOs) as well as with other county agencies] to improve coordination of services to children, adolescents and families. Objectives include:
1.1 Create a map of interagency linkages/Memoranda of Understanding (MOUs) between Mental Health and other county Departments such as Human Services, the Sheriff’s Department and Probation. Identify existing and additionally required MOUs.

1.2 Create updated Memoranda of Understanding (MOUs) that reflect learning regarding effective collaboration.

1.3 Use technology to better identify overlapping engagement with clients.

1.4 Use technology to better support child/youth team communication.

1.5 Revise the senior level child/youth mental health interagency structure to include new membership (including families and CBOs), build processes to address problems in teamwork and communication and study and address system barriers identified by interagency teams.

2 Develop and implement clear policy regarding the parameters of the mental health system. Objectives include:

   2.1 Develop policies regarding who is served that address payor and population options.

   2.2 Develop standard criteria for the level of services provided and entry/exit into specific programs.

   2.3 Review and update financial and business policies and procedures to govern revenue generation activities.

   2.4 Develop protocols for acute/crisis services triage and authorization as well as in specific ongoing services.

3 Expand the use of data to plan, monitor and evaluate services. Objectives include:

   3.1 Implement a Level of Care (LOC) system that prospectively authorizes clients for a projected amount of service and provides a consistent organizing principle to:

   • Assure that the right amount of care is provided to clients;
   • Understand the relationship between services provided and outcomes achieved; and,
   • Align demand and capacity at the caseload, unit and system wide levels.

   3.2 Develop new system and program level reports that bring together data regarding service utilization, client satisfaction and outcomes achieved. Provide clinicians with data regarding caseload activity, and supervisors with caseload data for all staff in the unit.

4 Develop new information technology to support all of the efforts of the mental health system, from clinicians to the Mental Health Director. Objectives include:

   4.1 Select and implement a Computer-based Patient Record (CPR) system. This should be considered a multi-year activity, phased-in gradually, bringing the most important functionality online first.
4.2 Develop a Decision Support System (DSS) to more easily provide reports to clinicians and management. The most effective way to complete this project is by combining this with the CPR project, through a single procurement process.

4.3 Develop an online Education and Community Resource Database, making important materials available to clients and clinicians, preferably through a web-based interface.

4.4 Increase the Applications Support staffing resources to support the implementation and ongoing operation of the new information technology initiatives.

5 Add to the acute/crisis services continuum to improve responsiveness to clients and relieve the impact on police and justice agencies as well as inpatient services. These service enhancements are different for the age groups—the detail can be found in the separate sections of the full plan. Objectives include:

5.1 Identify resources for implementation of priority changes to services as identified in age-specific plans.

5.2 Establish and implement measurement plans for acute/crisis services.

6 Add to or reconfigure ongoing services to improve responsiveness to clients. These service enhancements have been prioritized for the age groups—the detail can be found in the separate sections of the full plan. Objectives include:

6.1 Identify resources for implementation of priority changes to services as identified in age-specific plans. Assess potential resources for service expansion and/or funding redirection and prioritize projects.

6.2 Establish and implement measurement plans for ongoing services.

7 Expand efforts to assure culturally competent services for current and prospective clients. Objectives include:

7.1 Focus hiring efforts to include consumer and family partner staff who are part of diverse populations served.

7.2 Develop a culturally competent workforce that also has core language capacity for the diverse populations served.

7.3 Work in collaboration with community based organizations that serve diverse populations.

7.4 Provide access to information in all formats (e.g., web site, brochures, informational and educational materials) in core languages for diverse populations.

7.5 Make services available at times and places where diverse populations can easily access them.

7.6 Develop and deliver services that enable diverse populations to receive the services.

8 Create a comprehensive plan to improve mental health and substance abuse services collaboration that will lead to improved access, enhanced treatment capacity, and
integrated services approaches for individuals – youth and their families, and adults and older adults. Objectives include:

8.1 Collaborate with HAS’s Substance Abuse and Services Integration managers and staff to develop an inventory of services, gaps in services and identification of service priorities to include identification of how services for people with co-occurring AOD/Mental Health should be provided within and across systems of care.

8.2 Identify service development priorities incorporating age specific needs as outlined in the age specific plans that follow.

8.3 Identify resources for implementation of priority changes to services.

8.4 Establish and implement measurement plans for ongoing services.

9 Create safe and affordable housing for transition age youth, adult and older adult consumers of care through expansion of housing initiatives focused on community-based organizations, housing agencies and the housing industry. Assure availability of dedicated staff/resources to provide advocacy and community development activities that support the development of low income housing for mental health consumers. The San Mateo Housing Continuum of Care planning process and plan will continue to provide the framework and specify goals for special needs housing.

9.1 Establish the Supportive Housing Work Group currently convened by Mental Health Services as a formal committee of the Housing Continuum of Care.

9.2 Develop an inventory of current housing/specialized residential capacity.

9.3 Develop a housing strategic plan for persons with psychiatric disabilities as a component of the Continuum of Care to include 5-year housing development goals.

10 Improve public knowledge and education regarding mental health issues (stigma reduction) and how to access mental health services. Objectives include:

10.1 Participate in an internal county process to improve the Guide to Community Resources and make it a constantly updated on-line resource.

10.2 Develop new partnerships with community-based organizations and identify complementary ways to work together.

10.3 Work with a range of other community organizations and professionals to improve information availability about mental health.

11 Improve the business services capabilities of the organization to ensure that all available revenue is generated and costs are properly managed.

11.1 Revise the eligibility, billing and collections policies and procedures to clarify the responsibilities of all staff (support staff, clinicians, clinical managers, financial staff).

11.2 Re-engineer the budgeting process such that the supervisor of each team will be responsible for developing, monitoring, and making course corrections for their annual budgets.
Services for Children and Adolescents

Overview

This section summarizes the vision of the future mental health system for children and adolescents and their families. An array of services table provides a “map” of the services available or needed in San Mateo County and sorts these into those services delivered by the key components of the service delivery system: county delivered services, independent practitioner delivered services, and community based organization delivered services.

The vision of the future is depicted in flow charts that, while complex and dense, contain sufficient detail to describe both the complexity of the system and how the parts of the process of care ought to work together in the future. A glossary of acronyms and other references is located at the end.

Principles for the Mental Health Service Delivery System

- Services facilitate each child/youth’s achievement of personal goals on the journey to his/her fullest potential—the system’s mission and stewardship responsibility is to build strategies to achieve those goals and support the journey.

- Children and youth, with (or at risk of) serious emotional and behavioral disorders, and their families receive services that are family centered. This is an ongoing process that includes:
  - Meeting families where they are now and developing family and child/youth driven treatment goals;
  - Working with families as partners to promote individual and family strengths;
  - Maintaining children and youth in their homes with their families whenever possible, providing them the appropriate supports and services;
  - Placing children out of home, when necessary, in the least restrictive setting appropriate to their needs;
  - Delivering service in the most appropriate locations and environments in the community, based on individualized goals and service plans; and,
  - Working towards recovery for the child/youth, the use of natural supports and family self-sufficiency.

- Early intervention services are provided directly and through community partnerships, to engage families in services and provide education and support for family development.

- Culturally competent approaches that recognize current and prospective families’ cultures and assure the skills, knowledge and policies to deliver effective treatments are used in all our services. This includes:
o Respecting the diverse cultures represented by the families who are served and working to incorporate family partners who represent those cultures;
o Developing a culturally competent workforce that also has core language capacity for the diverse populations served;
o Working in collaboration with community based organizations that serve diverse populations;
o Providing access to information in all formats (e.g., web site, brochures, informational and educational materials) in core languages for diverse populations;
o Making services available at times and places where diverse populations can easily access them; and,
o Developing and delivering services that enable diverse populations to receive the services.

• Services are delivered through the System of Care—the entire interagency system. [System of Care has this broad meaning and does not define a specific type of provider, program or consumer of services]. Collaboration with other system partners is important to providing services and assisting children/youth and families in meeting their goals. This requires the development of methods to identify and solve problems at the system level, as well as case-by-case. Activities in support of collaboration include:
o Creating Memoranda of Understanding with partner agencies such as the inpatient, healthcare, juvenile justice, alcohol and drug, education, and youth and family services (Human Services Agency) systems as well as community based organizations;
o Structuring methods for partner agencies to collaborate, and including families as partners, at the policy, management and service levels;
o Developing commonly understood and agreed upon definitions and criteria;
o Developing ways to remove barriers and create flexibility so systems are responsive to child and family needs; and
o Acknowledging a stewardship responsibility to the community and other agencies and measuring stakeholder satisfaction.

• Accountability systems support stewardship by measuring satisfaction and outcomes, as well as establishing consistent quality and utilization management practices. This includes:
o Developing mechanisms that assure the expertise of the practitioners and providers in the system;
o Measuring the impact of best practice models as they are implemented;
o Planning and monitoring services to assure that the most cost effective approaches are being used;
o Installing processes that assure that services are delivered to priority populations—the right amount and kind of service at the right time; and.
Acknowledging that numeric measures alone don’t assure people are served well—there is a subjective aspect to providing and receiving services that we try to assess whenever possible.

- Stigma in the community is addressed through a variety of efforts and with community partners. As a part of this effort, all care givers in the delivery system work on the evolution of their attitudes and expectations as well as influencing those of the community.

**System Development Priorities**

The following are listed in order of priority for system development; the implications for revenue production to support the activity are noted.

- Increased capacity for daily structured services including:
  - New school based day treatment capacity for elementary age children
  - After school structured services for children and youth
  - More school based adolescent day treatment
  - Summer daily support and structure for children and adolescents
  *(Revenue implications would be tied to specific program analysis.)*

- Development of a range of alcohol and drug services that serve youth mental health consumers. *(Revenue implications would be tied to specific program analysis.)*

- New capacity and improved services for acute/crisis care including:
  - Respite for families of SED youth, planned and crisis
  - Clear point of telephone contact and outreach capacity (as part of new urgent care capacity)
  - Crisis residential and sub-acute beds
  *(Revenue implications would be tied to specific program analysis.)*

- Expanded outpatient/case management capacity including:
  - Increased capacity for individual and family counseling
  - Increased capacity for psychiatric management/prescribing (routine and urgent)
  - Comprehensive interdisciplinary outpatient program for eating disorders
  - Increased capacity for group counseling (using best practice models for target populations)
  - Increased capacity for psychological testing
  - Services available evenings and Saturdays [a specific cultural competence strategy]
  - Multifamily treatment groups
  - More transitional services for young adults
  *(Revenue implications would be tied to specific program analysis.)*
• Services for emotionally disturbed consumers and their families that are available without requiring formal enrollment in mental health services or associated documentation:
  o Youth tutors/mentors
  o Youth after school normalizing activities
  o Family natural supports and activities
  o Peer counselors/peer or other mentors targeted to emotionally disturbed youth
    *(No revenue producing capacity, but may have a cost offset to the paperwork and staff requirements associated with establishing active enrollment.)*

• Early intervention and support services that are available to the general population without formal enrollment in mental health services or associated documentation (e.g., parent groups on developmental stages/parenting skills, time limited transitional groups, caregiver/family support groups). *(No revenue producing capacity, but may have a cost offset to the paperwork and staff requirements associated with establishing active enrollment.)*

• Organized efforts to improve understanding and identification of MH issues, the services available in the community and self-advocacy. *(No revenue producing capacity.)*

• Development of additional access to community supports and services, especially transportation, additional residential capacity and options, and public guardian services for youth. *(No revenue producing capacity.)*

**Array of Services – Children and Adolescents and their Families**

The following grid identifies services currently available in San Mateo County, by source of funding, and perceived adequacy of capacity.

<table>
<thead>
<tr>
<th>Legend for Services</th>
<th>Agency</th>
<th>County Services/ MH $</th>
<th>Independent Practitioner Network/ MH $</th>
<th>Contract CBO Network/ MH $</th>
<th>Provided by other agencies with other funding sources (including other County $)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community Education/Consultation</td>
<td>San Mateo County Strategic Plan—3/25/02</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>Services</td>
<td>Agency</td>
<td>County Services/ MH $</td>
<td>Independent Practitioner Network/ MH $</td>
<td>Contract CBO Network/ MH $</td>
<td>Provided by other agencies with other funding sources (including other County $)</td>
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<td>------------------------</td>
<td>----------------------------------------</td>
<td>---------------------------</td>
<td>----------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>• improve understanding and identification of MH/AOD issues</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• organized efforts to improve understanding of services available in community and self advocacy in using MH and community services</td>
<td>Y*</td>
<td>N</td>
<td>N</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>• general consultation for MDs and hospitals</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>• consultation to childcare settings, Headstart, other early childhood programs</td>
<td>Y- special ed. population</td>
<td>N</td>
<td>N</td>
<td>Y - Headstart contracts</td>
<td></td>
</tr>
<tr>
<td>• general consultation to schools/community colleges</td>
<td>Y- special ed. population</td>
<td>N</td>
<td>N</td>
<td>Y - Community Based Organizations</td>
<td></td>
</tr>
</tbody>
</table>

**Early Intervention and Support Services**

*Educational/support focus, service enrollment not required, target general pop*

<table>
<thead>
<tr>
<th>Services</th>
<th>Agency</th>
<th>County Services/ MH $</th>
<th>Independent Practitioner Network/ MH $</th>
<th>Contract CBO Network/ MH $</th>
<th>Provided by other agencies with other funding sources (including other County $)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• time limited transitional groups (death, divorce, grief and loss, early adulthood)</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>• parent groups on developmental stages/parenting skills</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>Y*</td>
<td></td>
</tr>
<tr>
<td>• parent groups on early ID of youth AOD issues</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>?</td>
<td></td>
</tr>
<tr>
<td>• youth employment readiness</td>
<td>Y* - TDS</td>
<td>N</td>
<td>N</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>• teen parenting groups</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>Y-CBOs and schools</td>
<td></td>
</tr>
<tr>
<td>• gang involvement interventions</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>• youth violence prevention</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>Y*-CBOs</td>
<td></td>
</tr>
<tr>
<td>• dual dx ed/support groups</td>
<td>Y* - TDS</td>
<td>Y</td>
<td>Y</td>
<td>?</td>
<td></td>
</tr>
<tr>
<td>• caregiver/family support</td>
<td>Y* - border line group /Wrap</td>
<td>N</td>
<td>N</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>Services</td>
<td>Agency</td>
<td>County Services/ MH $</td>
<td>Independent Practitioner Network/ MH $</td>
<td>Contract CBO Network/ MH $</td>
<td>Provided by other agencies with other funding sources (including other County $)</td>
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</tr>
<tr>
<td>groups</td>
<td>Pilot</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• youth after school normalizing activities</td>
<td>Y* -few slots at Boys &amp; Girls Club</td>
<td>N</td>
<td>N</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>• youth tutors/mentors</td>
<td>Y*-Shadows</td>
<td>N</td>
<td>Y*-Shadows</td>
<td>Y</td>
<td></td>
</tr>
</tbody>
</table>

**Supports for SMI/SED population (may or may not be enrolled in services)**

<table>
<thead>
<tr>
<th>Services</th>
<th>Agency</th>
<th>County Services/ MH $</th>
<th>Independent Practitioner Network/ MH $</th>
<th>Contract CBO Network/ MH $</th>
<th>Provided by other agencies with other funding sources (including other County $)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• financial mgmt, other support groups</td>
<td></td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>Y –NAMI, NARSAD, NDMDA, CHADD</td>
</tr>
<tr>
<td>• self help organizations consumer operated</td>
<td></td>
<td>N</td>
<td>N</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>• self help/ socialization/drop in</td>
<td></td>
<td>N</td>
<td>N</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>• warm line service (peer telephone support)</td>
<td></td>
<td>N</td>
<td>N</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>• referral and support for family members</td>
<td>Y* -Access line</td>
<td>N</td>
<td>N</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>• peer counselors/peer or other mentors</td>
<td></td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>Y-NAMI Family to Parent</td>
</tr>
<tr>
<td>• peer advocates</td>
<td></td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>Y*-CBO’s</td>
</tr>
<tr>
<td>• family natural supports and activities</td>
<td>Y* -School Based (PV)/South Central OCD Family Group/ Wrap Pilot border line group</td>
<td>N</td>
<td>N</td>
<td>Y*-Parent to Parent</td>
<td></td>
</tr>
<tr>
<td>• church supports</td>
<td></td>
<td>N</td>
<td>N</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>• recovery groups</td>
<td>Y* -teen border line group</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td></td>
</tr>
</tbody>
</table>

**Crisis/initial access services**

<table>
<thead>
<tr>
<th>Services</th>
<th>Agency</th>
<th>County Services/ MH $</th>
<th>Independent Practitioner Network/ MH $</th>
<th>Contract CBO Network/ MH $</th>
<th>Provided by other agencies with other funding sources (including other County $)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• 1-800 Information &amp; Referral line</td>
<td>Y* - Access Line</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>• 1-800 access line</td>
<td></td>
<td>Y</td>
<td>N</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>Services</td>
<td>Agency</td>
<td>County Services/ MH $</td>
<td>Independent Practitioner Network/ MH $</td>
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<td>Provided by other agencies with other funding sources (including other County $)</td>
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<td>----------------------------------------</td>
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<td>----------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>• 1-800 crisis line, 24/7</td>
<td>Y*</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>• mobile crisis team (clinicians, police support)</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>Y* -school crisis response from CBO</td>
<td></td>
</tr>
<tr>
<td>• urgent care walk in clinic</td>
<td>Y- 8-5 clinics, after hours PES</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>• respite, crisis</td>
<td>Y*</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>• respite, planned</td>
<td>Y*</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>• crisis residential</td>
<td>May '02 -crisis facility –12 beds</td>
<td>N</td>
<td>Y</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>• crisis observation 23 hour beds</td>
<td>Y -PES</td>
<td>N</td>
<td>Y -Peninsula Hospital</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>• acute inpatient (involuntary, voluntary)</td>
<td>N</td>
<td>N</td>
<td>Y-Primarily for adolescents</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>• outstationed staff to homeless shelters/ programs</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td></td>
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<tr>
<td>• outreach to other special populations</td>
<td>Y* -special ed students</td>
<td>N</td>
<td>N</td>
<td>N</td>
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<tr>
<td>• outreach to jail/corrections</td>
<td>Y* -Juvenile Hall</td>
<td>N</td>
<td>N</td>
<td>N</td>
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</tr>
<tr>
<td>• assessment/ authorization to non-crisis care</td>
<td>Y - Access</td>
<td>N</td>
<td>N</td>
<td>N</td>
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</tr>
<tr>
<td><strong>Outpatient treatment services</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• individual/family tx/counseling</td>
<td>Y*</td>
<td>Y</td>
<td>Y</td>
<td>Y-CHC</td>
<td></td>
</tr>
<tr>
<td>• group tx/counseling (enrolled in services)</td>
<td>Y*</td>
<td>N</td>
<td>N</td>
<td>Y-CHC</td>
<td></td>
</tr>
<tr>
<td>• dual dx tx groups</td>
<td>Y* -TDS</td>
<td>Y</td>
<td>Y</td>
<td>Y-ACHIEVE</td>
<td></td>
</tr>
<tr>
<td>• multifamily groups</td>
<td>Y*</td>
<td>N</td>
<td>N</td>
<td>?</td>
<td></td>
</tr>
<tr>
<td>• psychiatric evaluation</td>
<td>Y</td>
<td>Y* -very limited for youth</td>
<td>N</td>
<td>Y-CHC</td>
<td></td>
</tr>
<tr>
<td>• psychiatric consultation</td>
<td>Y*</td>
<td>N</td>
<td>N</td>
<td>?</td>
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<tr>
<td>Services</td>
<td>Agency</td>
<td>County Services/ MH $</td>
<td>Independent Practitioner Network/ MH $</td>
<td>Contract CBO Network/ MH $</td>
<td>Provided by other agencies with other funding sources (including other County $)</td>
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<td>-----------------------</td>
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<tr>
<td>- psychiatric management/prescribing (routine and urgent)</td>
<td>Y</td>
<td>Y* -very limited</td>
<td>N</td>
<td>N</td>
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</tr>
<tr>
<td>- advice nurse (consult on medication issues)</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>- psychological testing</td>
<td>Y* -limited</td>
<td>Y</td>
<td>N</td>
<td>Y - CHC</td>
<td></td>
</tr>
<tr>
<td>- services on-site at primary care facilities</td>
<td>Y</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>- services available evening/Saturday</td>
<td>Y* -in home program</td>
<td>N</td>
<td>Y- TBS</td>
<td>Y* - CBO's</td>
<td></td>
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<tr>
<td>- services for homebound frail or physically disabled</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>- 24/7 intensive home/community case management</td>
<td>Y</td>
<td>N</td>
<td>Y</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>- school-based risk assessment, treatment and referral</td>
<td>Y - special ed Youth</td>
<td>N</td>
<td>N</td>
<td>Y - CBO's</td>
<td></td>
</tr>
<tr>
<td>- supported classroom</td>
<td>Y - special ed Youth</td>
<td>N</td>
<td>N</td>
<td>Y - CBO's</td>
<td></td>
</tr>
<tr>
<td>- stabilization classroom</td>
<td>Y</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>- day treatment/adolescent (TDS)</td>
<td>Y*</td>
<td>N</td>
<td>N</td>
<td>Y- CHC, ACHIEVE</td>
<td></td>
</tr>
<tr>
<td>- day treatment/elementary ages</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>- supported employment/supported education</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>Y- Stepping Stones, ACHIEVE</td>
<td></td>
</tr>
<tr>
<td>- transitional services for young adults</td>
<td>Y</td>
<td>N</td>
<td>Y</td>
<td>?</td>
<td></td>
</tr>
<tr>
<td>- individual skill building/coaching</td>
<td>Y* -Shadows</td>
<td>N</td>
<td>N</td>
<td>?</td>
<td></td>
</tr>
<tr>
<td>- intensive peer support</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>?</td>
<td></td>
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<tr>
<td>- after school structured services</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>Y*- Redwood City Schools</td>
<td></td>
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<tr>
<td>- summer daily structure and support (all ages)</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>- intensive eating disorder program</td>
<td>N</td>
<td>N</td>
<td>Y* -less intensive cases</td>
<td>Y-inpatient only</td>
<td></td>
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</table>

<p>| Case Management services                                               |                         |                       |                                       |                           |                                                                                  |</p>
<table>
<thead>
<tr>
<th>Services</th>
<th>Agency</th>
<th>County Services/ MH $</th>
<th>Independent Practitioner Network/ MH $</th>
<th>Contract CBO Network/ MH $</th>
<th>Provided by other agencies with other funding sources (including other County $)</th>
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<tbody>
<tr>
<td>- service coordination, including targeted case management /linkage and brokering</td>
<td>Y</td>
<td>N</td>
<td>N</td>
<td>?</td>
<td></td>
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<tr>
<td>- case specific interdisciplinary consults</td>
<td>Y</td>
<td>N</td>
<td>N</td>
<td>?</td>
<td></td>
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<tr>
<td>- hospital discharge planning</td>
<td>Y</td>
<td>N</td>
<td>Y</td>
<td>N</td>
<td></td>
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<tr>
<td>Access to Residential Services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- emergency housing/shelter (targeted for families)</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>A few beds provided by CBO’s</td>
<td></td>
</tr>
<tr>
<td>- therapeutic foster care</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>Y - Human Services</td>
<td></td>
</tr>
<tr>
<td>- foster care</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>Y - Human Services</td>
<td></td>
</tr>
<tr>
<td>- subsidized housing</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>Y - CBOs</td>
<td></td>
</tr>
<tr>
<td>- supported housing</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>Y - CBOs</td>
<td></td>
</tr>
<tr>
<td>- residential treatment facilities</td>
<td>Y - 5/02</td>
<td>N</td>
<td>Y</td>
<td>Y - CBOs</td>
<td></td>
</tr>
<tr>
<td>- secure residential</td>
<td>N</td>
<td>N</td>
<td>Y</td>
<td>N</td>
<td></td>
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<tr>
<td>Access to Alcohol and Other Drug services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- sobering stations</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>?</td>
<td></td>
</tr>
<tr>
<td>- social detox/residential</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>?</td>
<td></td>
</tr>
<tr>
<td>- outpatient medical detox</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>Y – Palm Ave, Detox</td>
<td></td>
</tr>
<tr>
<td>- inpatient medical detox</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>?</td>
<td></td>
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<tr>
<td>- intensive outpatient</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>?</td>
<td></td>
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<tr>
<td>- outpatient tx</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
<td>Y - El Centro, Insights, Pyramid, U-Turn</td>
<td></td>
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<tr>
<td>- day tx</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>?</td>
<td></td>
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<tr>
<td>Services</td>
<td>Agency</td>
<td>County Services/ MH $</td>
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</tr>
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<td>-----------------</td>
<td>------------------------</td>
<td>----------------------------------------</td>
<td>----------------------------</td>
<td>-----------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>• aftercare/12 step</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
<td>Y-AA, NA</td>
<td></td>
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<tr>
<td>• narcotic replacement tx</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>?</td>
<td></td>
</tr>
<tr>
<td>• residential tx (short/long)</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>Y- SS funding, Daytop, Thunderoul, Proj. Intermt</td>
<td></td>
</tr>
<tr>
<td>• transitional living</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>• peer support</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>?</td>
<td></td>
</tr>
<tr>
<td><strong>Access to Community Services and Supports</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• transportation</td>
<td>Y-Limited bus passes, cab vouchers</td>
<td>N</td>
<td>Y*-sexual abuse program</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>• eligibility assistance (SSI, etc.)</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>• safe and affordable housing options</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>Y-CBOs.</td>
<td></td>
</tr>
<tr>
<td>• physical health services</td>
<td>Y- primary care clinics</td>
<td>N</td>
<td>N</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>• structured activity programs</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>?</td>
<td></td>
</tr>
<tr>
<td>• supported education</td>
<td>Y*</td>
<td>N</td>
<td>N</td>
<td>?</td>
<td></td>
</tr>
<tr>
<td>• higher education</td>
<td>Y*</td>
<td>N</td>
<td>N</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>• competitive employment</td>
<td>Y*</td>
<td>N</td>
<td>N</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>• public guardian/conservator</td>
<td>Y-limited with youth</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>• advocacy/legal assistance for patient and family/caregivers</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>Y-CBOs.</td>
<td></td>
</tr>
<tr>
<td>• supervised visitation</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>Y-CBOs.</td>
<td></td>
</tr>
</tbody>
</table>
Process of Care Flow

This is a vision for the future—not all of the pieces are in place now, and it will take some time to fund and develop all of them—the flow provides a picture of what the system should work to put in place. It is assumed that:

- New or redirected resources will be needed as prioritized to implement the vision;
- Changes identified here will occur as prioritized over time; and,
- Detailed data and financial analysis will be part of the development of new programs.

The flow traces the process of providing services, from entry into the system of care. A given throughout is language appropriate materials and access, cultural competence, and geographic access. All services are described in terms of the functions provided, rather than program or provider names—there are several delivery options for most of the new or improved services. A glossary of terms is included on the last page.
San Mateo County Mental Health
Children/Youth Service Flow

Consumer needing services

Access Crisis/Acute Care Request

Access Non-crisis Request

Financial Screening/Program Eligibility/Authorization

Assessment/Service Planning

Service Delivery

Service Review

Service Episode Ends

Quality Process

San Mateo Mental Health Service Mandates

MediCal SED

Non-MediCal SED

MediCal Non-SED

Non-MediCal Non-SED

San Mateo County Strategic Plan—3/25/02 19
System of Care (SOC) Overview

SOC refers to the entire interagency system, not a provider/program classification or a level of care for service

<table>
<thead>
<tr>
<th>SOC Policy Oversight Team</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Establish the overarching commitment of all SOC partners (mental health, education, juvenile justice, child welfare, AOD, Regional Center, Representatives of families, CBOs, and line staff)</td>
</tr>
<tr>
<td>- Negotiate and maintain MOUs</td>
</tr>
<tr>
<td>- Legal responsibilities of each agency defined</td>
</tr>
<tr>
<td>- Clear criteria regarding which consumers receive this level of coordination</td>
</tr>
<tr>
<td>- Confidentiality provisions</td>
</tr>
<tr>
<td>- Technology support such as reports shared, computer list matching</td>
</tr>
<tr>
<td>- Troubleshoot MOU compliance within respective agencies</td>
</tr>
<tr>
<td>- Review and address system barriers identified by SOC consumer teams</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SOC Consumer Teams</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Level of team activity guided by criteria for which consumers have what level of team coordination, as team coordination has implications for caseload size in every system</td>
</tr>
<tr>
<td>- Facilitated by a team developer (this is a distinct team role that can be filled by a team member or designated resource)</td>
</tr>
<tr>
<td>- Consumer/family is center of the team</td>
</tr>
<tr>
<td>- There is a designated coordinator for the team (who may or may not also be team developer), this assignment may change depending on the needs of the consumer</td>
</tr>
<tr>
<td>- All involved systems participate, everyone is at the table for both real time and “virtual” meetings</td>
</tr>
<tr>
<td>- Roles are defined in the MOUs for each agency as well as specifically for each consumer team</td>
</tr>
<tr>
<td>- Each system representative has authority for the resources/services of their agency, applying the criteria and “rules” of their system</td>
</tr>
<tr>
<td>- There is commitment to communicate on an ongoing basis, return calls, and coordinate services (look at technology solutions such as restricted entry chat room for each consumer team)</td>
</tr>
<tr>
<td>- There is a clear process for joint services planning, service change planning and joint decision making with all partner agencies</td>
</tr>
<tr>
<td>- Consumer driven, common goals are developed that are reflected in the service plans of each agency; everyone has a copy of the goals and overall treatment plan</td>
</tr>
<tr>
<td>- Periodic review of service delivered and outcomes achieved—is it making a difference?—leads to changes in service planning</td>
</tr>
<tr>
<td>- Problems within teams regarding coordination according to the MOU are taken to the appropriate SOC Policy Team representative</td>
</tr>
<tr>
<td>- System barriers to delivery of appropriate services are identified and reported periodically to the Policy Team, including transportation which is a major system barrier to delivery of appropriate and timely services</td>
</tr>
</tbody>
</table>
Access Overview

**Public Knowledge/Community Education/Prevention**
- The Guide to Community Resources is available on-line or through a 1-800 service, widely known by all types of community service providers. On-line updates are provided. Libraries and community centers are involved in making the information available.
- Partnership with schools provides information to all parents regarding community services, including MH, teachers are aware of services, posters re: HELP for kids.
- Materials for pediatricians on when, where, how to refer.
- Work with faith and church groups.
- Develop new partnership with CBOs
  - Geographic assessment of regional needs
  - Build on and coordinate with their outreach capacity
  - Know which CBOs are in which schools, offering which services
  - Identify gaps in school based short term services, collaborate w/CBOs to fill gaps
  - Develop complementary services w/ CBOs so they can refer for a small piece of service (psychiatric assessment, consult, meds assessment)
- County MH provides listing of programs, staff, eligibility information on-line and updates regularly

---

**1-800 Access Line**
- General public referrals
- Non-SED MediCal referrals from CBOs, other partner agencies
- Back up to Liaison referrals for SED

---

**1-800 Crisis Line 24/7**
- Dispatch mobile team (adult focus)
- Work w/ ERs, police, OP providers, partner agencies, MDs
- Take direct calls from public
- Patch in from 911
- Triage and respond with range of options

---

**Community Services**
- CBO linkages
- Family support programs
- NAMI education for families

---

**Police/ERs**
- Address involuntary requests, safety or medical issues
- Work through acute care system for least restrictive option

---

**Crisis Request Resolution**
- Emergent need (NCQA=immediate)
- Urgent need (NCQA= 48 hours)
- Routine need for ongoing services (NCQA= 10 business days)
- Call resolves need

Go to Pg 23 for detailed steps

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**Non-Crisis Referral/Request for Services**
- General public referral
- Partner agency referral

Go to Pg 24, 25 for detailed steps

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San Mateo County Strategic Plan—3/25/02 21
Infrastructure Supports

System Infrastructure—Information Technology
- Community Information Guide on-line resource data base, in core languages
- Interagency information sharing protocols that meet state and federal requirements
- MH IT infrastructure is updated and has dedicated staff
- On-line county MH program information, regular updates
- Central Access data base to initiate and document all referrals
- On-line financial and demographic information on all enrolled consumers, regular updates
- On-line access to basic clinical record
- Records of prior service easily accessed, MH records are integrated into a single chart (and eventually an integrated health chart)
- Crisis plan on-line for those receiving intensive services
- On-line appointment scheduling, ability to “flag” assessment and first service appointments scheduled but not used, track access standards
- Automated method to quickly assess provider capacity, monitor capacity and availability (county, network and CBOs)
- On-line capacity for crisis system to make an intake appointment while with the consumer and family
- IT gathers information from first contact and is available on-line to next staff person, so consumer doesn’t have to repeat clinical or financial information
- IT system tracks, enables moving through the flow, monitoring to assure it is working
- On-line info re: who is in what MH program, including contractors
- List matching with other county agencies to know if current consumers are in jail, social services, in other services (24 hr access)
- Hospital discharge notes, lab work, diagnostic test results, H&Ps available on-line
- PES reports on-line, with tickler to notify re: the visit
- Restricted access chat rooms for SOC consumer teams
- Ability for staff to access e-mail from non-county computers
- Current county initiative to improve computer systems: opportunity to bring clinical orientation to system, make user friendly and allow information sharing with HSA, reports for clinicians, supervisors, program directors, system as a whole
- County web site/intranet with articles on health, education linkages to recent research findings, restricted line that connects pharmacies (med interactions)
- Off-site specialized consultations using videoconferencing

System Infrastructure—Finance and Business
- Client handout regarding financial screening, UMDAP process, address concerns of undocumented individuals
- Assistance with applications for MediCal
- Standard policies and procedures for financial screening and standard form for financial screening
- Reliable ongoing UMDAP process that updates information
- Reports to support clinicians and managers in managing both clinically and for the overall system
- Management and contracting structure including a contract process for all services purchased with MH funds from county agencies and CBOs
**Infrastructure Supports**

### System Infrastructure-Criteria and Policies
- Clear criteria for who MH serves—criteria developed with consumer input
- Access standards consistent with waiver and DMH requirements, consistent at all points of entry into the MH system
- Written protocol/criteria for screening and authorization to services—all staff trained to criteria and assessment skills
- Define MH/AOD Dual Dx and establish clarity regarding eligibility for MH services
- AOD providers have own capacity for psych consult and medications, MH level of collaboration is defined
- Clear policy regarding residency determination and eligibility for services
- Procedure for out of county placements
- Provider handbook for all MH providers (including independent practitioners and CBO providers) with community referral info, CBO info, county funded services and eligibility
- Member handbook provided to all enrolled consumers with information regarding how the system works
- Written criteria for crisis triage and use of acute options
- Protocols for transfer among IP facilities
- Protocols for joint tx planning with all contracted IP facilities, includes incorporation of IP tx plan, assessment of med changes, consult on AOD patients tapering down meds
- Written criteria for post 23 hour/residential/IP disposition planning
- Criteria for who gets free medications, establish copayment options
- Protocols for transfer of medical records from other systems
- Develop MH/AOD service approach, criteria, policies and procedures, best practice guidelines, harm reduction approaches
- Establish standards for county staff, network, and contracted providers regarding AOD skills
- Develop MOUs with other systems: confidentiality component, information sharing protocols (and use technology whenever possible to match system involvement)
- Develop clear program descriptions re: what is available, specialties, entry/exit criteria, list all services available, which have best practices models in place
- Develop system wide exit criteria
- Use upcoming change of outcome tools to review present process, streamline, provide supports and education to clinicians and families
- Develop process and resources for second opinions
- Protocols and quality/monitoring process developed with PCPs, operationalize the flow back to the PCPs
- Written criteria and referral options for dementia and OBS

### System Infrastructure-Other System Capacity
- Coordinating function for all acute care services that integrates planning, policies
- Capacity to deliver the services that are offered, either through county clinics, contracted providers, or network providers including: Dual peer recovery groups, Dual tx groups, dual groups for moms w/ babies, intensive OP tx, AOD specialists as part of teams, Dual residential options
- Develop adult team structure service model
- Align productivity documentation rules to service vision and training plan
- Develop training vision and plan via staffed process that includes contractors, consumers and builds on HSA resources
  - AOD assessment and best practices, true dual dx expertise
  - Skills in group services
  - Computer skills, technology tools
    - Outcome tools, how to use and why
- Space and vehicles
- Cell phones, computers for every staff person
- Laptops that uplink, computer access at all sites
- Upgrade and replace site equipment
- Pharmacies that deliver medications
- Provide on-line access for consumers to go to internet based resources

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San Mateo County Strategic Plan—3/25/02 23
Access Detail: Crisis and Acute Care Services

**First Contact**
- 1-800 Crisis Line 24/7
  - Triage and arrange response based on level of need, staff have AOD assessment skills too
- Emergent need
- Urgent need
- Routine need for ongoing services
- Call resolves need

**First Response**
- Juvenile Campus Assessment Center
  - For those in juvenile justice/child welfare system
  - MH screening
  - AOD assessment
- Urgent Care Clinic (s)
  - Staffed regional sites, during business hrs, centralized for extended hrs (evening and Sat.)
  - No appt needed for consult
  - Capacity to do outreach if indicated
  - AOD assessment, tox screen
  - Medications access
  - Referral for ongoing service, not from urgent care clinician
  - Follow up calls from parent staff
- MH Clinic/Contract Provider
  - Team provides crisis mgmt for those already in care

**Diversion**
- 23 Hour Observation
  - For current consumers, use urgent care display, and contact provider same day or next open hour
  - Focus on aftercare planning, triage to Access or other services
  - Gather collateral and other contact info
  - Determine eligibility
  - MH stabilization
  - Child psychiatry consults
  - AOD assessment/intervention
  - Medical evaluation
  - Medications

**Inpatient Services**
- Inpatient Services
  - Choice of IP site
  - Notify/liaison OP provider or Access for all County consumers (includes payors other than MediCal)
  - Articulation of tx goals, joint tx planning per protocols
  - AOD assessment/intervention
  - Psycho social, family evaluation, reassess current consumers
  - Discharge planning in communication with Access or
- In-Home Services
  - TBS and other home based services
  - Peer parent support
- Respite
  - Crisis and planned
  - Divert reactive situations
- AOD Services
  - Sobering and detox
- Step Down Residential
- MH stabilization
- AOD assessment, tox screen
- Medications
- Focus on aftercare planning

**Aftercare**
- AOD Services
  - Ongoing tx/integrated
- Step Down Residential
- Refer for OP Intake (see Pg 24)
  - Urgent next day appointment
  - Brief (e.g., 6) session follow up
  - More intensive/case management follow up
  - Follow up no shows with calls from parent staff
- Document Service (all)
  - If enrolled, note to record, to OP provider
  - Referral to community services
Access Detail: Non-Crisis Requests for OP Services

**Referral Sources**

- **Crisis System Referral**
  - Expedited access

- **General Public Referrals**

- **Partner Agency Referrals**
  - Access for non SED MediCal
  - Liaison for SED, specialized svc

- **Liaison/Specialized Program Staff**
  - Liaisons know all MH services and financial coverage/program eligibility, assure same steps and documentation as Access
  - CW/Regional clinic team
  - School liaisons for 26.5 SED
  - Probation team/assessment ctr
  - IP care managers planning aftercare services
  - Pre-three officer of the day/triage

**Intake Process/Authorization**

- **1-800 Access**
  - This is the major gateway into services, see detail next page for all the steps that happen at this point
  - Public gateway for referrals Public gateway for referrals
  - Foster parents may call Access
  - CBOs providing non-MH school based programs may call Access for specialized consults
  - HSA/FSA referrals that need more intensive services
  - Other counties’ clients moving here
  - Out of county placements coming here (includes adoptions out of county)
  - Track all local outgoing placements
  - Document every call and services offered
  - Payor source/coverage screening, MediCal eligibility determination
  - Consult with programs on ASO referrals, complex cases, potential 26.5 cases
  - Schedule callers for face-face assessment appointment at likely site of services
  - Schedule complex/question referrals for Access face-face assessment
  - Authorize eligibility and services
  - Assure clients are connected to services appropriate to level of urgency during process of intake and authorization (e.g., out of county cases may need to be seen in urgent care modality for initial meds)

**Programs Authorized**

- **No Formal MH Services**
  - Requests not eligible for MH services are connected to appropriate community resources

- **Outreach Efforts**
  - Initiate outreach as appropriate, including connection to acute care services
  - See Pg 19, CBO outreach partnership

- **Specialized Consult Needed**
  - Per standard criteria, for those being served by CBOs with case mgmt and programs
  - MH to provide psychiatric assessment, consultation and meds assessment

- **Network Providers (Independent Practitioners)**
  - Per standard criteria, MediCal referrals only

- **Pre-three Services**
  - All pregnant/postpartum (child 0-3) referrals
  - Level of response based on protocols for service level

- **Comprehensive MH Services County and Contract Providers**
  - Per standard criteria, some specialized services require special OK
  - Flexibility in whether to open as 26.5 or provide responsive episode services
  - Convene SOC team as appropriate
Access Detail: Financial Screening, Program Eligibility, Assessment and Authorization for Services

**Liaison Staff**
- Tasks the same as those below for Access staff

**Access Telephone Screening: Goal is Minimal Steps for Consumers**
Clinical Triage
- Define problem
- Triage urgency
- Determine most likely program
- Identify involvement of other systems
- Use consistent criteria to assign initial Level of Care (Hi, Med, Low)

Program Eligibility
- Each program has criteria for entrance and exit from services
- Schedule assessment at most likely program

Financial Screening
- MediCal eligibility determined
- For those with insurance, gather information, obtain approvals, provide information on ombuds, denial of benefits processes
- For those without insurance, explain financial process and documentation to bring to first session

**Access Face/face Assessment**
- For complex cases or where there are questions regarding next steps
- Home visits possible, if appropriate
- Committee convened as needed to review these cases

**Case Management**
- Case Management tracks all IP, residential, TBS, and other high intensity consumers and initiates access process

**Authorization for Services**
- Initial Level of Care assigned
- Authorization for assessment at program
- Appointment for assessment: the goals are to both see the likely ongoing care provider and give an appointment while the caller is on phone—need to develop consistent intake systems to achieve these
- Track caseload status at each site (number of cases, levels of care) to assess capacity for “new” versus “now”

**Consumer Information**
- Information about services available, choices
- Peer support arranged, if desired
- Transportation assistance options
- Referrals to additional community resources
- Information follow up in letter
- Include financial screening information

**Consumer Engagement**
- Establish time standard for first Face/ Face assessment
- Establish time standard for first service contact post assessment
- Follow up these “first” appointments on the computer
- Track offered appointments
- Peer support follow up calls for no-shows

**Complete Financial Screening**
- Screening started during Access call is on-line
- Screening/UMDAP done by program support staff prior to intake process (unless done in field or by liaison)
- Customer friendly, well trained staff
- Use skills of eligibility workers on CW teams

**San Mateo County Strategic Plan—3/25/02** 26
### Assessment and Service Planning

#### Assessment
- Complete clinical assessment
- Engage child/youth and family, identify service goals
- Provide information regarding potential services to support goals
- Identify involvement of other systems
- Obtain releases of information, informed consent
- Convene SOC team as needed (see Pg 18)
- Determine with family, SOC team what is clinically required right away vs. what is needed to achieve goals
- Determine whether to open as 26.5 or provide responsive episode services
- Confirm/revise LOC and provide information to consumer/family regarding length of and intensity of services to expect, specific program exit criteria
- Establish clear stages from beginning of service to end, with transitions along the way, and communicate this at the beginning of the service process
- Complete state mandated tools

#### Service Planning
- Develop family centered service plan based on goals, identify “graduation” goals
- Identify MH services, other services needed to meet goals
- Establish service mix and expected period of service
- Plan authorized by consumer/family
- Contact contracted providers, other programs as part of service mix and initiate services
- Document assessment, service plan, LOC/medical necessity in chart
- Distribute service plan to team (including family)

#### Partnerships With Other Systems
- Staff know MOUs, expectation of each agency
- Clear process for joint services planning, service change planning and joint decision making with all partner agencies
- Initial review of and resolution of disagreements regarding the planned amount and length of services, per LOC criteria, program exit criteria
- Agreements regarding communication, contacts, notification of changes (supported by technology)

### Service Delivery

#### MH Services Delivered
- Services delivered per service plan, individualized for consumer/family goals (see Priorities/Array for detailed menu)
- Specific programs are further developed consistent with best practices models for diagnostic groups and/or target populations
### Review of Services

**ReAssessment**
*(per plan or per change in circumstances)*
- Update clinical assessment
- Review achievement of service goals of consumer and family, revise
- Determine if planned services to support goals were delivered as planned
- Review involvement of other systems
- Convene SOC team as needed
- Use exit criteria to determine program completion
- Review/revise LOC (could be up or down)
- Revise service plan, or initiate planned end of episode
- Resolve differences with partner agencies regarding end of episode or step down in LOC
- Identify community resources for follow up
- Create transition group or process for consumers who no longer meet medical necessity/LOC criteria, but are having difficulty making the transition—assure cultural sensitivity in this process, provide information and exposure to CBOs

### Service Episode Ends

**End of Episode Process**
- Acknowledge and celebrate goals achieved and milestones accomplished by consumer and family
- Develop a plan for independent management that identifies natural supports to be used, and communication plan to stay in contact
- Complete closing satisfaction and outcome tools (depending on time frame since last done)
- Establish standard protocol for a follow up check back by phone or letter

**Partnerships With Other Systems**
- Clear process for joint services planning, service change planning and joint decision making with all partner agencies
- Initial review of and resolution of disagreements regarding the planned amount and length of services, per LOC criteria, program exit criteria
- Agreements regarding communication, contacts, notification of changes (supported by technology)
- CBOs may be ongoing caregivers for family (see Pg 19)
Quality and Utilization Management Processes

### Inpatient
- MediCal IP authorization, all admits tied to specific tx goals, collaborate with regions on plan
- Crisis residential authorization, all admits tied to specific tx goals, collaborate with regions on plan
- IP referral authorization for county served consumers covered by private insurance
- Advocacy role with other payors
- Length of IP stay management tied to achievement of jointly established tx goals
- Joint quality measurement process with IP, including written protocols and monitoring

### Access and ongoing services
- Track time to assessment, to first post assessment service
- Document initial LOC assigned
- Establish inter-rater reliability process for medical necessity, LOC, eligibility
- Review and affirm/change LOC at clinical assessment and at reassessment
- Feedback on appropriateness of referral and LOC
- Medication management reviews
- Chart audits

### Satisfaction/outcomes
- Consumer satisfaction surveys for IP stays, at other key points in the process
  - Consider surveys that ask directly: are you better, more satisfied, that get down to useful detail rather than high scores that don’t provide realistic information, tie satisfaction to progress towards goals (see MHSIP, check VA survey development)
  - Survey more consumers and include those not engaged
- Provider satisfaction surveys
- Plan and deliver education to parents and clinicians regarding the importance of the outcomes tools
- Identify person(s) to assist consumers and families in completion of tools, focus and track the paperwork
- Complete baseline outcomes tools
- Complete outcomes tools at required intervals and end of episode
- Analyze outcomes in relationship to LOC and best practices

### Measurement in general
- Assure a context of Quality Improvement from the top of the organization so numbers are not used punitively, but to support opportunities for improvement
- Use automation rather than hand counting methods
- Increased sophistication in standards, criteria, and best practice requires increased sophistication in what to measure
- Make measurement integrated with the service stream, with what clinicians do, and useful to them and connected to consumer goals
- Connect to the model of change/best practice in working with consumers
- Be clear about the difference between measurement for quality and for contract compliance
Quality and Utilization Management Processes

Best Practices

- Includes program models, medication protocols/algorithms, clinical pathways and guidelines
- The intent is to be prepared for specialized funding, but not be driven by it—and to integrate best practices into ongoing programs and services rather than developing them as program “silos”.
- A committee (includes mix of disciplines, contractors, levels of the system) regularly reviews results of state tools, IT reports, other sources of population data. Group tracks emerging research and recommended best practices, initiates new best practices, and maintains oversight of best practices already implemented.

- Implementation of best practices follows Shewhart PDCA Cycle
  - **Plan**
    - Track population/sub populations
    - Develop baseline data on utilization and outcomes
    - Review best practices and evidence
    - Select and develop best practice approach
    - Identify cultural issues associated with best practice and address
    - Develop policies, program consistent with best practice, specify exceptions/process for exceptions to best practice
    - Design measurement plan
    - Pilot best practice, with specific plan for review and decision making about full implementation
    - Develop consumer education materials
    - Train staff (including supervisors) on best practice (detailed and specific training that directly relates to their work). Training must address beliefs and values that are barriers to implementation
  - **Do**
    - Deliver services with best practice approach
    - Provide consumer education
    - Supervision focuses on assurance function
  - **Check**
    - Compliance with approach
    - Consumer outcomes
  - **Act**
    - Stay the course long enough to see the process have an impact as demonstrated by the data—use statistical analysis to support decisions
    - Confirm the best practice (delivered as planned and outcomes achieved) and make decisions about diffusion of the best practice, or
    - Change best practice (delivered as planned, outcomes not achieved), or
    - Address delivery issues (not delivered as planned),

Quality Plan

- As developed and updated
- Includes Quality Assurance chart review function

State Mandated Tools

- Baseline, interim and end of episode outcome and satisfaction tools
- Analysis of outcomes and satisfaction
- Adopt strength based tools, family centered, for local use
- Negotiate for differential amount of paperwork for low LOC

IT Reports

- Reports for clinicians, supervisors and program managers
- Integrate utilization, outcome and satisfaction data
- System wide, by consumer demographics
- Annual, over-time trends, seasonal variation, population variation examined

OBM

- Indicators part of overall County process
- Reports reviewed and actions folded into quality process
### Glossary

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AOD</td>
<td>Alcohol and Other Drugs</td>
</tr>
<tr>
<td>ASO</td>
<td>Administrative Service Organization (specifically, one operated by the California Mental Health Directors Association to support contracting for mental health services when children are placed out of county)</td>
</tr>
<tr>
<td>CBO</td>
<td>Community Based Organization</td>
</tr>
<tr>
<td>CCP</td>
<td>Coordinated care plan</td>
</tr>
<tr>
<td>Dx</td>
<td>Diagnosis</td>
</tr>
<tr>
<td>FSA</td>
<td>Family Service Agency</td>
</tr>
<tr>
<td>GAF</td>
<td>Global Assessment of Functioning (part of diagnosis process)</td>
</tr>
<tr>
<td>HSA</td>
<td>Human Services Agency</td>
</tr>
<tr>
<td>ICI</td>
<td>Initial contact information (a form that is filled out)</td>
</tr>
<tr>
<td>IT</td>
<td>Information technology</td>
</tr>
<tr>
<td>LOC</td>
<td>Level of care</td>
</tr>
<tr>
<td>MDT</td>
<td>Multidisciplinary team</td>
</tr>
<tr>
<td>MOU</td>
<td>Memorandum of Understanding</td>
</tr>
<tr>
<td>NCQA</td>
<td>National Committee for Quality Assurance</td>
</tr>
<tr>
<td>Network</td>
<td>Private providers of services, both independent practitioners and contract agencies</td>
</tr>
<tr>
<td>OBM</td>
<td>Outcome Based Management (San Mateo County process)</td>
</tr>
<tr>
<td>PCP</td>
<td>Primary care provider (medical)</td>
</tr>
<tr>
<td>PES</td>
<td>Psychiatric Emergency Services</td>
</tr>
<tr>
<td>PIN</td>
<td>Physician initial note</td>
</tr>
<tr>
<td>Purple</td>
<td>The document for the initial assessment</td>
</tr>
<tr>
<td>SED</td>
<td>Seriously emotionally disturbed</td>
</tr>
<tr>
<td>SMI</td>
<td>Seriously mentally ill (also sometimes, SPMI, seriously and persistently mentally ill)</td>
</tr>
<tr>
<td>SOC</td>
<td>System of Care, the umbrella of overall services from all agencies (in the past to designate certain programs or consumer level of care)</td>
</tr>
<tr>
<td>TBS</td>
<td>Therapeutic Behavioral Services</td>
</tr>
<tr>
<td>TDS</td>
<td>Therapeutic Day Schools</td>
</tr>
<tr>
<td>Tx</td>
<td>Treatment</td>
</tr>
<tr>
<td>UMDAP</td>
<td>Universal Method to Determine Ability to Pay</td>
</tr>
<tr>
<td>599</td>
<td>Specific program for youth at risk for non-public school placement</td>
</tr>
</tbody>
</table>
Services for Adults and Older Adults

Overview

This section summarizes the vision of the future mental health system for adults and older adults. An array of services table provides a “map” of the services available or needed in San Mateo County and sorts these into those services delivered by the key components of the service delivery system: county delivered services, independent practitioner delivered services, and community based organization delivered services.

The vision of the future is depicted in flow charts that, while complex and dense, contain sufficient detail to describe both the complexity of the system and how the parts of the process of care ought to work together in the future. A glossary of acronyms and other references is located at the end.

Principles for the Mental Health Service Delivery System

- Satisfied consumers who are achieving their goals are the measure of the system’s success.

- Services facilitate each consumer’s achievement of personal goals on the journey to his/her fullest potential—the system’s mission and stewardship responsibility is to build strategies to achieve those goals and support the journey.

- There is a dynamic relationship between consumer driven services and professional expertise—both are important and must be conceptually held together while finding the right balance. This is an ongoing process that includes:
  - Being creative and utilizing the creativity of the consumer to define a “life worth living” and its development;
  - Meeting consumers where they are now and developing consumer driven treatment goals;
  - Educating consumers regarding serious mental illness and why treatment compliance is important;
  - Assessing alcohol and drug as well as mental health issues and being prepared to discover/uncover substance use issues with consumers and support readiness for intervention;
  - Bringing the best clinical expertise and knowledge of the community to serving consumers;
  - Respecting consumers and the contributions of everyone working with the consumer (including family and other providers); and,
  - Promoting a dialogue between all levels of the system in support of team decision-making.
• Those who provide services are best able to be strong, compassionate and resourceful care givers when the system assures the tools and support to be responsive to consumers, including:
  o Fostering open communication and mutual respect at all levels of the service delivery system;
  o Supporting staff growth and learning through training and access to information about emerging service approaches;
  o Streamlining processes for delivering and documenting services; and,
  o Aligning demand and capacity for services.

• There is timely and appropriate access to services. An array of services and consumer supports are available, to be accessed identified in the individualized service plan of the consumer. To achieve this, the system seeks to maximize all potential funding as well as:
  o Utilizing new and better medications as they become available;
  o Studying best practices and their application in the system; and,
  o Prioritizing the expansion of or development of new services in order to fill gaps in the current system.

• Culturally competent approaches that recognize current and prospective consumers’ cultures and assure the skills, knowledge and policies to deliver effective treatments are used in all our services. This includes:
  o Developing a culturally competent workforce that also has core language capacity for the diverse populations served;
  o Working in collaboration with community based organizations that serve diverse populations;
  o Providing access to information in all formats (e.g., web site, brochures, informational and educational materials) in core languages for diverse populations;
  o Making services available at times and places where diverse populations can easily access them; and,
  o Developing and delivering services that enable diverse populations to receive the services.

• Collaboration with other system partners is important to providing services and assisting consumers in meeting their goals. This requires the development of methods to identify and solve problems at the system level, as well as case-by-case. Activities in support of collaboration include:
  o Creating Memoranda of Understanding with major partners such as the inpatient, healthcare, criminal justice, alcohol and drug, housing, and transportation systems;
  o Developing ways to remove barriers and create flexibility so systems are responsive to consumer needs; and
  o Acknowledging a stewardship responsibility to the community and other agencies and measuring stakeholder satisfaction.
• Accountability systems support stewardship by measuring satisfaction and outcomes, as well as establishing consistent quality and utilization management practices. This includes:
  o Developing mechanisms that assure the expertise of the practitioners and providers in the system;
  o Measuring the impact of best practice models as they are implemented:
  o Installing processes that assure that services are delivered to priority populations—the right amount and kind of service at the right time; and,
  o Acknowledging that numeric measures alone don’t assure people are served well—there is a subjective aspect to providing and receiving services that we try to assess whenever possible.

• Stigma in the community is addressed through a variety of efforts and with community partners. As a part of this effort, all caregivers in the delivery system work on the evolution of their attitudes and expectations as well as influencing those of the community.

**System Development Priorities**

The following, in order, are priorities for system development; the implications for revenue production to support the activity are noted.

• Development of a range of options for safe and affordable housing and residential capacity. This requires dedicated liaison staff assigned to advocacy and community development activities, with a strong knowledge base regarding the multiple funding streams and tax advantages that support the development of low income housing for consumers in the system. *(No revenue producing capacity.)*

• Early intervention and support services that are available to the population without formal enrollment in mental health services or associated documentation (e.g., depression groups, caregiver /family support groups, transitions of life groups). *(No revenue producing capacity, but may have a cost offset to the paperwork and staff requirements associated with establishing active enrollment.)*

• Development of a range of alcohol and drug services that will serve mental health consumers through advocacy, collaboration and joint efforts with AOD services. *(Revenue implications would be tied to specific program analysis.)*

• New capacity and improved services for acute/crisis care including:
  o Focused crisis line, 1-800, 24/7
  o Mobile crisis capacity
  o Inpatient diversion options including crisis residential and locked sub-acute beds that serve special needs consumers
  o Crisis observation capacity
  o Out-stationed staff at shelters and outreach to special populations [a specific cultural competence strategy]
 *(Revenue implications would be tied to specific program analysis.)*
• Expanded outpatient/case management capacity including:
  o More 24/7 intensive home/community case management teams
  o More individual/family counseling capacity
  o More psychiatric consultation, especially for PCPs, other MDs and hospitals
  o More group treatment capacity, and specifically, dual diagnosis group capacity
  o Services available evenings and Saturdays [a specific cultural competence strategy]
  o More services on site at primary care facilities
  o Additional transitional services for young adults
  o Programs for older adults
  *(Revenue implications would be tied to specific program analysis.)*

• Services for SMI and SED consumers and their families that are available without requiring formal enrollment in mental health services or associated documentation (e.g., consumer operated self-help organizations and financial management and other support groups). *(No revenue producing capacity, but may have a cost offset to the paperwork and staff requirements associated with maintaining active enrollment when it is no longer needed.)*

• Organized efforts to improve understanding and identification of MH issues, the services available in the community and self-advocacy. *(No revenue producing capacity.)*

• Development of additional access to community supports and services, especially transportation. *(No revenue producing capacity.)*

**Array of Services – Adults and Older Adults**

The following grid identifies services currently available in San Mateo County, by source of funding, and perceived adequacy of capacity.

<table>
<thead>
<tr>
<th>Legend for Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y= have</td>
</tr>
<tr>
<td>Y*= have, but need more</td>
</tr>
<tr>
<td>N= don’t have</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Services</th>
<th>Agency</th>
<th>County Services/ MH $</th>
<th>Independent Practitioner Network/ MH $</th>
<th>Contract CBO Network/ MH $</th>
<th>Provided by other agencies with other funding sources (including other County $)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Education/Consultation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• organized efforts to</td>
<td>Y*</td>
<td>N</td>
<td>Y*-WRA</td>
<td>Y-Pyramid</td>
<td></td>
</tr>
</tbody>
</table>

San Mateo County Strategic Plan—3/25/02 35
<table>
<thead>
<tr>
<th>Services</th>
<th>Agency</th>
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<th>Contract CBO Network/ MH $</th>
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</tr>
</thead>
<tbody>
<tr>
<td>improve understanding and identification of MH/AOD issues</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Alternatives, El Centro de Libertad, P-90</td>
</tr>
<tr>
<td>• organized efforts to improve understanding of services available in community and self advocacy in using services</td>
<td>Y*</td>
<td>N</td>
<td></td>
<td>Y*</td>
<td>?</td>
</tr>
<tr>
<td>• general consultation for MDs and hospitals</td>
<td>Y*-PCI</td>
<td>N</td>
<td>N</td>
<td></td>
<td>?</td>
</tr>
<tr>
<td>• consultation to childcare settings, Headstart, other early childhood programs</td>
<td>Y*</td>
<td>N</td>
<td></td>
<td></td>
<td>Y-Headstart contracts</td>
</tr>
<tr>
<td>• general consultation to schools/community colleges</td>
<td>Y-for youth</td>
<td>N</td>
<td></td>
<td>Y- supported education programs</td>
<td>?</td>
</tr>
</tbody>
</table>

**Early Intervention and Support Services**

*Educational/support focus, service enrollment not required, target general pop*

<table>
<thead>
<tr>
<th>Services</th>
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<th>Contract CBO Network/ MH $</th>
<th>Provided by other agencies with other funding sources (including other County $)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• time limited transitional groups (death, divorce, grief and loss, early adulthood)</td>
<td>N</td>
<td>N</td>
<td></td>
<td>Y*</td>
<td>Y*-Kara for grief counseling, need Spanish language</td>
</tr>
<tr>
<td>• depression groups</td>
<td>N</td>
<td>N</td>
<td></td>
<td>N</td>
<td>Y*</td>
</tr>
<tr>
<td>• anxiety/panic groups</td>
<td>N</td>
<td>N</td>
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<td>• dual dx ed/support groups</td>
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<td>• caregiver/family support groups</td>
<td>N</td>
<td>Y</td>
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<tr>
<td>• anger management groups</td>
<td>N</td>
<td>N</td>
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**Supports for SPMI/SED population (may or may not be enrolled in services)**

<table>
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<th>County Services/ MH $</th>
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<td>• financial mgmt, other support groups</td>
<td>N</td>
<td>N</td>
<td></td>
<td>Y*</td>
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<tr>
<td>• self help organizations consumer operated</td>
<td>N</td>
<td>N</td>
<td></td>
<td>Y -Peninsula Network, SOS</td>
<td>Y -DRA</td>
</tr>
<tr>
<td>• self help/ socialization</td>
<td>N</td>
<td>N</td>
<td></td>
<td>Y* -Pen Ntwk</td>
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<td>/drop in center</td>
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<td></td>
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<td>Friendship Ctrs</td>
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<tr>
<td>• warm line service (peer telephone support)</td>
<td>N</td>
<td>N</td>
<td></td>
<td></td>
<td>Y* - REACH, SAIL intensive</td>
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<tr>
<td>• referral and support for family members</td>
<td>Y*</td>
<td>N</td>
<td>Y</td>
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<tr>
<td>• peer counselors/ community friends</td>
<td>Y*</td>
<td>N</td>
<td>Y*</td>
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<tr>
<td>• peer advocates</td>
<td>Y*</td>
<td>N</td>
<td>Y*</td>
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<tr>
<td>• family natural supports and activities</td>
<td>Y*</td>
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<td>Y*</td>
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<td>• church supports</td>
<td>N</td>
<td>N</td>
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<td>• recovery groups</td>
<td>N</td>
<td>N</td>
<td>N</td>
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<td>Y- DRA throughout county</td>
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<td><strong>Crisis/initial access services</strong></td>
<td></td>
<td></td>
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<tr>
<td>• 1-800 Information &amp; Referral line</td>
<td>Y* - Access line</td>
<td>N</td>
<td>N</td>
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<tr>
<td>• 1-800 access line</td>
<td>Y</td>
<td>N</td>
<td>N</td>
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<tr>
<td>• 1-800 crisis line (24/7)</td>
<td>Y* - PES (not 1-800)</td>
<td>N</td>
<td>N</td>
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<td>Y* - Suicide Hotline</td>
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<tr>
<td>• mobile crisis team (clinicians, police support)</td>
<td>N</td>
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<td>• urgent care walk in clinic</td>
<td>N</td>
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<td>• locked sub-acute residential</td>
<td>N</td>
<td>N</td>
<td>Y*-lack special needs, not capacity</td>
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<td>• crisis residential</td>
<td>Y*</td>
<td>N</td>
<td>Y</td>
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<td>• crisis observation 23 hour beds</td>
<td>Y - PES</td>
<td>N</td>
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<tr>
<td>• acute inpatient (involuntary, voluntary)</td>
<td>Y- 3AB</td>
<td>N</td>
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<td>• dual dx inpatient</td>
<td>N</td>
<td>N</td>
<td>Y-Redwood Center</td>
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<tr>
<td>• outstationed staff to homeless shelters/ programs</td>
<td>Y*</td>
<td>N</td>
<td>N</td>
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<tr>
<td>• outreach to other special populations</td>
<td>Y*</td>
<td>N</td>
<td>N</td>
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<tr>
<td>• outreach to</td>
<td>Y*</td>
<td>N</td>
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<td>jail/corrections</td>
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<tr>
<td>• assessment/authorization to non-crisis care</td>
<td></td>
<td>Y- Access</td>
<td>N</td>
<td>N</td>
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<td>Outpatient treatment services</td>
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<tr>
<td>• individual tx/counseling</td>
<td></td>
<td>Y*</td>
<td>Y</td>
<td>N</td>
<td>Y</td>
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<tr>
<td>• family tx/counseling</td>
<td>Y*-PCI, Pre-three, FSST, Coastal</td>
<td>Y*</td>
<td>Y</td>
<td>N</td>
<td>Y</td>
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<tr>
<td>• group tx/counseling (enrolled in services)</td>
<td>Y*</td>
<td>Y*</td>
<td>N</td>
<td>?</td>
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<tr>
<td>• dual dx tx groups</td>
<td>Y*</td>
<td>Y*</td>
<td>Y- WRA, El Centro, Avalon, some residential</td>
<td>Y-WEC</td>
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<tr>
<td>• psychiatric evaluation</td>
<td>Y</td>
<td>Y*</td>
<td>Y- Caminar</td>
<td>?</td>
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<tr>
<td>• psychiatric consultation</td>
<td>Y*</td>
<td>Y*</td>
<td>N</td>
<td>?</td>
<td></td>
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<tr>
<td>• psychiatric management/prescribing (routine and urgent)</td>
<td>Y</td>
<td>Y*</td>
<td>Y</td>
<td>?</td>
<td></td>
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<tr>
<td>• advice nurse (consult on medication issues)</td>
<td>Y</td>
<td>N</td>
<td>Y*</td>
<td>N</td>
<td></td>
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<tr>
<td>• ECT</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>• Lab service</td>
<td>Y*- fragmented</td>
<td>N</td>
<td>N</td>
<td>?</td>
<td></td>
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<tr>
<td>• psychological testing</td>
<td>Y* - interns, HEPC, Beck Depression Interface</td>
<td>Y</td>
<td>N</td>
<td>?</td>
<td></td>
</tr>
<tr>
<td>• services on-site at primary care facilities</td>
<td>Y -brief only, no psychiatry</td>
<td>N</td>
<td>N</td>
<td>?</td>
<td></td>
</tr>
<tr>
<td>• services available evening/Saturday</td>
<td>N</td>
<td>Y</td>
<td>Y*</td>
<td>Y</td>
<td></td>
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<tr>
<td>• services for homebound frail or physically disabled</td>
<td>Y*- for &gt; 60</td>
<td>N</td>
<td>N</td>
<td>?</td>
<td></td>
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<tr>
<td>• 24/7 intensive home/community case management</td>
<td>Y* -MIOCR</td>
<td>N</td>
<td>Y* Transitions, REACH, SAIL intensive</td>
<td>?</td>
<td></td>
</tr>
<tr>
<td>• day treatment services</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>?</td>
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### Services

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<th>Independent Practitioner Network/ MH $</th>
<th>Contract CBO Network/ MH $</th>
<th>Provided by other agencies with other funding sources (including other County $)</th>
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</thead>
<tbody>
<tr>
<td>• supported employment /supported education</td>
<td>Y* -FSST</td>
<td>N</td>
<td>Y*</td>
<td>?</td>
<td></td>
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<td>• transitional services for young adults</td>
<td>Y*</td>
<td>N</td>
<td>Y*</td>
<td>?</td>
<td></td>
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<tr>
<td>• programs for older adults (organized focus)</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>?</td>
<td></td>
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<tr>
<td>• intensive peer support</td>
<td>N</td>
<td>N</td>
<td>Y*- REACH, SAIL intensive</td>
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### Case Management services

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<tbody>
<tr>
<td>• service coordination, including targeted case management /linkage and brokering</td>
<td>Y</td>
<td>N</td>
<td>Y</td>
<td>?</td>
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<tr>
<td>• case specific interdisciplinary consults</td>
<td>Y*</td>
<td>N</td>
<td>Y</td>
<td>?</td>
<td></td>
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<tr>
<td>• representative payee/financial services</td>
<td>Y* -use support as well as clinical staff</td>
<td>N</td>
<td>Y*</td>
<td>?</td>
<td></td>
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<tr>
<td>• hospital discharge planning</td>
<td>Y* -needs improved coordination</td>
<td>N</td>
<td>N</td>
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### Access to Residential Services

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<th>Contract CBO Network/ MH $</th>
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<tbody>
<tr>
<td>• emergency housing/shelter</td>
<td>N</td>
<td>N</td>
<td>Y -40 Transitions 15 Spring St.</td>
<td>Y –Options, Clara/Mateo Shelter</td>
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<tr>
<td>• board and care</td>
<td>N</td>
<td>N</td>
<td>Y–267 beds in various facilities</td>
<td>?</td>
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<tr>
<td>• adult foster care</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>?</td>
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<tr>
<td>• subsidized housing</td>
<td>N</td>
<td>N</td>
<td>Y -148 Shelter Plus 22 After Care</td>
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<tr>
<td>• supported housing</td>
<td>N</td>
<td>N</td>
<td>Y –60 beds</td>
<td>?</td>
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<tr>
<td>• home ownership initiatives</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>?</td>
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<td>• residential treatment facilities</td>
<td>N</td>
<td>N</td>
<td>Y- 57 beds</td>
<td>?</td>
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<tr>
<td>• secure residential</td>
<td>N</td>
<td>N</td>
<td>N</td>
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<td>Access to Chemical Dependency services</td>
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<td>• sobering stations</td>
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<td>• social detox/residential</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>Y- Palm Ave. Detox</td>
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<tr>
<td>• outpatient medical detox</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
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<tr>
<td>• inpatient medical detox</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>Y–Sequoia</td>
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<tr>
<td>• intensive outpatient</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>Y –WRA, El Centro</td>
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<td>• outpatient tx</td>
<td>Y*-DDx groups, FSST, PCI liaison</td>
<td>N</td>
<td>Y-WRA</td>
<td>Y-El Centro, WRA, Free at Last, Pyramid</td>
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<tr>
<td>• day tx</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>Y</td>
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<td>• aftercare/12 step</td>
<td>N</td>
<td>N</td>
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<td>Y-AA, NA</td>
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<td>• narcotic replacement tx</td>
<td>N</td>
<td>N</td>
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<td>Y – methadone clinic</td>
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<td>• residential tx (short/long)</td>
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<td>N</td>
<td>Y-WRA, P-90</td>
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<td>• transitional living</td>
<td>N</td>
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<td>Y</td>
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<td>• pre treatment</td>
<td>N</td>
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<td>• peer support</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>Y</td>
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<td>Assistance w/Access to Community Services and Supports</td>
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<td>• transportation</td>
<td>Y* - need less expensive alternatives</td>
<td>N</td>
<td>Y*</td>
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<td>• eligibility assistance (SSI, etc.)</td>
<td>Y*</td>
<td>N</td>
<td>Y*</td>
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<td>• safe and affordable housing options</td>
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<td>N</td>
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<td>• physical health services</td>
<td>Y*</td>
<td>N</td>
<td>Y</td>
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<td>• structured activity programs</td>
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<td>Y</td>
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<td>• supported education</td>
<td>Y*</td>
<td>N</td>
<td>Y*</td>
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<td>• higher education</td>
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San Mateo County Strategic Plan—3/25/02 40
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<tr>
<td>• competitive employment</td>
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<td>Y*</td>
<td>N</td>
<td>Y*</td>
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<td>• public guardian/conservator</td>
<td></td>
<td>Y -AAS</td>
<td>N</td>
<td>Y</td>
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<tr>
<td>• advocacy/legal assistance for patient and family/caregivers</td>
<td></td>
<td>Y*</td>
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<td>Y*</td>
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**Process of Care Flow**

This is a vision for the future— not all of the pieces are in place now, and it will take some time to fund and develop all of them —the flow provides a picture of what the system should work to put in place. It is assumed that:

- New or redirected resources will be needed as prioritized to implement the vision;
- Changes identified here will occur as prioritized over time; and,
- Detailed data and financial analysis will support the development of new programs.

The flow traces the process of providing services, from entry into the system of care. A given throughout is language appropriate materials and access, cultural competence, and geographic access. All services are described in terms of the functions provided, rather than program or provider names—there are several delivery options for most of the new or improved services. A glossary of terms is included on the last page.
Adult/Older Adult Process of Care Flow

Consumer needing services

Access

Crisis/Acute Care Request

Access

Non-crisis Request

Financial

Screening/Program Eligibility/Authorization

Assessment/Service Planning

Service Delivery

Service Review

Service Episode Ends

San Mateo

Mental Health Service Mandates

MediCal SMI

Non-MediCal SMI

MediCal Non-SMI

Non-MediCal Non-SMI

Quality Process

San Mateo County Strategic Plan—3/25/02
Access Overview

**Public Knowledge/Community Education/Prevention**
- County MH provides listing of programs, staff, referral system, eligibility information on-line (web site) and updates regularly (we provide clarity about what we can do, the community understands the what, who and how). Two different entry phone services (see right) are clearly distinguished.
- Relationships with local cable and media, public affairs announcements reach wide audience with education on the depth and breadth of mental illness
- The Guide to Community Resources is available on-line or through a 1-800 service, widely known by all service providers. On line updates are provided on resources and how to access. The MH information in the Guide appropriately directs people toward crisis and access services
- Develop new partnership with CBOs
  - Work w/ community agencies and groups
  - Build cross cultural efforts through agencies that are natural points of entry for key populations
  - Provide education re: SMI and MH services
  - Develop liaison relationships and improve outreach
  - Identify how to advocate in regard to other agencies
  - Obtain feedback on access to MH services
- Work collaboratively w/ AOD providers
- Work with law enforcement, education
- Provide screenings, booths at community events, be part of mobile health van

**1-800 Access Line**
- General public referrals
- Consumer community advocates
- Coordinate with community I&R line
- For 1-800 question line regarding resources
- Staffed with both profession and peer staff

**Police Agencies**
- Training provided on how to intervene, how to access MH services
- Joint policy development on 5150 process, filing charges, advance directives

**1-800 Crisis Line**
- Dispatch mobile team
- Work w/ ERs, police, OP providers, partner agencies, MDs
- Take direct calls from public
- Patch in from 911
- Triage and respond with range of options

**Crisis Request Resolution**
- Emergent need (NCQA=immediate )
- Urgent need (NCQA= 48 hours )
- Routine need for ongoing services (NCQA= 10 business days )
- Call resolves need

**Non-Crisis Referral/Request for Services**
- General public referral
- Partner agency referral

**ERs**
- Address 5150 requests, safety or medical issues
- ERs at 5150 facilities obtain MediCal authorization
- Other ERs refer cases

**Community Services**
- CBO linkages
- Localized AMIs
- Consumer operated services
- Client to client outreach

**Go to Pg 44 for detailed steps**
### System Infrastructure-Information Technology
- Community Information Guide on-line resource data base, in core languages
- Interagency information sharing protocols that meet state and federal requirements
- MH IT infrastructure is updated and has dedicated staff
- On-line county MH program information, regular updates
- Central Access data base to initiate and document all referrals
- On-line financial and demographic information on all enrolled consumers, regular updates
- On-line access to basic clinical record
- Records of prior service easily accessed, MH records are integrated into a single chart (and eventually an integrated health chart)
- Crisis plan on-line for those receiving intensive services
- On-line appointment scheduling, ability to “flag” assessment and first service appointments scheduled but not used, track access standards
- Automated method to quickly assess provider capacity, monitor capacity and availability (county, network and CBOs)
- On-line capacity for crisis system to make an intake appointment while with the consumer and family
- IT gathers information from first contact and is available on-line to next staff person, so consumer doesn’t have to repeat clinical or financial information
- IT system tracks, enables moving through the flow, monitoring to assure it is working
- On-line info re: who is in what MH program, including contractors
- List matching with other county agencies to know if current consumers are in jail, social services, in other services (24 hr access)
- Hospital discharge notes, lab work, diagnostic test results, H&Ps available on-line
- PES reports on-line, with tickler to notify re: the visit
- Restricted access chat rooms for SOC consumer teams
- Ability for staff to access e-mail from non-county computers
- Current county initiative to improve computer systems: opportunity to bring clinical orientation to system, make user friendly and allow information sharing with HSA, reports for clinicians, supervisors, program directors, system as a whole
- County web site/intranet with articles on health, education linkages to recent research findings, restricted line that connects pharmacies (med interactions)
- Off-site specialized consultations using videoconferencing

### System Infrastructure-Finance and Business
- Client handout regarding financial screening, UMDAP process, address concerns of undocumented individuals
- Assistance with applications for MediCal
- Standard policies and procedures for financial screening and standard form for financial screening
- Reliable ongoing UMDAP process that updates information
- Reports to support clinicians and managers in managing both clinically and for the overall system
- Management and contracting structure including a contract process for all services purchased with MH funds from county agencies and CBOs
Infrastructure Supports

System Infrastructure-Criteria and Policies
- Clear criteria for who MH serves—criteria developed with consumer input
- Access standards consistent with waiver and DMH requirements, consistent at all points of entry into the MH system
- Written protocol/criteria for screening and authorization to services—all staff trained to criteria and assessment skills
- Define MH/AOD Dual Dx and establish clarity regarding eligibility for MH services
- AOD providers have own capacity for psych consult and medications, MH level of collaboration is defined
- Clear policy regarding residency determination and eligibility for services
- Procedure for out of county placements
- Provider handbook for all MH providers (including independent practitioners and CBO providers) with community referral info, CBO info, county funded services and eligibility
- Member handbook provided to all enrolled consumers with information regarding how the system works
- Written criteria for crisis triage and use of acute options
- Protocols for transfer among IP facilities
- Protocols for joint tx planning with all contracted IP facilities, includes incorporation of IP tx plan, assessment of med changes, consult on AOD patients tapering down meds
- Written criteria for post 23 hour/residential/IP disposition planning
- Criteria for who gets free medications, establish copayment options
- Protocols for transfer of medical records from other systems
- Develop MH/AOD service approach, criteria, policies and procedures, best practice guidelines, harm reduction approaches
- Establish standards for county staff, network, and contracted providers regarding AOD skills
- Develop MOUs with other systems: confidentiality component, information sharing protocols (and use technology whenever possible to match system involvement)
- Develop clear program descriptions re: what is available, specialties, entry/exit criteria, list all services available, which have best practices models in place
- Develop system wide exit criteria
- Use upcoming change of outcome tools to review present process, streamline, provide supports and education to clinicians and families
- Develop process and resources for second opinions
- Protocols and quality/monitoring process developed with PCPs, operationalize the flow back to the PCPs
- Written criteria and referral options for dementia and OBS

System Infrastructure-Other System Capacity
- Coordinating function for all acute care services that integrates planning, policies Capacity to deliver the services that are offered, either through county clinics, contracted providers, or network providers including: Dual peer recovery groups, Dual tx groups, dual groups for moms w/ babies, intensive OP tx, AOD specialists as part of teams, Dual residential options
- Develop adult team structure service model
- Align productivity documentation rules to service vision and training plan
- Develop training vision and plan via staffed process that includes contractors, consumers and builds on HSA resources
- AOD assessment and best practices, true dual dx expertise
- Skills in group services
- Computer skills, technology tools
  - Outcome tools, how to use and why
- Space and vehicles
- Cell phones, computers for every staff person
- Laptops that uplink, computer access at all sites
- Upgrade and replace site equipment
- Pharmacies that deliver medications
- Provide on-line access for consumers to go to internet based resources
Access Detail: Crisis Requests and Acute Care Services

**First Contact**
- 1-800 Crisis Line 24/7
  - Triage and arrange response based on level of need
  - Staff have AOD assessment skills
  - Call resolves need

**First Response**
- Mobile Crisis 24/7
  - Police support as needed
  - Go to ERs, service sites, homes
  - Backed by MD
  - AOD assessment

- Urgent Care Clinic
  - No appt needed for consult
  - AOD assessment/intervention
  - Medications access
  - Referral for ongoing care
  - Follow up calls
  - Could be at regions during business hrs, centralized for extended hrs (evening and Sat.)
  - Could also be centralized for new (Access)
  - Requires specific staffing and support in any site

- MH Clinic/Contract Provider
  - Team/OD provides crisis mgmt for those already in care (business hours)
  - Could be combined with Urgent Care clinic
  - 24/7 intensive teams provide all hours

- Warm Line
  - Staffed by consumers

**Diversion**
- 23 Hour Observation
  - For current consumers, use urgent care display, and contact provider same day or next open hour
  - Focus on aftercare planning, triage to Access or other services
  - Gather collateral and other contact info
  - Determine eligibility
  - MH stabilization
  - AOD assessment/intervention
  - Medical evaluation
  - Medications

- Crisis Residential
  - MH stabilization
  - AOD assessment/intervention
  - Medications
  - Focus on aftercare planning w/ Access
  - Specific beds for dual dx, women w/ children

- In-Home/Respite Services
  - Respite beds
  - Home based services
  - Peer support

**Inpatient Services**
- Inpatient Services
  - Determine eligibility/authorization
  - Notify OP provider or Access re: all County consumers (includes payors other than MediCal)
  - Access team on unit to see all MediCal new ASAP, Resource Mgmt sees all current, previous
  - Articulate tx goals, joint tx planning per joint protocols
  - AOD assessment/intervention
  - Psycho social, family evaluation, reassess current consumers
  - Visit by peer support
  - Collaborate w/ Pts. Rights Advocates
  - Discharge planning in communication with Access or provider

**Aftercare**
- In-Home/Respite Services
  - Referrals to community services

**Transitional Beds**
- Transitional Beds
  - AOD Services
    - Ongoing tx
    - Dual dx integrated

**Refer for OP Intake (see Pg 46)**
- Urgent next day/evening appointment
- Brief follow up with transfer to community resources
- Temporary intensive case management
- Case management follow up

**Document Service (all levels of acute intervention)**
- If enrolled, note to record, liaison to OP provider
- Referrals to community services/PCPs for follow up

**San Mateo County Strategic Plan—3/25/02**
## Access Detail: Non-Crisis Requests for OP Services

### Referral Sources
- **Crisis System Referral**
  - Expedited access
- **General public referrals**
- **Partner agency referrals**
  - Includes PCPs, Regional Center, shelters, HSA, CJ, women and infant

### Intake Process/Authorization
- **1-800 Access**
  - This is the major gateway into services, see detail next page for all the steps that happen at this point
  - Public gateway for referrals
  - Other counties’ clients moving here
  - Out of county placements moving here
  - Document every call and services offered
  - Payor source/coverage screening, MediCal eligibility
  - Different levels of assessment based on telephone screening
    - Low LOC to network and PCI
    - Med-Hi LOC to Regional or Specialty MH
    - New vs. known consumers
  - Schedule callers for face/face assessment appointment
  - Screen clients for financial, residential, and medical necessity eligibility
  - Assure access to medications during entry process
  - Assure clients are connected to services appropriate to level of urgency during process of intake and authorization (‘in the meantime’)
  - Quality oversight of access process, consistent policies, including time standards
  - Specialty MH services are those that do direct intake and assessment/authorization
  - Specialty MH liaison staff use same tools and do same documentation as Access staff (acting in delegated capacity to fulfill Access function)
  - When Specialty services are completed (and no other services were provided), refer to Access for authorization/LOC for ongoing care; if case is shared, team reassessment to determine LOC and next steps

### Programs Authorized
- **No Formal MH Services**
  - Requests not eligible for MH services are connected to appropriate community resources
- **Outreach Efforts**
  - Initiate outreach as appropriate, including connection to acute care services
  - See Pg 42, CBO outreach partnership
- **Primary Care Interface**
  - Assess for brief services and provide services
  - Go through Access to schedule those needing more intense services
- **Independent Practitioner Network**
  - Per standard criteria, MediCal referrals only
- **Pre-three Services**
  - All pregnant/postpartum (child 0-3) referrals
  - Level of response based on protocols
- **Other Specialty Services**
  - Per standard criteria and policy
- **Comprehensive MH Services**
  - County and Contract Providers
    - Per standard criteria, face to face assessment provided at program site by Access staff
    - Consumer choice of location
    - Resource Mgmt authorizes 24/7 intensive CM
    - County staff are care coordinators for all consumers served by contractors except 24/7

### Liaison Staff
- Specialty MH liaisons know all MH services and financial coverage /program eligibility
  - Criminal justice (see below)
  - Primary Care Interface (AOD skills added to teams)
  - Pre to three ODs
  - Senior MH services
  - IP liaison staff
  - Senior MH Services
  - Youth to Adult Program

### MH/CJ Liaisons
- MIOCRE
- MH Court (DA and Judge part of team)
- Jail (consult/assure meds follow consumers, access to clients for discharge planning, calls prior to discharge)
- Probation (designated liaison from both agencies)
- Parole (designated liaison from both agencies, planned transition process, CDC# for records)
- CYA (transitions)

San Mateo County Strategic Plan—3/25/02
Access Detail: Financial Screening, Program Eligibility, Intake Assessment and Authorization for Services

**Liaison Staff**
- Tasks the same as those below for Access staff

**Access Telephone Screening:**
**Goal is Minimal Steps for Clients, Giving Assessment Appointment While On Phone**

**Clinical Triage**
- Define problem
- Triage urgency
- Determine most likely location of service, based on consumer choice as well as consumer geography
- Identify involvement of other systems, gather collateral information
- Use consistent criteria to screen to initial Level of Care (Hi, Med, Low)
- Initiate record

**Program Eligibility**
- Each program has criteria for entrance and exit from services
- Schedule assessment at most likely county program, including specialty programs,
- Schedule assessment with Access for complex or questionable intakes, or
- Authorize directly to network
- Track transitions from Specialty only program to broad array of services, combined network provider and county case management

**Financial and Residential Screening**
- MediCal eligibility determined
- Residence determined
- For those with insurance, gather information, obtain approvals, provide information on ombuds, denial of benefits processes
- For those without insurance, explain financial process and documentation to bring to first session regarding residence and financial status

**Face/Face Assessment**
- All assessment data on computer system
- Initial clinical assessment performed by licensed clinicians [see alternate models for who does first assessment]
- Home visits as appropriate
- Includes AOD assessment and consultation
- Review prior service records, expedited process for known consumers
- Identify involvement of other systems
- Obtain releases of information
- Consult/collaborate with tx team, especially on IP discharges, regarding service options
- Complete initial assessment documentation (purple)
- Confirm/revise LOC
- Orient to services, not closed to assessor until hand off complete
- This step is both clinical assessment and system authorization/gate keeping role
- Refer and follow up on non-eligibles

**Authorization for Specialty Services**
- Authorization for services/LOC
- Scheduled appointment with team/provider of services (if different)
- Track caseload status at each site (number of cases, levels of care) to assess capacity for “new” versus “now”

**Alternate Models**
A. Access schedules assessment/authorization at program site, to be done by clinician on team likely to be ongoing care provider
B. Access staff on-site in program locations does assessment/authorization, coordinates with teams
C. Access schedules assessment/authorization with designated program staff at site, coordinates with teams

**Consumer Engagement**
- New consumer orientation groups
- Peer support follow up calls for no-shows
- Establish time standard for first Face/Face assessment
- Establish time standard for first service contact post assessment
- Follow up these “first” appointments on the computer

**Consumer Information**
- Information about services available, choices
- Peer support/community friend arranged, if desired
- Transportation assistance options
- Referrals to additional community resources such as child care
- Information follow up in letter
- Include financial screening information
Assessment and Service Planning

**Service Planning Assessment**
- Assessment resides with team
- Complete the clinical assessment, including AOD
- Identify service goals of consumer
- Provide information regarding potential services to support goals
- Identify involvement of other systems
- Obtain releases of information
- Convene SOC team as needed
- Determine what is clinically required right away vs. what is needed to achieve goals
- Complete state mandated tools
- Confirm/revise LOC

**Service Planning**
- Treatment goals include AOD goals per assessment
- Make use of consultative services
- Care coordinator identified and can refer for any services in the Array, based on LOC
- Access to supports and socialization not dependent on level of case management, appropriate to level of care
- Some services currently part of a specialty program can be accessed on a partial basis
- Plan authorized by consumer, a service contract w/ goals established by consumer
- Provide consumer education on dx, medications, understanding of symptoms, involvement in new consumer orientation groups
- Assess ability of family to support client and connect them to supports for families
- Engage natural supports in planning and services
- Access to services on varying days and times
- Health needs addressed through nursing assessment, then transfer to an ongoing PCP
- Establish concept of hope, recovery, and movement from services from the beginning, the plan includes goals for service exit

**Service Partners**
- Housing agencies
- IMDs
- Vocational agencies
- Domestic violence agencies
- Public Health
- Conservator services
- Private therapists
- Self help groups
- 12 step groups
- AOD providers
- CBOs, non MH
- Family Resource Centers
- PCPs
- VA
- Other health systems
- Other holistic health providers
- Other counties
- Higher education
- Transportation agencies
- Churches
- Child care
- Recreation

**Complete Financial Screening**
- Screening started during Access call is on line
- Screening/UMDAP done by support staff prior to intake process (unless completed by Access or liaison)
- Customer friendly, well trained staff

**Partnerships With Other Systems**
- Supported by MOUs that clarify roles and decision making, confidentiality and information sharing
- Staff know MOUs, expectation of each agency
- Clear process for joint services planning, service change planning and joint decision making with all partner agencies, discharge planning beginning at intake
- Agreements regarding communication, contacts, notification of changes (supported by technology)
### MH Services Delivered
- Services delivered per service plan, individualized for consumer goals (see Priorities/Array for detailed menu), with access to all services offered
- Medication services organized separately so goal changes over time can be achieved without affecting meds services—study meds role in regard to other services
- Specific programs are further developed consistent with best practices models for diagnostic groups and/or target populations, including new and better medications, recovery orientation and an array of MH/AOD integrated tx services
- Services are available evenings and Saturdays (look at PCP clinics as possible sites)
- Use facilitated focus groups and other peer settings to support consumer education and skill development
- Psychiatric and medical care is coordinated, supported by an integrated lab system
- Services are provided by a team with clear roles and structure to communicate; the consumer is at the center of the team, coordinates own services whenever possible, and there is a standard process for determining who is the single point of authority for each consumer
- State mandated tools completed at established intervals
- Care coordination role (primary clinician) includes:
  - Single point of accountability on record and in fact
  - Clear role expectations, authority is conferred by clinical relationship and system design (teams, MOUs)
  - Authority to approve/disapprove services provided by other parts of the MH system and to build relationships with other service systems
  - Match service capacity to clients, assure accountability to client and to system
  - Keep communication moving
  - Coordination of transitions (IP, moves)
  - Coordination with supportive services
  - Connection of all services so they are fluid
  - Consumer education (see web site)
  - Supported by IT that collects consumer data over time in one location
  - Fiscal responsibility for service utilization

### MH Services Delivered

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### Review of Services

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<td>(per plan or per change in circumstances)</td>
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<tr>
<td>• Led by care coordinator/primary clinician</td>
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<tr>
<td>• Client is partner in decision making regarding changes in care coordinator</td>
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<tr>
<td>• Update clinical assessment</td>
</tr>
<tr>
<td>• Review achievement of service goals with consumer, revise</td>
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<tr>
<td>• Determine if planned services to support goals were delivered as planned</td>
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<tr>
<td>• Seek consultation as needed</td>
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<tr>
<td>• Review involvement of other systems</td>
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<tr>
<td>• Convene SOC team as needed</td>
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<tr>
<td>• Use exit criteria to determine program completion, if specialty program, work w/ regions and Access to determine next steps, or use overall system exit criteria</td>
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<tr>
<td>• Review/revise LOC</td>
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<tr>
<td>• Revise service plan, or initiate planned end of episode with clear point of reentry with new goals</td>
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<tr>
<td>• Identify community resources for follow up (CBOs as individual/family tx resource/sliding scale)</td>
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### Service Episode Ends

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<td>• Recovery and self help model, increase self reliance</td>
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<td>• Acknowledge and celebrate goals achieved and milestones accomplished by consumer</td>
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<tr>
<td>• Develop a plan for independent management that identifies natural supports to be used, and communication plan to stay in contact</td>
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<tr>
<td>• Complete closing satisfaction and outcome tools (depending on time frame since last done)</td>
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<tr>
<td>• Service process has addressed work, housing, basic needs</td>
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<tr>
<td>• Connect with self help and recovery system throughout the county per plan</td>
</tr>
<tr>
<td>• Engage families and natural supports in plan</td>
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<tr>
<td>• Formal follow up structure, check back</td>
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<tr>
<td>• Provide aftercare, relapse prevention drop in groups</td>
</tr>
<tr>
<td>• Transition to medication alternatives (PCPs, new capacity tied to self help)</td>
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<tr>
<td>• Consultation to PCPs who agree to do follow up meds</td>
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### Partnerships With Other Systems

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<td>• Clear process for joint services planning, service change planning and joint decision making with all partner agencies</td>
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<tr>
<td>• Agreements regarding communication, contacts, notification of changes (supported by technology) and high level of collaboration</td>
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<tr>
<td>• Collaborate to integrate consumers into mainstream services</td>
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</table>
Quality and Utilization Management Processes

Quality/Utilization Management Processes

Inpatient
- MediCal IP authorization, all admits tied to specific tx goals, collaborate with regions on plan
- Crisis residential authorization, all admits tied to specific tx goals, collaborate with regions on plan
- IP referral authorization for county served consumers covered by private insurance
- Advocacy role with other payors
- Length of IP stay management tied to achievement of jointly established tx goals
- Joint quality measurement process with IP, including written protocols and monitoring

Access and ongoing services
- Track time to assessment, to first post assessment service
- Document initial LOC assigned
- Establish inter-rater reliability process for medical necessity, LOC, eligibility
- Review and affirm/change LOC at clinical assessment and at reassessment
- Feedback on appropriateness of referral and LOC
- Medication management reviews
- Chart audits

Satisfaction/outcomes
- Consumer satisfaction surveys for IP stays, at other key points in the process
  - Consider surveys that ask directly: are you better, more satisfied, that get down to useful detail rather than high scores that don’t provide realistic information, tie satisfaction to progress towards goals (see MHSIP, check VA survey development)
  - Survey more consumers and include those not engaged
- Provider satisfaction surveys
- Plan and deliver education to parents and clinicians regarding the importance of the outcomes tools
- Identify person(s) to assist consumers and families in completion of tools, focus and track the paperwork
- Complete baseline outcomes tools
- Complete outcomes tools at required intervals and end of episode
- Analyze outcomes in relationship to LOC and best practices

Measurement in general
- Assure a context of Quality Improvement from the top of the organization so numbers are not used punitively, but to support opportunities for improvement
- Use automation rather than hand counting methods
- Increased sophistication in standards, criteria, and best practice requires increased sophistication in what to measure
- Make measurement integrated with the service stream, with what clinicians do, and useful to them and connected to consumer goals
- Connect to the model of change/best practice in working with consumers
- Be clear about the difference between measurement for quality and for contract compliance
Quality and Utilization Management Processes

Best Practices

- Includes program models, medication protocols/algorithms, clinical pathways and guidelines
- The intent is to be prepared for specialized funding, but not be driven by it—and to integrate best practices into ongoing programs and services rather than developing them as program “silos”.
- A committee (includes mix of disciplines, contractors, levels of the system) regularly reviews results of state tools, IT reports, other sources of population data. Group tracks emerging research and recommended best practices, initiates new best practices, and maintains oversight of best practices already implemented.

- Implementation of best practices follows Shewhart PDCA Cycle
  - **Plan**
    - Track population/sub populations
    - Develop baseline data on utilization and outcomes
    - Review best practices and evidence
    - Select and develop best practice approach
    - Identify cultural issues associated with best practice and address
    - Develop policies, program consistent with best practice, specify exceptions/process for exceptions to best practice
    - Design measurement plan
    - Pilot best practice, with specific plan for review and decision making about full implementation
    - Develop consumer education materials
    - Train staff (including supervisors) on best practice (detailed and specific training that directly relates to their work). Training must address beliefs and values that are barriers to implementation
  - **Do**
    - Deliver services with best practice approach
    - Provide consumer education
    - Supervision focuses on assurance function
  - **Check**
    - Compliance with approach
    - Consumer outcomes
  - **Act**
    - Stay the course long enough to see the process have an impact as demonstrated by the data—use statistical analysis to support decisions
    - Confirm the best practice (delivered as planned and outcomes achieved) and make decisions about diffusion of the best practice, or
    - Change best practice (delivered as planned, outcomes not achieved), or
    - Address delivery issues (not delivered as planned),

Quality Plan

- As developed and updated
- Includes Quality Assurance chart review function

State Mandated Tools

- Baseline, interim and end of episode outcome and satisfaction tools
- Analysis of outcomes and satisfaction
- Negotiate for differential amount of paperwork for low LOC
- Balance measurement and use of resources

IT Reports

- Reports for clinicians, supervisors and program managers
- Integrate utilization, outcome and satisfaction data
- System-wide, by consumer demographics
- Annual, over-time trends, seasonal variation, population variation examined

OBM

- Indicators part of overall County process
- Reports reviewed and actions folded into quality process
## Glossary

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Definition</th>
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<tbody>
<tr>
<td>AOD</td>
<td>Alcohol and Other Drugs</td>
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<tr>
<td>ASO</td>
<td>Administrative Service Organization (specifically, one operated by the California Mental Health Directors Association to support contracting for mental health services when children are placed out of county)</td>
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<tr>
<td>CBO</td>
<td>Community Based Organization</td>
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<tr>
<td>CCP</td>
<td>Coordinated care plan</td>
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<tr>
<td>Dx</td>
<td>Diagnosis</td>
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<tr>
<td>FSA</td>
<td>Family Service Agency</td>
</tr>
<tr>
<td>GAF</td>
<td>Global Assessment of Functioning (part of diagnosis process)</td>
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<tr>
<td>HSA</td>
<td>Human Services Agency</td>
</tr>
<tr>
<td>ICI</td>
<td>Initial contact information (a form that is filled out)</td>
</tr>
<tr>
<td>IT</td>
<td>Information technology</td>
</tr>
<tr>
<td>LOC</td>
<td>Level of care</td>
</tr>
<tr>
<td>MDT</td>
<td>Multidisciplinary team</td>
</tr>
<tr>
<td>MOU</td>
<td>Memorandum of Understanding</td>
</tr>
<tr>
<td>NCQA</td>
<td>National Committee for Quality Assurance</td>
</tr>
<tr>
<td>Network</td>
<td>Private providers of services, both independent practitioners and contract agencies</td>
</tr>
<tr>
<td>OBM</td>
<td>Outcome Based Management (San Mateo County process)</td>
</tr>
<tr>
<td>PCP</td>
<td>Primary care provider (medical)</td>
</tr>
<tr>
<td>PES</td>
<td>Psychiatric Emergency Services</td>
</tr>
<tr>
<td>PIN</td>
<td>Physician initial note</td>
</tr>
<tr>
<td>Purple</td>
<td>The document for the initial assessment</td>
</tr>
<tr>
<td>SED</td>
<td>Seriously emotionally disturbed</td>
</tr>
<tr>
<td>SMI</td>
<td>Seriously mentally ill (also sometimes, SPMI, seriously and persistently mentally ill)</td>
</tr>
<tr>
<td>SOC</td>
<td>System of Care, the umbrella of overall services from all agencies (in the past to designate certain programs or level of care)</td>
</tr>
<tr>
<td>TBS</td>
<td>Therapeutic Behavioral Services</td>
</tr>
<tr>
<td>TDS</td>
<td>Therapeutic Day Schools</td>
</tr>
<tr>
<td>Tx</td>
<td>Treatment</td>
</tr>
<tr>
<td>UMDAP</td>
<td>Universal Method to Determine Ability to Pay</td>
</tr>
<tr>
<td>599</td>
<td>Specific program for youth at risk for non-public school placement</td>
</tr>
</tbody>
</table>
Information Technology

Overview

This section summarizes the planning work that examined how information technology could be used to improve the operating effectiveness of the organization.

The Information Systems Department is a vital part of San Mateo County Mental Health’s (SMCMH) support service system. The Department has four key customers:

- **Clients** who are able to obtain mental health educational information and communicate with SMCMH staff.
- **Clinicians and Clinical Support Staff** who use information technology to support the delivery of service to individual clients and manage their caseloads.
- **Management** who use data and reports to manage the organization.
- **All Staff** who use data to more effectively do their jobs and improve the quality of service.

Strategic planning related to information technology needs to consider the needs of these key stakeholders.

**Computer-Based Patient Record (CPR) System**

Currently San Mateo County Mental Health is supported by a computer system that handles client registration, service tracking, billing and limited managed care functionality. Noticeably absent is clinical functionality to support the service delivery process. Rather than considering the selection and implementation of a full, new behavioral health information system, the county should focus on selecting and implementing a Computer-based Patient Record (CPR) system. This will allow new IT efforts to focus on clinicians rather than being absorbed with bringing up a new billing system. Highlights of what should come with the CPR system include:

- **Contact Logging:** All contacts at all “doors” are logged into a user-defined online form that gathers information on the nature of the contact and basic data such as name, phone number, language requirement, etc. The system will need to check to see if the client has been or is currently a client at SMCMH. If the client has a previous record in the system, the log will be automatically filled with the latest information held in the system and then verified. If the contact is not a request for service, basic information is collected regarding the type of contact and disposition.

- **Consumer Access Screening:** Provides user-defined online client screening forms to assist in the determination of whether the client requires services from the crisis system, hospitalization, referral for outpatient services, or
referral to other community resources. Includes access needs information, presenting problems and other relevant clinical information.

- **Crisis Alerts:** Supports the ability of non-crisis staff to enter alerts into the system via a user-defined form to notify other staff that an individual is at risk of going into crisis with a description of the issues and links to a client’s medication record and other key data. The system administrator should have control over where and how these alerts appear. The system should support a user-defined expiration period for an alert (e.g. removed from the system after 10 days).

- **Crisis Episode Tracking:** Provides user-defined screens for tracking key crisis service data including date and time of initial request (dispatch), date and time of face to face contact with the person in crisis, referral source, location of service, and type of service, types of consultations obtained, etc. Supports the tracking of the length of crisis episodes including the ability to accurately handle time tracking that spans multiple days (e.g. 11pm through 2am of the next day).

- **Clinical Assessments:** Allows for the development of multiple user defined online assessment forms to support mental health client assessments. Can accommodate check boxes, table-driven entries, and free form text entry of assessment information. Supports user-defined taxonomy of assessment structures (e.g. domains, conditions, etc.) as well as the ability to add in third party assessment tools.

- **Treatment and Discharge Planning:** Allows for the development of multiple user-defined data entry forms that supports the different methods of treatment and discharge planning as well as service review across different programs (e.g. inpatient mental health, residential drug and alcohol treatment, outpatient child day treatment). Allows for the development of structured planning formats as well as the entry of free-form text.

- **Progress Notes:** Able to create a variety of user-defined input screens and underlying databases to track clinical information. This includes Inpatient, Outpatient, Crisis, Outreach, Residential and Consumer Satisfaction Surveys. Allows for the recording of group notes including the ability to create one master group note for all members of a group with customized additions for each group member.

It is important to note that San Mateo County should not attempt to create a fully integrated clinical record at once. This is a huge task that should ideally be done in multiple phases, automating the most important processes first. This approach gives clinical staff time to become acclimated to a new way of working, IS staff the opportunity to develop the right skill base for implementing a clinical record system, and the technology a chance to catch up to the demands of customers.
Phase 1 of clinical automation should focus on 3 goals: 1) automating processes that have the potential to improve care; 2) eliminating redundant data collection and storage by creating one-time data capture; and 3) “cleaning up” dysfunctional ways of doing business. Staff should be very thoughtful in choosing the automation projects that are tackled in Phase 1, using a clear method for identifying and prioritizing changes that will meet one or more of the three goals.

The following template is a suggestion for selecting and procuring a new system.
## SAN MATEO MENTAL HEALTH CPR PROCUREMENT PROCESS PLAN

**Request for Proposal Procurement Process**

<table>
<thead>
<tr>
<th>Task</th>
<th>Begin Date</th>
<th>End Date</th>
<th>Duration</th>
<th>Lead/Participants</th>
<th>Notes</th>
<th>Date Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Determine System Specifications / Requirements</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>2. Review information with key ISD Stakeholders</td>
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<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Revise RFP</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Advertise in newspapers</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Send RFP to selected vendors &amp; anyone responding to ad</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Vendor's Conference - Conference Call</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Letter of Intent due from potential vendors</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Proposals due by 5:00 PM</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Preliminary Review of Proposals</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>10. Work session to decide who to consider finalists; call and schedule onsite demos (up to 3)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Hold demonstrations</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Final reference checks for top vendors</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Full day work session to decide apparently successful vendor</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. On-Site Visits</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. Notify vendors of selection</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16. Complete contract negotiations</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17. Vendor onsite week to develop implementation plan, data conversion plan, customization plans</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18. Formally begin implementation activities</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Decision Support System (DSS)

Several important aspects of San Mateo County Mental Health’s strategic plan include using data to improve clinical, financial and operational processes. To achieve these goals better reports and reporting tools are necessary.

As part of the procurement process for the new Computer-based Patient Record, SMCMH should acquire a robust data reporting toolset that will support the CPR system and allow for reporting integration with the other mental health information systems. This project should create a foundation for putting meaningful reports into the hands of executive, supervisory, and line-staff on a regular basis.

For example, SMCMH should prioritize the development of a report that will go to every clinician each month that includes important statistics about that clinician's caseload. This would roll up into a Supervisor's Report that combines summary data from the individual clinician reports and a Department-Wide Report that's a rollup for all reporting units in that department. (See example below.)

The Decision Support System should include the following capabilities:

- Provides for the development and maintenance both standard and ad hoc reports for internal and external users of the system.
- Has the capability of reporting on any group of data fields in the entire CPR and related databases including user-defined fields.

<table>
<thead>
<tr>
<th>Agency XYZ</th>
<th>Clinician: Joe Smith</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinician Caseload Report</td>
<td>Report Date: Jan-2000</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Client Name</td>
<td>Level of Care</td>
</tr>
<tr>
<td>Bob Jones</td>
<td>2</td>
</tr>
<tr>
<td>Beth John</td>
<td>1</td>
</tr>
<tr>
<td>Bill Jack</td>
<td>2</td>
</tr>
<tr>
<td>Louis Wise</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>10</td>
</tr>
<tr>
<td>Total</td>
<td></td>
</tr>
</tbody>
</table>

- Level 1 Clients: 1
- Level 2 Clients: 2
- Level 3 Clients: 1
• Provides data sets that group files from multiple tables into logical reporting groupings.
• Has the ability to perform multi-layered sorts and selects.
• Has the ability to utilize wild cards in any data position of a field to select items.
• Has the ability to compute on any field or group of fields.
• Has the options of outputting reports to the screen, printer, standard ASCII file format and PC application formats (XLS, WK*, MDB, DIF, etc.). A simple procedure is available to download these files to PCs.
• Designed for use by non-technical personnel; reports can be created by staff without programming backgrounds.

**Education and Community Resource Database**

There are several places in the child and adult client workflows where access to mental health educational and community resource information is invaluable to both clients and clinicians.

San Mateo County has a well-developed web presence through the County’s website and intranet. This work should be leveraged and expanded upon to bring additional resources to mental clients and clinicians. The website could include subscriptions to third party health education material, links to a host of other websites, access to mental health research publications, self-developed materials and more.

The following example is from the award-winning site in Jefferson County, Colorado where Columbine High School is located. The site became a critical community resource after the shootings and hosted an online chat room staffed by mental health counselors for several months.
Application Support Staffing Resources

Adequate information systems staffing is required to support these new information technology initiatives while continuing to maintain current systems. To understand how San Mateo County Mental Health compares to similar organizations we completed a survey for Stanislaus and Butte Counties. Stanislaus has an annual mental health budget of approximately $60,000,000; Butte’s is approximately $30,000,000. By comparison, San Mateo’s mental health budget is approximately $75,000,000.

Key tasks in these organizations include IT Management, Network Administration, Desktop Support, Application Support, and Management Reporting. In our study we separated out the functions that are handled by information systems staff assigned to mental health - Application Support, Management Reporting, and a portion of IT Management. Currently SMCMH has 2.5 full time equivalents fulfilling these functions.

For these same functions Stanislaus County has 9.0 FTEs and Butte 6.0 FTEs. It should be noted that both organizations consider that they are “adequately” staffed for this work. By any measure, this clearly demonstrates that San Mateo is severely understaffed for these
activities. Interviews with staff regarding their workloads, deadlines, and project plans confirm this shortfall.

In this environment it is critical that no new information systems projects be taken on without additional allocation of resources. **At a minimum, one FTE each will be required for the Computer Patient Records and Decision Support System projects.** Without these minimal staffing adjustments these projects should not be pursued.
Business Services

Overview

This section summarizes the mission-critical business services initiatives that are necessary to support San Mateo County Mental Health.

Client and Third Party Revenue Generation

To gain a perspective on the effectiveness of San Mateo County Mental Health’s client and third party revenue generation effectiveness we compared the county with three peers. The comparison was a calculation of total client and third party (Medicare, Private Insurance) revenues per year divided by number of clients served. The result is average revenue per client per year from these sources. This method will account for share of cost collections from MediCal enrollees, individuals with Medicare coverage, and UMDAP-self-pay payments from uninsured individuals.

Average Self-Pay and Third Party Revenue per Client per Year

<table>
<thead>
<tr>
<th>County</th>
<th>Average Revenue per Client per Year</th>
<th>Comparison to San Mateo</th>
</tr>
</thead>
<tbody>
<tr>
<td>San Mateo County</td>
<td>$28.12</td>
<td></td>
</tr>
<tr>
<td>Butte County</td>
<td>$67.28</td>
<td>239% higher than San Mateo</td>
</tr>
<tr>
<td>Solano County</td>
<td>$62.04</td>
<td>221%</td>
</tr>
<tr>
<td>San Diego County</td>
<td>$78.71</td>
<td>280%</td>
</tr>
</tbody>
</table>

In examining additional data and the eligibility, billing and collections systems and staffing that is currently in place we noted the following:

- Current billing staff are well trained, very knowledgeable, and excellent at their jobs.
- There is a historical trail of well-developed billing and collection policies and procedures.
- There isn’t a formal Eligibility, Billing and Collections Policy and Procedures Manual that contains the summary and detailed rules in a single place.
- There are no staffing resources in place to ensure that the policies and procedures are carried out consistently across the organization, that new staff are trained on these materials, and that performance reports are used to monitor clinic-by-clinic performance.

To address these issues we are making two recommendations for change:

- Revise the eligibility, billing and collections policies and procedures into an integrated manual to clarify the responsibilities of all staff (support staff, clinicians, clinical managers, financial staff).
Identify a full-time position that will be responsible for “circuit riding” to all clinics to provide training and ongoing technical assistance to all staff regarding eligibility, billing and collections issues.

These two interventions can bring together the good work that now exists regarding billing policies and procedures, engage all staff in the organization in “playing their part”, and ensure that these efforts are maintained on an ongoing basis.

**Decentralized Budgeting System**

Currently, budget development and ongoing monitoring activities are handled by senior management and fiscal staff. Program managers and supervisors have almost no involvement in these activities.

A best practice fiscal management system would push this responsibility down to the supervisory level in the organization so that many individuals would become responsible for building, monitoring and managing their budgets. This allows for early identification of problems and creative solutions based on being “on the front lines”.

This process should be supported by an annual budgeting work plan, Excel-based budgeting templates, a monthly reporting system that tracks budget against actual, and an accountability structure that requires supervisors to report on the status of their budgets each month.

The following flowchart illustrates how this process would work.
1. Annual Review
   of Vision, Mission, Values

2. Annual Goals
   What strategies will we focus on this year?

3. Dept. Initiatives
   What the focus of each department this year?

4. Department Workplans
   Task, Lead, Start - End Dates, Resources

5. Dept. Budgets
   Projected revenues & expenses to run the dept. and support new initiatives

6. Key Metrics
   To measure progress

7. Reality Check
   Are workplans, budgets, & metrics realistic?

8. Adopt Annual Plan
   Board approval, finalize details?

9. Monthly Reports
   Revenue, expense, metrics?

10. Monitor
    In Balance?

11. Go Forth
    and prosper...

No

Yes