

Santa Barbara County  
Department of Behavioral Wellness  
Strategic Plan: Prioritization of Departmental Objectives  
2016-2018

## Introduction

The Behavioral Wellness Office of Quality Care and Strategy Management is pleased to share a draft *Strategic Plan: Prioritization of Department Objectives, 2016-2018*. Each section represents a synthesis of 20 documents created between 1998 and 2015, many of which were subject to a variety of stakeholder processes. A list of the documents consulted appears on the last page of this document.

Please also note that:

- We have grouped major goals and objectives under eight broad strategic initiatives that could be carried into the future.
- This format was inspired by the excellent work created by San Mateo County Behavioral Health, but the content is solely based on a review of needs and concerns expressed by stakeholders of Santa Barbara County over a number of years.
- For each potential initiative, we include a description of the challenge addressed, followed by a series of suggested measurable activities and deadlines.
- To ensure accountability and follow-up, implementation of each activity would be assigned to one or more of the staff persons listed on the next page.
- The number or numbers that follow each activity refer to one or more supporting documents from the list on page 16.

Please don't hesitate to contact me if you have questions, concerns or suggestions.

Sincerely,

Alice Gleghorn, PhD  
Department of Behavioral Wellness Director

Suzanne Grimesey, MFT  
Department of Behavioral Wellness Chief Quality Care and Strategy Officer

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### Why have a Strategic Plan?

- 1) Create a “big picture”/ comprehensive overview of objectives and activities
- 2) Establish priorities and set a well-crafted, practical, and achievable course of action
- 3) Develop long-term monitoring and progress review of large-scale initiatives and activities
- 4) Ensure fidelity of original intent and function of objectives

## Mission

The mission of the Department of Behavioral Wellness is to promote the prevention of and recovery from addiction and mental illness among individuals, families and communities, by providing effective leadership and delivering state-of-the-art, culturally competent services.

## Values

Decisions and service delivery reflect the following values:

- Quality services for persons of all ages with mental illness and/or substance abuse
- Integrity in individual and organizational actions
- Dignity, respect, and compassion for all persons
- Active involvement of clients and families in treatment, recovery, and policy development
- Diversity throughout our organization and cultural competency in service delivery
- A system of care and recovery that is clearly defined and promotes recovery and resiliency
- Emphasis on prevention and treatment
- Teamwork among department employees in an atmosphere that is respectful and creative
- Continuous quality improvement in service delivery and administration
- Wellness modeled for our clients at all levels; i.e., staff who regularly arrive at the workplace healthy, energetic and resilient
- Safety for everyone

## Guiding Principles:

- ❖ **Client & Family-Driven System of Care & Recovery:** Individuals and families participate in decision making at all levels, empowering clients to drive their own recovery.
- ❖ **Partnership Culture:** We develop partnerships with clients, family members, leaders, advocates, agencies, and businesses. We welcome individuals with complex needs, spanning behavioral health, physical health, and substance use disorders, and strive to provide the best possible care.
- ❖ **Peer Employment:** Client and family employees are trained, valued, and budgeted-for in ever-increasing numbers as part of a well-trained workforce.
- ❖ **Integrated Service Experiences:** Client-driven services are holistic, easily accessible, and provide consistent and seamless communication and coordination across the entire continuum of care delivery providers, agencies and organizations.
- ❖ **Cultural Competence, Diversity and Inclusivity:** Our culturally diverse workforce represents this community. We work effectively in cross-cultural situations, consistently adopting behaviors, attitudes and policies that enable staff and providers to communicate with people of all ethnicities, genders, sexual orientations, religious beliefs, and abilities.
- ❖ **Focus on Wellness, Recovery and Resilience:** We believe that people with psychiatric and/or substance use disorders are able to recover, live, work, learn and participate fully in their community.
- ❖ **Strengths-Based Perspective:** Recovery is facilitated by focusing on strengths more than weaknesses, both in ourselves and in our clients.
- ❖ **Fiscal Responsibility:** We efficiently leverage finite resources to provide the highest quality care to our clients, including those whom are indigent.
- ❖ **Transparency and Accountability:** There are no secrets. We do what we say we will do, or we explain why we can't.
- ❖ **Continuous Quality Improvement:** We reliably collect and consistently use data on outcomes in our system of clients and other pertinent populations (such as incarcerated and homeless), as well as data related to perceptions of families, employees, and community-based organizations, to fuel a continuous quality improvement process.

# Departmental Objectives

## Welcoming and Engagement

### W&E

Welcoming &  
Engagement

#### TriWest Area(s) and Findings:

##### Systemic

S-1: A Dysfunctional  
ADMHS  
Organizational  
Climate

#### Objective Leads

April Howard  
Pam Fisher  
Ana Vicuña  
Celeste Andersen  
Suzanne Grimmesey

#### Challenge:

Over the years some clients and family members have expressed dissatisfaction with experiences at Behavioral Wellness service sites. Hurried personnel, confusing processes, inconsistency and unwelcoming physical environments are among the problems that have been identified.

#### Strategy:

Create new policies, procedures, manuals and trainings to increase welcoming and engagement. Simplify navigation and ensure a seamless system of service delivery.

#### Phase 1 Activities (July 2016-December 2016):

- Complete standardization and full implementation of weekly client orientation groups by 12/31/16 (AH, AV, CRa, SF, AP).
- Create the operational manual to support a welcoming and engagement plan 12/1/16 (PF, YM, AV; 1a,2,5,6,7,8,9,14,15).
  - *Team Based Care*
  - *Practice Guidelines*
  - *Handling urgent needs*
- Hire 3 part-time extra help recovery assistants (1 for each region) that function as consumer and family peer navigators by 12/31/16 (PF, TW; 1a,6,7,9,11,14).
- Train system to the “Accessing a Welcoming and Integrated System of Care and Recovery” policy by 10/1/16 (CA, AV, YM).
- Review and modify all Behavioral Wellness client notices, informational brochures, outreach materials and the web site to ensure that communications are clear, use plain language and are translated in Spanish to the fullest extent possible by 12/1/16 (SG, EB, YM; 1a,5,7,8,9).

#### Phase 2 Activities (January 2017-June 2017):

- Implement approved welcoming and engagement policies by 2/1/17 (PF; 1a,2,5,6,7,8,9,14,15).
- Conduct mandatory annual staff trainings on welcoming and engagement by 5/1/17. (TL; 1a, 2,3,5,6,7,8,9,14,15).

#### Key Indicators of Success:

- Improved consumer and family member satisfaction with navigating the system
- Consumers and family members will be better informed about accessing services
- Behavioral Wellness will have a clear policy on how consumers are welcomed into the system and directed to appropriate levels of care
- Expanded consumer and family member peer support for clients countywide
- All staff will be trained to the Accessing and Welcoming an Integrated System of Care and Recovery
- Annual mandatory trainings will be provided on welcoming and engagement

# Increasing Access to Assessment, Treatment and Referrals

## IA

### Increasing Access to Assessment, Treatment and Referrals

#### TriWest Area(s) and Findings:

##### Systemic

S-3: There is a profound lack of effectively organized clinical leadership within ADMHS, and a consequent lack of clinical support to financial and compliance functions.

##### Clinical

CO-2.2: Access to care in general is inadequate and decreasing over time.

CO-2.5: Access to specialized supports for people with complex needs is lacking.

CO-2.7: Access to psychiatry services is lacking.

#### Objective Leads

April Howard  
Ana Vicuña  
Suzanne Grimmesey  
Ole Behrendsten  
Christine Cole  
Marshall Ramsey

#### Challenge:

A variety of factors contribute to a behavioral health system that offers uneven access to services, including a lack of standardization across regions, inadequate specialized supports for people with complex needs, and barriers to timely access to psychiatric appointments.

#### Strategy:

Major improvements will result from the implementation of team-based care; public information campaigns; streamlined screening and centralized appointment scheduling; and the development of system tools that accurately capture and measure wait times for care.

#### Phase 1 Activities (July 2016-December 2016):

- Complete implementation of regional team-based care by 8/1/16 (AH, AV, CRa, SF, AP; 1a,3,4,7,10,12).
- Standardization of Team Based Care by 10/31/16
- Assess wait times from date of request to service to first offered assessment appointment to first actual appointment. By doing so, reduce the wait time to first team-based appointment as evidenced in system data reports by 10/1/16 (AV, CC, MR; 1a,3,12).
- Standardization of Orientation groups by adult clinics and children's clinics 11/30/16
- Complete standardization of team-based care model by 10/31/16.

#### Phase 2 Activities (January 2017-June 2017):

- Create and implement effective staff and stakeholder public awareness campaigns that explain how the new access, assessment, referral and linkage system works. Outreach efforts will focus on Latino families, public school students, teachers, transition age youth and primary care physicians, AOT. Campaign implementation will occur by 1/31/17 (SG, EB, YM; 1a,4,5,7,9,12).
- Development a measurement tool to assess wait times from date of referral to first psychiatrist appointment. By doing so, reduce the wait time to see a psychiatrist. To be completed by 1/31/17 (AV, OB; 1a,3,12).

#### Phase 3 Activities (July 2017-December 2017):

- Implement the use of a pre-consumer screening tool and establish a centralized access screening and appointment scheduling function within QCM 10/1/16 (CC, AV, SG; 1a).
- Implement the use of pre-consumer screening tool to establish a centralized access screening and appointment scheduling function for SUD 7/1/17
- Modify or create assessment tools that are culturally competent and recovery-based by 12/1/17 (AV, DH, YM, EG; 1a,3,7,12). Update APA and expand to the 16 modules to be completed and data collected-

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#### Objective Leads

April Howard

Ana Vicuña

Suzanne Grimesey

Ole Behrendsten

Christine Cole

Marshall Ramsey

#### Key Indicators of Success:

- Improved client outcomes through implementation of regional team-based care
- Increased public awareness about accessing behavioral health services, particularly in the Latino community
- Increased engagement of underserved and unserved communities
- Improved capability in the IT system to more precisely measure wait times for care
- Reduction in the wait time for adult and child psychiatric appointments
- Reduction in wait time from referral to first team-based care appointment
- Clinical assessment tools revised to adequately respond to the diverse behavioral health client and community populations of Santa Barbara County

# Enhancing Innovation, Collaboration and Integration

## IC&I

Enhancing  
Innovation,  
Collaboration &  
Integration

### TriWest Area(s) and Findings:

#### Systemic

S-2: ADMHS lacks effective empowered partnerships to help it articulate a core vision and improve system level performance and outcomes through mission-driven continuous improvement.

#### Clinical

CO-2.5: Access to specialized supports for people with complex needs is lacking.

CO-2.6: Collaboration is better for the Alcohol and Drug Program (ADP), but access is lacking in key areas.

### Objective Leads

Ana Vicuña  
Yaneri Muñoz  
Elisa Gottheil  
John Doyel  
Suzanne Grimesey

### Challenge:

In 2013, the TriWest Group found that “[Behavioral Wellness] lacks effective empowered partnerships to help it articulate a core vision and improve system level performance and outcomes through mission-driven continuous improvement.”

### Strategy:

Advance the integration of alcohol/drug, mental health and primary care services. Create a culture of collaboration and innovation by using and publicizing successful continuous quality improvement (CQI) activities.

### Phase 1 Activities (July 2016-December 2016):

- Determine the core functions of the medical integration teams by 8/1/16 (AV; 4,8,7,9,12).
- Determine the core functions of the co-occurring disorder teams for both adult and TAY program by 8/1/16 (AV).
- Develop medical integration and COD operational guidelines and complete training of staff in three service sites by 12/1/16 (YM, EG; 3,4,7,8,9,10,12,14, 17,18,19).
- Train *Living in Balance* as the standardized curriculum for the three co-occurring disorders (COD) sites by 12/31/16 (AV; 3,4,7,8,9,10,12,14,17,18,19).
- Enhance and begin monitoring new medical integration programs at three adult service sites by 10/31/16 (AV; 4,8,7,9,12).
- Enhance and begin monitoring COD teams at the three adult service sites by 8/1/16 (AV; 3,4,7,8,9,10,12,14,17,18,19).
- Complete first draft of the Drug Medi-Cal Organized Delivery System (DMC-ODS) Implementation Plan by 8/1/16 (JD).
- Present DMC-ODS draft plan to the Board of Supervisors by 12/6/16. The draft DMC-ODS plan will be submitted to DHCS for approval immediately following BOS approval (JD).

### Phase 2 Activities (January 2017-June 2017):

- In accordance with ODS requirements, provide differential diagnosis training for all mental health clinicians and initiate formal training for alcohol and drug staff in mental health conditions by 1/31/17 (EG,3,4,7,8,9,10,12,14,17,18,19).
- Complete training of all team supervisors and program managers in continuous quality improvement (CQI) techniques by 1/31/17 (SG,1,3,4,5,7,8,9,10,12).
- Implement the DMC-ODS Waiver county-wide by 6/30/17 (JD).



# Enhancing Innovation, Collaboration and Integration

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### Objective Leads

Ana Vicuña  
Yaneri Muñoz  
Elisa Gottheil  
John Doyel  
Suzanne Grimesey  
Deana Huddleston

### Key Indicators of Success:

- Development of operational guidelines that detail team-based care descriptions, roles and functions for the medically integrated and co-occurring teams.
- Implementation of Living in Balance curriculum in Co-Occurring Disorder teams.
- Development of plan to evaluate effectiveness of Medically Assisted Treatment (MAT)
- Improved response to consumers with physical health conditions and those with co-occurring substance abuse and mental health conditions
- Organized Delivery System (ODS) plan approved by DHCS and implemented county-wide
- Increased number of continuous quality improvement (CQI) activities
- Improved staff skills for differential diagnoses of mental illness/substance use disorders

# Supporting Prevention and Early Intervention

## PEI

### Supporting Prevention & Early Intervention

#### TriWest Area(s) and Findings:

##### Clinical

CO-2.4: Detailed clinical policies are lacking to guide routine clinical service delivery, including uniform standards for initial and continued access to care by level of care, standards to guide transitions between levels of care, and functioning of interdisciplinary teams.

#### Objective Leads

April Howard  
Ana Vicuña  
Crystal Ramirez  
John Doyel  
Suzanne Grimmesey

### Challenge:

Expand options for individuals with alcohol, drug and/or mental health conditions to address problems before they become more acute, complex, traumatic and costly. Offer more interventions designed to reduce the “revolving door” of recidivism and re-hospitalization.

### Strategy:

Reduce hospitalization and incarceration through prevention and early interventions that lessen harm and trauma for individuals and free up scarce behavioral health resources needed by persons with acute needs.

### Phase 1 Activities (July 2016-December 2016):

- Implement 3-4-50 Framework projects targeting tobacco cessation, sedentary lifestyle, and nutrition by 12/31/16 (AH, AV, CRa). Through this process, a menu of activities will be developed which can be used by Supervisors to individualize per client and team need.
- Continue implementing the 2012-2017 Behavioral Wellness Alcohol and Drug Program AOD Strategic Prevention Plan and issue annual progress reports to the Executive Team, Steering Committee and Mental Health Commission beginning 12/1/16 (JD, 4,13,19).

### Phase 2 Activities (January 2017-June 2017):

- Create Crisis Triage program manuals and provide staff training by 4/1/17 (AV, TL 3,4,10,12,18).
- Increase awareness of mental health and substance use issues through community wellness screenings, community events and outreach initiatives (i.e. May Mental Health Awareness Month) (ongoing) (SG).
- Ensure an AOD component in community awareness activities that include Mental Health Awareness Month, Recovery Happens Month, Red Ribbon Month, Alcohol Awareness Month, etc. (ongoing) (JD).
- Incorporation of SBIRT into outreach/education and awareness activities such as education at table events, community speaking/education (ongoing) (JD).

### Phase 3 Activities (July 2017-December 2017):

- Determine if Anka Crisis Residential has an adequate program manual and modify it as needed by 4/1/17 (AV, YM, TL, EG, 3,4,10,12,18).
- Provide ongoing support to First Episode Psychosis (FEP) Outreach and Education project. Complete by 10/1/17 when SAMHSA grant funding ends (SG).

# Supporting Prevention and Early Intervention

## PEI

Supporting  
Prevention &  
Early  
Intervention

### TriWest Area(s) and Findings:

#### Clinical

CO-2.4: Detailed clinical policies are lacking to guide routine clinical service delivery, including uniform standards for initial and continued access to care by level of care, standards to guide transitions between levels of care, and functioning of interdisciplinary teams.

### Objective Leads

April Howard  
Ana Vicuña  
Crystal Ramirez  
John Doyel  
Suzanne Grimesey

## Phase 4 Activities (January 2018-June 2018):

- Establish a collaboration with Glendon Association, Alcohol and Drug Program (ADP) and mental health stakeholders for a Suicide Prevention Campaign. ADP will include information on the influence of AOD on suicides, with possible interventions. Include national database information for this campaign by 2/1/18 (SG, EB, JD).

## Key Indicators of Success:

- Improved health and wellbeing of consumers using the 3-4-50 Framework and tobacco cessation tools
- Increased treatment engagement of Transitional Age Youth experiencing first episode psychosis
- Crisis Triage staff will have clear program procedures and operational standards
- Increased community awareness about behavioral health issues
- Community awareness efforts will include substance use disorders and screening methods
- Implementation of the 2012-2017 Behavioral Wellness Alcohol and Drug Program AOD Strategic Prevention Plan
- Development of Crisis Residential program manuals to ensure consistency in operations, practices and standards
- Increased public awareness efforts related to suicide prevention and the relationship between substance use disorders and suicide

# Empowering Consumers and Families

**EC&F**

Empowering  
Consumers &  
Families

## TriWest Area(s) and Findings:

Systemic  
S-1: A  
Dysfunctional  
ADMHS  
Organizational  
Climate

## Objective Leads

Pam Fisher  
Tina Wooton  
Yaneri Muñiz  
Ana Vicuña  
Elisa Gottheil  
Talia Lozipone  
Alice Gleghorn

## Challenge:

The Mental Health Services Act requires a consumer- and family-driven system based on wellness, recovery and resiliency. According to the evaluation performed by Tri -West in 2013 Behavioral Wellness had few perspectives from people with disclosed lived experience consistently involved in top-level decision-making and no clear blueprint for a transition to a recovery-based service delivery system. Although more peer staff members are being hired, a supportive infrastructure to ensure their success has not been put into place. No safeguards are in place to protect the integrity of the peer support function and prevent peer staff from being converted to “mini-clinicians.”

## Strategy:

Ensure the transition to a recovery model through mandatory staff trainings, policies, procedures and staff manuals, the elevation of peer perspectives in top-level decision-making, a career ladder and formal mentoring program for peer staff.

## Phase 1 Activities (July 2016-December 2016):

- Identify or develop modules of training for peer hired staff with specific content about how to make use of their life experience as part of helping others on the job (WRAP, Nutrition, etc. including prior evidence based curriculum) by 12/31/16 (PF, TW).
- Leadership team to review and update the draft of the Peer Integration Plan including recommendations for implementing a recovery model at Behavioral Wellness by 12/31/16 (PF, TW, 6,7,8,11,12,17).
- Continue implementation of NorCal WISE Project grant to support peer WRAP trainers skill acquisition (e.g. computer skills), conference opportunities and vocational training interests by 12/31/16 (TW, TL).

## Phase 2 Activities (January 2017-June 2017):

- Require a mandatory training for all staff on the recovery model and peer concepts by 3/17/17 (PF, TW, EG, TL). The training will cover the following content (consider Loma Linda SCRIP curriculum):
  - a. Recovery model and concepts
  - b. Peer integration in the workforce
  - c. Ways to increase and gain greater participation of clients and their families in the treatment planning development process
  - d. How to achieve an authentic collaboration between the client and clinician in creating realistic, achievable goals that consolidates the client’s hopes and dreams as well as treatment goals that impact presenting impairments

# Empowering Consumers and Families

## EC&F

Empowering  
Consumers &  
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### TriWest Area(s) and Findings:

Systemic  
S-1: A  
Dysfunctional  
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Tina Wooton  
Yaneri Muñoz  
Ana Vicuña  
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Talia Lozipone  
Alice Gleghorn

## Phase 2 Activities (January 2017-June 2017) *Cont'd*:

- Leadership team to review and update the draft of the peer employment plan that defines job specialization, vocational skills development and training requirements. 3/31/16 (PF, TW).
- Begin implementation of recovery model operational plan by 3/31/17 (PF, TW,6,7,8,11,12,17).
- Work to continue to modify and draft policies and procedures to support implementation of a recovery model at Behavioral Wellness by 6/30/17 (PF, TW, YM 6,7,8,11,12,17).
- Designate Leadership agenda item for input and updates on peer issues to influence major decisions affecting consumers and families *before* the decisions are made 1/31/17 (AG, 6,8,11,12,14,17).

## Phase 3 Activities (July 2017-December 2017):

- Launch of recovery model operational plan by 9/1/17 (PF,TW,6,7,8,11,12,17).
- Expand the hiring of peers so that there is representation in each clinical site by 12/31/17 (PF, TW, KAS).
- Develop and provide peer mentoring opportunities – Ongoing (PF, TW).

## Phase 4 Activities (January 2018-June 2018):

- Report recovery model operational plan including percentage of completion for mandatory training for staff, participation in peer mentoring groups, completed peer training, and the number and sites throughout the system where peers are employed by 1/31/18 (PF, TW, 6,7,8,11,12,17).

## Key Indicators of Success:

- Adoption and integration of the Recovery Model including necessary policy revisions, staff trainings
- Staff trained on peer workplace integration and involvement in client care Peer Employment Plan will be developed and launched
- Peer employees will be more successful in the workplace as a result of NorCal WISE Project grant activities
- Development of policies and operational structure to increase involvement of clients and family members in treatment planning
- Funding approved for additional Peer Expert Pool members
- Development of a peer employment plan
- Implementation of a peer mentoring program
- Increased decision-making role with Leadership Team for the Consumer & Family Member Advisory Committee

# Reducing Disparities

**RD**

Reducing Disparities

## TriWest Area(s) and Findings:

### Clinical

CO-2.3: Despite impressive improvements in the number of bilingual Spanish-speaking staff hired and the number of Latino/Hispanic people served each year, significant disparities related to race, ethnicity and culture persist.

### Objective Leads

Yaneri Muñiz  
Talia Lozipone  
Enrique Bautista

## Challenge:

The Mental Health Services Act requires meeting the needs of un-served and under-served cultural groups and providing culturally competent services. Behavioral Wellness needs to increase attention to gender, faith, veterans, physical disabilities.

## Strategy:

Establish a Cultural Competency Plan focused on system-wide implementation of cultural competency initiatives and standards. Provide updated trainings that create awareness on local issues as well as national diversity trends.

## Phase 1 Activities (July 2016-December 2016):

- With stakeholder input, develop first draft Behavioral Wellness Cultural Competence Plan development by 12/1/16 (YM, 1,4,6,7,8,9,12,14,15,17,20).
- Submit draft for a FY 16-17 Behavioral Wellness Cultural Competence Plan by 10/31/16. (YM, 1,4,6,7,8,9,12,14,15,17,20)
- Analyze existing cultural competence trainings to identify gaps in knowledge and understanding of local cultural groups in Santa Barbara y Relias by 12/31/16 (YM, TL).
- Obtain approval for MHSA-Innovation Evidence Based Practices/Cultural Adaptation Project by 12/31/16 (CRo, 1a,3,9,10,12,15).
- Ensure equal access to care for limited English proficiency (LEP) clients through contracts with interpreters. Target underserved communities with significant language barriers such as the Mixtec community in Santa Maria by 11/15/16. (YM)
- Acknowledge local culture-specific holidays countywide (ongoing) (YM).
- Develop criteria and categories for identification of Behavioral Wellness bilingual/bicultural civil service and contract staff and develop a process for tracking and managing bilingual/bicultural staff by 12/31/16 (YM).

## Phase 2 Activities (January 2017-June 2017):

- Develop and establish a 2-tier bilingual allowance policy that provides differential compensation for staff with basic and advanced bilingual skills by 3/1/17.
- Celebrate cultural holidays countywide (ongoing) (YM).
- Issue an evaluation of the cultural competence/reducing disparities program and progress toward implementing the cultural competence plan and make presentations to the Cultural Competence Committee, LAC, CFMAC, Steering Committee and Mental Health Commission no later than 6/30/17 (YM, 1,4,6,7,8,9,12,14,15,17,20).
- Launch new cultural competence trainings by 3/1/16 (YM, TL 1,1a,4,6,7,8,9,12,14,).
- Implement cultural competence trainings that focus on local cultural groups in Santa Barbara via Relias by 12/31/16 (YM, TL).

# Reducing Disparities

## RD

Reducing Disparities

***NOTE: Strategic activities for fiscal year (FY) 17-18 will be developed based on feedback from various department and community stakeholders.***

### TriWest Area(s) and Findings:

#### Clinical

CO-2.3: Despite impressive improvements in the number of bilingual Spanish-speaking staff hired and the number of Latino/Hispanic people served each year, significant disparities related to race, ethnicity and culture persist.

### Key Indicators of Success:

- Departmental cultural competency trainings will be incorporated into Relias
- Implementation of the Cultural Competence Plan
- Increased ability of clinical staff to work with consumers from diverse populations
- The Organized Delivery System (ODS) plan's programs/services will be culturally competent.
- Quarterly bilingual/bicultural staffing level reports presented to Leadership Team
- Acknowledge and celebrate cultural holidays
- Increased access to services for clients with limited English proficiency
- Services to identified culturally discrete groups will represent prevalence of mental illness/substance use in that subset. NIMH – National Institute of Mental Health
- Implementation of 2-tier bilingual allowance policy
- Distribution of Cultural Competency Plan and Reducing Disparities progress reports

### Objective Leads

Yaneri Muñoz  
Talia Lozipone

# Achieving Clinical Excellence

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Excellence

## TriWest Area(s) and Findings:

### Clinical

CO-2.2: Access to care in general is inadequate and decreasing over time.

CO-2.4: Detailed clinical policies are lacking to guide routine clinical service delivery, including uniform standards for initial and continued access to care by level of care, standards to guide transitions between levels of care, and functioning of interdisciplinary teams.

CO-2.5: Access to specialized supports for people with complex needs is lacking.

### Objective Leads

Suzanne Grimesey  
Elisa Gottheil  
Deana Huddleston  
Ole Behrendtsen  
Ana Vicuña  
Yaneri Muñoz  
April Howard  
Christine Cole  
Laura Zeitz  
Leslie Lundt  
Marshall Ramsey  
Stacy McCrory

## Challenge:

Clinical policies and procedures are not standardized across service sites and regions.

## Strategy:

Implement the Mental Health Services Act (MHSA) Plan Update, which defines a reconfiguration of all outpatient clinics into behavioral service sites featuring specialized teams guided by the principles of the MHSA and using evidence-based clinical practices. Also, adopt county-wide behavioral health clinical standards, policies and procedures to ensure consistency.

## Phase 1 Activities (July 2016-December 2016):

- Provide a dedicated resource for the standardization of the Assertive Community Treatment (ACT) fidelity model in Santa Barbara by 8/31/16 (SG).
- Ensure all clinicians complete latest Assessment and Treatment Planning training by 12/31/16 (SS, DH).
- Provide documentation and note review training to clinical supervisors and managers by 12/31/16 (DH, SS).
- Develop policies and procedures surrounding clinical practices/standards and implementation and oversight of Medication Assisted Treatment (MAT) services by 12/31/16 (OB).
- Develop and approve comprehensive and standardized policies and procedures defining system-wide clinical standards - including defining level of care, staff caseloads (training, experience, client acuity), frequency of services based on disposition for services to children, transition-age youth, adults and older adults by 12/31/16 (AV, YM, 1,3,4,7, 8,9,10,12,17,18).
  - Define levels of care and transitions to lower or higher levels of care for MHSA adult programs (Co-Occurring, Medical Integration, WRR, Justice Alliance, ACT) and children's programs (TAY, RISE, Spirit, WRR) for Children's programs and provide training to all department staff by 12/31/16. (AV, SF, AP, CR)
  - Develop ASAM and transitions from lower to higher levels of care for ADP program 12/31/16 (AV, SF, AP, CR)
  - Track staff caseloads by treatment team (team-based care). Identify frequency of services based on disposition for services (based on the comprehensive assessment) by 12/31/16. (AV, SF, AP, CR)
- Modify or create assessment tools that are culturally competent and recovery based by 12/31/16 (AV, YM, DH, SS).
- Develop client performance outcomes for all clients (i.e. CANS, MORS, FSP) by 12/31/16 (AV, AH, SF, AP, CR, JE).
  - CANS/MORS/FSP will be completed on 100% of open cases. Data reports will be generated monthly to monitor compliance by 10/31/16 (Currently at 60%). (AH, AV)



- CANS/MORS data reporting that is an outcome measure over time by 12/31/16. (AH, AV)

## Achieving Clinical Excellence

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**TriWest Area(s) and Findings:**

**Clinical**

CO-2.2: Access to care in general is inadequate and decreasing over time.

CO-2.4: Detailed clinical policies are lacking to guide routine clinical service delivery, including uniform standards for initial and continued access to care by level of care, standards to guide transitions between levels of care, and functioning of interdisciplinary teams.

CO-2.5: Access to specialized supports for people with complex needs is lacking.

**Objective Leads**

Suzanne Grimesey  
Elisa Gottheil  
Deana Huddleston  
Ole Behrendtsen  
Ana Vicuña  
Yaneri Muñoz  
April Howard  
Christine Cole  
Laura Zeitz  
Marshall Ramsey  
Stacy McCrory

### Phase 1 Activities (July 2016-December 2016) *Cont'd:*

#### Crisis and Inpatient Services

- Implement High Utilizers of Multiple Systems (HUMS) Plan to target top 200 users of urgent/emergency medical, psychiatric and substance use services by 12/31/16 (AV, Crisis Action Team).
- Develop a plan to study impact of crisis system enhancements on 5150 holds and psychiatric inpatient hospital length of stay by 9/30/16 (AH).
- Provide analysis of operations of Alameda and Cottage Grove programs for enhancement and quality improvement by 8/31/16 (AH, LL).
- Expand Homeless services by 12/31/16 (CR, LZ).

### Phase 2 Activities (January 2017-June 2017):

- Implement comprehensive and standardized policies and procedures defining system-wide clinical standards for services to children, transition-age youth, adults and older adults by 6/30/17 (AV, YM, 1,3,4,7, 8,9,10,12,17,18).
- Train system staff on MAT services by 1/31/17 (JD, OB).
- Develop tracking and database mechanism of MAT users to determine successes and utilization rate by 4/30/17 (JD, MR, AH, OB).
- Create Forensic Team program manual by 3/31/17 (AV,3,10,12).
- Establish a North Crisis Stabilization Unit (CSU) program manual and train staff by 6/31/17 (or upon opening of facility) (LZ, YM).
- Implement Lompoc Crisis Residential by 6/30/17 or upon program opening (LZ).

### Phase 3 Activities (July 2017-December 2017):

- Expand Forensic Teams and Homeless services by 7/31/17 (AV, 3,4,10,12).
- Implement North Crisis Stabilization Unit (CSU) by 7/31/17 or upon program opening (LZ).

### Phase 4 Activities (January 2018-June 2018):

- Partner and collaborate with Marian Medical Center to increase the number of inpatient psychiatric beds by 50 %, or 8 beds by 1/31/18 or upon initiation of partnership. (OB, LL; 1a,4,12)
- Expand standardization of ACT fidelity model to Lompoc and Santa Maria by 1/2018 (PF, TS).

# Achieving Clinical Excellence

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## TriWest Area(s) and Findings:

### Clinical

CO-2.2: Access to care in general is inadequate and decreasing over time.

CO-2.4: Detailed clinical policies are lacking to guide routine clinical service delivery, including uniform standards for initial and continued access to care by level of care, standards to guide transitions between levels of care, and functioning of interdisciplinary teams.

CO-2.5: Access to specialized supports for people with complex needs is lacking.

### Objective Leads

Suzanne Grimesey  
Elisa Gottheil  
Deana Huddleston  
Ole Behrendtsen  
Ana Vicuña  
Yaneri Muñoz  
April Howard  
Christine Cole  
Laura Zeitz  
Leslie Lundt  
Marshall Ramsey  
Stacy McCrory

## Key Indicators of Success:

- Improved staff skills for assessment and treatment planning
- Improved quality of consumer health record documentation
- Development of policies and procedures for Medically Assisted Treatment (MAT)
- Clinical assessment tools will be modified to be recovery oriented, and adequately assess the culture and diversity factors impacting a consumers life
- Development of a plan to monitor Behavioral Wellness and contract provider client outcomes
- Development of a plan to address the needs of the High Utilizers of Multiple Systems
- Standardization of and fidelity to the Assertive Community Treatment (ACT) model in all three regions
- Expanded Crisis Response System with a North Crisis Stabilization Unit and a Lompoc Crisis Residential
- Methods developed to train staff on MAT practices and monitor outcomes
- Development of a plan to evaluate impact of crisis system enhancements on 5150s
- Completed evaluation of the effectiveness of Alameda and Cottage Grove
- Expanded forensic and homeless services countywide
- Development of a Forensic Team program manual to ensure operational consistency
- Expansion of inpatient beds capacity in North County
- Adoption of policies and procedures that define clinical care standards
- Train clinical staff on clinical care standards, evidence-based practices, policies and procedures

# Increasing Organizational Capacity



## Challenge:

The ability of the Department to support the range and quality of programs needed to fulfill its mandates requires an adequate and consistent level of funding, as well as staff, stakeholder and community trust and confidence.

## Strategy:

Strengthen critical components of administrative infrastructure, including the gathering and reporting of outcome data and client scheduling. Share outcomes for all programs with key stakeholder groups.

### Sub-category 1: Administration

#### **Phase 1 Activities (July 2016-December 2016):**

- Provide semi-annual system-wide metric outcome reports beginning 7/1/16 (AH, 1,3,4,8,9,10,12,14,17,18).
- Realign administration/operations division (allocation of contracts, MIS, facilities), including hiring vacant positions, by 7/31/16 (LW, CRI, ET).
- Hire a Contracts Manager, Human Resources Manager and Fiscal Manager by 11/7/16 (LW, AG).
- Define administrative duties of the Contracts Manager and Human Resources Manager and teams to support operations with goals addressing delays and barriers by 11/30/16. (LW)
- Produce a clear guide to clarify HR process to ensure supervisors contribute to expediting processes:
  - Identify/develop current mechanism to monitoring hiring/onboarding progress and
  - Continue onboarding checklist with timelines by 12/31/16 (LW, CA, KAS).
- Performance evaluation (EPR) improvement by changing EPRs to reflect documentation and training requirements/standards. Begin training supervisors on how to account for productivity/training in EPR by 12/31/16 (LW, AV, KAS).
- Increase timeliness and efficiency in processing of Board of Supervisor letters for docketing by 12/31/16. This will be achieved by training for contracts and leadership staff by the Clerk of the Board and the Deputy CEO (LW).
- Purchase and install state-of-the-art software/hardware (i.e. Service Now inventory of assets, helpdesk request tracking, contract management) initial limited roll-out to IT for help desk management by 12/31/16. (MR)
  - Facilities service request management solution 12/31/16. (MR, ET)
- Allocate human resources to prioritize position control, including monitoring extra help and civil service positions by 12/31/16. (LW, AV, CRI)

TriWest Area(s):

#### **Systemic**

S-3: There is a profound lack of effectively organized clinical leadership within ADMHS, and a consequent lack of clinical support to financial and compliance functions.

#### **Objective Leads**

Lindsay Walter  
Ernest Thomas  
Ana Vicuña  
April Howard  
Marshall Ramsey

# Increasing Organizational Capacity



TriWest Area(s):

**Systemic**

S-3: There is a profound lack of effectively organized clinical leadership within ADMHS, and a consequent lack of clinical support to financial and compliance functions.

**Objective Leads**

Celeste Andersen  
Marshall Ramsey  
Ana Vicuña  
April Howard  
Christine Cole

**Phase 2 Activities (January 2017-June 2017):**

- Comprehensive software application (proposed ServiceNow) to provide a solution for improving service delivery across the organization:
  - IT service desk solution fully implemented 1/31/17 (MR)
  - Streamline Human Resources Process by reviewing new technical, centralized hiring, onboarding checklist and timelines adequate support to internal human resource demands by 3/31/17. (LW)
    - Initial service desk application roll out (6/30/17) (MR, LW)
- Develop recruitment and retention plan including reviewing status and barriers, such as bilingual/bicultural staffing by 4/31/17. (LW, CRI)
- Monitor performance evaluation (EPR) process enhancements, continue training on EPRs, and report on completion rates by 6/30/17. (LW, AV)
- Present periodic progress reports on achieving strategic goals to the Mental Health Commission, the Steering Committee and the Board of Supervisors beginning 1/1/17. (AG,1,3,4,5,7,8,9,10,12,14,17,18)

**Phase 3 Activities (July 2017-December 2017):**

- Expand Service Delivery software to contract management to provide enhanced internal and external customer service by 9/30/17. (LW, MR)
- Create new administrative infrastructure by adding staff to implement Organized Delivery System (ODS), Continuum Care Reform (CCR) for Kids and ongoing support by 7/31/17. (LW)

**Phase 4 Activities (January 2018-June 2018):**

- Manage new organized delivery system with ongoing administrative support by 1/31/18. (LW)

**Sub-category 2: Compliance**

**Phase 1 Activities (July 2016-December 2016):**

- Complete training implementation of “Accessing a Welcoming and Integrated System of Care and Recovery” policy by 10/31/16 (CA, YM, AV).
- Improve proficiency with Clinician’s Gateway by expanding existing training to focus on technical skill development by 12/31/16 (CA, CC, MR).

# Increasing Organizational Capacity



TriWest Area(s):

**Systemic**

S-3: There is a profound lack of effectively organized clinical leadership within ADMHS, and a consequent lack of clinical support to financial and compliance functions.

**Objective Leads**

Chris Ribeiro  
Lindsay Walter  
Ana Vicuña  
Marshall Ramsey

## Phase 1 Activities (July 2016-December 2016) *Cont'd*:

- Support regular monitoring of the treatment plan report and review with Clinical Leads and at Team Supervisor's Training - ongoing (CA, AV, DH).
- Create a pool of expert CG users to support technical troubleshooting at all the clinic sites for the purpose of reducing problems with documentation completion by 12/31/16. (CA, AV)
- Modify or create policies addressing access, use and termination of use of the electronic system by 12/31/16. (CA, MR)
- Identify preliminary specification for Clinician Gateway Scheduler, and set timeline for development by 12/31/16. (MR)

## Phase 2 Activities (January 2017-June 2017):

- Complete initial inventory of assets (i.e. electronic equipment such as computers, laptops, printers) by 1/31/17. (MR)
- Provide an asset analysis and needs assessment by 1/31/17. (MR)
- Ensure completion of all mandatory systems trainings by 6/31/17. (TL)

## Phase 3 Activities (July 2017-December 2017):

- Create and implement a training plan for Scheduler by 7/31/17. (CA, MR)

## Phase 4 Activities (January 2018-June 2018):

- Ensure completion of all mandatory systems trainings by 6/31/18. (TL)
- Establish Compliance Audit Plan for ODS & CCR for kids programs by 6/31/18. (CA)

### Sub-category 3: Fiscal

## Phase 1 Activities (July 2016-December 2016):

- Review crisis system structure to analyze resources and sustainability by 9/31/16 (JE, AV, LL, CRi, HR, LZ)
- Review ACT programs to analyze resources, fiscal viability and sustainability by 9/31/16. (CRi, PF, TS)
- Develop and implement budgeting process involving program managers and supervisors for ongoing budget preparation by 12/31/16. (TBD)
- Develop an ODS fiscal cost structure to develop rates by 12/31/16. (CRi)
- Automate monthly billing process for all non-Medi-Cal clients (Guarantor) by 9/30/16. (CRi, MR)

# Increasing Organizational Capacity



## Phase 2 Activities (January 2017-June 2017):

- Develop a regular quarterly utilization management committee to ensure resources are targeted appropriately by 6/31/17. (CRi)
- Edit P&P to address billing for non-Medical clients by 3/31/17. (CRi)

## Key Indicators of Success:

### Administration:

- Semi-Annual Metrics Reports provided to the Board of Supervisors
- Restructure existing administrative roles to meet operational needs
- Strengthen and support the operational structure by hiring key administrative positions and define roles
- Definitions of Human Resource processes will be in place, and new contract and human resources management software will be implemented
- Improved documentation of clinical services through supervision and accountability
- Contracts and other Board of Supervisor documents will be docketed on time
- Clinical and administrative operational needs will be monitored through ongoing position control analyses
- Development of an employee retention plan
- Improved rate of on-time Employee Performance Reviews
- Improved communication about performance to key stakeholders
- Improved administrative and fiscal capacity to meet the demands of and ensure sustainability of new initiatives

### Compliance:

- Staff will be trained to the “Accessing a Welcoming and Integrated System of Care and Recovery” policy
- 90% of treatment plans will be current and active; completed on time
- Increased capacity to provide training and technical assistance to staff on clinical software utilization
- Improved regulation of the clinical software package
- Employee Performance Reviews will include documentation/training standards
- Completed asset inventory and needs assessment
- 100% of staff completed required annual trainings
- Implementation of a standardized consumer scheduling procedure

### Fiscal:

- Completed analysis of programs to determine fiscal viability and sustainability, with crisis system and ACT programs prioritized
- Continued involvement of program staff in budgeting process
- Development of cost structure for the Organized Delivery System
- The non-Medi-Cal billing policy & procedure will be revised and the process for billing non-Medi-Cal clients will be streamlined
- Quarterly meetings of the utilization management committee

### TriWest Area(s):

#### Systemic

S-3: There is a profound lack of effectively organized clinical leadership within ADMHS, and a consequent lack of clinical support to financial and compliance functions.

## Selected Behavioral Wellness Documents

### 2014

1. ADMHS Current Mission and Values (retrieved from ADMHS web site 7/14; original approval date not indicated)
- 1a. Accessing Behavioral Health Services in Santa Barbara County: System Strengths and Needs Analysis, April Howard, Ph.D., July 24, 2014
2. Draft Policy for Welcoming Access to Crisis Response and Evaluation for Clients with Co-Occurring Conditions (6/14)
3. ADMHS Quality Improvement Work Plan, FY 2014-15
4. ADMHS D Pages FY 2014-16
5. ADMHS Communications Plan (4/14)
6. ADMHS Peer Integration Framework (3/14)
7. Recommendations for the Design of Care and Recovery Centers (Change Agents 1-22-14)

### 2013

8. Santa Barbara County Behavioral Health System Vision and Guiding Principles (Steering Committee, 12/13)
9. Executive Team and Manager Commitments (12/13)
10. Planning for the Integration of MHSA and ADMHS Systems Change (PowerPoint 12/5/13)
11. Peer Action Team Proposal (approved 7/9/13)
12. TriWest Report, May 2013

### 2012

13. AOD Strategic Prevention Plan, 2012-2017

### 2011

14. ADMHS Strategic Plan FY 2011-2012

### 2010

15. ADMHS Cultural Competence Plan 2010

### 2007

16. Santa Barbara County Alcohol and Drug Program Strategic Prevention Plan, 2007-2012

### 2004

17. ADMHS Model of Care (4/04)
18. ADMHS Goals for FY 2003-2004, Winter 2004

### 2002

19. ADP Strategic Plan 2002

### 1998

20. ADMHS Five-Year Strategic Plan for Adult Services, 1998 (updated in 2004)