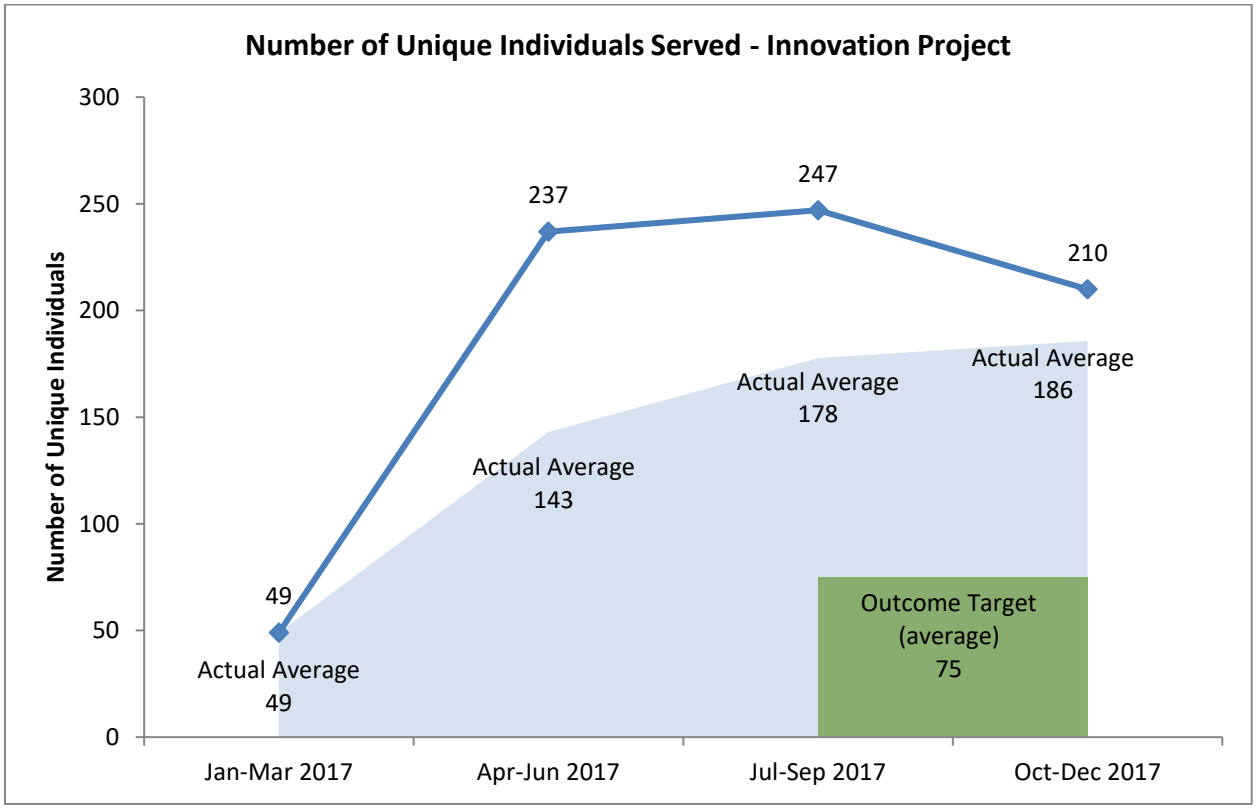
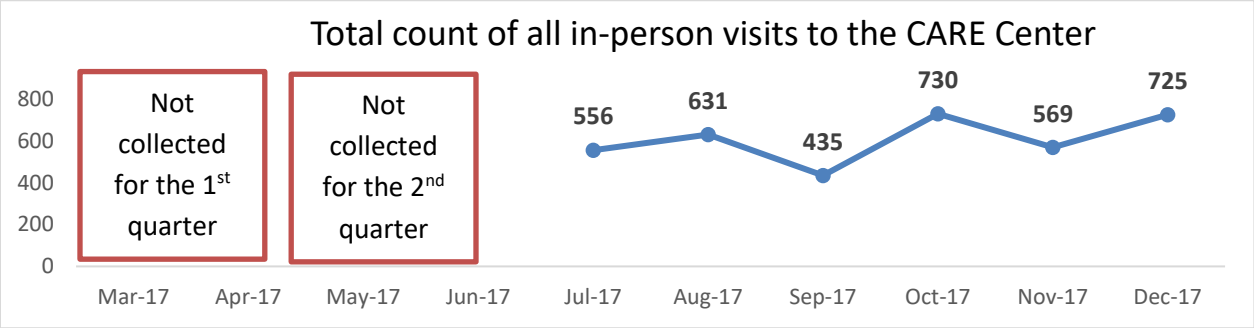
# CARE Center Activity Report – Innovation Project
## January 2017 through December 2017

To determine if providing access to mental health services after traditional office hours will improve access to services, reduce mental health crisis (including trips to the hospital emergency departments) and bridge service gaps, the Shasta County Health and Human Services Agency has contracted with Hill County Health and Wellness Center to provide new and expanded mental health services at the Counseling and Recovery Engagement (CARE) Center. Funding is provided through the Mental Health Services Act (MHSA) for the Innovation Project portion of this center. The CARE Center contract was approved as of January 2017, and they officially opened for business on March 12, 2017. For this report, data was gathered using the CARE Center Quarterly Progress Reports for January 2017 through December 2017. Please note that due to the CARE Center not actually opening for business until early March 2017, the first quarter reflects less than one month of data. Additionally, there are several measures where their data systems and/or electronic health record were in process, or where methodology changed, so they could not be tracked. As of the Oct-Dec 2017 quarter, all measures are now tracked and reported on, although further refinement of the data collection is still underway for some measures.

The outcome target numbers are for the CARE Center to serve an average of 75 unique individuals per quarter by the end of year one (12/31/17), 113 per quarter by the end of year two (12/31/18), and 128 per quarter by the middle of year three (6/30/19).



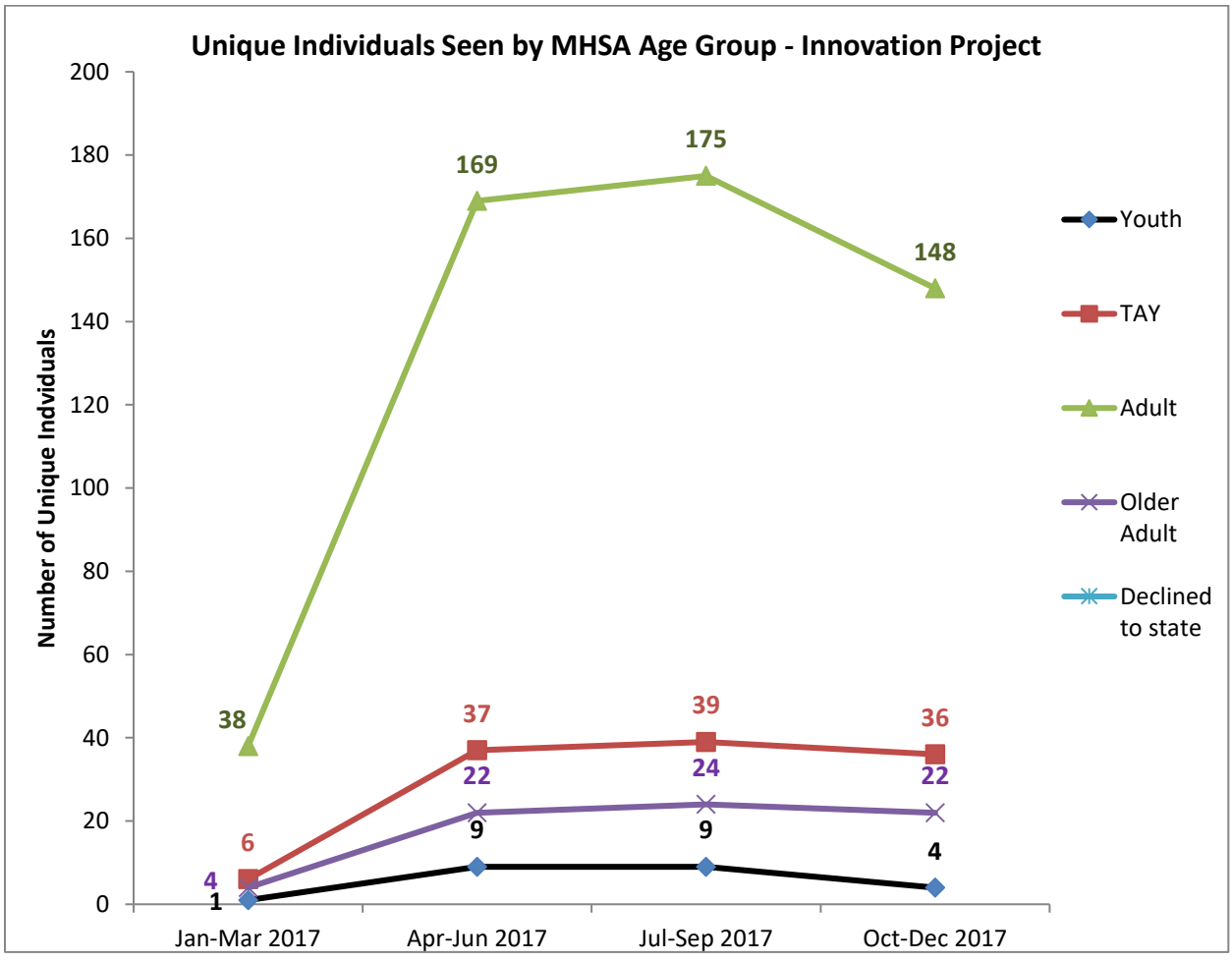
Due to much higher utilization of the Care Center than anticipated, the number of in-person visits per month are being tracked as of July 2017. Please note these do not include phone calls, and that most clients visit more than once - this is not an unduplicated person count.




All demographics questions are optional, so each includes the category "Declined to State".

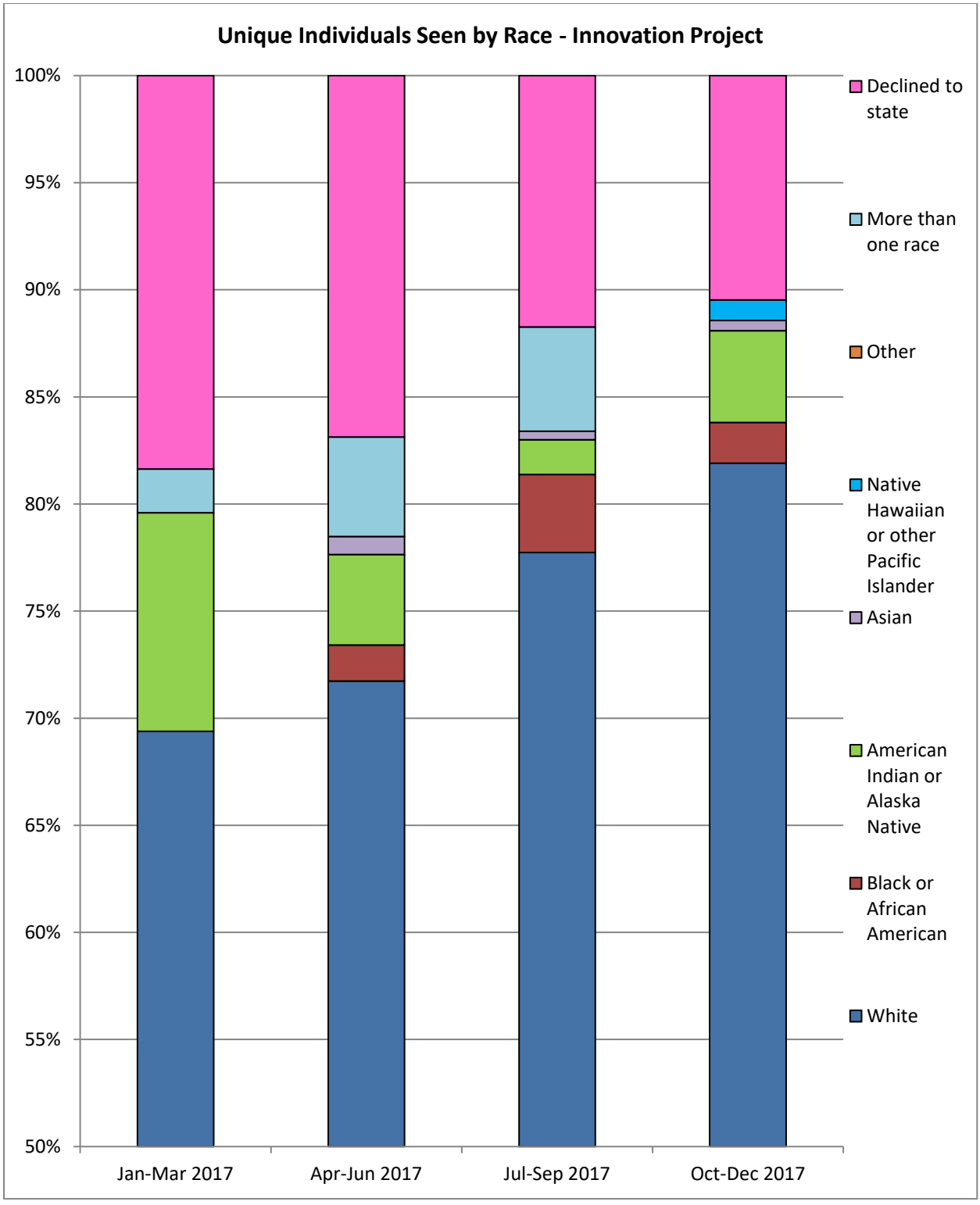
## AGE

The MHSA uses four age categories: Youth – ages 0-15, Transition Age Youth – ages 16-25, Adult – ages 26-59, and Older Adult – ages 60 and up.



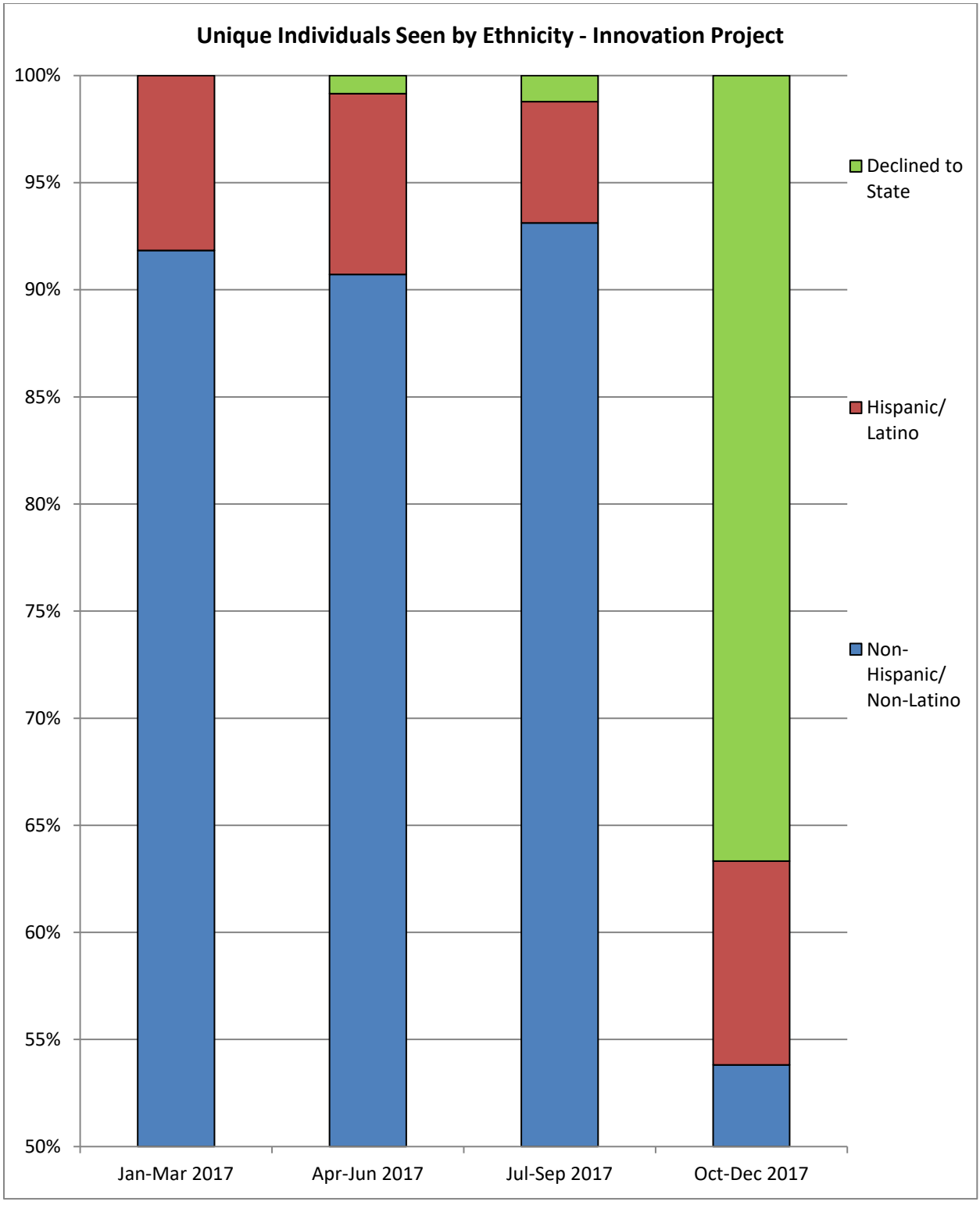
**RACE**

Because of the low gross numbers for some of these races, actual counts are not reported to help protect consumer confidentiality.



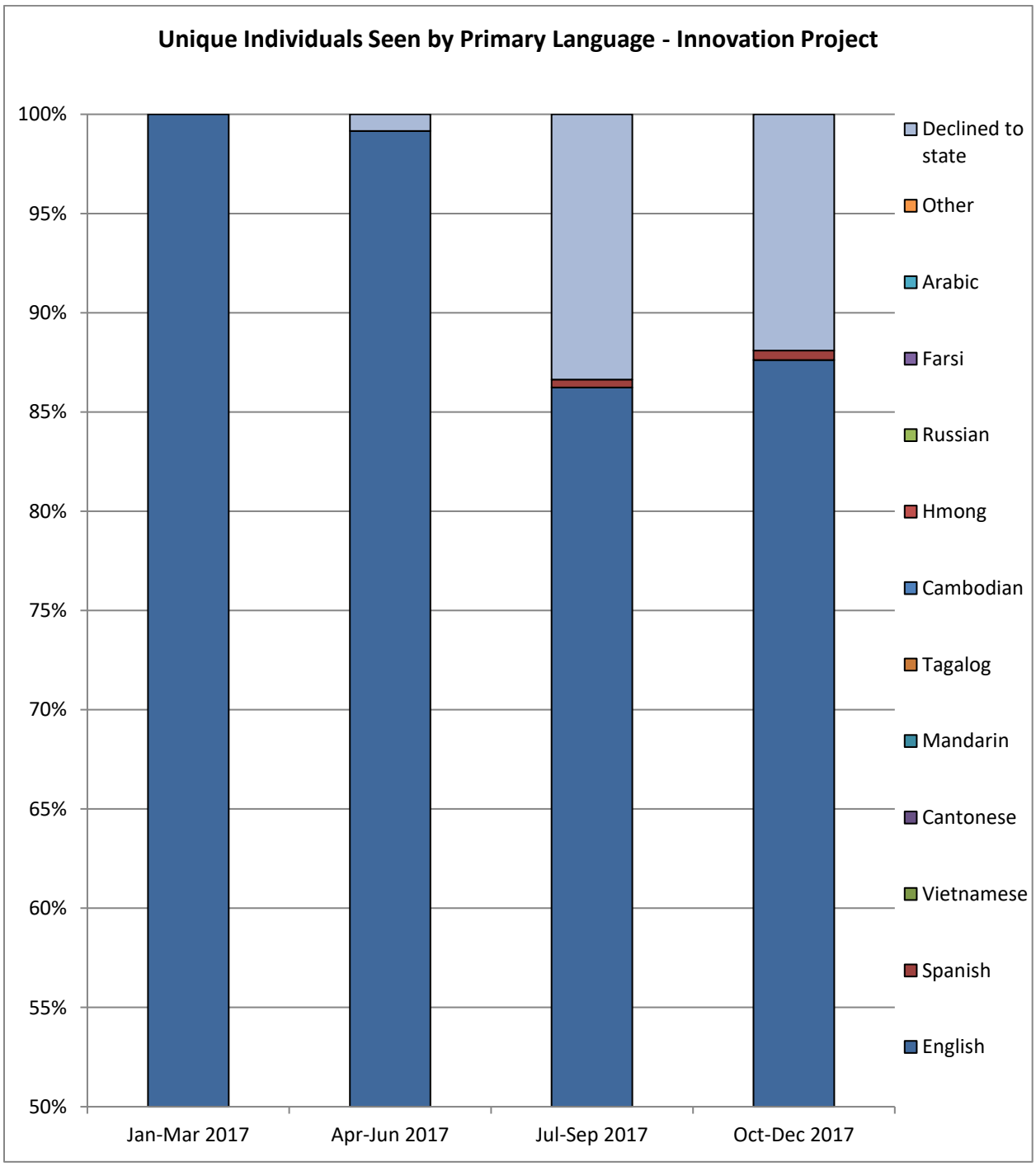
**ETHNICITY**

Because of the low gross numbers for some of these ethnicities, actual counts are not reported to help protect consumer confidentiality.

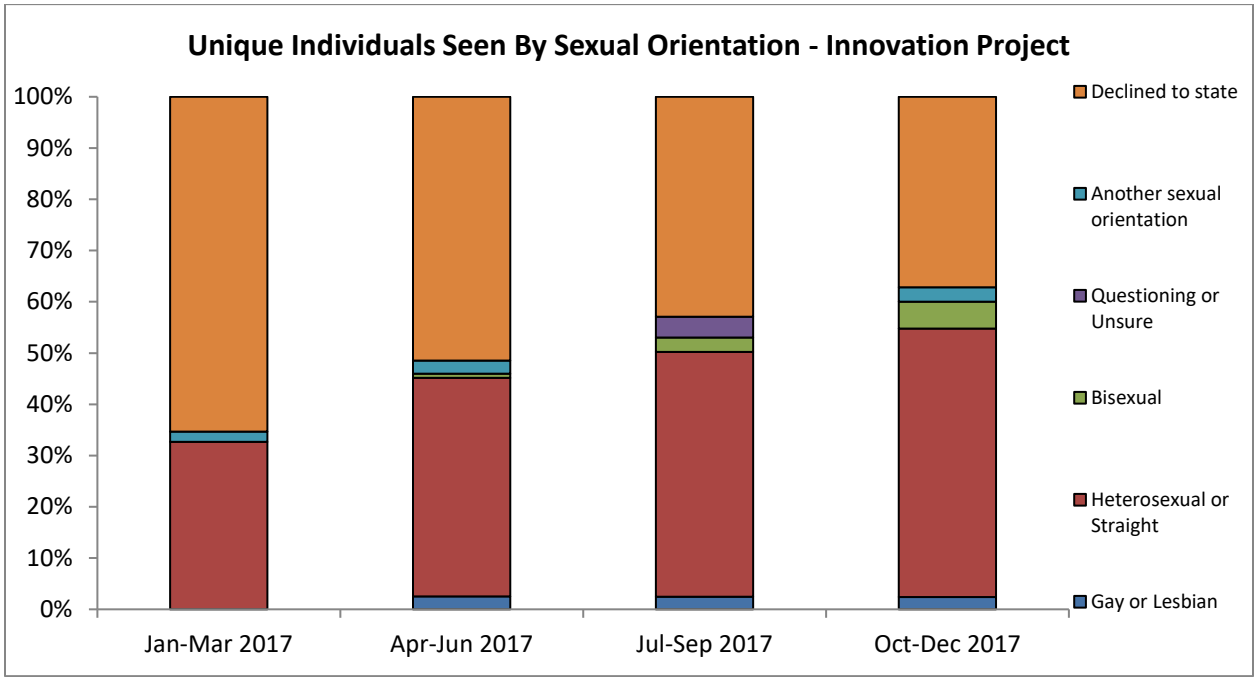


**PRIMARY LANGUAGE**

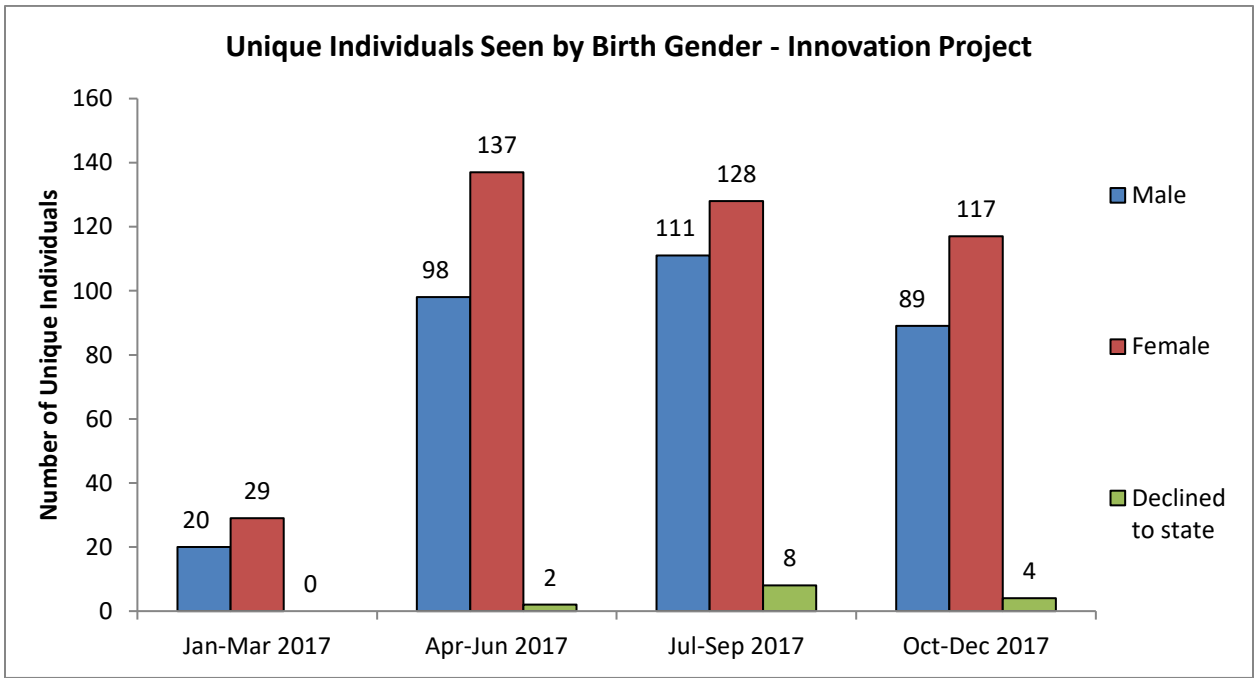
The primary language of consumers served by the CARE Center is English for nearly 100% of the people. Because of the low gross numbers for some reported languages, actual counts are not reported to help protect consumer confidentiality.



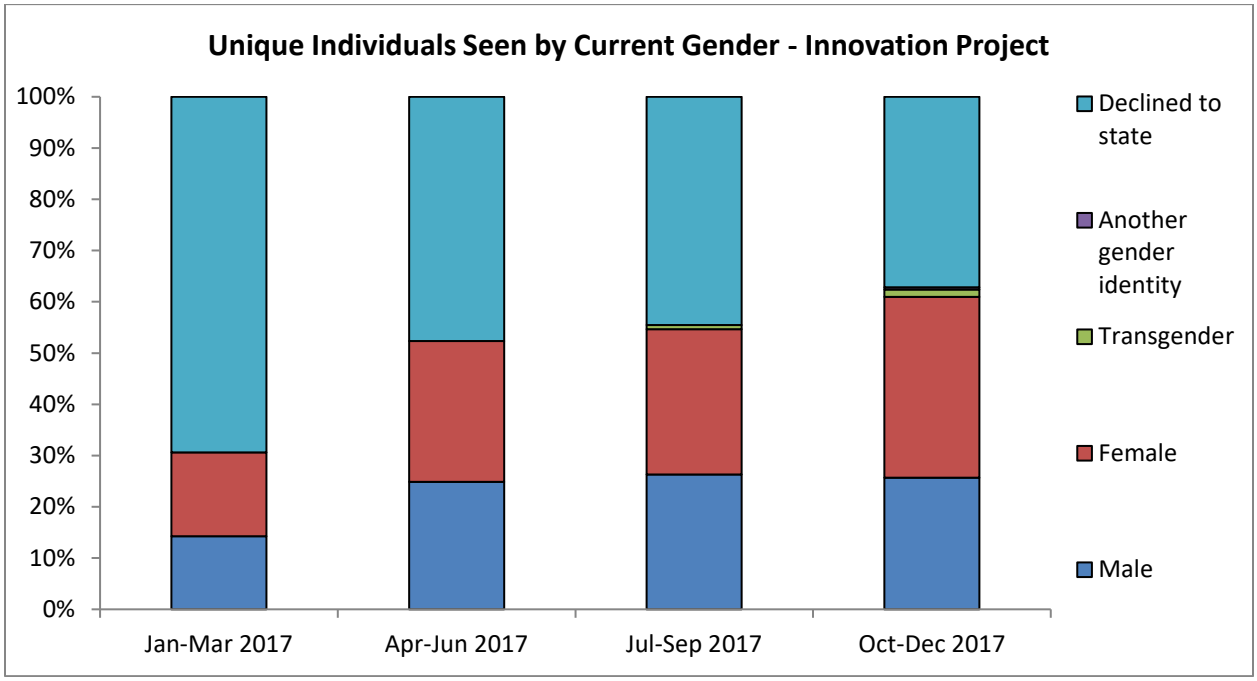
## SEXUAL ORIENTATION



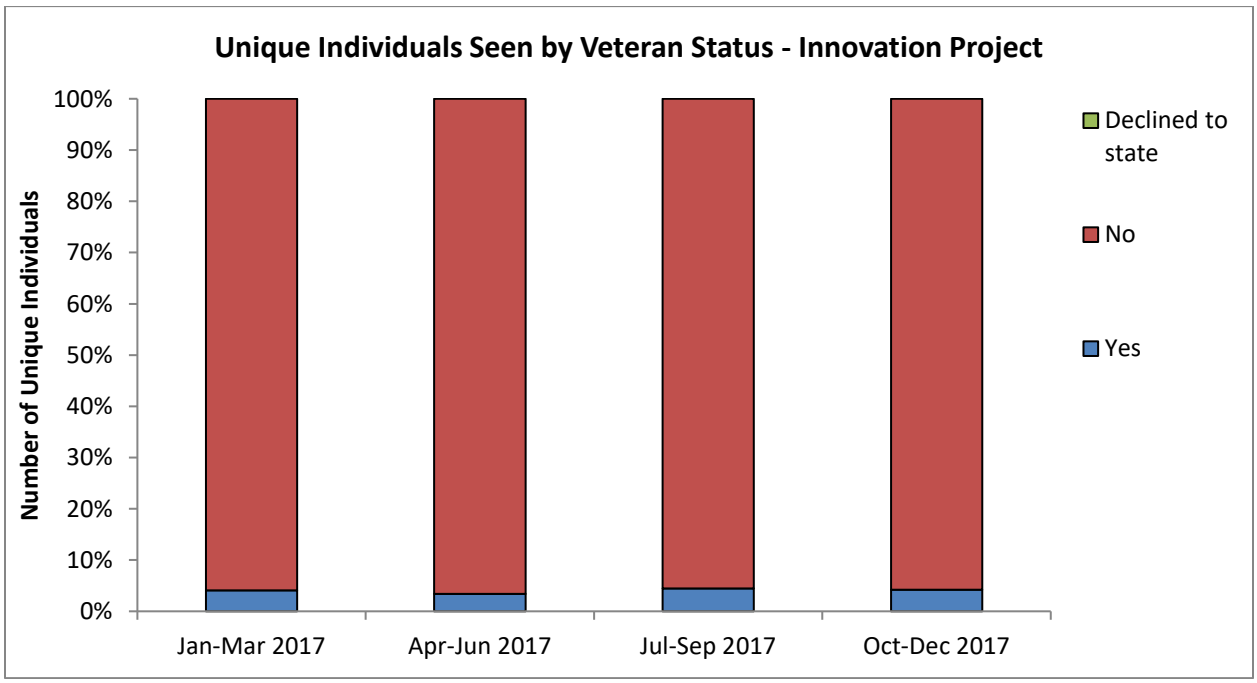

## BIRTH GENDER



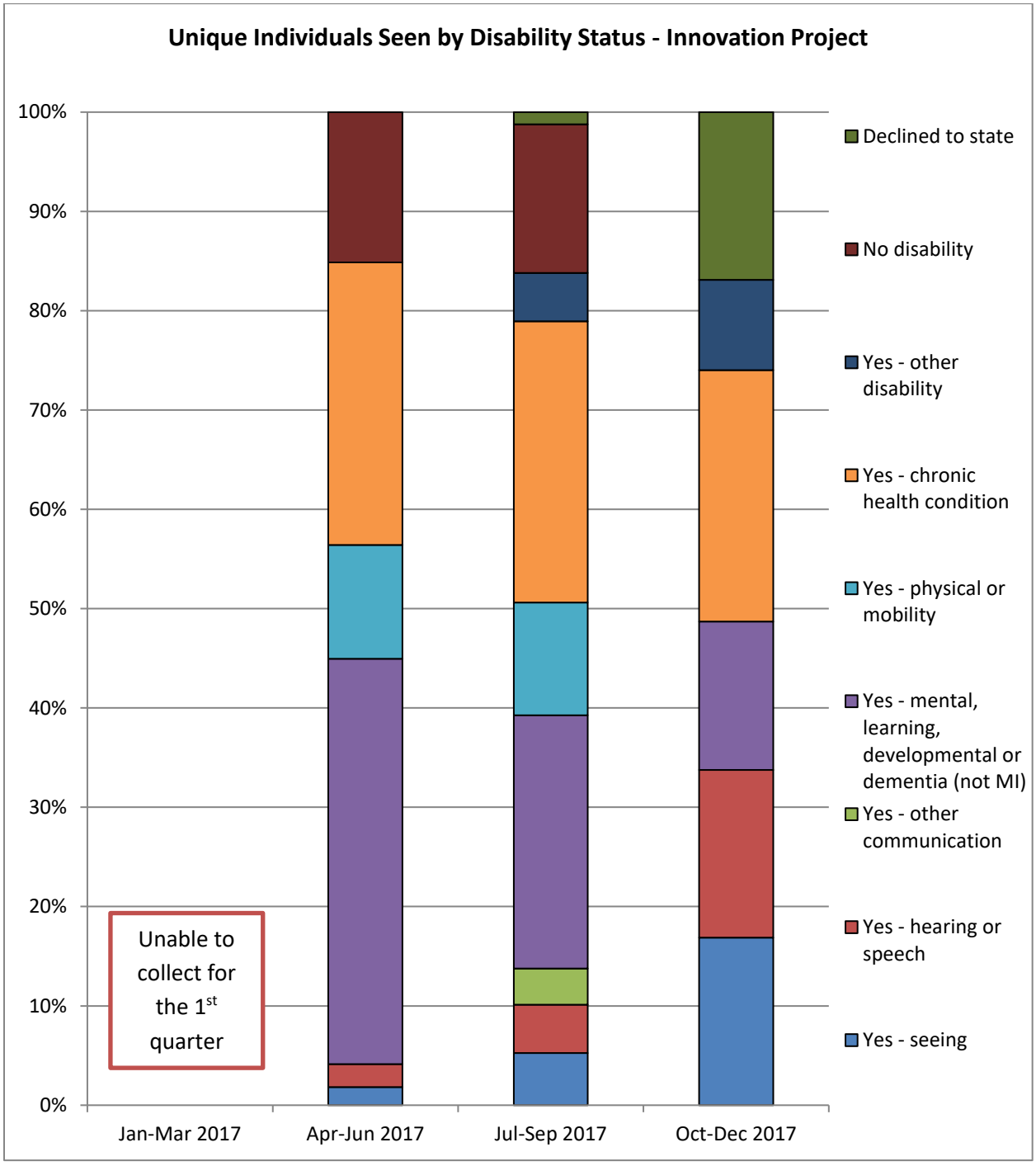
## CURRENT GENDER




## VETERAN STATUS



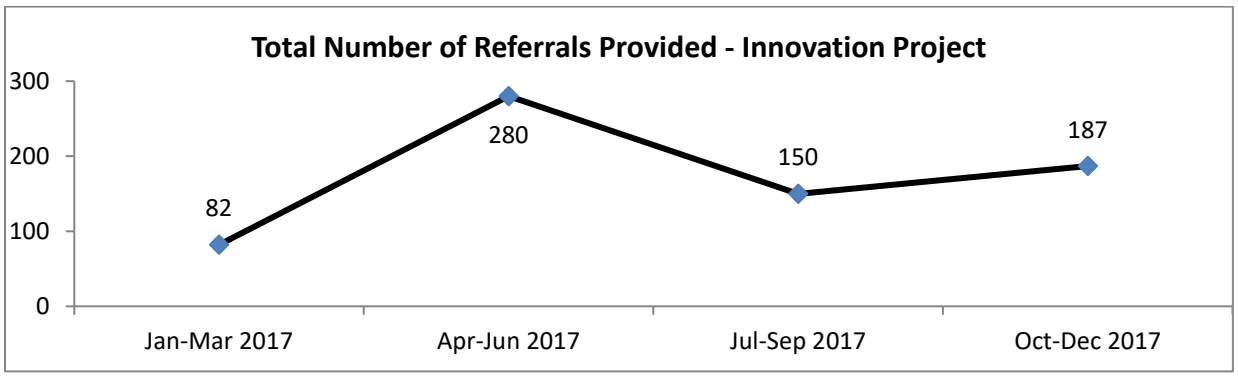
**DISABILITY STATUS**



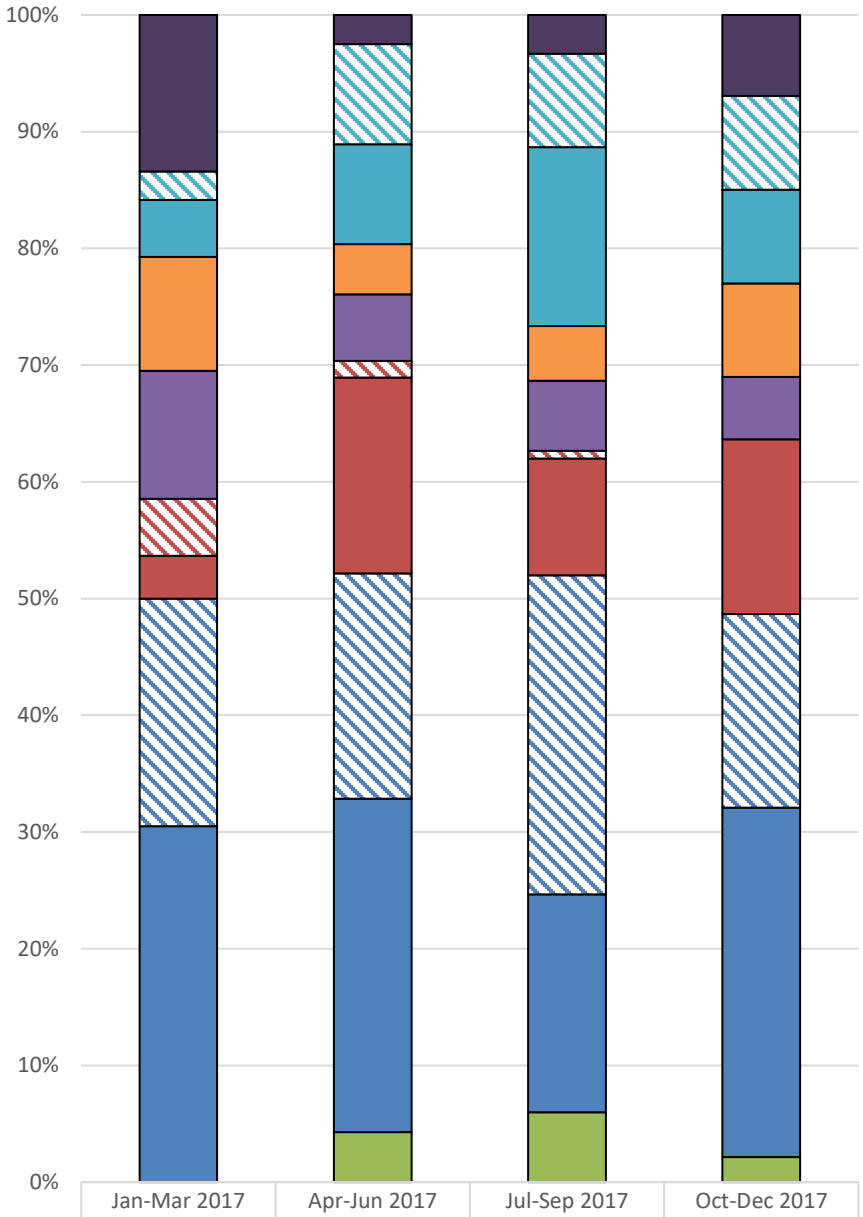
**NUMBER OF OUTSIDE REFERRALS PROVIDED AND SUCCESSFULLY ACCESSED**

There are many other departments and agencies to which individuals can be referred for items or services not directly provided by the CARE Center Innovation Project, and these are all reported to Shasta County in specific granular detail. For the purposes of this report, referrals have been categorized into 8 main types, and the reported numbers consolidated into these categories by external referrals and internal Hill Country referrals where applicable. The referral type categories are:

- "Basic Needs" which include referrals to:
  - Emergency clothing resources
  - Emergency food resources
  - Financial benefit application assistance
  - Health insurance application assistance (Medicare/Medi-Cal/etc.)
  - Transportation assistance
- "Behavioral/MH Services" which include referrals to:
  - Assisted Outpatient Treatment (AOT) program by Hill Country
  - Hill Country behavioral health services at various clinic locations
  - Mental health community services
  - Mental health county services
  - Specialty/psych health care services
  - Support group
  - Wellness and recovery
- "Community Groups" which include referrals to:
  - Community groups
  - Other external referrals
  - Other Hill Country referrals
- "Emergency Department Hospital"
- "Housing/Shelter Services"
- "Medical Health Services" which include referrals to:
  - Hill Country medical services at various clinic locations
  - Primary health care services
- "Substance Use Services" which include referrals to:
  - Medication-Assisted Treatment (MAT)
  - Substance Use Disorder (SUD) treatment

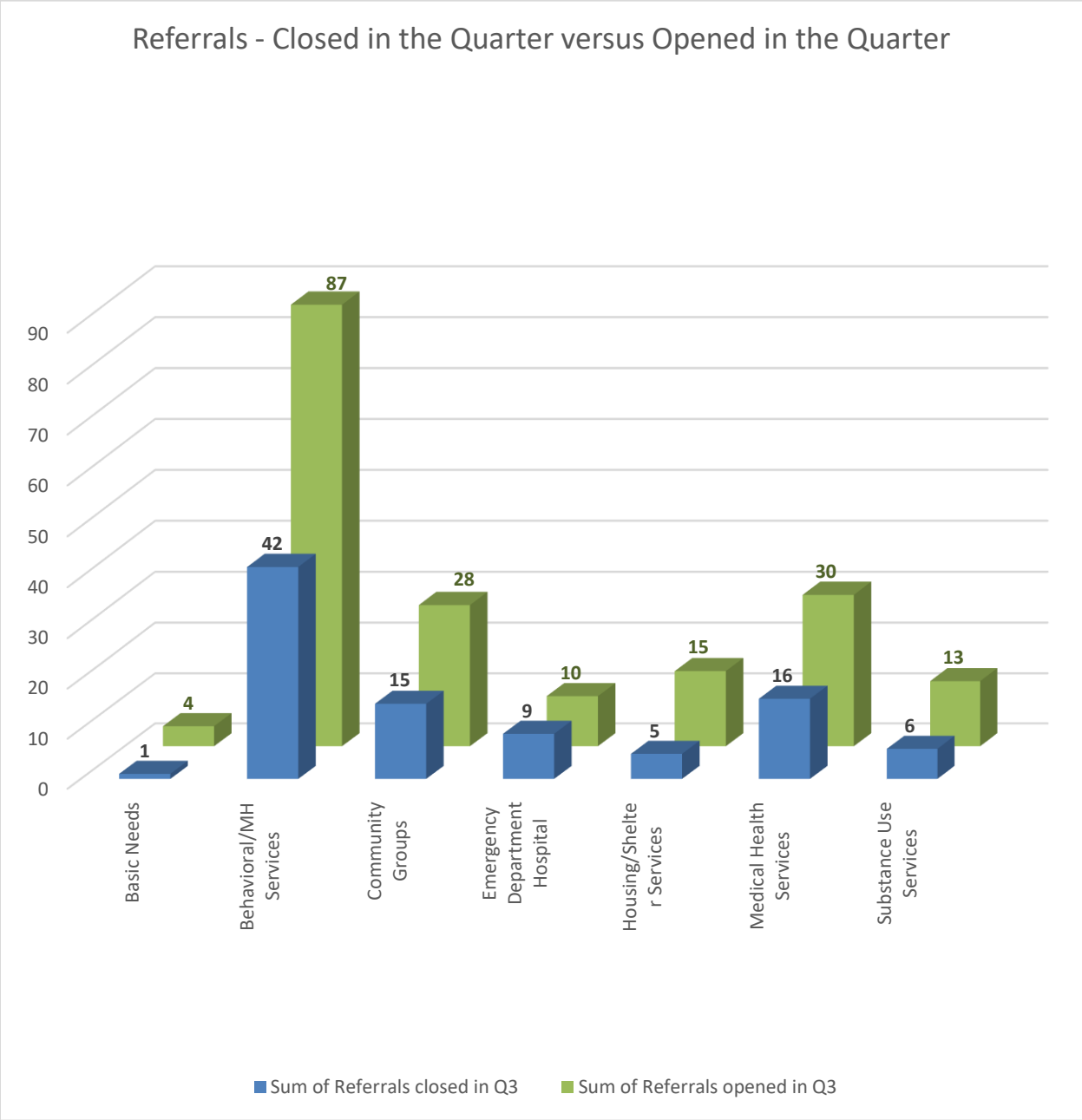


## Referrals Provided by Category - Innovation Project




| | Jan-Mar 2017 | Apr-Jun 2017 | Jul-Sep 2017 | Oct-Dec 2017 |
|---|---|---|---|---|
| Substance Use Services | 11 | 7 | 5 | 13 |
| Medical Health Services Hill Country | 2 | 24 | 12 | 15 |
| Medical Health Services External | 4 | 24 | 23 | 15 |
| Housing/Shelter Services | 8 | 12 | 7 | 15 |
| ED Hospital | 9 | 16 | 9 | 10 |
| Community Groups Hill Country | 4 | 4 | 1 | 0 |
| Community Groups External | 3 | 47 | 15 | 28 |
| Behavioral/MH Services Hill Country | 16 | 54 | 41 | 31 |
| Behavioral/MH Servivces External | 25 | 80 | 28 | 56 |
| Basic Needs | 0 | 12 | 9 | 4 |

Referrals are also tracked to see if the individuals who are referred to services provided by entities other than the CARE Center are successful in completing the referral. Success is measured by the person being provided a warm hand-off, and getting connected to the new service provider. The CARE Center is not being held accountable for whether the person was granted the benefits or items they were referred for, as that is outside the CARE Center staff's control. To track this measure, the CARE Center is reporting on numbers of referrals closed in each quarter, compared to referrals opened. Please note that due to the timing of some referrals, they will not show as closed until a later quarter. Some referral categories may also reflect closed referrals that had been opened in a prior quarter.

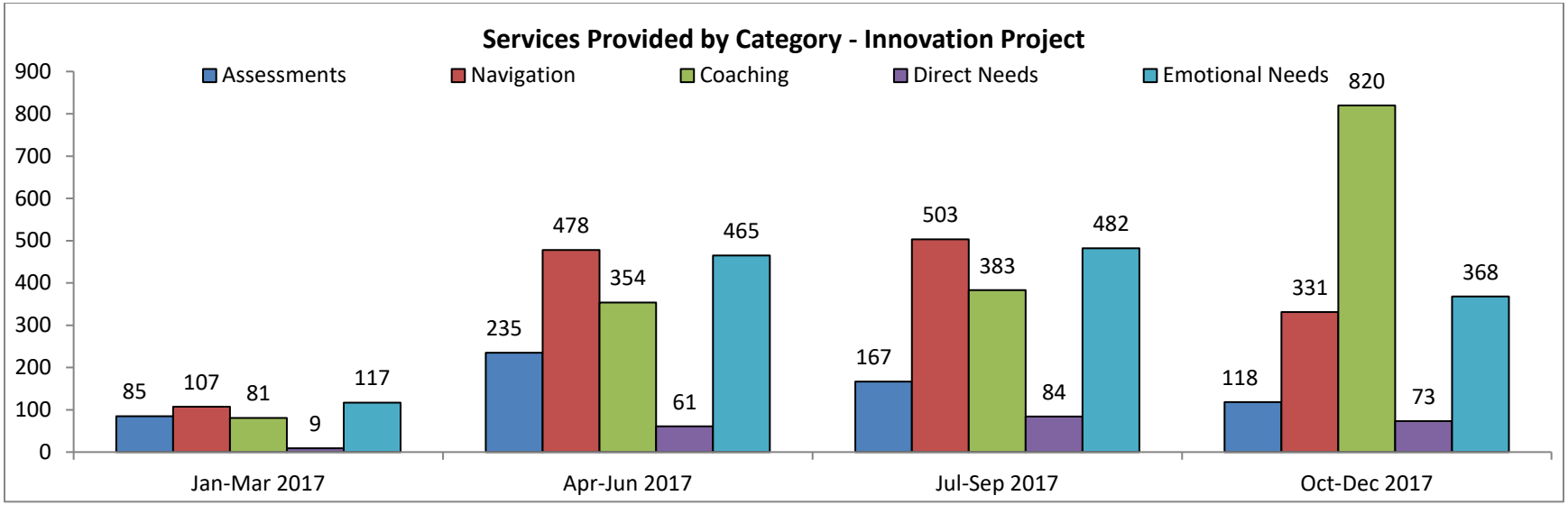


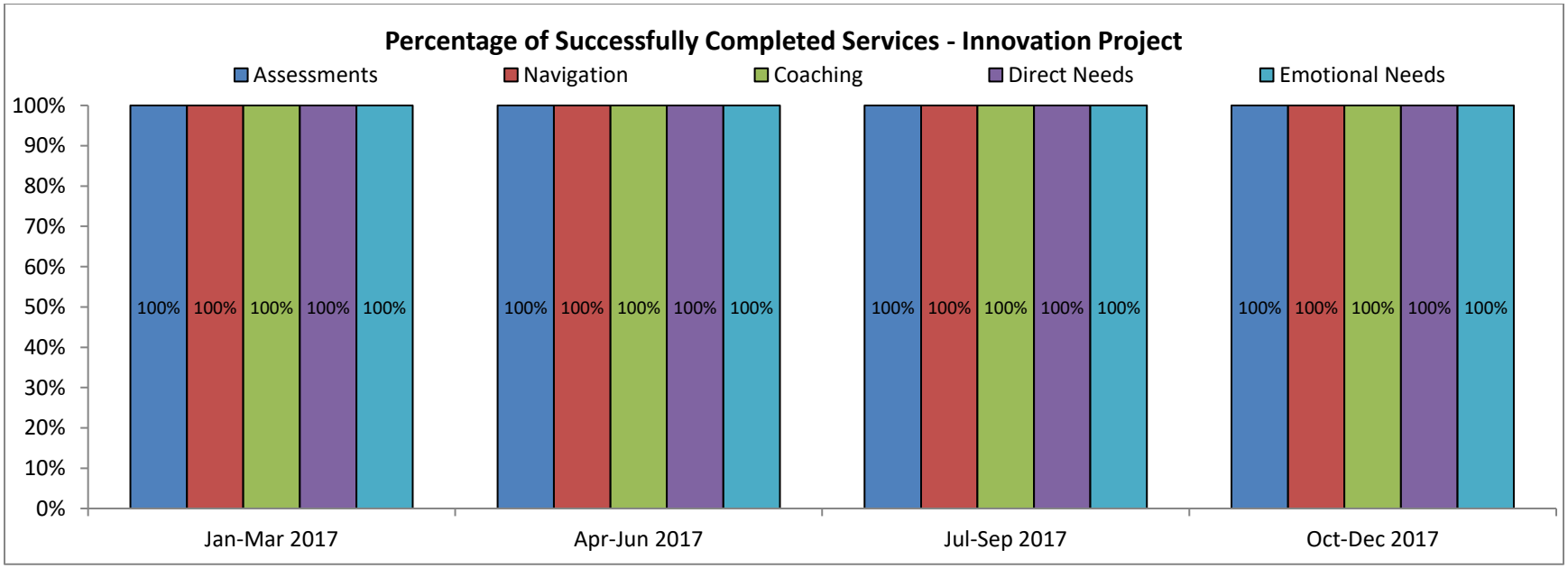
**NUMBER OF SERVICES PROVIDED AND SUCCESSFULLY COMPLETED**

Individuals can access a large number of services directly through the CARE Center Innovation Project, and these are all reported to Shasta County in specific granular detail. These services are provided directly by CARE Center staff members (including clinical staff, case managers, and peer volunteers). For the purposes of this report, services have been categorized into 5 main types, and the reported numbers consolidated. These service type categories are:

- "Assessments" which include
  - Mental health assessments
  - Needs assessments
  - Wellness and recovery assessments
- "Navigation" which includes
  - Advocacy
  - Navigation
  - Referral linkage and follow up
- "Coaching" which includes
  - Development of support systems
  - Goal and action planning
  - Skill building
  - Wellness coaching
- "Direct Needs" which include
  - Basic needs
  - Food/clothing
  - Transportation
- "Emotional Needs" which include
  - Crisis intervention/emotional support
  - Mental health follow up
  - Social services

Services are also tracked to see if the individuals who are needing the service(s) provided by the CARE Center are successful in accessing the services, and either completing the activities or receiving any tangible items involved with each service.


Services Provided by Category - Innovation Project
Assessments
Navigation
Coaching
Direct Needs
Emotional Needs
900
800
700
600
500
400
300
200
100
0
85
107
81
9
117
235
478
354
61
465
167
503
383
84
482
118
331
820
73
368
Jan-Mar 2017
Apr-Jun 2017
Jul-Sep 2017
Oct-Dec 2017


Percentage of Successfully Completed Services - Innovation Project
Assessments
Navigation
Coaching
Direct Needs
Emotional Needs
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
100%
Jan-Mar 2017
Apr-Jun 2017
Jul-Sep 2017
Oct-Dec 2017

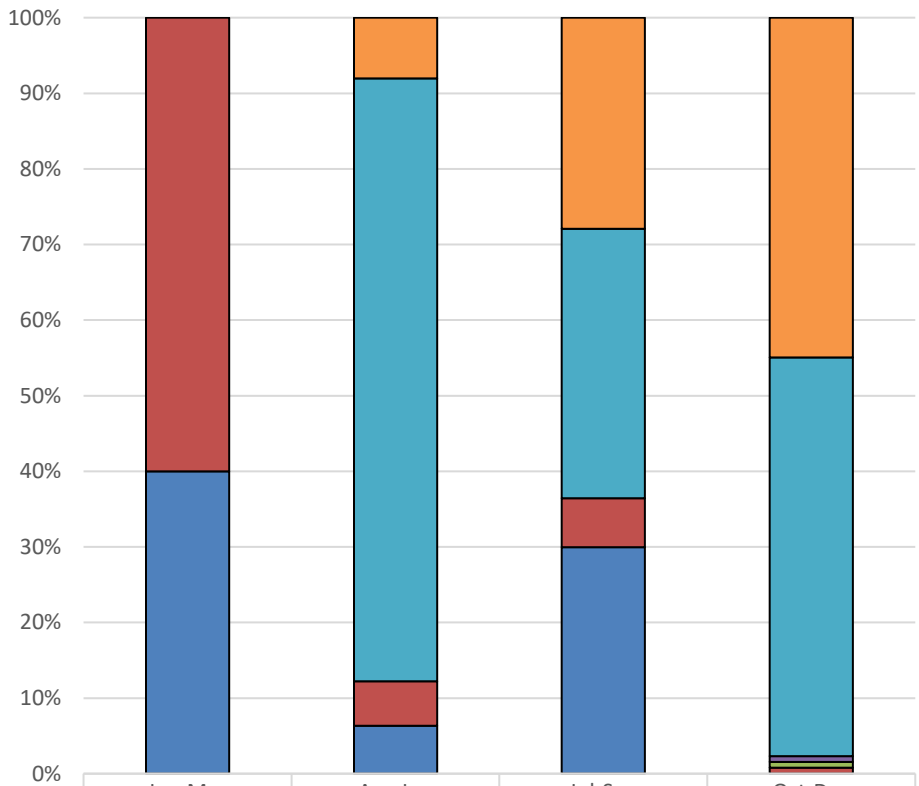
## HOUSING STATUS

To help track the impact and effectiveness of services, the CARE Center has been asked to track the housing status of individuals accessing the Innovation Project services at the time they first start services, and then at the 3-month and 6-month points after that first service. The target outcome numbers are to see a 15% increase in housing stability/permanence at the 3-month mark, and a 20% increase at the 6-month mark.

Housing status has been divided up into the following categories:

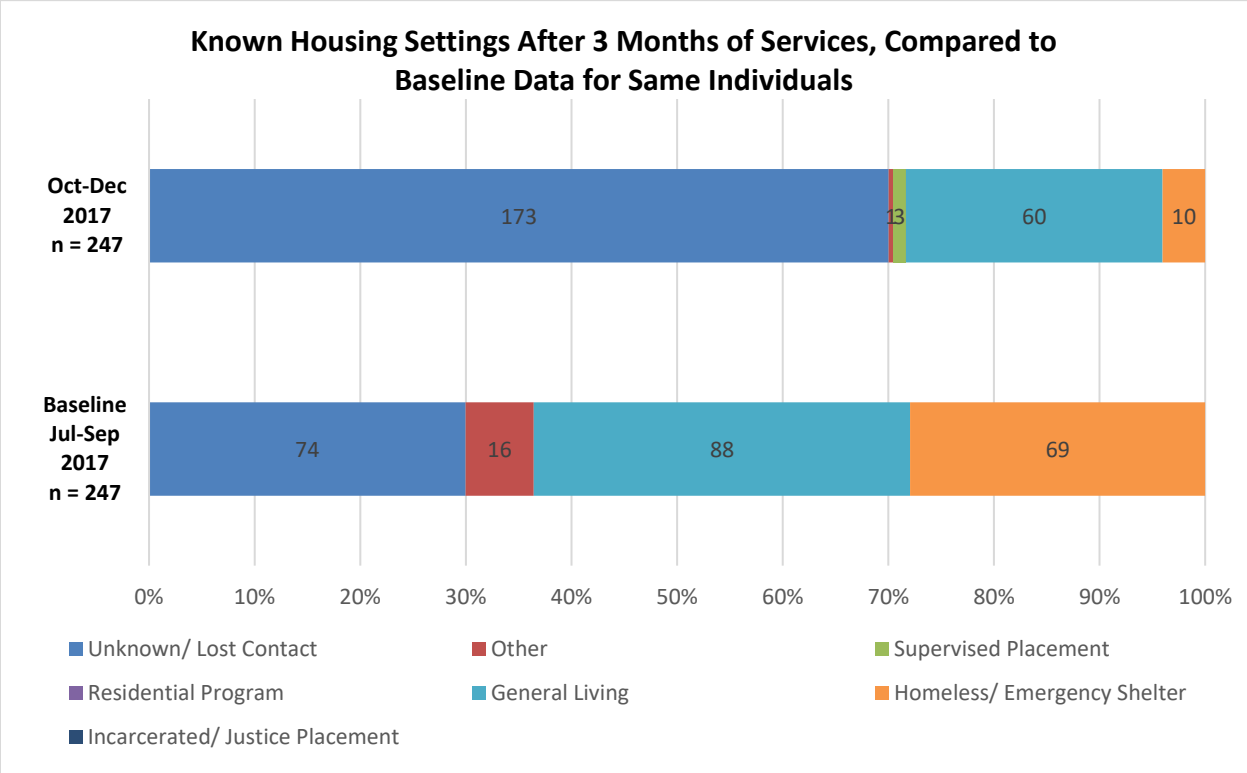
- Homeless/emergency shelter
- General living, which includes the following:
    - Apartment or house, alone or with family/roommates
    - Foster home
    - Single room occupancy
- Residential program, which includes the following:
    - Community treatment program
    - Group home (any level)
    - Long term care facility
    - Residential treatment program
    - Skilled nursing facility (any type)
- Supervised placement, which includes the following:
    - Assisted living facility
    - Community care facility, such as a Board and Care
    - Congregate placement
- Inpatient psychiatric hospitalization, which includes the following:
    - Psychiatric Health Facility (PHF)
    - Institute of Mental Disease (IMD)
- Incarcerated/justice placement, which includes the following:
    - Jail
    - Prison
    - Juvenile hall
    - Juvenile justice placement
- Other
- Unknown

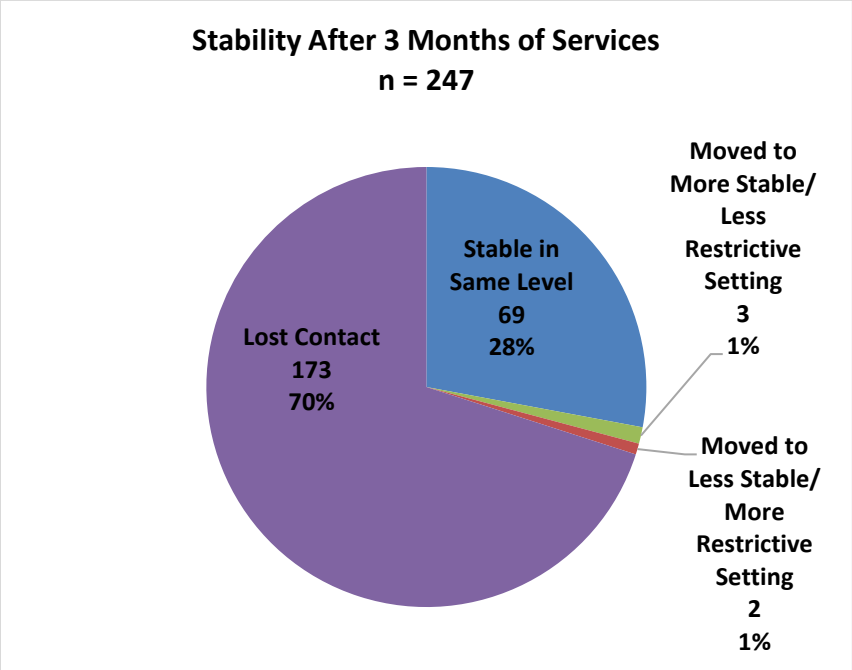
## HOUSING STATUS AT START OF SERVICES




| | Jan-Mar 2017 | Apr-Jun 2017 | Jul-Sep 2017 | Oct-Dec 2017 |
|---|---|---|---|---|
| Homeless/ Emergency Shelter | | 19 | 69 | 58 |
| General Living | | 189 | 88 | 68 |
| Residential Program | | | | 1 |
| Supervised Placement | | | | 1 |
| Other | 3 | 14 | 16 | 1 |
| Unknown | 2 | 15 | 74 | |

## HOUSING STABILITY 3 MONTHS AFTER SERVICES AT THE CARE CENTER

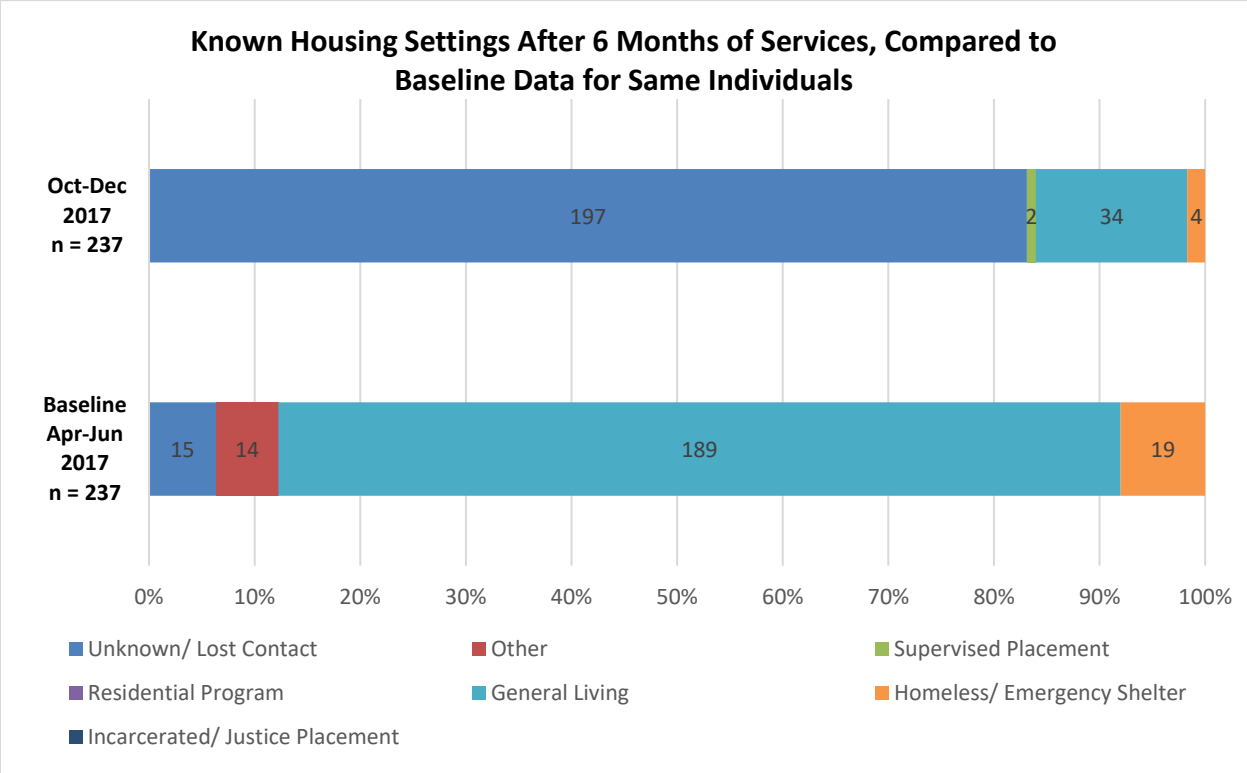


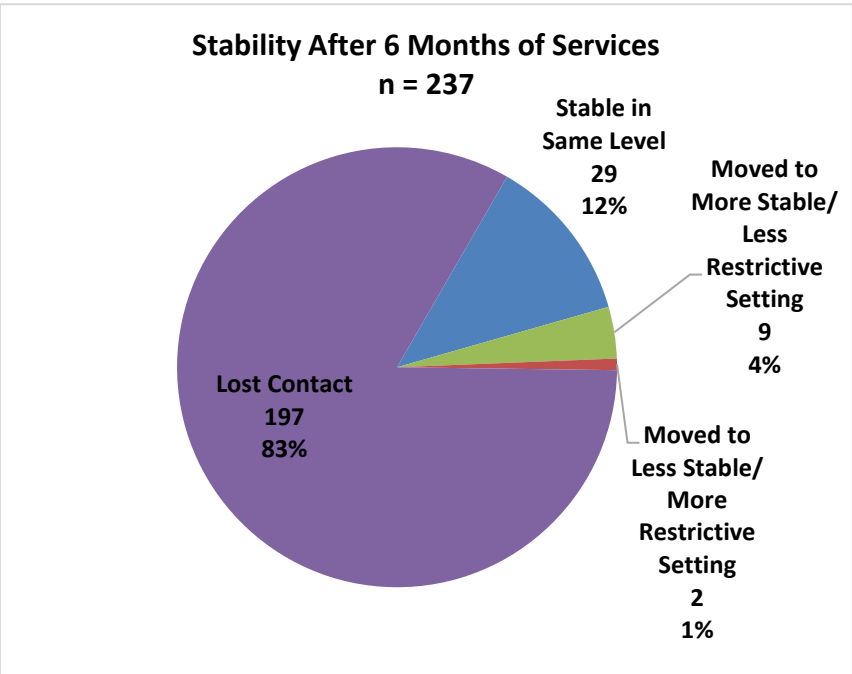




For those who moved to more stable/less restrictive settings, 1 transitioned from Homeless/E.S. to General Living, 1 from Homeless/E.S. to Supervised Placement, and 1 from Residential Program to General Living.

For the 2 people who moved to a less stable/more restrictive setting, 1 transitioned from General Living to Supervised Placement, and 1 from Residential Program to Supervised Placement.

## HOUSING STABILITY 6 MONTHS AFTER SERVICES AT THE CARE CENTER



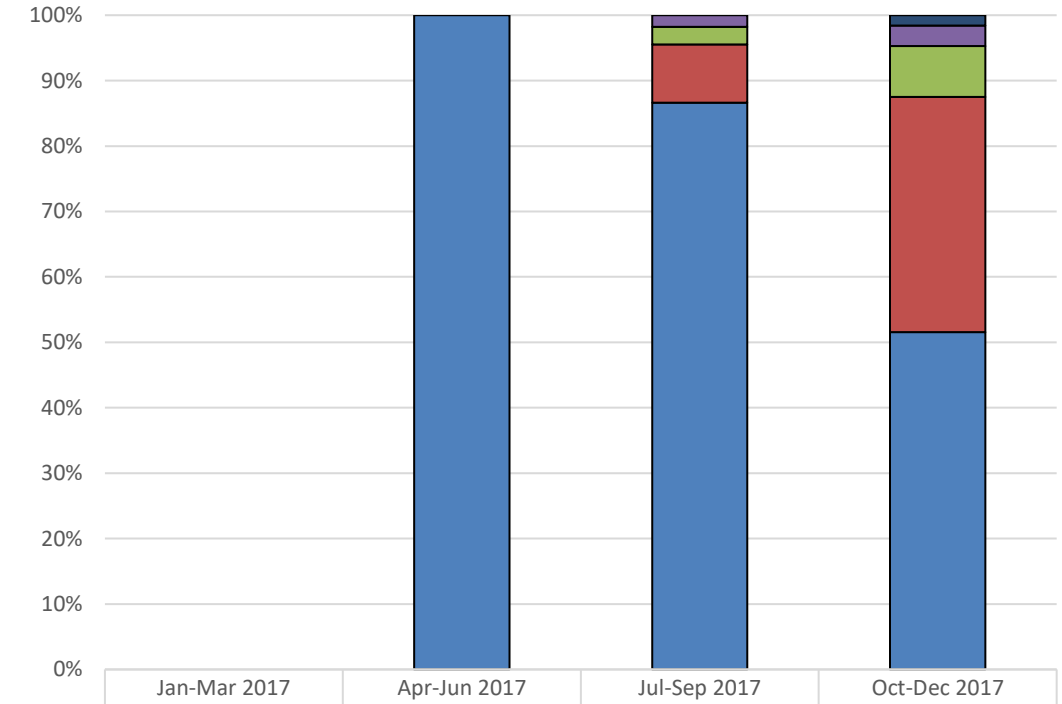

For those who moved to more stable/less restrictive settings, 8 transitioned from Homeless/E.S. to General Living, and 1 transitioned from Homeless/E.S. to Supervised Placement.

For the 2 people who moved to a less stable/more restrictive setting, one transitioned from General Living to Homeless/E.S. and the other from General Living to Supervised Placement.

## EMERGENCY DEPARTMENT VISITS

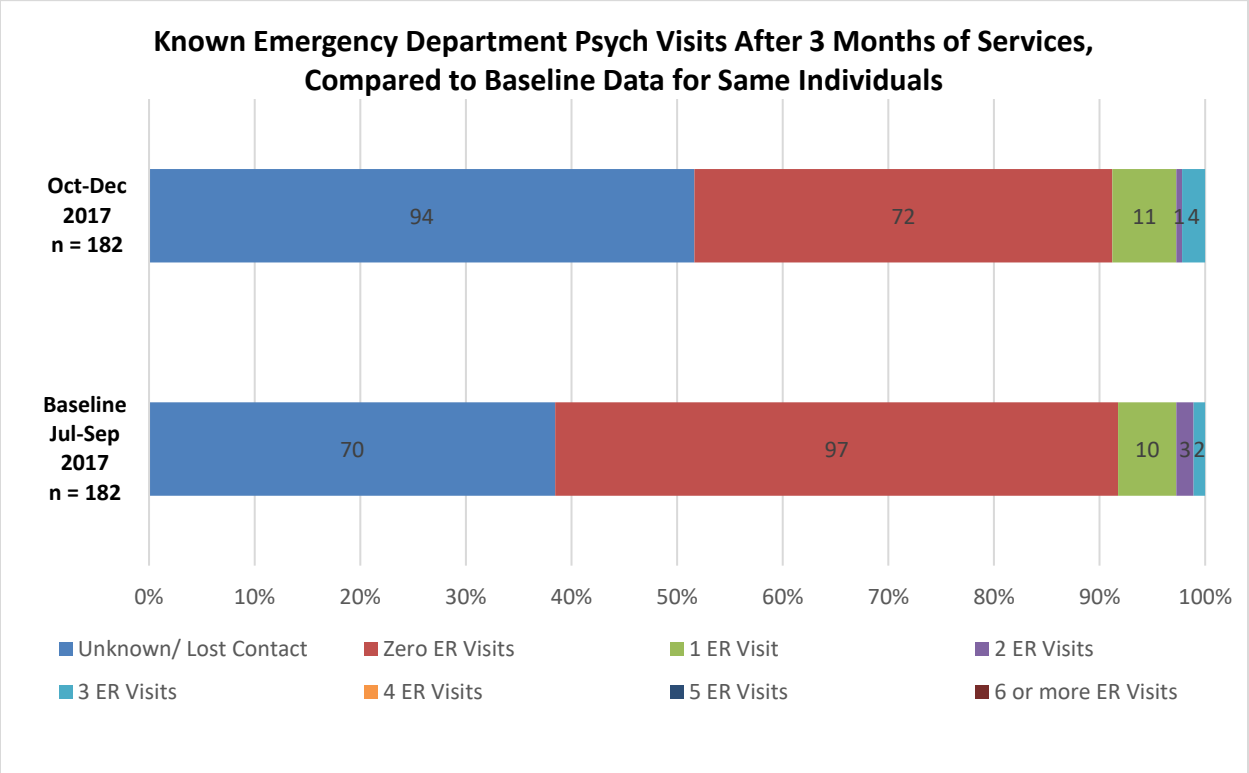
One of the goals of the Innovation Project is to reduce the number of emergency department visits for psychiatric reasons. Statistics are being tracked directly from the hospitals, but to measure the impact and effectiveness for individuals, the CARE Center has been asked to track the number of ER visits individuals report having made in the 6 months prior to the time they first start services at the CARE Center, and then at the 3-month and 6-month points after that first service. The target outcome numbers are to see a 15% decrease in ER visits at the 3-month mark, and a 20% decrease at the 6-month mark.

## BASELINE EMERGENCY DEPARTMENT PSYCHIATRIC VISITS – PRIOR TO CARE CENTER SERVICES

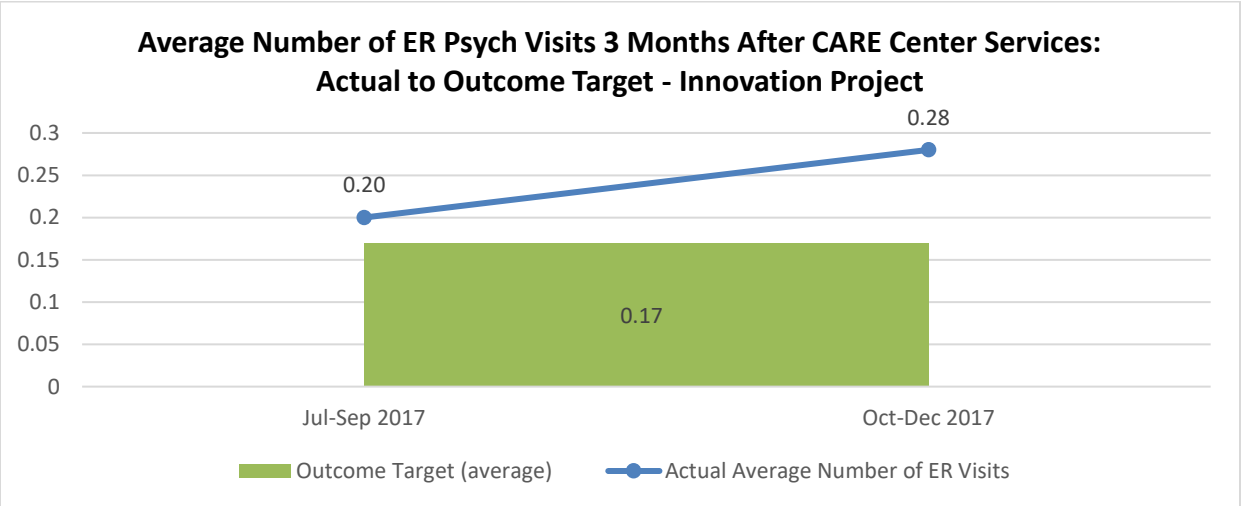



| | Jan-Mar 2017 | Apr-Jun 2017 | Jul-Sep 2017 | Oct-Dec 2017 |
|---|---|---|---|---|
| 6 or more ER Visits | Unable to collect for the 1st quarter | 0 | 0 | 1 |
| 5 ER Visits | | 0 | 0 | 0 |
| 4 ER Visits | | 0 | 0 | 0 |
| 3 ER Visits | | 0 | 2 | 2 |
| 2 ER Visits | | 0 | 3 | 5 |
| 1 ER Visit | | 0 | 10 | 23 |
| Zero ER Visits | | 14 | 97 | 33 |

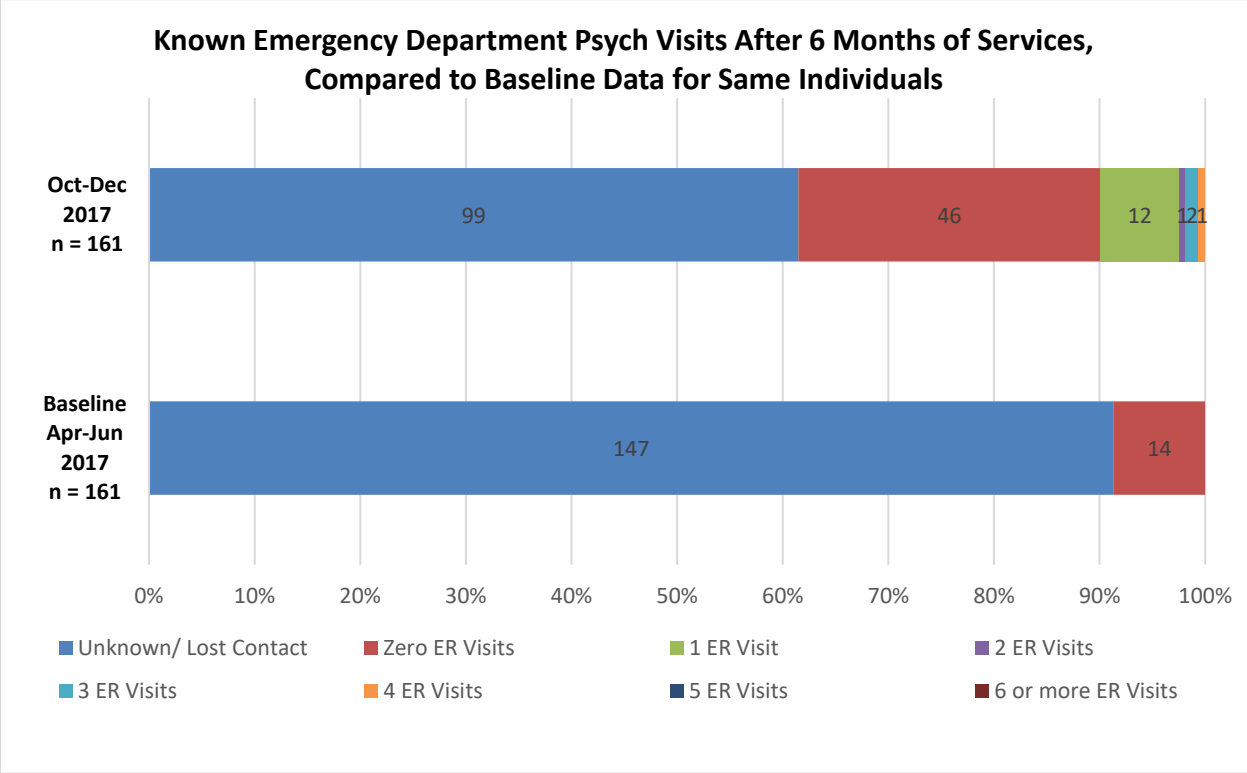
## EMERGENCY DEPARTMENT PSYCH VISITS 3 MONTHS AFTER SERVICES AT THE CARE CENTER



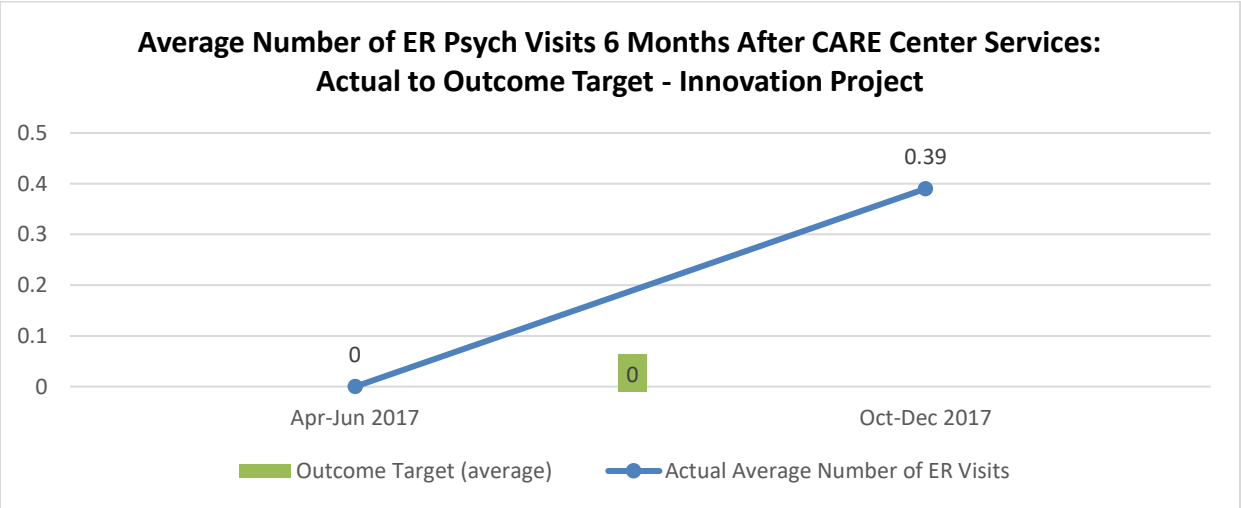

The average number of ER visits in the prior 6 months for the Jul-Sep 2017 quarter was 0.2 per individual who had visit data reported (excluding all in the Unknown/Lost Contact category). This makes the target number for the 3-month mark in the Oct-Dec 2017 quarter 0.17 or fewer ER visits on average.



## EMERGENCY DEPARTMENT PSYCH VISITS 6 MONTHS AFTER SERVICES AT THE CARE CENTER




The average number of ER visits in the prior 6 months for the Apr-Jun 2017 quarter was zero as no individuals had any visits reported. This makes the target number for the 3-month mark in the Oct-Dec 2017 quarter zero ER visits on average as well.

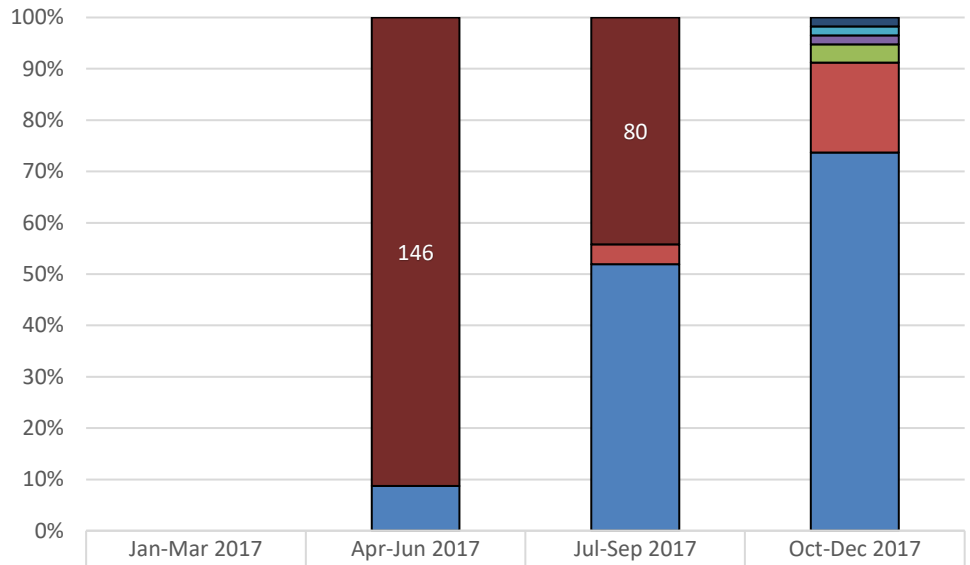


## PSYCHIATRIC INPATIENT HOSPITALIZATIONS

Another goal of the Innovation Project is to reduce the number of psychiatric inpatient hospitalizations, and the number of days spent in the hospital during those hospitalizations. The CARE Center has been asked to track the number of psychiatric inpatient hospitalizations and number of days spent in the hospital that individuals report having made in the 6 months prior to the time they first start services at the CARE Center, and then at the 3-month and 6-month points after that first service. While the number of hospitalizations can be tracked, getting an accurate count for number of days has proven to be extremely problematic, given both the mental status of the people being served, and the short, intensive time-limited duration of the services being provided. Due to this, only the numbers of hospitalizations will be tracked. The target outcome number is to see a 15% decrease in hospitalizations at the 3-month mark, and a 20% decrease at the 6-month mark.

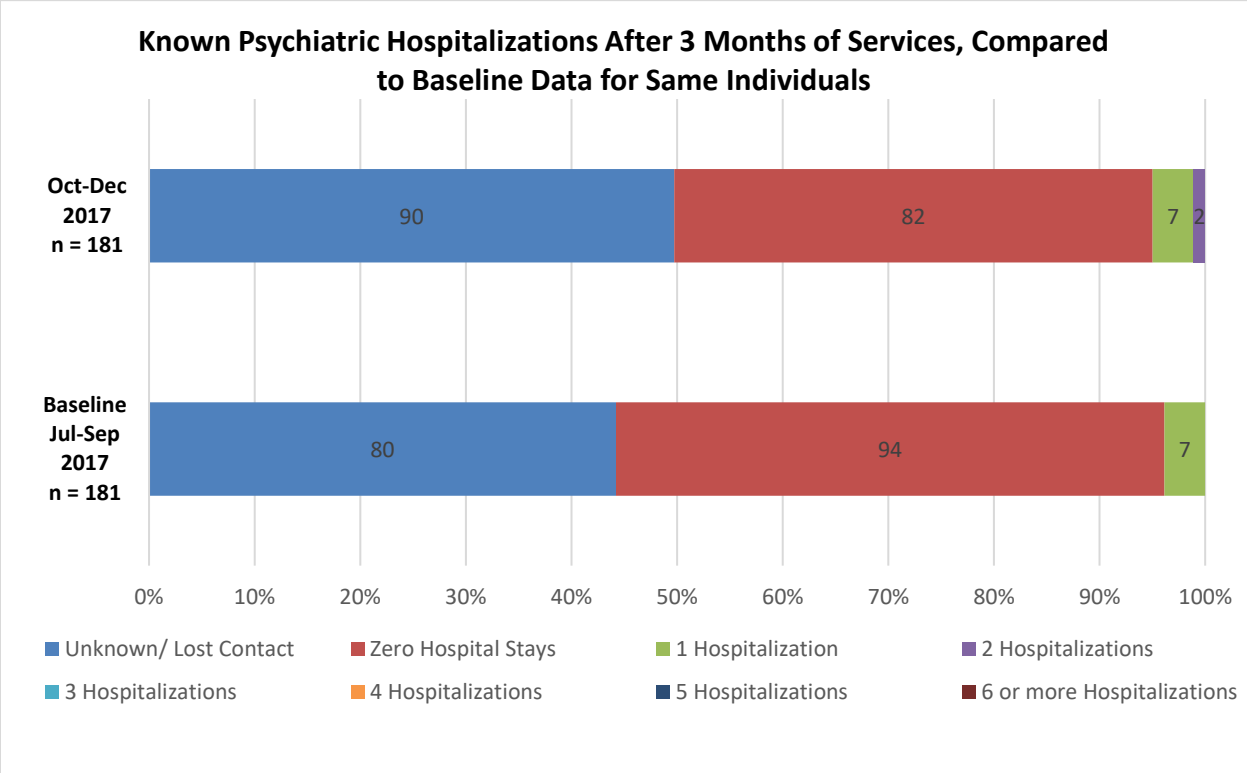
## BASELINE PSYCHIATRIC HOSPITALIZATIONS – PRIOR TO CARE CENTER SERVICES

**Unique Individuals by Number of Psychiatric Hospitalizations in 6 Months Prior to CARE Center Services - Innovation Project**

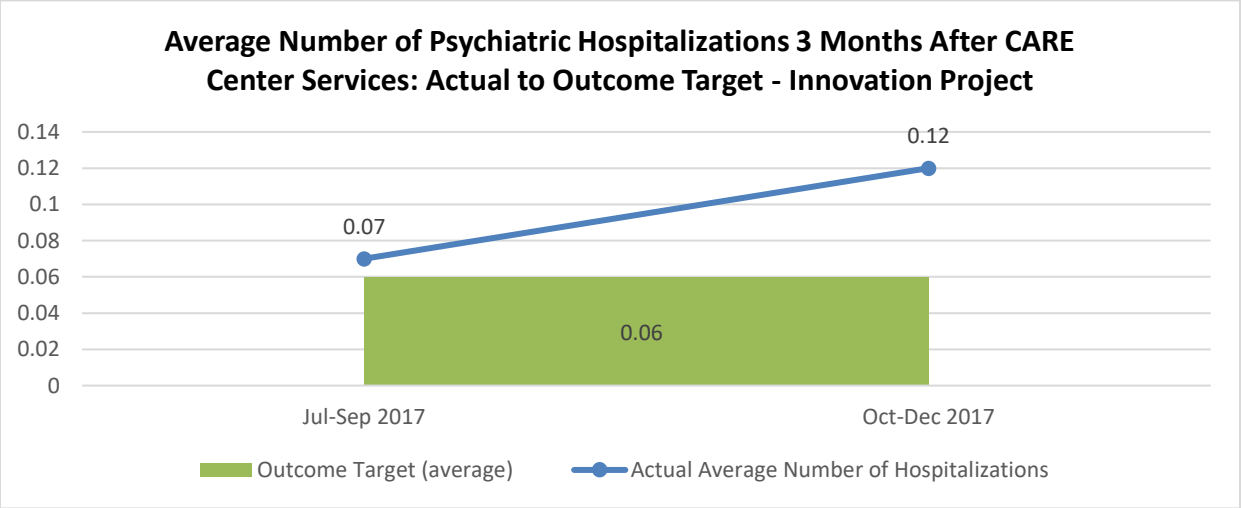



| | Jan-Mar 2017 | Apr-Jun 2017 | Jul-Sep 2017 | Oct-Dec 2017 |
|---|---|---|---|---|
| Unknown | | 146 | 80 | 0 |
| 6 or more Hospitalizations | | 0 | 0 | 1 |
| 5 Hospitalizations | Unable to collect for the 1st quarter | 0 | 0 | 0 |
| 4 Hospitalizations | | 0 | 0 | 1 |
| 3 Hospitalizations | | 0 | 0 | 1 |
| 2 Hospitalizations | | 0 | 0 | 2 |
| 1 Hospitalization | | 0 | 7 | 10 |
| Zero Hospital Stays | | 14 | 94 | 42 |

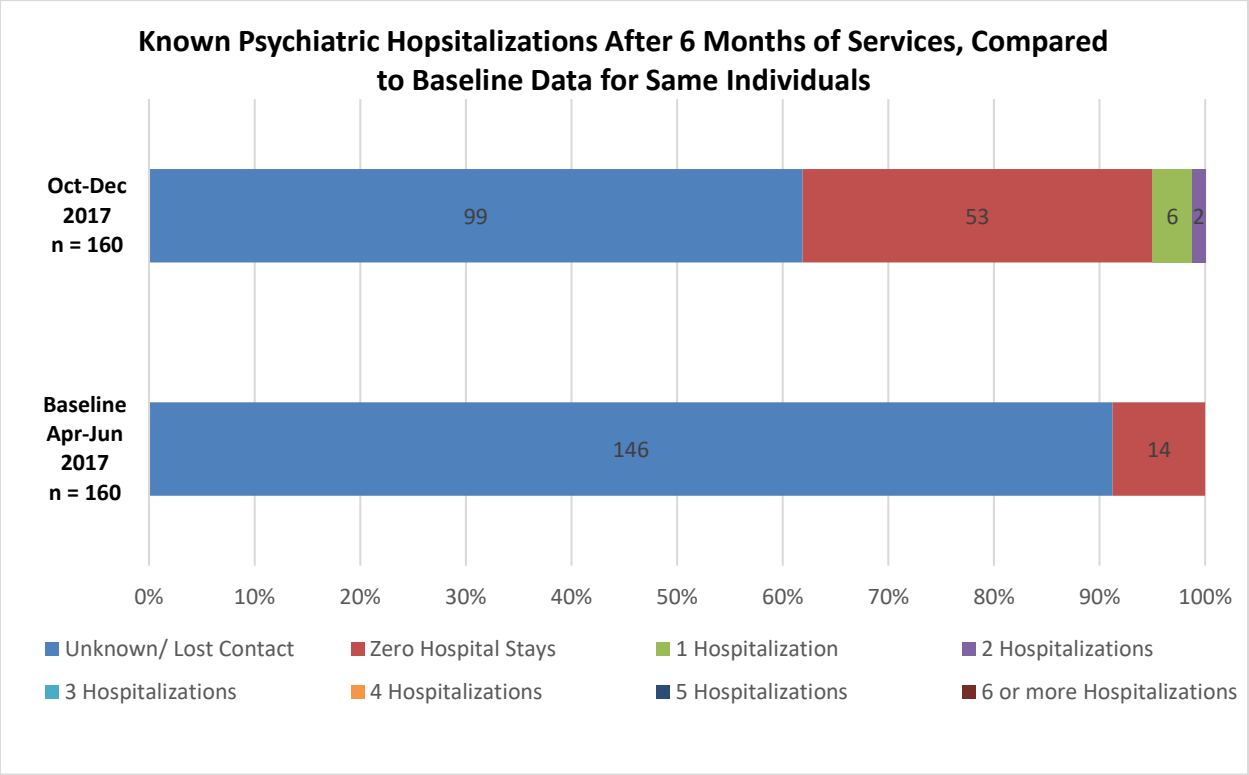
## PSYCHIATRIC HOSPITALIZATIONS 3 MONTHS AFTER SERVICES AT THE CARE CENTER



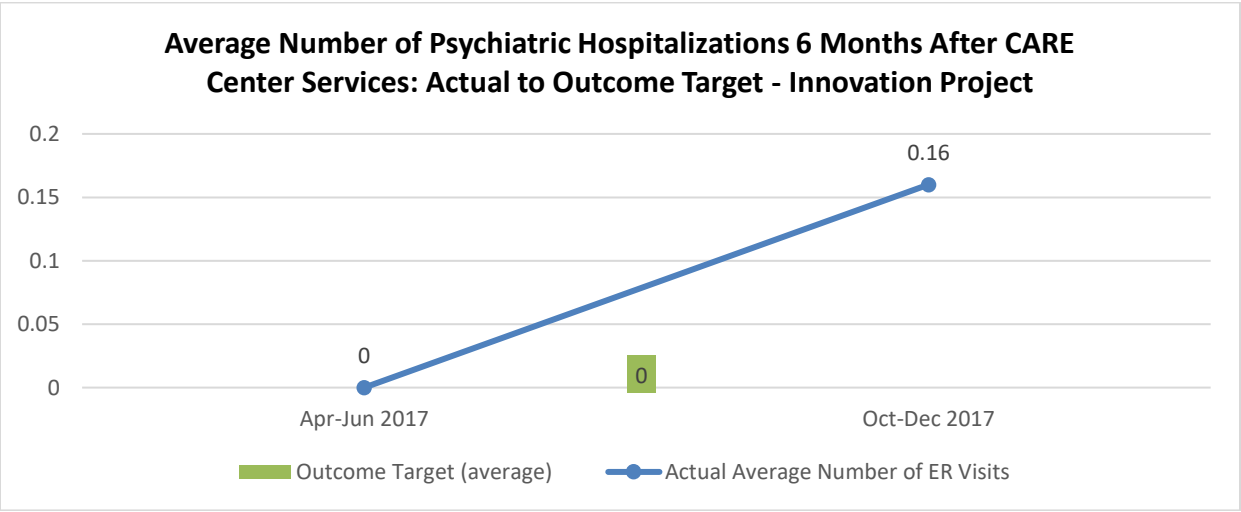

The average number of psychiatric hospitalizations in the prior 6 months for the Jul-Sep 2017 quarter was 0.07 per individual who had any hospitalizations. This makes the target number for the 3-month mark in the Oct-Dec 2017 quarter 0.06 or fewer hospitalizations on average.



## PSYCHIATRIC HOSPITALIZATIONS 6 MONTHS AFTER SERVICES AT THE CARE CENTER



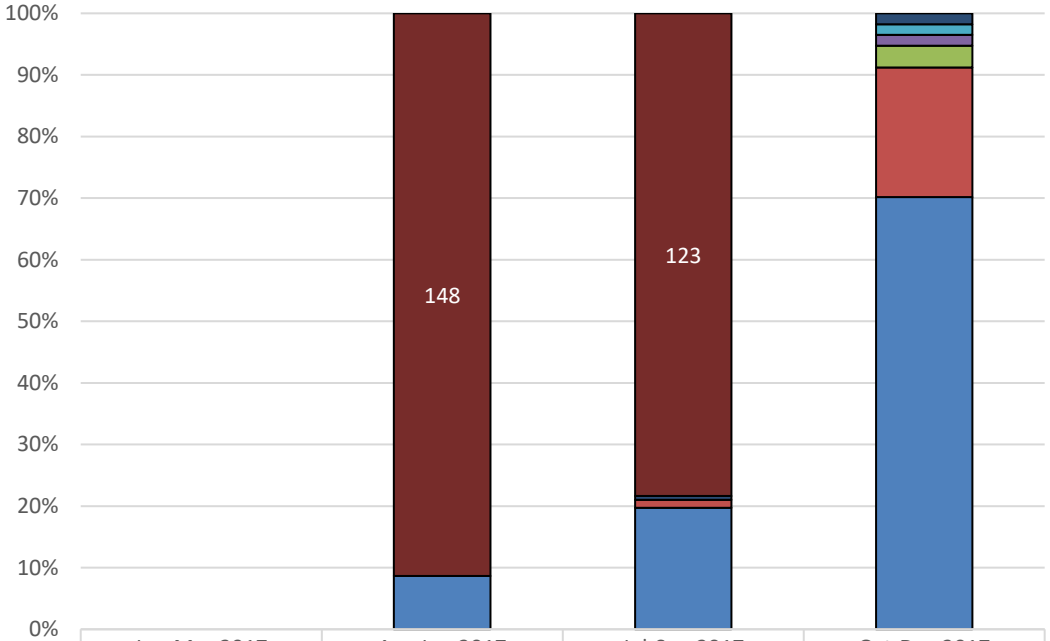

The average number of psychiatric hospitalizations in the prior 6 months for the Apr-Jun 2017 quarter was zero as no individuals had any hospitalizations reported. This makes the target number for the 3-month mark in the Oct-Dec 2017 quarter zero ER visits on average as well.



## ARRESTS

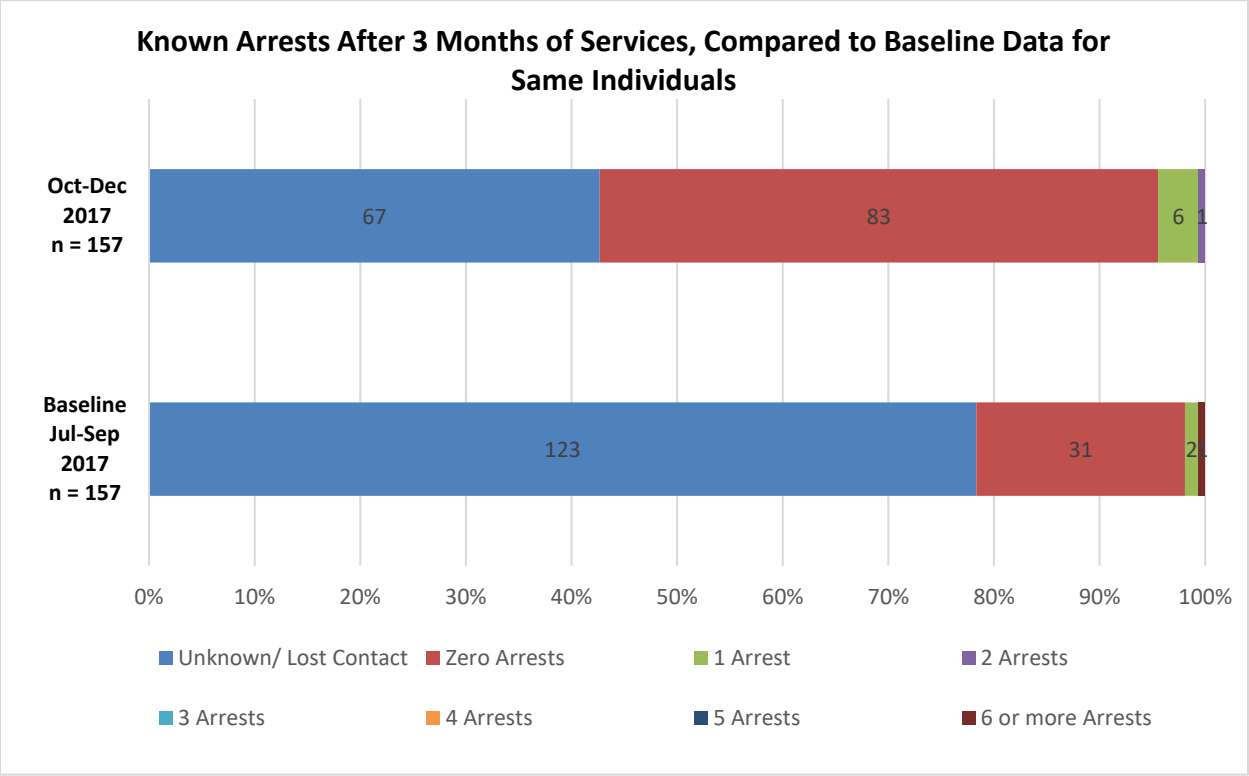
Another goal of the Innovation Project is to reduce the number of arrests, and the number of days spent incarcerated. The CARE Center has been asked to track the number of arrests and number of days spent incarcerated that individuals report having made in the 6 months prior to the time they first start services at the CARE Center, and then at the 3-month and 6-month points after that first service. However, as mentioned in the above section, while the raw number of times arrested is generally available, getting an accurate count of the number of days incarcerated at each arrest has proven problematic. Due to this, only the number of arrests will be tracked. The target outcome numbers are to see a 15% decrease in arrests at the 3-month mark, and a 20% decrease at the 6-month mark.

## BASELINE ARRESTS – PRIOR TO CARE CENTER SERVICES

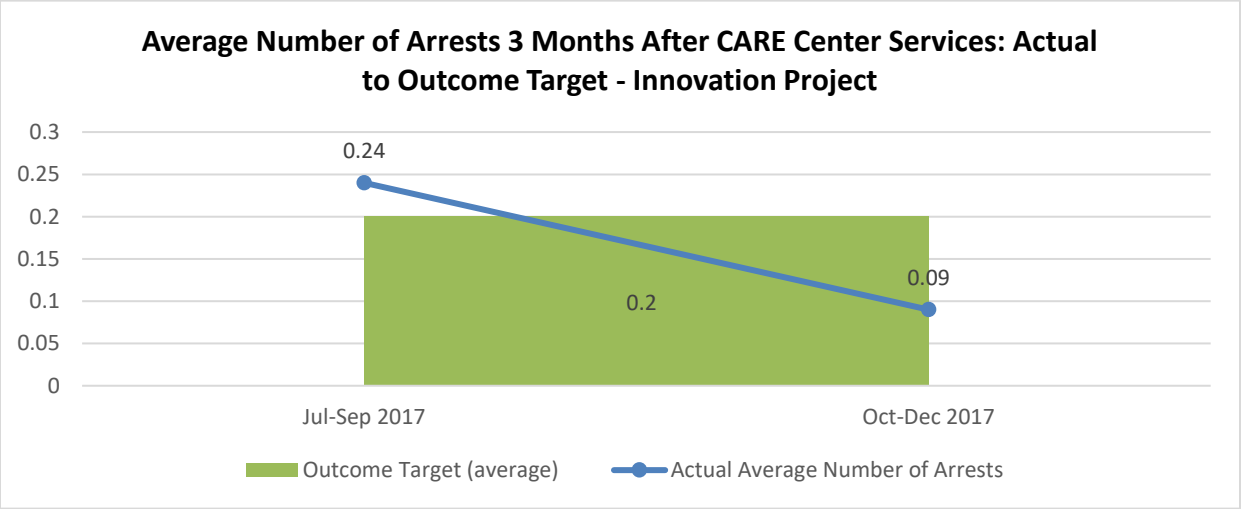



| | Jan-Mar 2017 | Apr-Jun 2017 | Jul-Sep 2017 | Oct-Dec 2017 |
|---|---|---|---|---|
| Unknown | | 148 | 123 | 0 |
| 6 or more Arrests | | 0 | 1 | 1 |
| 5 Arrests | Unable to collect for the 1st quarter | 0 | 0 | 0 |
| 4 Arrests | | 0 | 0 | 1 |
| 3 Arrests | | 0 | 0 | 1 |
| 2 Arrests | | 0 | 0 | 2 |
| 1 Arrest | | 0 | 2 | 12 |
| Zero Arrests | | 14 | 31 | 40 |

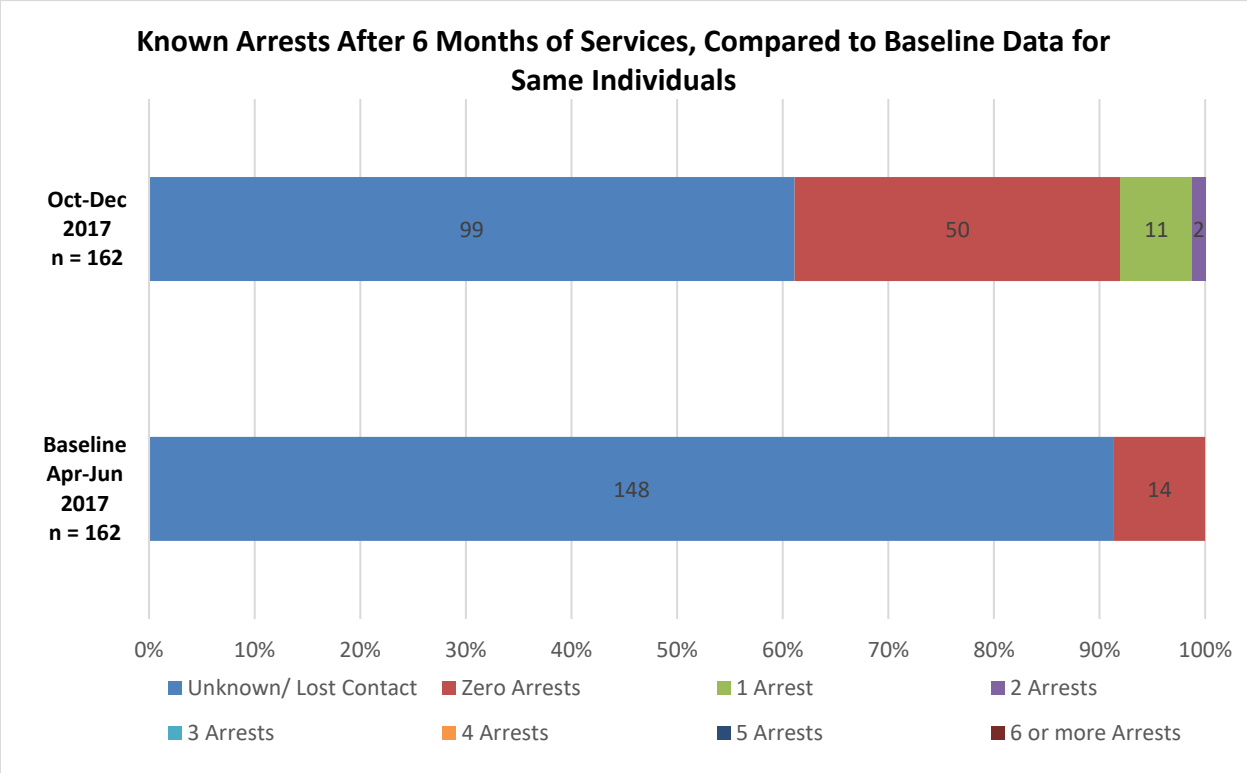
## ARRESTS 3 MONTHS AFTER SERVICES AT THE CARE CENTER



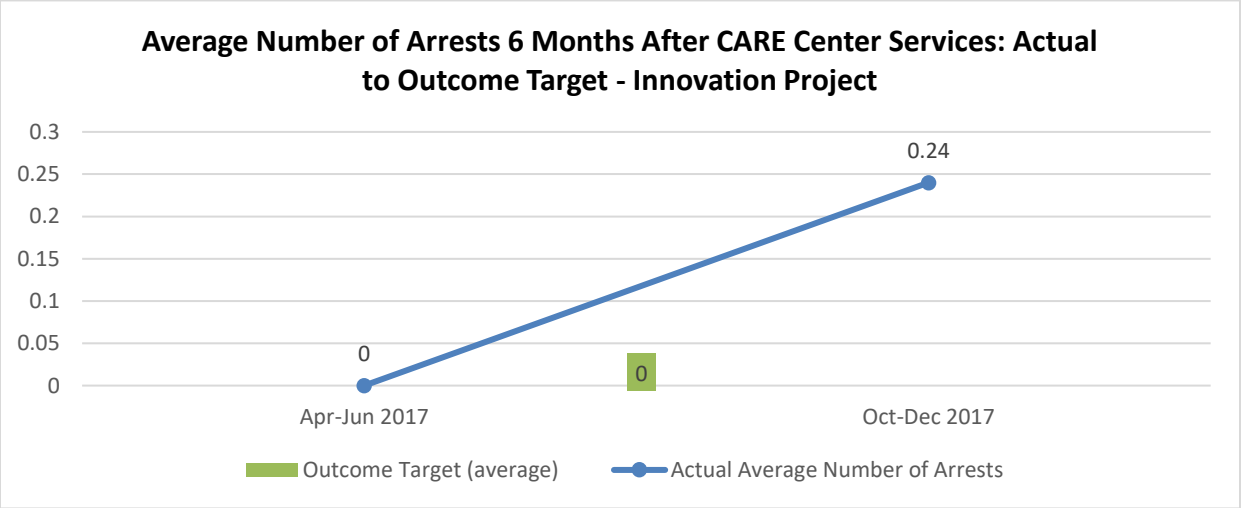

The average number of arrests in the prior 6 months for the Jul-Sep 2017 quarter was 0.24 per individual who had arrest data reported (excluding all in the Unknown/Lost Contact category). This makes the target number for the 3-month mark in the Oct-Dec 2017 quarter 0.20 or fewer arrests on average.



## ARRESTS 6 MONTHS AFTER SERVICES AT THE CARE CENTER

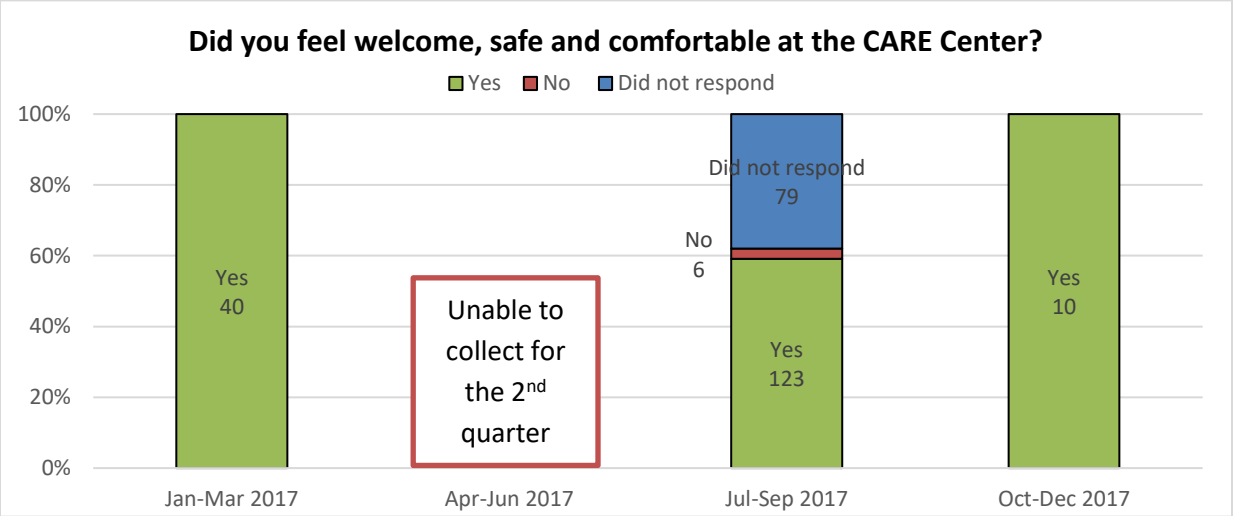


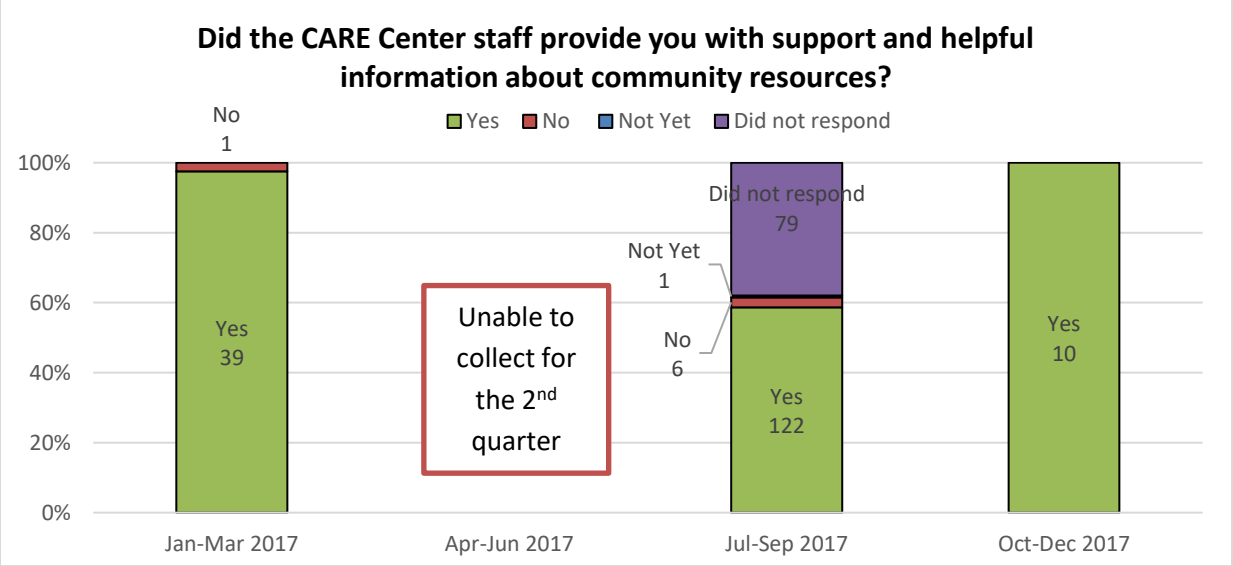

The average number of arrests in the prior 6 months for the Apr-Jun 2017 quarter was zero as no individuals had any arrests reported. This makes the target number for the 3-month mark in the Oct-Dec 2017 quarter zero arrests on average as well.

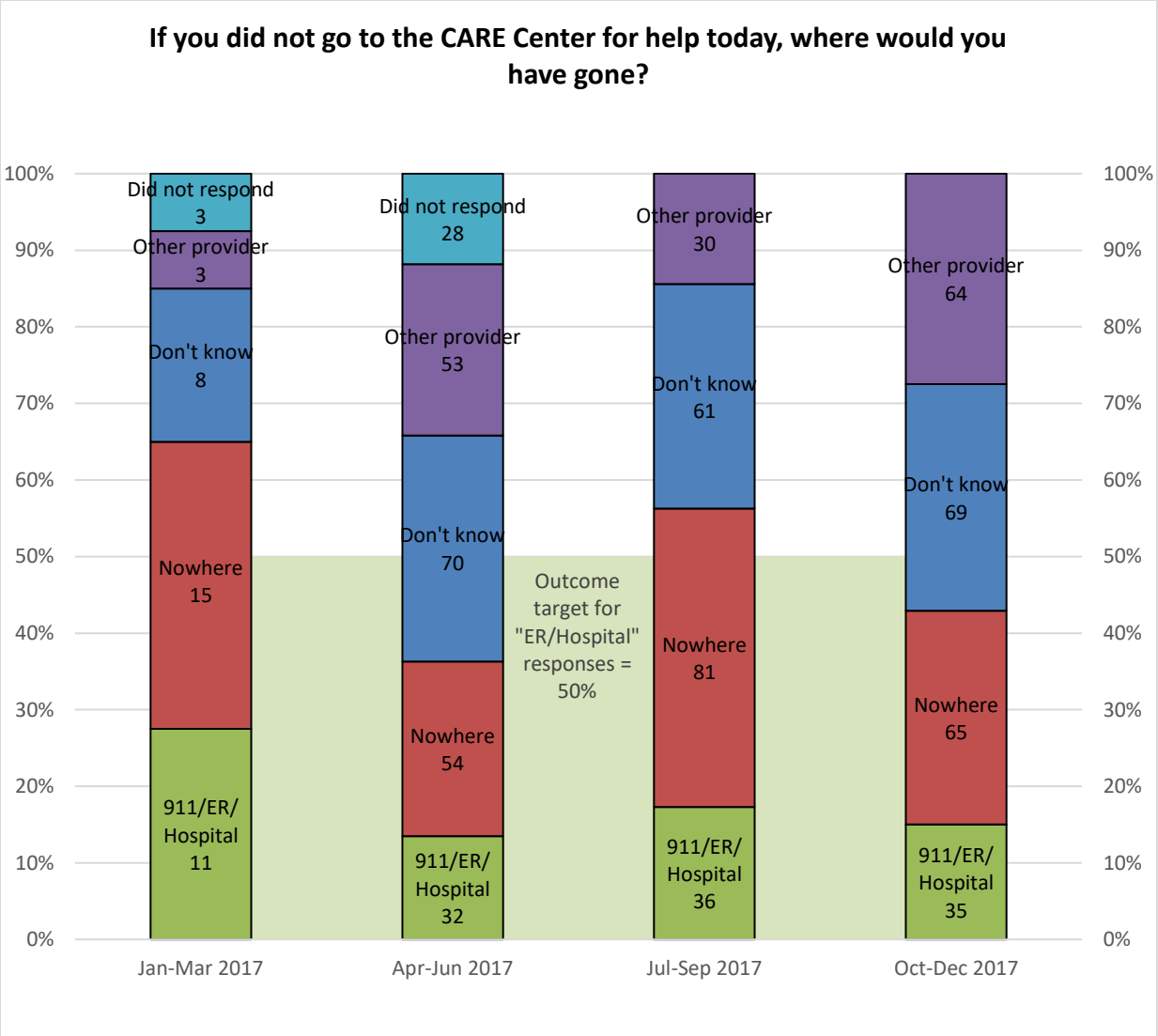


## CUSTOMER SURVEYS

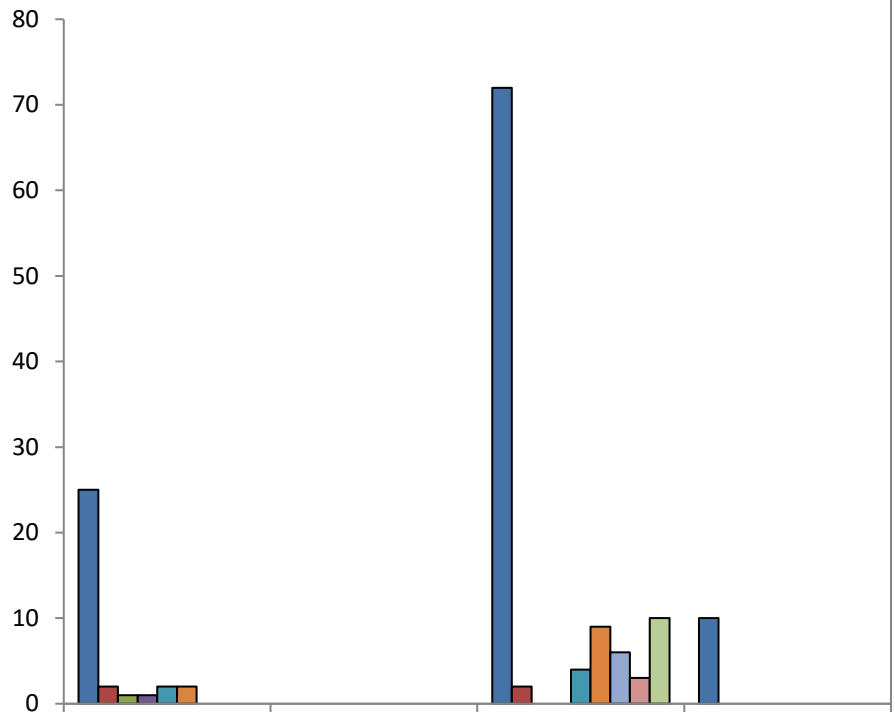
In the first quarter, each person served was offered the chance to complete a simple 4-question survey. Survey changes were made in the second quarter, and not all data points are available. Full survey results were again available in Jul-Sep 2017 quarter and moving forward.




If you did not go to the CARE Center for help today, where would you have gone?
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Did not respond 3
Other provider 3
Don't know 8
Nowhere 15
911/ER/ Hospital 11
Did not respond 28
Other provider 53
Don't know 70
Nowhere 54
911/ER/ Hospital 32
Other provider 30
Don't know 61
Nowhere 81
911/ER/ Hospital 36
Other provider 64
Don't know 69
Nowhere 65
911/ER/ Hospital 35
Outcome target for "ER/Hospital" responses = 50%
Jan-Mar 2017
Apr-Jun 2017
Jul-Sep 2017
Oct-Dec 2017

**Was there something you were hoping for from the CARE Center that you did not receive, or what can we do better?**




| | Jan-Mar 2017 | Apr-Jun 2017 | Jul-Sep 2017 | Oct-Dec 2017 |
|---|---|---|---|---|
| Happy with experience/ services | 25 | | 72 | 10 |
| Medication | 2 | | 2 | 0 |
| Dental Care | 1 | | 0 | 0 |
| Services for alcoholics in crisis | 1 | | 0 | 0 |
| More and/or different groups | 2 | | 4 | 0 |
| Other facility amenities (music, TV, coffee, snacks etc.) | 2 | | 9 | 0 |
| More staff/ better trained staff | 0 | | 6 | 0 |
| Food & clothing | 0 | | 3 | 0 |
| Other | 0 | | 10 | 0 |

Unable to collect for the 2nd quarter