A. SYSTEMS OF CARE (SOC)

Mission of Health and Human Services Agency (HHSA) Mental Health Services (MHS)

The mission of the Health and Human Services Agency is: "Through partnerships, and emphasizing prevention, assure a healthier community and access to needed services, while promoting self-reliance and personal responsibility." Mental Health Services adds to that mission: "To provide quality, cost-effective mental health treatment, care, and prevention services by dedicated and caring staff to people in the service population." Under Substance Use Disorders" the mission is further enhanced: Lead the County of San Diego in reducing substance use disorders through community engagement.

Client Population Served by the Mental Health Plan (MHP)

CHILD, YOUTH & FAMILIES (CYF) SYSTEM OF CARE (SOC)

Clients who are seriously emotionally disturbed (SED), as defined below, and who are:

- Youth up to age 21,
- Clients with co-occurring mental health and substance use,
- Medi-Cal eligible and meet medical necessity,
- Indigent, and/or
- Low income/underinsured.

Seriously Emotionally Disturbed (SED) Clients:

The priority population for CYF Services, including clients seen under MHSA, is seriously emotionally disturbed (SED) children and youth. SED clients must meet the criteria for medical necessity and further are defined as follows (per California Welfare & Institutions Code Section 5600.3):

Seriously emotionally disturbed children or adolescents means minors under the age of 18 years who have a mental disorder as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance use disorder or developmental disorder, which results in behavior inappropriate to the child's age according to expected developmental norms. Members of this target population shall meet one or more of the following criteria:

(A) As a result of the mental disorder the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community; and either of the following occur:

(i) The child is at risk of removal from home or has already been removed from the home.

(ii) The mental disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment.

(B) The child displays one of the following: psychotic features, risk of suicide or risk of violence due to a mental disorder.

(C) The child meets special education eligibility requirements under Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the Government Code.

CYF SOC Principles

Children, Youth and Families Services (CYFS) programs, regardless of funding source, serve a broad and diverse population of children, adolescents, transitional youth and families throughout San Diego County. An array of services is provided through Organizational Providers, Fee For Service Providers, and Juvenile Forensic Providers. CYFS San Diego is a "System of Care" County. The System of Care is based on Child and Adolescent Service System Program (CASSP) System of Care principles and the Wraparound Initiative of the State of California (All County Information Notice 1/28/99, April 17, 1999; and SB163, Wraparound Pilot Project). System of Care Principles (May 2005) shall be demonstrated by ongoing client and parent/caregiver participation and influence in the development of the program's policy, program design, and practice demonstrated by:

- Individualized services that are responsive to the diverse populations served
- Integrates mental health and substance abuse into a behavioral health system,
- Integrates physical health for the overall advancement of health and wellness,
- Underscores the importance of natural community resources,
- Values the complexity of cultural diversity, AND
- Strengthens our commitment to youth and families

CYF SOC Values:

- **Collaboration of four sectors:** The cornerstone of the CSOC is a strong four sectors partnership between youth/families, public agencies, private organizations and education that ensure accountability to achieve System of Care (SOC) goals and quality outcomes consistent with SOC philosophy.

- **Integrated:** Among the four sector partners services are comprehensive, accessible coordinate behavioral and physical health care, provide seamless transition of care and utilize natural community supports.

- **Youth guided, family driven:** Youth and families actively participate in service delivery, planning, and program and policy development.

- **Individualized:** Services are flexible and designed to meet and build upon the unique needs, strengths and potential of each youth, and family.

- **Strength-based:** Individualized plans and services identify and utilize youth/family strengths to facilitate health and wellness.

- **Community-based**: Sector partners offer an array of services in each region and strengthen family and youth connections to neighborhood and local community resources.

- **Outcome driven**: Service delivery systems continuously improve services by measuring and evaluating outcomes and use results to modify practices.

- **Culturally Competent:** Service providers honor the diversity of cultures; address the complexities within and between cultures, and provide accessible and relevant services. Providers, Medi-Cal and Non Medi-Cal shall plan and deliver services in a manner consistent with the Children, Youth and Families System of Care philosophy and principles. Services shall be community-based and utilize family and youth functional strengths.

- **Trauma Informed:** Sector partners recognize that trauma and chronic stress influence coping strategies and behavior, respond with compassion, and commit to the prevention of re-traumatization and the promotion of self-care and resilience.

All providers are encouraged to utilize the 2019 young adult developed Trauma-Informed Care Code of Conduct. This document, created by young adults with lived experience, is intended to guide programs in developing policies and procedures related to trauma informed care, to inform trainings for staff, and to be offered to clients to outline the commitment of the program to follow trauma informed principles.

Providers shall demonstrate family partnership in the development and provision of service delivery. Providers shall also demonstrate organizational advancement of family partnership in the areas of program design, development, policies and procedures, etc.

All facilities shall comply with the requirements of the Americans with Disabilities Act (ADA) and California Title 24.

Measuring outcomes is an integral aspect of System of Care principles. Standard outcomes have been established for all CYFS providers. *Specialized programs may have individual program outcomes either in addition to or in lieu of standard outcomes measured by all programs.* These system goals are tracked and reported as system wide outcomes in an annual report.

CYF Goals

Programs shall provide developmentally appropriate clinical services described herein to accomplish the following goals:

- Maintain client safely in their school and home environment
- Reduce recidivism related to criminal habits and activities
- Increase school attendance and performance resulting in a higher rate of successful completion of their educational program (with high school diploma or equivalent)
- Improve client's mental health functioning at home, school, and in the community
- Increase the individuality and flexibility of services to help achieve the client and family's goals
- Increase the level and effectiveness of interagency coordination of services
- Increase the empowerment of families to assume a high level of decision-making in all aspects of planning, delivering, and evaluation of services and supports

Outcome Objectives

All treatment providers shall achieve the outcome objectives as found in the Data Requirements section of this handbook.

FAMILY & YOUTH PARTNERSHIPS

Family Youth Professional Partnership embodies a set of values, principles, and practices critical to achieving optimal outcomes for children, youth and their families served in the Behavioral Health Services (BHS) CYF SOC. The concept and role of Youth and Family Support Partners (Y/FSP) was developed through a community process. In various settings, family and youth serve on advisory groups, make presentations, act as trainers, and provide direct, billable service to families and youth clients within the CYF SOC. In addition, Youth/Family Partners (Y/FSP) advise Behavioral Health Administration and other agencies' leadership teams regarding policy and programmatic issues and work with CYF providers. These efforts result in improved responsiveness to family and youth and increased awareness of agency, family and youth cultures as well as family's sense of ownership of their child's treatment plans.

Y/FSPs have firsthand experience as a child or youth or a parent/caregiver of a child/youth that is receiving or has received services from *public agencies serving children* systems in delivering culturally relevant services and increase a family's and/or youth's ability to:

- Access and/or engage in services and resources.
- Foster their ability to gain greater self-sufficiency.
- Enhance navigation to community supports and relationships.
- Reduce stigma associated with behavioral health services and/or diagnosis.

Types of Youth or Family Partners:

Youth or Family Partner: An overarching term for an individual with experience as a child or youth or a parent/caregiver of a child/youth who is or has received services from a public agency serving children and families. Youth & Family Partner roles may include, but are not limited to Administrative, Advocacy/Community Engagement, Training and Supervision, Support Partners (direct service), Peer to Peer; and Outcome and Evaluation activities.

Youth Support Partner (YSP): An individual that has experience as a child/youth receiving services from a public agency serving children, youth and families and who is employed full or part time to provide direct (potentially billable) services to a child, youth, or family receiving behavioral health services.

Family Support Partner (FSP): An individual with experience as a parent/caregiver of a child/youth that has or is currently receiving services from a public agency serving children/families and who is employed full or part time to provide direct (potentially billable) services to a child, youth, or family receiving behavioral health services.

Y/FSP AS DIRECT SERVICE PROVIDERS

Through system reform the value and benefits of Youth and Family Support Partners was identified. Support Partners do not require a professional license, but have firsthand experience in navigating a *public agency serving children* as well as specific training in the supportive role. Title 9, Chapter 11 of the California Code of Regulations governs the provision of services to Medi-Cal eligible clients and its provisions determine San Diego County Behavioral Health Services (BHS) policy regarding service provisions to all clients, however funded. Title 9 allows the provision of direct service, with appropriate billing, by staff who are unlicensed and appropriately supervised when they are providing Rehabilitation (MHS-Rehab), Case Management/Brokerage (CMBR), Intensive Care Coordination (ICC), and Intensive-Home Based Services (IHBS) to an identified client and his or her collateral persons such as family members, when these services are connected to the child/youth's Client Plan goal(s).

Y/FSP: SELECTION, TRAINING AND SUPERVISION

The process for employment and supervision of Youth/Family Support Partners (Y/FSPs) as follow:

1. Selection of Y/FSPs: YSPs must be at least 12 years of age, meet work permit requirements and be no older than 25 years of age. FSPs must be at least 18 years of age and have high school diploma or equivalent. They must have direct experience a parent or caregiver of a child and/or youth (current or past) in a public agency serving children, youth and families.

2. Training: Minimum Curriculum should include the role and function of the Y/FSP, the role of supervision, basic knowledge of Principles of Family Youth Professional/System Partnership, Pathways to Well Being / Katie A, Children's System of Care (CSOC), community and system resources to which youth/family may be referred. This also includes the safety, cultural competency, boundaries and dual relationships, Systems' Mandate or introduction to peripheral systems on the child/youth's continuum of care Mandated Reporting confidentiality, documentation requirements, conflict resolution and effective listening. Other training as specified by employer or BHS-CYF.

3. Supervision: Y/FSP must receive individual supervision at least once a month to ensure quality services, but not less than one hour per 10 hours of direct service provided. Peer to Peer Support Partner Supervision outside of one's employer may provide mutual support, continuing education, and promote fidelity to the role of a FYSP and the Principles of Family Youth Professional Partnership.

Operational Guidelines for Youth/Family Support Partners(Y/FSPs):

- Y/FSPs shall not be employed by the agency where they or their families are currently receiving services.
- Productivity: For each full time equivalent (FTE) Y/FSPs, a minimum of 32,400 Minutes / 540 hours (30% productivity level) per year will be spent in billable services.
- Clients Choice: If client/family opts to transfer/change to different Y/FSPs, this will be recorded on the agency's Suggestion and Transfer (S&T) Log and reported in the agency's Monthly/Quarterly Status Report.
- Caseload: Y/FSPs shall carry a minimum client load of 20 unduplicated clients per FTE per fiscal year unless otherwise specified in the program's SOW.

Duties and Responsibilities of the Y/FSPs

- Attend and participate in meetings which may include Individualized Education Programs (IEP), court proceedings, and transition planning teams.
- Engage family to be active in the treatment process, attend treatment team meetings, Wrap Team Meetings, participate in Child and Family Team (CFT) meetings, assist families with referrals and locating resources, complete initial intake, needs assessment and collect outcome measures as required.
- Offer supportive counseling within scope of practice as well as facilitate skill building.
- (30% productivity level) per year of the FYSP billed services must be documented so that the activity can be tied directly to the treatment goals of the identified client leaving 70% of time.

PROVISION OF SERVICES AND CLAIMING

Services and claiming for Y/FSPs shall be classified as Rehabilitation Services (MHS-R), Case Management/Brokerage (CMBR), Intensive Care Coordination (ICC), or Intensive Home Based Services (IHBS) and limited by the individual employee's experience. Y/FSPs with additional qualifications may be eligible to provide additional services within their scope of practice.

Claiming to Other Funding Sources

Claiming to other funding sources, such as MAA (if included in the contract budget), may be possible for a different set of activities and documentation requirements may also differ. Programs are responsible for knowing the requirements of the specific funding stream if the program receives funding from sources other than CYF. Medi-Cal payments for an eligible client receiving claimable services may not be supplemented by other funding sources except as permitted in Title 9.

YOUTH & FAMILY PARTNER ROLES OTHER THAN DIRECT SERVICES

Youth and Family Partnership in the design and monitoring of the CSOC is an integral component of BHS-CYF. The youth and family Partnership should be integrated into standard system activities through numerous strategies which include:

- Youth and Family Partners with voting authority in advisory groups, e.g., Program Advisory Groups, County BHS- CSOC Council, County BHS Quality Review Council (QRC), and advisory boards of specific programs and agencies, Youth and Family service recipients as well as Youth/Family Support Partners (Y/FSP) in system audits/reviews and focus groups such as the External Quality Review (EQR).
- Involvement of Youth/Family Partner in Source Selection Committees for BHS-CYF procurements.
- Contract, policy, procedures and guidelines language that reflect current policy and procedure regarding Youth/Family Professional Partnership.
- Identify a single entity as the County BHS-CYF liaison as a key point of contact for administration partnership, dissemination of information, feedback gathering and source of Youth/Family for administrative tasks.

In addition, Family and Youth Liaison shall be included in work groups dealing with policy and program development and Quality improvement evaluations. In instances where the process involves sensitive or confidential information, Youth/Family Partners who are not current employees/consultants may be formally enrolled as volunteers to the agency and asked to sign an oath of confidentiality. Y/FP should be trainers for a broad range of professional trainings regarding children's system of care, effective practices, wraparound, P2W and other topics. Key administrators in public and private agencies should have a formal partnership relationship with a Youth/Family Administrative Partner. Staff of BHS-CYF and contracted agencies may make

themselves available for presentations and respond to the concerns of family and/or youth organizations and/or the BHS-CYF Liaison.

Youth/Family Partnership, both as direct service providers and partners for policy, program, and practice development shall be monitored. All documentation by Y/FSPs in the medical records shall be subject to annual Medical Record Reviews through the County Quality Management (QM) unit. Programs are tasked with implementing regular internal monitoring to ensure that proper documentation and claiming standards are in compliance. In addition, for items not reflected in charting, such as inclusion of Youth/Family Partners in advisory boards, planning groups, and the like, the monitoring shall be completed via review of sign- in sheets, meeting minutes and group deliverables.

ADULT/OLDER ADULT SYSTEM OF CARE

Clients who are:

- Adults ages of 18-59
- Older adults age 60 and over
- Transitional Age Youth who will be turning 18 and transitioning from the children's mental health system into the adult mental health system
- Clients with co-occurring mental health and substance use
- Medi-Cal eligible
- Indigent

and meet the following conditions may be served by the MHP:

San Diego County Adult / Older Adult Outpatient Mental Health provides recovery oriented services to promote both clinical improvement and self-sufficiency, with the goal of ultimately freeing clients of the need for our services. By definition, clients eligible for our specialty Mental Health System services are those that cannot be appropriately treated within a primary care environment, or by a primary care physician. Every effort will be made to serve clients within the Recovery oriented Mental Health System until they are either stabilized (able to function safely without Mental Health resources), or until they no longer require complex biopsychosocial services in order to maintain stability.

Individuals we serve include:

1. Individuals with a serious psychiatric illness that threatens personal or community safety, or that places the individual at significant risk of grave disability due to functional impairment.
2. People with a serious, persistent psychiatric illness who, in order to sustain illness stabilization, require complex psychosocial services, case management and / or who require unusually complex medication regimens. Required psychosocial services may

include illness management; or skill development to sustain housing, social, vocational and educational goals.

Individuals we may serve, to the extent resources allow, but who otherwise may be referred to other medical providers, include:

1. Individuals with serious psychiatric illness that may be adequately addressed in a primary care practice, either by a primary care practitioner or an affiliated mental health professional within a primary care practice setting, when the acute symptoms do not place the individual at risk of danger to self or others, and do not threaten the individual's ability to sustain independent functioning and housing within the community.
2. Individuals with lesser psychiatric illness, such as adjustment reactions, anxiety and depressive syndromes that do not cause significant, functional impairment that could be addressed within the context of a primary care setting or other community resources.

Such individuals may also have their needs addressed, either alone or in combination with medication prescribed within their primary care practice, through community supports such as supportive therapy, peer and other support groups, or self-help and educational groups. When co-occurring substance abuse is a factor, Co-occurring Disorders programs might also constitute an alternative resource.

The specialty Mental Health System will provide expedited evaluation and/or access for clients who are being maintained in the community with other resources, at such time as their condition destabilizes and they meet one of the criteria for inclusion, above. We will also provide support for the primary care community for those clients referred to primary care for maintenance in the primary care system. In order to accomplish these goals, the specialty Mental Health System will make every effort to provide:

1. Crisis screening services for individuals with acute symptoms, to provide triage to appropriate services within the specialty Mental Health System when needed.
2. Psychiatric consultation, as needed, to primary care providers for clients referred to primary care for chronic disease management after treatment in the Mental Health System.

Psychosocial Rehabilitation and Recovery

Adult/Older Adult Mental Health Services (A/OAMHS) espouses the philosophy and practices of biopsychosocial rehabilitation and recovery in its system of care.

Psychosocial rehabilitation in a recovery-oriented system helps people with mental disabilities to: (1) learn to manage the symptoms of their disorder; (2) acquire and maintain the skills and resources needed to live successfully in the community; and (3) pursue their own personal goals and recognize and celebrate their individual strengths. The service focus is on normalization and

recovery, and the person is at the center of the care planning process. Personal empowerment, the ability to manage one's disorder and move toward mastery of one's personal environment, is the path to recovery.

The psychosocial rehabilitation and recovery approach includes a variety and continuum of interventions and models, including, but not limited to, peer education, family education, clubhouses, skills development, resource development, housing support, job support, money management, and relapse prevention. Integration of this approach with needed medical services results in a comprehensive approach to recovery.

Additional information on San Diego County Systems of Care and psychosocial rehabilitation can be found in the System Redesign Implementation Plan for Adult/Older Adult Mental Health Services, 1999.

Services for Dual Diagnosis (Mental Illness and Co-occurring Substance Use Disorders)

San Diego County Adult/Older Adult Mental Health, Children, Youth and Families Services and Substance Use Disorders, recognize that clients with a dual diagnosis, a combination of mental illness and substance use disorders, may appear in all parts of the system. These conditions are associated with poorer outcomes and higher cost of care. Integrated treatment of co-occurring substance use and mental health diagnosis is recognized evidence-based practice.

The MHP has adopted the Comprehensive, Continuous, Integrated System of Care (CCISC) model that espouses a treatment and recovery philosophy that promotes the integrated treatment of clients with mental illness and substance use issues. Individuals who meet mental health treatment eligibility criteria and who also have a secondary diagnosis of substance use shall receive treatment focused on the mental health diagnosis and the impact of the substance use issue. Upon intake to a mental health program, the presence of substance use by clients shall be assessed. During treatment, substance use is reassessed on an ongoing basis and discussed with the client in terms of its impact on and relationship to the primary mental health disorder. Client Plans shall clearly reflect any services that may be needed to address the co-occurring substance use problems. Progress notes shall meet all Medi-Cal and Title 9 documentation requirements and must list a mental health diagnosis or problem as the focus of the intervention.

To support the implementation of the Dual Diagnosis Initiative, Mental Health Services recommends the development of Dual Diagnosis Capable programs. Programs participating in the CCISC Initiative shall demonstrate the following to be considered dually capable:

- San Diego Charter adoption and implementation
- COMPASS completion
- Action Plan development
- Program Policies:

  - Welcoming Policy/Statement
  - MHS Co-occurring Disorders Policy
  - Other
- Training and supervision of staff in Integrated Treatment Practice Model
- Integrated Screening
- Integrated Clinical Assessment
- Integrated Psychiatric Assessment
- Implementing Stage of Change Interventions
- Measure of client progress as evidence in the client plan and in progress notes (Outcomes: stage of change level, number of relapses, reduction of alcohol/drug use by type, number of months clean and sober, other)
- QM Baseline Monitoring Tool compliance

For additional information on the Dual Diagnosis initiative, please refer to the County of San Diego Health and Human Services Agency, Adult/Older Adult Mental Health, Children, Youth and Families Services, Substance Use Disorders, Charter and Consensus Document for Co-occurring Psychiatric and Substance Abuse Disorders, March 2003; and the County of San Diego, Mental Health Services Policy and Procedures Specialty Mental Health Services for Clients with Co-occurring Substance Use No. BHS 01-02-202 and the HHSA, Dual Diagnosis Strategic Plan, 2002.

Services to Older Adults

Older adults living with mental illness comprise a segment of the population whose co-occurring health and social problems present ongoing challenges and opportunities for providers of adult mental health services. Recognizing the compounding effects of untreated mental illness on older adults (increased risk for institutionalization, hospitalization and medical services, increased mortality and social isolation, untreated medical illnesses, as well as the barriers that prevent older adults from accessing mental health services); San Diego County has taken steps to develop the Older Adult System of Care. To that effect, an Older Adult Mental Health Strategic Plan was developed and approved by San Diego County Board of Supervisors in October 2000. The Older Adult Mental Health Strategic Plan sets forth values and principles to guide the process of implementation of this three- to five-year plan. The Older Adult Mental Health Strategic Plan describes the vision, mission, and target population and makes policy recommendations for the implementation of an integrated, coordinated Older Adult System of Care that is age appropriate, cost effective, and based on best practices.

The mission of the Older Adult System of Care is to "ensure quality, cost-effective culturally competent, age-appropriate integrated mental health treatment, care, prevention and outreach services to older adults through collaboration with consumers, advocates and other professionals and agencies working with the older adult community." Providers will participate in ongoing training regarding meeting the unique needs of our older adult clients. In addition, providers will

participate in networking efforts with providers of collateral services for older adults, in order to continue to develop the system-wide capacity to meet these clients' mental health existent and future demands more adequately.

For additional information, please refer to the California Department of Mental Health, Older Adult System of Care Framework and the San Diego County Health and Human Services Older Adult Mental Health Strategic Plan, October 2003, President's Freedom Commission Report, Older Adults, 2004.

Peer-Supported Recovery and Rehabilitation Services

As with the fields of physical disability and -substance use disorder service, there is a long history of peer support within mental health services. The County of San Diego AMHS recognizes the value of mutual support and peer counseling and encourages programs to employ qualified people who bring consumer experience to their jobs. AMHS supports the provision of consumer-provided services throughout the system of care, including, but not limited to, outpatient clinics, case management programs and clubhouses. Volunteers also offer peer recovery services, and AMHS supports programs such as NAMI's Peer to Peer and Warm Line, which offers volunteers the opportunity to use their consumer experiences to help educate and support others.

Providers shall utilize the talents of peer staff and volunteers in working with clients, as well as informing the efforts of professional staff. Providers will integrate the role of peer self-help groups, peer advocacy groups in outpatient programs and the regional Clubhouses as part of the client support system and as an adjunct to mental health services.

Homeless Outreach Services

The target population for the provision of Homeless Outreach Services are individuals who are homeless and may have a serious mental illness and/or substance use disorder. Homeless Outreach consists of the following services:

- Outreach and engagement
- Screening for mental health, physical health, and substance use disorders
- Linkage to services which may include:
    - Mental Health
    - Substance Use Disorder
    - Physical Health
    - Social Services
    - Housing
    - Employment Services
    - Advocacy
    - Other services as indicated
- Referral and placement in emergency homeless shelters

- Short-term care coordination and case management
- Coordination and collaboration with other providers to include psychiatric hospitals and other fee-for-service (FFS) providers

Homeless Outreach Workers (HOWs) respond to community requests, as directed by their COR. HOWs will be notified of any known environmental safety hazards at the time of the initial referral and program shall notify COR of any safety concerns identified during outreach. Program shall develop policies and procedures for Outreach Safety in the community. Programs are required to complete a follow up report for COR requested HOW outreach services. For an overview of the HOW services model and documentation requirements, see Appendix TBD– HOW Service Model & Data Collection Flow Chart (also available on BHS Technical Resource Library (TRL)).

Homeless Funds

Homeless incidental funds are used for client-related needs including food, clothing, transportation, and other incidentals necessary for accessing ongoing benefits.

Short Term & Bridge Housing

The homeless outreach services workers are the point of access and mange utilization of Short Term & Bridge Housing located in Central and North Regions. Participants utilizing these beds engage with the homeless outreach workers and Peer Support Specialists (through separately contracted provider) to work towards identified goals. The County's COR team reconciles the billing invoices on a monthly basis and oversees the utilization of these beds. The following is a current list of providers utilized by the homeless outreach staff:
Interfaith Community Services (M/F-North Inland)
Ruby's House (F-Central)
United Homes (M/F-North Coastal)
Urban Street Angels (TAY-M/F-Central)

Emergency Shelter Beds

The homeless outreach services workers are the gatekeepers and managers of the utilization of emergency and transitional short term shelter beds located in all the regions, with the exception of the South region. Participants utilizing these beds engage with the homeless outreach workers and Peer Support Specialists to work towards identified goals. The County's program monitor reconciles the billing invoices on a monthly basis and oversees the utilization of these beds. The following is a current list of shelters utilized by the homeless outreach staff:

Broadway Home
Center for Community Solutions
Chipper's Chalet
United Homes

MPH Guest Home
North County Interfaith Council
Volunteers of America

Staff Productivity Standard:

Outpatient programs shall meet or exceed the minimum productivity standard for annual billable and non-billable time by providing at least 64,800 minutes per year (60% productivity level), unless otherwise specified in the program's Statement of Work.

Additional References:

Regional Homeless snapshot: Data source Service Point, prepared by the regional Task force on the Homeless.

Homeless Services Profile: An update on Facilities and Services for Homeless Persons throughout San Diego County.

Blueprint for Change: Ending Chronic Homelessness for Persons with Serious Mental Illness and/or Co-occurring Substance Use Disorders, U.S. Department of Health and Human Services; Substance Abuse and Mental Health Services Administration Center for Mental Health Services; www.samhsa.gov.